National Health Insurance – what the people want, need and deserve!

To the Editor: At the 2008 SAMA conference ‘The Future of Health Care in South Africa – How Will It Be Provided and Funded?’, I addressed the history of South Africa’s health policy, in particular the views of the mass movements on health and access to health care, traced back to the Freedom Charter (1955). Their continued appeal for a state-run preventive health scheme, free medical and hospital care (with special attention to mothers and children) and better access to health care is highlighted in frameworks such as the Reconstruction and Development Plan (1994), the ANC’s National Health Plan for South Africa of 1994 (developed with the World Health Organization and UNICEF), the Constitution of the Republic of South Africa (1996), the White Paper for the Transformation of the Health System of South Africa (1997) and the National Health Act (2004).

National Health Insurance (NHI) was an aspiration of the people as a human right; its development was therefore inevitable. Despite detractors, this vision came to fruition in the Policy on National Health Insurance (Green Paper), gazetted on 12 August 2011. This argues for the necessity for such a system and that the NHI will ensure that ‘everyone has access to appropriate, efficient and quality health services’. It meets our constitutional obligation (Section 27: ‘[e]veryone has the right to have access to health care services ...’) and our obligation to do what is socially and morally just.

The NHI Green Paper refers to the previous government’s attempts at health care reform, e.g. the Commission on Old Age Pension and National Insurance (1928), the Committee of Enquiry into National Health Insurance (1935), Gluckman’s National Health Service (1928), the Committee of Enquiry into National Health and Social Insurance (1935), Gluckman’s National Health Service Commission (1942 - 1944), and subsequent committees and task teams of the current government. The NHI principles and objectives cannot be contested, because it underpins respect for social justice. It recommends piloting to deal with the challenge, with special emphasis on targeting the views of the mass movements on health and access to health care.

The role of the ‘community health’ nurse too should be revisited in this regard. The role of the ‘community health’ nurse too should be revised in this regard.

Much increased and appropriate production of health professionals is required. Medical and dental schools and nursing colleges are called on to take up the challenge, with special emphasis on targeting recruitment from rural areas. Together with intersectoral efforts to reduce determinants of health such as poverty alleviation, improved access to good education, water and sanitation, adequate nutrition, shelter and an enhanced social welfare network, this will improve health outcomes, impact positively on the economy and make this country better for its citizens. Congratulations to the Minister and the National Department of Health for leadership, for commitment and for initiating this policy milestone.

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Time to decriminalise drugs?

To the Editor: The editorial on the decriminalisation of drugs,1 and the debate that it sparked off,2 refer. The potential medically beneficial effects of cannabis were alluded to in the editorial. My personal dealings with a family with a child with Friedreich’s ataxia, who has skeletal deformities causing constant severe pain, have convinced me that there is a place for the medicinal use of cannabis. In this case, albeit anecdotal, the only treatment that helps is cannabis. Opioids are virtually useless and are complicated by nausea and severe constipation. After personal communications some years ago with the late Professor Frances Ames, then a senior neuropsychiatrist at Groote Schuur Hospital, cannabis was tried. It was obtained illegally, as my letters and appeals to the police chief concerned were all left unanswered. In this case, cannabis provides significant pain relief and some degree of euphoria, which helps the patient through his otherwise cheerless days. He is highly intelligent, and fully aware of his hopeless prognosis.

Unfortunately, however, the use of cannabis is, and remains, a criminal offence, even for medicinal purposes. Therefore, in this case it is technically a crime to relieve this young man’s pain. Cannabis is the only drug that helps him.

Maybe the torchbearers of a lily-white, idealistic, drug-free society must look a little deeper. This particular patient, by his own admission, would much prefer a little immune suppression, a little ‘harming of the brain’, and even death to living with unbearable and unrelenting severe skeletal pain.

Surely we need to give decriminalisation (of at least cannabis, for medicinal use) another think. It may indeed be medically criminal not to.

Alcoholism is a disease (it is surely not a crime) that will never be cured by the criminalisation of alcohol use. Drug addiction is a disease (surely it is also not a crime) that likewise cannot be cured by labelling the addict a criminal.

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Antimicrobial resistance patterns in outpatient urinary tract infections – the constant need to revise prescribing habits

To the Editor: We commend the retrospective survey of antimicrobial susceptibility at 3 Military Hospital in Bloemfontein1 and appreciate the concern about very high rates of culture-negative urine received at the laboratory. Possibly many such samples came from patients...
already receiving antimicrobials. We feel that it would have been better to screen urine samples received for culture for the presence of any antimicrobials in the sample to ensure judicious therapeutic intervention.

Recently, investigators at the Hamad Medical Corporation, Doha, Qatar, carried out antibiotic screening of 1 680 urine samples (employing Escherichia coli ATCC 25922 and Staphylococcus aureus ATCC 25923) that were being processed for culture. There were 2 494 culture-positive urine samples that included 388 samples with antibacterial substances. Among these samples were 345 sterile samples, 32 with insignificant growth samples, and 11 with mixed growth.2

Screening urine samples received at 3 Military Hospital in Bloemfontein1 would not be an insurmountable task. Antibacterial substance screening of urine samples was feasible even more than 40 years ago at the All India Institute of Medical Sciences, New Delhi,3 where screening of 426 urine samples was done by employing the standard Oxford strain of S. aureus. There was demonstrable antibacterial activity in 127 samples, accompanied by bacterial growth in 63 samples. Isolates included E. coli – 28 isolates, Klebsiella species – 13, Pseudomonas aeruginosa – 10, Proteus spp. – 6, S. aureus – 3, Alkaligenes faecalis – 2, and Streptococcus faecalis – 1. A history of prior antibiotic use could be obtained in 25 cases only, though there was no relevant information in the laboratory requisition slips. It was also possible in 7 cases to identify the antibiotics being used by the patients. The isolates in the urine samples were resistant in vitro to the prescribed antibiotics. Even with a adequate amount of antibiotic in the urine, there was little benefit to the individual.

Obviously, any sterile culture report on a urine sample from a patient with a demonstrable antibacterial activity could be erroneously unless a subsequent urine culture is found to be sterile. Laboratory personnel would not ignore patients with rather low bacterial counts in any urine sample with concurrent antibacterial activity. Such isolates might represent either a declining population of susceptible bacteria or an ascending antibiotic-resistant bacteria population.

Last but not least, any expenditure for carrying out concurrent screening for antibacterial substances in all urine samples cultured at 3 Military Hospital in Bloemfontein1 or elsewhere would be better to screen urine samples received for culture for the presence of any antimicrobials in the sample to ensure judicious therapeutic intervention.

Dr van Vuuren replies: All urine samples included in our study were processed by the National Health Laboratories Services (NHLS) in Bloemfontein. In line with standard procedure, Bacillus subtilis ATCC 6633 was used to screen for the presence of antibiotics, and a leukocyte count performed on all urine samples sent for culture at the NHLS. If there is no growth of bacteria in the presence of antibiotics, significant numbers of leukocytes warrant further investigation.

As we excluded culture-negative samples from our analysis, we obviously cannot comment on the number of samples with no growth due to the presence of antibiotics. Apart from the possibilities mentioned in our article, antibiotic administration prior to sample collection may be another cause for negative cultures.

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SAMJ News Editor Chris Bateman replies: The article was the result of a confluence of events. Firstly, several deans of medicine...