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Critical Care in South Africa

Critical care in South Africa is more developed than in other parts of Africa, but faces specific challenges, especially from infectious diseases. South Africa has the highest number of people infected with HIV in the world. TB is a particular health burden, and trauma from motor accidents and interpersonal violence is also prevalent. Social support is lacking and the country also has chronic health issues such as nutrition.

Private healthcare provides an integral part of the health services at all levels including ICU. Twenty percent of the population has medical insurance, which entitles them to care in private hospitals. Private hospitals account for sixty percent of healthcare spending and employ seventy percent of medical specialists. (Hodgson and Hardcastle 2013). The public healthcare system accounts for forty percent of spending (3.7% of GDP) and thirty percent of medical specialists (Hodgson and Hardcastle 2013). Most South Africans depend on an overstrained public service (Gopalan, D 2013, pers. comm., 30 June).

In the late 1960s there were some single function units such as post-operative ventilation of cardio-thoracic cases. The first multidisciplinary unit was opened in1970. Dr Neil Goodwin, the first full time intensivist on the African continent, was brought out from Sweden to run the unit with the assistance of dedicated anaesthetic registrars. In the mid 1970s units opened all over the republic, with the first Non-White ICU opening at King Edward VIII hospital in Durban in November 1974.

The Critical Care Society of Southern Africa (CCSSA) was formally constituted in 1978 following correspondence in the South African Medical Journal. The society is for all healthcare professionals involved in Critical Care – doctors, nurses, technicians, etc. The society is instrumental in guiding the development of Critical Care in South Africa, and plays an active role in setting of standards, training, negotiations with government and private health funders. The CCSA runs an annual national conference. (Gopalan, pers. comm.)

Most doctors working in ICU are not accredited. There are about 80 intensivists in South Africa. Critical Care has been recognised as a specialty in South Africa for more than ten years, and requires two years' training after first specialising in one of the disciplines such as Anaesthesiology, Internal Medicine, Surgery, and Paediatrics (Gopalan, D 2013, pers. comm., 30 June). The Sub-Specialty Certificate in Critical Care of the College of Physicians of South Africa is recognised by the Colleges of Medicine of South Africa –and comprises a written and oral examination.

Provinces are responsible for health. Currently only three provinces approach the international recommendation of ICU beds per 100,000. (Hodgson and Hardcastle 2013). Five out of nine provinces have fewer than 1: 100,000 beds. (Hodgson and Hardcastle 2013). Most ICUs in the private sector function as open ICUs as opposed to the state sector where ICUs are closed (Gopalan, D 2013, pers. comm., 30 June). Telemedicine has a very limited role, but would be useful where care is often remote. (Gopalan, D 2013, pers. comm., 30 June).

The challenges for critical care in the country are the health burden of infectious diseases and lack of infrastructure and resources – ICU beds, personnel, equipment and drugs. Inadequate transport, portering and laboratories also make functioning extremely difficult. Distances between referral centres and the lack of appropriate transfer facilities also impede care. (Gopalan, D 2013, pers. comm., 30 June).

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