Private practice: Adapt or die

To the Editor: All doctors in private practice should be well aware that the National Health Insurance (NHI) scheme is a clear and inevitable danger. To judge from the comments of ANC luminaries, the government will probably do its usual bull-in-a-china-shop act by ramming the bill through parliament without much regard for the opinions of other stakeholders. And if the government's past form in handling health care is anything to go by, implementation of NHI in South Africa is likely to be a disaster.

With this sword hanging over our collective heads, the lack of any real debate or innovative thinking among doctors in private practice is quite astounding. The prohibitive cost of the system has indeed been pointed out, that many or most young doctors will emigrate, and that health care delivery via the NHI will be sadly ineffective – as is generally the case with state-run systems. But, so far, the ANC has given every indication that these arguments will have little influence on their decision.

Is there anything that we (and by 'we', I mean all doctors in private practice) can do to avert the coming disaster?

I believe that an important first step is to realise that unbridled medical consumerism, as is practised in South Africa today, is something that should be of the past. Globally, societies are moving away from it; even in the USA, the very heartland of capitalism, the Obama administration is trying to improve the wasteful and ineffective health care system, where a sizeable minority have no medical care at all. In South Africa, with its preponderance of indigent people, the status quo is all the more unsustainable. Let us therefore accept that changes are inevitable.

For private practice to survive, compromises will have to be made, and perhaps some profound ones at that. As an example of what I mean, consider the following suggestion: that we volunteer to help in state hospitals for a certain time period each week. It would hardly be deleterious for a practitioner to spend, say, 3 hours a week caring for indigent patients, and it could send out a powerful and positive message. Imagine what a difference it would make if private practitioners assisted widespread in public facilities, working with their characteristic efficiency! (It may also help us to rediscover our roots as doctors – the establishment of a mini-Médecins Sans Frontières …)

In addition, a gesture like this could just make the implementation of NHI superfluous or, at the very least, give us more bargaining power. I must stress, however, that (*i*) to achieve any meaningful results, such a scheme would have to be implemented on a large scale, with every private practitioner getting involved (granted, it might not be all that voluntary); and (*ii*) we will have to think of further ways to tackle the problem.

Obviously, all the other stakeholders in the health care industry will have to contribute. Private hospitals, pharmaceutical companies and well-off medical aid companies will, in the interests of their own survival, have to make some compromises.

All is not lost. But we need to initiate some action right now.

Willem Theron
Eugene Marais Hospital
Pretoria
theronpw@mweb.co.za

A fairer deal for pneumococcal vaccination

To the Editor: In South Africa, 51 300 children under 5 die each year; pneumonia is a leading cause.[1] The incidence of invasive pneumococcal disease has more than doubled in the last two decades, to >500 per 100 000 children. This rise is associated with the HIV epidemic, with 75% of cases of invasive pneumococcal disease occurring in HIV-infected children.[2]

The launch of PCV-7 as part of the primary immunisation programme in September 2008 was welcome news. However, recent negotiations by other developing countries have shown that South Africa is paying far more than it should for a sub-optimal vaccine formulation.

In September 2009, the Brazilian Government negotiated a deal to obtain GSK's 10-valent vaccine for $US17 per dose, falling to $US7 in time.[3] Despite Brazil having an almost identical GDP to that of South Africa,[4] the South African government is paying $26 per dose for Wyeth's 7-valent vaccine (in the private sector, the cost is as high as $US60 per dose). While PCV-7 covers 70% of invasive isolates and is therefore a worthwhile vaccine to roll out, PCV-10 would increase coverage to up to 85%.[5]

The usual justification given by manufacturers for the high cost of medicines and vaccines is the need to make a return on their R&D investment; but Wyeth has already netted its manufacturer over US$2.7 billion in worldwide sales of PCV-7.[6] Given that South Africa participated in the clinical development of pneumococcal vaccines,[7] it would seem reasonable that the country be accorded a fairer price, particularly because the high cost is hampering implementation in some provinces. A more affordable vaccine would encourage the provision of adequate stocks across the country and allow vaccination plans to include a catch-up strategy for older children to ensure maximum coverage.

South Africa's Department of Health can ill afford to pay for costly interventions when cheaper alternatives exist. A recent Treasury report made it clear that the health sector needed to make efforts to achieve optimal value for money; insisting on a better price for PCV would be a good place to start.

Nathan Ford

Médecins sans Frontières
Johannesburg
nathan.ford@joburg.msf.org

Daniel Berman

Access to Essential Medicines Project
Médecins sans Frontières
Geneva

Lisa Frigati

Red Cross War Memorial Children's Hospital
Cape Town

1. Chopra M, Daviaud E, Pattinson R, Fonn S, Lawn JE. Saving the lives of South Africa's mothers, babies, and children: can the health system deliver? *Lancet* 2009; 374: 835-846.
2. Zar HJ, Madhi SA. Pneumococcal conjugate vaccine – a health priority. *S Afr Med J* 2008; 98(6): 463.
3. Jack A. GSK signs lifetime deal with Brazil for pneumococcal vaccine. *Financial Times* 28 September 2009.
4. United Nations Development Programme. *Human Development Report*. New York: United Nations, 2009.
5. Von Gottberg A, de Gouvbeia L, Quan V, *et al*. Vaccine-preventable invasive pneumococcal disease, South Africa. *S Afr J Epidemiol Infect* 2007; 22: 95 (abstract 101).
6. Maggon K. *Global Vaccine Market Review 2008*. Google Knol. http://knol.google.com/k/krishan-maggon/global-vaccine-market-review-2008-world/3fy5eowy8suq3/8# (accessed 5 November 2009).
7. Klugman KP, Madhi SA, Huebner RE, Kohberger R, Mbelle N, Pierce N. Vaccine Trialists Group. A trial of a 9-valent pneumococcal conjugate vaccine in children with and those without HIV infection. *N Engl J Med* 2003; 349: 1341-1348.

A jaw for a tooth

To the Editor: I fully support the sentiments expressed by Dr N T Ospovat[1] when he criticised the Editor for producing an editorial which has little to do with medicine and much to do with politics.[2]

It is not the province of the Editor of the *SAMJ* to embark on a career of political journalism in our journal. He has abused his position as Editor and foisted upon us his naïve and bigoted political views. In most Western countries, the Editor would be asked to resign, in consequence.

He owes the medical fraternity an apology.

Charles Isaacson

Emeritus Professor of Pathology
University of the Witwatersrand Medical School
Johannesburg
charlesi@worldonline.co.za

1. Ospovat NT. A jaw for a tooth – a biased report. *S Afr Med J* 2009; 99: 546.
2. Ncayiyana DJ. A jaw for a tooth – the human rights cost of the Gaza invasion. *S Afr Med J* 2009; 99: 125.