News bites

International

Patents stymie access to vital nutrition

'There isn't enough Plumpy'nut, or its generic equivalents, known collectively as ready-to-use therapeutic foods (RUTFs), to meet the demand in East Africa, let alone help feed the estimated 20 million children worldwide who are extremely malnourished. The reason: Plumpy'nut, the original RUTF, is patented. That patent bars operators in North America and most of Europe from large-scale production of RUTFs that could drive down the price. Companies in developing countries, meanwhile, are allowed to produce Plumpy'nut but can't yet make it cheaply or in large quantities. That tension has spurred a vociferous debate: How can the need for affordable humanitarian relief be balanced with a profit motive that spurs innovation – and a business model that promotes industry in developing countries – but stymies more efficient production? 'It doesn't matter if people are priced out of the market for an iPad,' says Owen Barder, a senior fellow and director for Europe at the Center for Global Development. 'But it's not at all fine when it's a vaccine or Plumpy'nut.' The Plumpy'nut formula is simple … each serving comes in a foil packet. It needs no refrigeration and is ready to eat. With three daily packets of Plumpy'nut, the recommended regimen, a child can make enormous strides in just a few weeks, says Stéphane Doyon, the nutritional team leader at Doctors without Borders (MSF). What makes RUTFs truly transformative for aid organisations is the way they changed the model of care for malnutrition, allowing for treatment at home. Shifting to RUTFs also eases demands on staff in the field. The patent that protects Plumpy'nut and three similar products is owned by the French company Nutriset. The company sharply restricts patent licensing in industrialised countries, but readily licenses companies in the developing world, providing them with the technology and training they need to produce it. Generics cannot be made in or shipped to countries with local producers of Plumpy'nut. Nutriset says that by restricting licensing in industrialised countries that can manufacture its products inexpensively on a massive scale, it is protecting local producers in places like Malawi and Niger, where a lack of infrastructure limits the scale of production. That makes Plumpy'nut 10 – 15% more expensive there, according to UNICEF.

TB death rate halved – everywhere but Africa

The TB death rate is expected to be reduced by half by 2015 everywhere except Africa, where the AIDS epidemic has also fuelled a spike in TB. India and China account for about 40% of the world's TB cases. In recent years, health experts have also warned of the increasing threat of drug-resistant TB, a signal that many people with TB aren't being treated properly. Last month, officials warned that drug-resistant TB is spreading fast in Europe and that there are few drugs left to treat it. WHO estimated countries need another R7.8 billion to fund TB programmes in 2012. In the report, officials said they didn't have enough data to know whether the global outbreak of drug-resistant TB is increasing, decreasing or stable. Last year, a new rapid test for drug-resistant TB was unveiled in more than two dozen countries, allowing patients to be treated sooner and stopping the disease's spread. 'But the promise of testing more people must be matched with the commitment to treat all detected,' Mario Raviglione, the director of WHO's TB department, said. 'It would be a scandal to leave diagnosed patients without treatment.'

Africa

Cross-border co-operation vital to mitigate Africa's cholera tragedy

UNICEF is calling for a redoubling of efforts to combat one of the biggest cholera outbreaks in the history of West and Central Africa, where 85 000 cases and 2 466 deaths had been reported by the first week of October this year. In addition, case fatality rates (CFR) are unacceptably high, ranging from 2.3% to 4.7%, reaching much higher levels at district level in many countries (ranging from 1% to 22% in Cameroon, for example). Children are more vulnerable to cholera, as they dehydrate faster, and malnourished children are especially at risk. The most significant increases this year are in Chad, Cameroon and in western Democratic Republic of Congo (DRC). Aggravating matters are challenges of access, ensuring staff presence in medical facilities and establishing surveillance systems to monitor cases and numbers in parts of North-East DRC. There are three major cross-border cholera epidemic outbreaks in West and Central Africa: the Lake Chad Basin (Chad, Cameroon, Nigeria and Niger), the West Congo Basin (DRC, Congo and the Central African Republic) and Lake Tanganyika (DRC and Burundi). Smaller cholera epidemics in Benin, Cote d'Ivoire, Ghana, Guinea, Liberia and Togo are under control. UNICEF is providing treatment kits, conducting community awareness campaigns on hygiene and assisting with epidemiological surveys to ensure better targeting of control efforts. UNICEF says it is clear in this emergency that authorities can play a key role to save lives. Information exchange between cross- border districts on caseloads and population movements, as well as cross-border inspections for disinfection and chlorination are proven ways to contain the disease and save lives. The organisation called upon governments to coordinate the preparation and response not only within their borders, but to ensure close collaboration with neighbouring countries. Cross-border coordination had to be 'encouraged at all levels, from the district to the national level'. A cross-border epidemiological study covering the Lake Chad Basin (Cameroon, Chad, Nigeria and Niger) was initiated by UNICEF in 2010, and is now in its second phase. The study provides critical evidence for informing cholera prevention and response interventions, which have to be coordinated across borders. Cross-border coordination between teams in Kinshasa and Brazzaville has also been initiated for the more recent cholera outbreak in the West Congo Basin.

Nigeria: Lagos begins free mental treatment

The Lagos State Government has developed a new mental health policy that would guarantee free treatment of mental disorders at all levels of care. Giving insight into the policy, Commissioner for Health, Dr Jide Idris, said that apart from free treatment, people with mental illness will be offered referral to specialist services for further assessment, treatment and care as required. 'Mental, neurological and substance abuse account for 14% of the global burden of diseases, and in Lagos alone an average of 14% of the total population suffer from one form of mental illness or the other. These illnesses may not necessarily be psychosis but untreated minor mental illnesses which affect the quality of life.' The policy will ensure that anyone who has attempted suicide has a mental health evaluation free of charge and also develop local systems for suicide audit to learn lessons and take necessary action.

According to Idris, the objective of the State government is to sharpen the concept of recovery and define its principal features. 'We will promote, implement and adopt any appropriate and culturally acceptable method for bringing relief to those suffering from mental illness,' he added.

Private health care 'a monster'

South Africa's private health care system is a monster that will swallow the country whole, Health Minister Aaron Motsoaledi said at the early October launch of the national human resources strategy. 'People think I am mad, but the health care system wasn't always this way. Our shortage (in medical staff) is self-created. Health is a fundamental human right. And if we don't work together, this monster will swallow us whole. This is not a joke, I will talk this madness until people join the madness.'

Improving human planning, development and management was instrumental in the overhaul of the health system. The health sector needed a skilled workforce able to respond to the burden of disease and citizens' expectation of quality service. He added that a medical staff shortage was caused by poor planning by the apartheid government. 'We are suffering because of their messes. We are also creating our own messes, but we need to stop this. The country used to be fragmented by colour, but it is fragmented by economics now.'

Motsoaledi said the strategy included the revamping of existing hospitals, the creation of a new medical school, and increasing the quota of medical students accepted by universities each year. 'We need many, many, many students to increase the output of doctors. Almost three times what we have now. And even if we do this for 10 years, we still won't meet the amount of doctors that we need,' he said. 'The training of people from rural areas is important because when they finish study, they go back to practice in their areas. I did the same thing.'

Motsoaledi said many private practitioners needed to move back into the public health care sector to improve the quality of medical care and education. 'How to get these doctors back is the million dollar question. We are planning for this and we will reveal our plans soon.'

The Democratic Alliance said Motsoaledi unfairly criticised private health care. 'Resolving the health human resource crisis in South Africa will be impossible without all players in the health care sector on board,' DA MP Mike Waters said. 'The minister ... must resist the temptation to play the blame game and alienate key allies in the effort to provide a quality public health service.'

The Congress of SA Trade Unions (Cosatu) strongly agreed with Motsoaledi. 'It is not just [about] money, but the misallocation of resources, with a private health sector making rocketing profits and an underfunded and mismanaged public sector,' spokesperson Patrick Craven said.

Disabled to benefit from new tax

A new medical tax credit will come into force in March 2012, replacing the existing medical aid cap amount. This will give employees more deductions and provide extra benefits for the disabled, who currently qualify for the same cap amount as everyone else for PAYE purposes. The current cap amount allows tax payers to qualify for a deduction from their taxable income of R720 a month for each of the first two individuals that are covered by their medical aid contribution and R440 for each additional medical aid dependant when PAYE is calculated. 'With the new medical tax credit, employees paying medical aid contributions will qualify for a deduction of R216 a month from their net tax for themselves, plus an additional R216 for the first medical aid dependant and R144 for each additional dependant,' says Roy Warren, executive chairman of NuQ. He says that if the employee or any of the dependants are disabled or over 65, the employee will be entitled to a further deduction from net tax of R216 a month. 'The draft Act is ambiguously worded in respect of this additional tax credit, and it is possible that an additional R216 a month is to be allowed for each person over 65 or disabled,' he adds. Disabled employees currently qualify for the same cap amount deduction as anyone else and the fact that they are disabled is not taken into consideration when calculating PAYE. 'Of course, when their annual tax return is submitted to SARS, they will be allowed their full medical aid contribution as a deduction from income, but from March next year employers will need to keep track of all disabled employees and the dependants who are covered by their medical aid contributions,' says Warren. This could pose a challenge as there is no guidance in the draft Act as to how employers are expected to ensure that the claimed disability is genuine. Employers will also need to keep track of the ages of employees' dependants to determine whether they are under or over 65.

Expert warns of secrecy bill's influence on health care

The Protection of Information Bill would eliminate a major pillar of accountability, which would affect health care negatively, Alex van den Heever, a health economist from the University of the Witwatersrand's School of Public and Development Management has warned.

'If someone proposes a national central purchaser for health care and makes virtually all decisions including tendering secret, it would be difficult to get to the bottom of issues,' Van den Heever told delegates at the Health Association of South Africa (Hasa) conference in late September. He highlighted the need to strengthen governance and accountability structures for health systems reform in South Africa to succeed. There were many failings in the public health care structures, and that could greatly hinder any kind of reform.

Referring to media reports about alleged tender corruption by politicians in Limpopo and KwaZulu-Natal, he said despite such reports and information being widely available in the public space, there was no prompt reaction by various law enforcement agencies and supervisory structures. 'The question is: What is wrong with our supervisory structures? All these things lead to poor health outcomes,' he said.

Van den Heever added that medical aid schemes were exposed to serious governance and conflict of interest issues because of a lack

of an enforceable governance framework. The conference follows the announcement by health minister Aaron Motsoaledi early this year that the government will be rolling out the national health insurance scheme to provide affordable health coverage to all South Africans.

Early sexual activity of SA children

Many South African children are having sex for the first time when they are between the ages of 14 and 15, according to a Human Sciences Research Council (HSRC) study which recommends that parents talk to their children about sexuality from the age of five. It also revealed that out of the children who were sexually active, barely half used a condom when they last had sex. The research shows that silence on sexual issues by key figures generated misconceptions and myths, further contributing to risky sexual practices.

The HSRC recommends that the basic education curriculum be amended to include accurate and comprehensive information. About 2 000 children and their parents were interviewed in the Western Cape, Limpopo, Eastern Cape and KwaZulu-Natal for the study. Only 49% of the children said they used a condom when they last had sex. More than half said their parents had no knowledge of their sexual activity.

Chris Bateman

SINGLE SUTURE

Note well

One might wish to be ever so slightly cautious if a patient came into a consultation with a relative who seemed to be making copious notes of everything said by the doctor. One such case reached the Medical Protection Society (UK), when a patient who underwent correction of breast asymmetry later experienced complications and made a claim against her surgeon. The patient's breast surgery and follow-up couldn't be faulted, but the details of what were discussed at the preoperative consultations were scanty, with no evidence that the surgeon had warned about the possibility of infection and scarring, and the case had to be settled for a 'moderate sum'.

www.medicalprotection.org/uk