

## Doctors and the medical aid industry

**To the Editor:** I respond to the comments of Dr Groenveld<sup>1</sup> from what is so unfortunately branded 'the other side'.

How sad that SAMA, the HPCSA, government, medical aids, and the public all get berated by the learned writer. How naïve (with respect) to maintain that in a R50 billion private health care industry, stakeholders as vital as doctors 'should not be required to be businessmen'. If you aren't, then don't be resentful if other stakeholders do treat it as a business.

This does not mean that the stakeholders should question each other's right to existence either, or treat health care as a zero sum game where we all fight for a bigger slice. We shouldn't aspire in South Africa to have the unregulated USA model which consumes 15% of GNP and still leaves 40 million uninsured, or the UK National Health where doctors are told exactly what to do.

So, we don't have a perfect system in South Africa, but let's at least move forward from adversarial finger-pointing, without hankering after an unrealistic utopia of unbridled freedom regardless of cost, which is not grounded in the reality of working South Africans.

Solution? Nothing simple — no right and wrong, but pragmatic stakeholders forging partnership relationships to work out a range of possibilities that give us greater access to

affordable, appropriate, cost-effective, quality care.

Let us give credit to those pioneering funders and practitioners who have risked sacrificing the comfort of armchair critic status in favour of the partly successful but promising models upon which we can base our future successes. A decade after the early acrimonious engagements we now find clinicians on both sides of the table representing IPAs and managed care organisations — talks are still tough, but no longer as naïve, arrogant or petulant.

I am not sure that our health care system can afford anything other than all of us rolling up our sleeves and jointly evolving workable answers.

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1. Groenveld PWL. Doctors and the medical aid industry (Briewe). *S Afr Med J* 2004; **94**: 140-141.

## Infant feeding and prevention of mother-to-child HIV transmission

**To the Editor:** I fail to understand how your reviewer was unable to recognise the fairly obvious flaws in the paper by Hilderbrand *et al.*,<sup>1</sup> and did not grasp the seriousness and impact of such faulty data on public perceptions of infant feeding. This error of judgement is compounded by the *Journal's* egregious running title on the cover stating: 'HIV — formula feeds increase child survival'. In fact the paper does not have child survival or mortality as an outcome, and you are merely trading on the terminology of the global revolution in child health promotion. This prominent display is both disingenuous and misleading.

I have criticisms of the methods employed to answer questions on infant feeding in HIV, and the authors' interpretation of their results. I will deal only with the latter. The single most important inference they draw from their findings is that formula feeding for infants of HIV-infected women is feasible and safe in urban environments with sufficient potable water.

However the evaluation of 'urban environments' is far more complicated than their methods allow,<sup>2</sup> and one may have rural settings where there is access to 'sufficient potable' water. Their data do not assist in deciding what is 'sufficient', so the key resource they identify is 'potable water'.

The Nairobi (urban) randomised controlled trial of breast- versus formula-feeding in infants of HIV-infected mothers<sup>3</sup> shows the weakness of their postulate. Mortality, and the incidence of diarrhoea, pneumonia and other illnesses were similar in both the breast- and formula-fed arms; nutrition was