Almost runaway technological advances have put radiology at the cutting edge of diagnostic and therapeutic healthcare, increasing its reach beyond the wildest dreams of its oldest living practitioners. Yet the government’s inability to pragmatically leverage willing private sector information technology (IT) skills and capacity has left South Africa (SA) way short of what it could potentially offer most of its patients.

With just 1.48 radiologists per 100 000 people in SA and universal healthcare coverage now a longstanding non-negotiable government priority, public/private collaboration is at the core of any success. Izindaba has learnt that a powerful vendor-neutral archiving and storage IT portal with the potential to deliver cost-effective, high-quality image reporting across primary, secondary and tertiary healthcare platforms has been on offer to government for the past 6 months – without any official ‘uptake’. Developed by the Radiological Society of South Africa (RSSA), the portal has been met with major enthusiasm and ‘head office’ lobbying by public sector radiology department chiefs – yet the private sector-managed fee-for-service instrument remains effectively on ice when it comes to 80% of the population. This while some tertiary hospitals (according to reliable Izindaba sources) sit with an annual tally of more than 100 000 black and white unreported (i.e. uninterpreted) X-rays, illustrating what an enormous difference such a referral system could make to healthcare outcomes. Any healthcare facility with a picture archiving and communication system (PACS) and sufficient bandwidth could send images to the central RSSA-managed portal for interpretation and feedback by a radiologist – empowering the state team managing the patient to render far better care.

Approached for comment, the executive director of the RSSA, Dr Richard Tuft, said the single-format portal was of international digital technology standard and ‘solves the problem of different technology being used to store and read images’. ‘We want to use the capacity of the private sector to help out the state with the reporting of images. It’s been demonstrated internationally to improve healthcare outcomes. We have this expandable virtual and potential system – but no client!’ Asked about the fee-for-service charges, he declined to give figures except to say it was ‘not a particularly high’ rate. ‘We have to pay the consulting radiologists whether they’re in the public or private sector, pay for the technology, manage the system and pay for quality control via random peer review,’ he added.

Radiology’s message to government – ‘we want to help out’

Tuft said that quality was paramount, with the consulting radiologist able to interpret whether he or she was seeing pathology. Asked what he’d do if he had a ‘magic wand’ to change things, he replied: ‘I think the biggest thing would be for the Department of Health to accept that the private sector is not automatically going to oppose the NHI – large groupings are very keen to actively assist but are
being excluded from the process. With fibre-optic networks now commonplace, technology and IT have to be absolutely paramount if the NHI is to have any chance [of succeeding].

Tuft said there is enormous expertise, proficiency and willingness ‘out there’, yet the government seemed ‘almost trying to reinvent the wheel in every possible area. We’re all working in the same direction in the same country’, he added. The RSSA had a ‘very active’ National Health Insurance standing committee that was already helping government with basic specifications for health departments at different levels of government.

What’s possible …

With radiologists (interpreting images) and radiographers (capturing images) having to upskill themselves virtually on a month-to-month basis, cross-sectional imaging today enables pinpoint diagnoses, allowing clinicians to focus treatment as never before. Taking a patient into theatre to ‘cut and see what we find’ is ancient history. Now an abnormality is detected via any one of a number of software packages: for example cardiac, anatomy and pathology. There are a host of software in radiology as an example of ‘post-processing and reconstruction’ and colour reconstructions with extremely fast acquisition times. It’s here that the focus of telemedicine was to support rural areas. ‘Tech and IT have to be number one priority for medical care generally. Images are part of it, but if a clinician wants to discuss a case with another clinician they need to send all the data possible, not just radiology images.’

Her top solutions to the current challenges were better funding and an increase in posts for radiologists and radiographers nationally, and more training of ultrasonographers – although this did not solve the ongoing outflow of her staff to the private sector. ‘Those in academic medicine and those who want to do research generally stay, though,’ she emphasised. Steve Biko Academic Hospital is 9 years into a digital system, putting it years ahead of many of its peers, although all SA’s tertiary teaching hospitals are now digital, enabling many student exams to be run digitally.

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Lockhat said that all the heads of department at every academic hospital in SA met regularly to discuss challenges and solutions, in order to create ‘a common vision and goal, and to co-ordinate teaching programmes’. She pointed to advanced ‘post-processing and reconstruction’ software in radiology as an example of astounding fast advances in her field. ‘You can improve detailed imaging of anatomy and pathology. There are a host of software packages: for example cardiac, neurological, virtual colonography, oncology tumour tracking, CT and MRI software creating exquisitely detailed images and colour reconstructions with extremely fast acquisition times. It’s here that the magic lies.’

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