

Getting back to where it all started – the patient

How has the private healthcare environment in South Africa (or the USA for that matter) moved so far away from the majority of patients most needing it – and how does it return to the core values of affordability, caring, equity and access? The Board of Healthcare Funders conference grappled with these difficult questions at the end of July and in early August this year in the chilly shadow of Cathkin Peak in the Drakensberg – a fitting metaphor for the looming reality of National Health Insurance (NHI). Frank admissions were made about 'over-commercialisation' and harsh words were spoken to government by closed medical scheme unions, but no one had a tailor-made, one-size-fits-all template for correcting the regulatory chaos in private healthcare or fixing the cynical tender-prenurial (the national health minister's own words) state healthcare sector. The one memorable ray of hope that shone into the Champagne Sports Resort venue as the sun set on the final day was a stated mutual willingness to make NHI work via an urging from BHF leaders to members to 'get on board' and deal with this new behemoth-on-the-block, or risk disappearing forever in its shadow. Chris Bateman reviews the conference in Izindaba.¹⁻³

Poor maternal outcomes

South Africa has no reason to congratulate itself on its performance regarding maternal and perinatal outcomes. No improvement in health outcomes for the past 12 years has been shown by the National Committee for Confidential Enquiries into Maternal Deaths. Schoon and Motlolometsi examine why, in spite of efforts to improve results, South African maternal and perinatal health professionals consistently underperform.⁴

The Saving Mothers reports and others have regularly linked staff skills issues with avoidable deaths. Concerns have been raised regarding the quality of training of doctors and nurses by academic institutions. The Department of Health questions why it has to embark on in-service training of existing health workers in order to be able to render the required service needs.

The authors consider that the most devastating effect on the maternal services is the integration of midwifery as a subject in the comprehensive training programme. Since maternal outcomes depend on achieving and maintaining a high level of skill, the problem is also accentuated by a rotation system of professional nurses, resulting in incompetence in the labour wards and clinics (this problem is mirrored in the medical profession by the replacement of longer-term medical officers with rotating interns and community service doctors).

The authors conclude that the current scope and training design for maternal care are flawed and require revision if South Africa is to improve maternal health outcomes.

A practical and immediately applicable way of addressing poor maternal and perinatal outcomes is described by Woods and Theron in their comment on the paper.⁵ The use of the Perinatal Education Programme can be expanded as a well-trying and tested programme for in-service training.

Sexuality and disability

Following the blockbuster presentation of the Olympic Games in London, the Paralympic Games for the disabled drew wide support and viewing. The remarkable performances these athletes were

able to achieve against the odds posed by their circumstances were moving tributes to human grit and perseverance. Double amputee Oscar Pretorius was prominent in his appearance in the Olympics as well as in the Paralympics. Mall and Swartz address another aspect of the adjustment of the disabled to be able to function optimally in society, namely their sexuality.⁶

Historically, health practitioners have underestimated the capacities of disabled people, and from clinical encounters view disability as an illness, whereas in reality most disabled people are not ill. An optimal emancipatory approach gives maximum choice and control to disabled people in all matters in their lives, including health. This is especially pertinent in the field of sexuality and disability.

Healthcare practitioners face dilemmas in providing sexual healthcare to disabled patients. Although the HIV/AIDS epidemic has forced critical thinking about some of the issues, obstacles remain to encouraging a completely emancipatory approach. A balance must be sought, given that disabled people have a right to a healthy sexuality and should be advised of the risk of sexual abuse and HIV infection. The clinician's own discomfort is a large and hidden issue.

Point-of-care diagnosis of TB

Those of us brought up in the era of guinea pig inoculation to diagnose tuberculosis (TB) have watched with appreciation the advances in these diagnoses. The World Health Organization has recently endorsed Xpert MTB/RIF (Xpert) as a first-line diagnostic when HIV-associated TB or multidrug-resistant TB is suspected. Kate Clouse and colleagues describe their experiences in applying this technology as the initial, routine, point-of-care (POC) diagnostic for all TB suspects at an NGO-operated primary care clinic with a high HIV and TB burden.⁷

The motivation for POC technology for testing for HIV, CD4, TB, etc. is to provide same-day results, hasten treatment initiation, and avoid loss to follow-up. Placing Xpert at POC resulted in increased case detection, same-day initiation in over 80% of new cases, and knowledge of the *Mycobacterium tuberculosis* strain's susceptibility to rifampicin on the day treatment is started. Unanticipated benefits included that clinic staff were enthusiastic about same-day results, clinicians valued the ability to rapidly assess rifampicin resistance, and clinic staff requested a TB test for themselves when symptomatic. The infrastructure, instrument and human resource requirements for POC positioning of Xpert exceeded expectations. Programmes will therefore need to carefully weigh the benefits against infrastructure and human resource needs when deciding on a POC or laboratory policy for implementation of Xpert MTB/RIF.

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