## Choices in health care spending

**To the Editor.** It is encouraging that the US Medical Director of a major drug company endorses the concept of 'accountability for reasonableness'.[1] However, the company's position cannot be accepted uncritically. Drug companies often emphasise cost-effectiveness analyses as the primary factor in deciding whether or not a new drug is 'affordable'. Thus the drug company promoting an expensive new product asserts, as in the case of Xigris, that the cost of just under US$50 000 per quality-adjusted life-year saved compares favourably with other procedures (e.g. kidney transplantation).

In our editorial[2] we rejected a narrow, technically orientated approach. We argued that although highly technical procedures such as calculations of cost-effectiveness and estimates of life-years saved are necessary, this must not be the *only* factor considered in making allocation choices. A decision about how to spend society's limited medical resources is a value judgement that specifies and balances all morally relevant factors — including distributive justice, social utility and economic efficiency — without giving any single one an *a priori* advantage.[3] In the case of an expensive new drug such as Xigris society may, when forced to make a tough choice, reasonably decide that its moral values compel saving or extending the lives of *identifiable* patients — say those afflicted with HIV/AIDS or patients who may be cured with a kidney transplant — rather than the few who could be saved by paying an equivalent amount to treat 16 patients in order to save one unidentifiable life.

Cost-effectiveness analyses based on US dollars are largely irrelevant to South Africa and other developing countries. The US alone spends more than 50% (US$1.2 trillion — 14% GDP, with per capita expenditure of almost $5 000) of the total health care expenditure in the world on 5% of the world's population. In contrast, South Africa spends about 8.1% of GDP on health care, with a public sector health services budget of US$3.4 billion in 2000/01 — about 4% of GDP, amounting to R779 per person (approximately $100 per capita). South Africa ranks 94 on the Human Development Index, not far above Zimbabwe at 117. South Africa's health administrators must be very selective about what they learn positively from recommendations from the US, and there is much negative that we can learn from them. Drugs that are affordable as a matter of course in the US and other rich nations may not be relevant or affordable in our context.

Debate such as has occurred in this and the previous issue of *SAMJ* should be encouraged. However, the discussion must be carried forward in full recognition by all stakeholders of the stark realities that face health administrators in South Africa. Demands for health services have increased exponentially, and the capacity of the public sector to proved decent quality services to all citizens has shrunk. The AIDS pandemic will exacerbate an already critical situation. It is in this context that our health administrators must assess the claims of drug companies and manufacturers, often based on data and cost-effectiveness analyses more relevant and useful in the rich countries of the developed world than in developing countries like South Africa.

**S R Benatar**
**T E Fleischer**

*Bioethics Centre*
*University of Cape Town*

1. Macias WL, Levy H. The value of innovation (Debate). *S Afr Med J* 2003; **93:** 502-503 (this issue).
2. Benatar SR, Fleischer TE. New treatments: costs, benefits and decision-making procedures (Editorial). *S Afr Med J* 2003; **93:** 433-434.
3. Beauchamp T, Childress J. *Principles of Biomedical Ethics*. 5th ed. Oxford: Oxford University Press, 2001.

## Drotrecogin alfa (activated) in South African private hospital ICUs

**To the Editor:** We wish to comment on the article by Taylor and Burns.[1] They advance several concerns with the PROWESS trial of drotrecogin alfa (activated protein C) (DroAA) in severe sepsis[2] as reasons for withholding this agent from patients covered by their medical scheme in South Africa. These concerns may be valid and have been extensively debated at both local and international congresses. However, the fact is that DroAA is accepted by the FDA in the USA and regulatory authorities in Europe as an effective treatment of severe sepsis.

Bleeding complications are an inherent risk of all drugs with anticoagulant activity, including heparins, warfarin and antiplatelet agents. Excess bleeding in trial patients has not prevented various anticoagulants from being used in the treatment of thrombotic disorders such as acute myocardial infarction and deep-vein thrombosis, especially with pulmonary embolisation. Healthy debate follows the introduction of any new intervention in medical practice but cannot be cited by funders, whose primary concern is financial rather than clinical, as an excuse to withhold even expensive treatment from deserving patients. By the current standards of evidence-based medicine, DroAA is an acceptable agent for treatment of severe sepsis.

DroAA is particularly important in the treatment of patients with meningococcal septicaemia,[3] in which situation it was available on compassionate grounds throughout the world before release. Should the agent be withheld from patients with meningococcal septicaemia, the risk of complications is dramatically increased and mortality and length of stay in the ICU and in hospital are increased. The cost of the agent in this setting will be more than offset by the reduced need for ICU and hospital care, as demonstrated by a recent case in

KwaZulu-Natal. Funders will have to assume responsibility for morbidity and mortality of patients with meningococcal septicaemia for whom they choose to deny treatment with DroAA.

DroAA has been used in South Africa to treat patients with severe sepsis who are potentially salvageable but failing to improve or deteriorating despite best supportive care. The proviso that patients be deteriorating is a pragmatic stance taken by intensivists in South Africa to make sure that only the most deserving patients receive the agent. These patients are also required to meet the inclusion and exclusion criteria for the PROWESS trial.[4] Best supportive care will include appropriate source control and inotropes, lung protective ventilation, insulin and steroids as appropriate, nutrition, infection control, appropriate antibiotics and high-quality nursing care.[5] This care is best supervised by an intensivist. Despite the assertion of Taylor and Burns that there is a shortage of intensivists in South Africa, the undersigned all provide intensivist services in private hospitals throughout South Africa. We do not only care for our own patients but are available to provide advice to non-intensivist colleagues. We are all deeply aware of the impact that excessive and inappropriate use of DroAA will have on funders such as Medscheme. However, the fear of this use has not been borne out by clinical practice under intensivist supervision. None of the undersigned has treated more than three patients with APC since its release 8 months ago. Given the cost of other interventions such as cancer chemotherapy and coronary bypass surgery this hardly seems excessive or likely to impact significantly on Medscheme's ability to provide care for its beneficiaries. We would like to appeal to Medscheme and other funders that DroAA not be withheld from patients deemed appropriate by intensivists.

**R E Hodgson**

*PO Box 50247*
*Musgrave*
*4062*

**P G Williams**

*P O Box 5562*
*Weltevreden Park*
*1715*

**A P Foden**

*236 Panorama Medi-Clinic*
*Panorama*
*Cape Town*

**D Grolman**

*Suite 29*
*Sandton Medi-Clinic*
*Bryanston*
*Johannesburg*

1. Taylor B, Burns D. Should health care money in South Africa be spent on drotrecogin alfa? *S Afr Med J* 2003; **93**: 500-501 (this issue).
2. Bernard GR, Vincent JL, Laterre PF, *et al*. Efficacy and safety of recombinant human activated protein C for severe sepsis. *N Engl J Med* 2001; **344** (10): 699-709.
3. Faust SN, Levin M, Harrison OB, *et al*. Dysfunction of endothelial protein C activation in severe meningococcal sepsis. *N Engl J Med* 2001; **34**(9): 408-416.
4. Sollet J-P, Garber GE. Selecting patients with severe sepsis for drotrecogin alpha (activated) therapy. *Am J Surg* 2002; **184**(5): 11S-18S.
5. Vincent JL, Abraham E, Annane D, Bernard G, Rivers E, Van den Berghe G. Reducing mortality in sepsis: New directions. *Crit Care* 2002; **6**(S3): S1-18.

## Nocturnal enuresis guidelines

**To the Editor.** The authors and Ferring are to be congratulated on their efforts in producing a useful document to aid practitioners in the management of nocturnal enuresis and to publicise the fact that treatment is widely available.[1]

However, I feel it is inappropriate to condemn the use of tricyclic antidepressants in the treatment of this condition. Caution is understandable, but in my 15 years of treating a large number of enuretic children at Red Cross War Memorial Children's Hospital and in private practice in Cape Town, I have yet to come across a serious, irreversible side-effect related to the use of these drugs. It is true that side-effects do occur, and patients have to be counselled. It is also true that overdosage with desmopressin (DDAVP) can result in fluid overload and hyponatraemia, a potentially lethal side-effect.

One side-effect of DDAVP compared with imipramine, which the authors did not mention, is that of impoverishment. I surveyed three local pharmacies and found the average price of a month's supply of DDAVP 0.2 mg tablets to be R710.92 compared with R105.00 for Tofranil 25 mg and R29.26 for an imipramine generic. Most families would find it difficult to find R700 per month to spend on treatment of what is, in the authors' own words, a non-lethal disorder, even for a limited period.

Concerning the enuresis alarm, it is my experience that while this certainly is the best treatment, its use requires remarkable dedication on the part of the parents and the child as well as a degree of insight, understanding and acceptance of the condition that unfortunately does not exist in all families. Many parents are still of opinion that enuresis is caused by laziness or naughtiness, and a harsh and disciplinarian attitude is adopted.

Imipramine increases functional bladder capacity and improves arousal from sleep in response to a full bladder, two of the three components of the three-part model of enuresis presented by the authors. It is not a perfect drug, but it nevertheless deserves a place in the management of monosymptomatic nocturnal enuresis in South Africa.

**L D Jee**
*Consultant Urologist*

*Red Cross War Memorial Children's Hospital*
*Cape Town*

1. Van Dyk JC, Duvenage F, Coetzee LJF, *et al*. South African guidelines for the management of nocturnal enuresis. *S Afr Med J* 2003; **93**: 338-340.