

Response to: Prescribed Minimum Benefits complaints: A 5-year retrospective review

To the Editor: Complaints about the provision of dyslipidaemia medication according to prescribed minimum benefits conditions were the second most common category at the Council for Medical Schemes.^[1] The nature and the outcome of the complaints were not provided, but are of interest to improve the delivery of healthcare in South Africa (SA).

On behalf of the Lipid and Atherosclerosis Society of Southern Africa (LASSA), we express our concern about the suboptimal management of dyslipidaemias. Atherosclerotic cardiovascular disease (ASCVD) is now highly prevalent in developed and developing countries. Treatment of dyslipidaemia is central to the prevention of ASCVD. Control of low-density lipoprotein cholesterol (LDLC) is the most important lipid goal for ASCVD prevention. The SA guidelines^[2] have been updated because lower LDLC targets are advised.^[3] Guidelines cater well for most persons at risk of ASCVD, but those with more severe or unusual dyslipidaemias require greater expertise to make a correct diagnosis, avoid unnecessary investigations or futile treatment and to optimally utilise newer, albeit expensive, therapies. The management of these is often poorly supported, resulting in unnecessary suffering, worse outcomes of severe illnesses and raised costs due to (avoidable) complications. Diagnostic and therapeutic errors have far worse implications for patients with severe disorders. The plight of persons with familial hypercholesterolaemia (FH) in SA has been highlighted,^[4] but other lipid disorders are also affected, e.g. severe hypertriglyceridaemia and pancreatitis. At least 500 000 people are estimated to require lipidological expertise in SA. Problems with the management of severe dyslipidaemia in SA have been reported at a medical scheme^[5] and the Council for Medical Schemes.^[6] The decisions are made by staff who lack insight into the severe disorders. LASSA, which could contribute expertise, is not consulted.

While undergraduate teaching appropriately focuses on commonly encountered multifactorial cardiovascular risk with easily treatable dyslipidaemias, once qualified, medical practitioners encounter policies that incompletely support treatment. Postgraduate training in internal medicine, paediatrics, cardiology and endocrinology does not adequately prepare specialists for the management of severe disorders. The limited expertise is compounded by retirement without succession, and limited laboratory investigation in both the private and public healthcare sectors. LASSA set up courses to improve insight into disorders of lipid and lipoprotein metabolism despite progressive loss of support at tertiary healthcare institutions,

but did not attract practitioners who determine treatment policies, and therefore the concern about management remains for patients with severe lipid disorders.

An attempt to draw attention to severe dyslipidaemias at the non-communicable disease Indaba in 2022, at which the Minister of Health was expected, did not improve support for lipidology. Subsequent attempts to embark on planning with the Minister of Health and health science faculties failed. In the interests of best healthcare, it is suggested that tertiary hospitals provide specialised lipid clinics, and that one national laboratory is established to investigate patients, with good clinical expertise, to confirm the diagnosis, to provide relevant local research and to provide input into policies for best management.

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