Regional Considerations – South Africa

In South Africa, we have two health care sectors – private and public.

Private psychiatry (30% of population – those with medical insurance) has access to the atypicals (with managed care restrictions). We have cloz, ris, olanz, quet, ami, zip and soon aripip available. The [IPAP algorithm] would basically be suitable for our private sector (although aripip and consta approval still pending). Although, do you really think that olanz deserves its sole status as an alternative to cloz in [node 7]?

Public psychiatry (70%) has very restricted access to atypicals. We still have to make extensive use of conventionals here. We [have] some access to risp, and very limited access to olanz, quet and ami. We do have clozapine (historically – its been available for about 25 years) – but we restrict its use to refractory and intolerant patients because firstly, it is much more expensive (i.e. not generic), and secondly, we are required to perform regular haematological monitoring (similar frequency to the USA), because neither Norvartis nor the authorities are prepared to risk possible medico-legal consequences. For the public sector, the document 'when no atypical other than cloz is available' is closest to our situation. Except, we would not use cloz as first-line. But we would use it in refractory patients at a much earlier stage.

Regarding the conventionals, we use 3 strategies to reduce EPS risk; using low-potency conventionals; co-prescribing prophylactic anticholinergics; and using a low-dose of high potency conventionals. However, although these strategies reduce acute EPS to levels closer to atypicals, the risk of TD is not reduced. We are therefore arguing for greater availability of atypicals in the public sector – on ethical rather than financial grounds.