

Cold comfort for NHI-wary GPs?

Western Cape GPs in private practice feel sidelined by the Western Cape health department's formalised, extended rollout of family planning and infant vaccination services via the private sector – using mainly chain-store pharmacies like Clicks and Dischem.

While admittedly *ad hoc* and relatively informal in the past, the distribution of free state family planning products and vaccines via private doctors – who mostly used them as a 'value-added' service during other consultations – allowed flexibility and reach. In overhauling the system to comply with legislation and achieve better stock control and monitoring, the department allegedly failed to take doctor considerations into account, creating a prohibitive tender-driven, bureaucratic application process which is a disincentive to the three main GP groupings. *Izindaba's* Chris Bateman spoke to their chairpersons,^[1] who said that a small dose of consultation in the planning stages could have enabled problem areas like a fairer capitation model and the financial implications of the province's insistence on a weekly 'free consult' day to be thrashed out. The province's service 'footprint' – significantly enlarged via dispensing nurses in the big pharmacies – could have been that much larger. Cold comfort for GPs already nervous as to how they'll fit into the NHI.

Further perspectives on National Health Insurance

An editorial^[2] warns of the challenges faced in implementing NHI as a result of the extant disparities in health in SA. These are acknowledged in a second editorial,^[3] and in a Forum article that moots the establishment of a Health Promotion and Development Foundation (HDPF).^[4] Matsoso and Fryatt^[5] explain how, in the first 16 months of the NHI rollout, some of these challenges are being addressed.

If financed adequately, an HDPF would pull together the government departments – national, provincial and local – involved with health, social development, transport and traffic, development planning, human settlements and education. Other key partners would include civil society, universities and research organisations such as the Medical Research Council and Human Sciences Research Council, and the private sector.

Globally, health promotion has emerged as a viable tool for comprehensive and equitable health and social development, and the proposed HPDF would undertake to: (i) support strategic thinking and advocacy on health promotion and social development issues; (ii) support special projects to further the health promotion and development agenda; (iii) conduct research and support knowledge dissemination through grants, evaluation research and knowledge translation; (iv) support sporting and cultural organisations that directly or indirectly promote health and social capital; and (v) support capacity building in health-promoting activities.

Emergency Triage Assessment and Treatment (ETAT)

The Emergency Triage Assessment and Treatment (ETAT) package was developed by the World Health Organization to address the problem of poor triage and emergency care of children in the developing world. It was specifically designed for use by health workers in busy, under-staffed and under-resourced settings.

Introduced successfully in the large national hospital in Blantyre, Malawi, ETAT accounted for a fall in the inpatient mortality rate

of 11 - 18% to 4%. In a recent multi-country trial of fluid therapy for severely ill children, an anticipated mortality of up to 20% was reduced to 10%, probably because of ETAT.^[5] Recently adapted for use at Red Cross War Memorial Children's Hospital (RCH) in Cape Town,^[6] the tool correctly identified many critically unwell children and differentiated those most likely to require admission from those likely to be able to go home. While it was confirmed as an appropriate tool for RCH, its usefulness in children presenting to district, regional and community emergency settings requires further evaluation.

Tuberculosis in healthcare workers

Colleagues from the University of KwaZulu-Natal report the experience of 62 doctors in whom tuberculosis (TB) was diagnosed between 2007 and 2009.^[7] Eighty per cent had pulmonary TB (multidrug-resistant in 4) and the remainder extrapulmonary disease. None had worked in TB clinics or wards but rather in general ward and clinic settings.

In only half was the diagnosis made on initial presentation. Some went on – unnecessarily – to computed tomography (CT) scans, upper oesophagoscopy (in a colleague complaining of dysphagia), lung function testing, bronchoscopy, tissue biopsy (of pleura, lymph node and lung), magnetic resonance imaging scans and CT angiograms, and ran into complications following invasive tests.

A third of the respondents considered defaulting on their treatment because of drug side-effects. While personal illness experiences rendered them more empathic with respect to their own TB patients, one colleague regretted entering the high-risk clinical arena and opted instead for laboratory work. The majority reported lack of infection control in the workplace and unhelpful attitudes of senior medical colleagues and administrators: 'Our own colleagues and our management show[ed] an uncaring attitude towards us!'

See also the *Izindaba* article 'One doctor's misfortune boosts TB treatment activism'.^[8]

Updated asthma management

Two guidelines on the management of asthma, in adults and children, are offered as Parts 2 and 3 of this month's *SAMJ*,^[9,10] with a contextual editorial from the country's leading physicians in the field.^[11]

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