Occupation-specific dispensation – partial solution

Our news editor, Chris Bateman, has been able to get behind the scenes in the drama of the occupation-specific dispensation (OSD) negotiations that have been one of the causes of the public sector doctors' dissatisfaction with the state.[1] The outcome of negotiations is that mid-level-category public sector doctors, least rewarded in the OSD settlement (of 7 August), will have to wait another 8 months to see whether negotiations to be re-opened for them will sweeten their packages. According to Bateman strategically placed government sources said that because of intense health budget pressures in the context of an overall economic crisis, voluntary additional money for the OSD was 'fairly unlikely'.

This whole debacle illustrates the folly of downgrading an important profession and forcing them to enter the bargaining chamber in cahoots with others (NEHAWU and DENOSA) because they lack the required numbers. Such bargaining action is akin to requiring parliamentarians, because of insufficient numbers, to team up with municipal workers to negotiate their salary packages.

The well-documented denigration of medical personnel and of scientists by Mbeki and his health minister Manto Tshabalala-Msimang has been an equally important factor driving the medical profession into conflict with the state. The new minister and his deputy will require much statesmanship to heal the rifts.

Preventable tracheal stenosis

Groote Schuur Hospital experienced a marked increase in patients with tracheal stenosis. Raynham, Lubbe and Fagan[2] therefore re-examined the problem to identify new trends.

Tracheal stenosis occurs because of damage to endotracheal tissue that causes cicatricial stenosis. The cuff of the endotracheal tube (ETT) has been implicated as the main cause of tracheal injury. Tracheal stenosis can be very difficult to treat, often presenting as an airway emergency weeks or months after extubation or decannulation.

The authors identified a breakdown in correct management of intubated patients through poor monitoring of ETT cuff pressures in ventilated patients. Questions are raised about adequate ICU funding for equipment such as pressure monitors. It also raises the spectre of medico-legal action by patients who develop tracheal stenosis following intubation and ventilation when ETT cuff pressures have been inadequately monitored.

South African health – the importance of good data

Several papers in this issue of *SAMJ* deal with data related to health in South Africa. Progress has been made, but many problems remain and require ongoing attention.

In their editorial[3] Tracey Naledi and her colleagues describe their Burden of Disease Reduction Project to reduce the burden of disease and promote equity in health. This shift in thinking from facilities to a population-based approach to health demonstrates increased awareness about the crucial role of upstream factors on population health.

In a 'debate' Rob Dorrington[4] questions whether the 2008 HSRC survey indicates a turning tide of HIV prevalence in children, teenagers and the youth.

Responding to Dorrington on behalf of the HSRC, Thomas Rehle and Olive Shisana[5] assert that the survey findings are superior to modelling approaches, also quoting a great statistician: 'Essentially all models are wrong, but some are useful'. Dorrington rounds off[6] by challenging their response, but not by basing his argument on the basis of a model. He suggests that the interpretation of the results should be more cautious and scientific and prepared to acknowledge the limitations of the survey.

Two papers address the importance of death certification. The quality of cause of death certification at an academic hospital is addressed by Nojilana and colleagues.[7] They found that errors were sufficiently serious to affect identification of underlying cause for death in almost a third of cases, confirming the need to improve the quality of medical certification. An intervention study to improve death certification reported by Pieterse *et al.*[8] delivered promising results.

The IeDEA Southern Africa collaboration[9] provides the results of a massive programme to report on the national ART programme. It describes dramatically increased enrolment over time and discusses the significant benefits and problems brought about by the roll-out.

Using mathematical models Adam and Johnson[10] estimate adult antiretroviral coverage in South Africa. Mathematical models provide a simple alternative to costly surveys for estimating the change in the unmet need for treatment as the HIV epidemic progresses.

JPvN

1. Bateman C. SDO deal – a flicker of hope for mid-level doctors. *S Afr Med J* 2009; 99: 618-622.
2. Raynham OW, Lubbe DE, Fagan JJ. Tracheal stenosis: Preventable morbidity on the increase in our intensive care units. *S Afr Med J* 2009; 99: 645-646.
3. Naledi T, Househam KC, Groenewald P, Bradshaw D, Myers J. Improving data to reduce the burden of disease – lessons from the Western Cape. *S Afr Med J* 2009; 99: 641-642.
4. Dorrington R. Does the 2008 HSRC survey indicate a turning tide of HIV prevalence in children, teenagers and the youth? *S Afr Med J* 2009; 99: 631-633.
5. Rehle T, Shisana O. National population-based HIV surveys – the method of choice for measuring the HIV epidemic. *S Afr Med J* 2009; 99: 633-636.
6. Dorring ton R. Response. *S Afr Med J* 2009; 99: 636-637.
7. Nojilana B, Groenewald P, Bradshaw D, Reagon G. Quality of cause of death certification at an academic hospital in Cape Town, South Africa. *S Afr Med J* 2009; 99: 648-652.
8. Pieterse D, Groenewald P, Bradshaw D, Burger EH, Rohde J, Reagon G. Death certificates: Let's get it right! *S Afr Med J* 2009; 99: 643-644.
9. Cornell M, Technau K, Fairall L, *et al*. Monitoring the South African National Antiretroviral Treatment Programme, 2003 - 2007: The IeDEA Southern Africa collaboration. *S Afr Med J* 2009; 99: 653-660.
10. Adam MA, Johnson LF. Estimation of adult antiretroviral treatment coverage in South Africa. *S Afr Med J* 2009; 99: 661-667.