Meetings, bloody meetings. No, I’m not swearing at you. I’m quoting John Cleese, who made a training video on how to run meetings productively. It should be compulsory viewing for any newly elected chairman! (Hint).

You might have gathered that I attend a lot of meetings. If you promise not to tell anyone, I’ll let you into a secret. Sometimes, I absolutely hate going. On occasion, it’s because I get bored very easily. When I was an intern, my tutor told me that I have a low threshold of boredom. He was quite right. At other times, I have better things to do, like write to you. It’s very frustrating when you have to go to a meeting and you know that the work is piling up on your desk and it isn’t going to go away until you sit there and do it.

However, there are times when it is absolutely worthwhile to attend meetings. The entire agenda may be fascinating or there may be one nugget of information that changes the way you think.

One such meeting was the recent Metropolitan Engage Forum. Important topics were discussed and I made copious notes. Between them, Prof Morgan Chetty of the University of KwaZulu-Natal and Sham Moodley of the Independent Community Pharmacy Association (ICPA) unknowingly wrote, or certainly influenced, this editorial. How? They both spoke at the Forum. Their topics were similar, namely using general practitioners and pharmacists, respectively, to make primary healthcare accessible to everyone.

**Putting their money where someone else’s mouth is**

Prof Chetty said something that really gripped my imagination. He tells me that it wasn’t a new thought and that he’d presented it at the BHF conference last year, but to me it was a light bulb moment. He said that the Council for Medical Schemes should include primary health care services in the prescribed minimum benefits.

(He also said that the PMBs are not sustainable and that the Risk Equalisation Fund should have been in place before the introduction of PMBs. That’s another whole discussion.)

So think about what he said about PHC services. The Ministry of Health has recognised that the only way to contain the massive costs incurred by many chronic conditions is by re-engineering the primary health care system. It makes total sense. Think about cardiovascular disease, diabetes, chronic respiratory diseases, certain cancers, human immunodeficiency virus and acquired immune deficiency syndrome. In all these examples, prevention is better than cure. The National Health Insurance discussion documents all state that we need to shift our health delivery focus from curative to preventative and rehabilitative.

In my opinion, Prof Chetty’s suggestion is spot on. The concept of PMBs is laudable. It makes perfect sense to make sure that no medical scheme member is deprived of appropriate therapy for these conditions.

But (the big “but”) what happens at primary care level? What suffers when the medical scheme member’s benefits are depleted? Obviously it’s primary care that suffers. So the “minor” ailments are ignored, because patients would need to pay for their management out of their own pockets. And when they neglect to do so, what happens to them? Yup. They may well land up in hospital, where it costs a lot more to take care of them than it would have done to ensure that the initial complaint was treated.

In fact, in his presentation, Sham highlighted the fact that many minor ailments are underdiagnosed and undertreated. “So what?”, you may ask. Think of it. What types of conditions are considered to be minor ailments? Sham quoted a UK study that identified the following complaints as accounting for 75% of the minor conditions with which patients present, namely back pain, indigestion, dermatitis, nasal congestion, headaches, constipation, migraines, acne, coughing and muscle spasms. Certainly, many can be treated in the pharmacy, and yes, many consumers pay for medicines out of their own pockets. But what are the complications that may arise from under-diagnosis or under-treatment of such ailments? Coughing alone is enough to be of concern. When any of these conditions becomes chronic, whether naturally or through neglect, the long-term implications become more costly than they would have been had the patient been counselled about the possible causes, and if necessary, referred for further investigation.

And I haven’t even mentioned screening tests, such as blood glucose and cholesterol, blood pressure monitoring or immunisation, all of which can reduce or prevent major expenditure at a later stage.

I understand the problem of a limited pool of money having to pay for everything. It’s just never going to happen. However, if the healthcare system is going to be re-engineered, maybe the medical scheme benefits should also be re-engineered. Perhaps the medical schemes and their members would benefit if attention to prevention, as well as early diagnosis and management, of illness, was given higher priority.

**Lorraine Osman**