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THE NEW APPROACH TO MEDICAL AID SOCIETIES

The recent decision of the Federal Council to extend the medical aid society movement to groups of persons which have enlisted the help of insurance companies does not seem to be clearly understood by many of our members.

At the outset it is important to understand very definitely that *no* insurance company *per se* is recognized by the Association; nor is there any present intention of recognizing them. They will continue to operate along their chosen lines, and their contract is between themselves and their patients and not with the doctor. The patient contracts with the doctor as a private individual and looks to his insurance company to provide him with the assistance for which he pays a premium.

For those who are not clear regarding the position of medical aid societies, it should be stated that any group of persons having a common interest may apply to the Medical Association for recognition as an approved society provided they can show that their members fall within the lower or middle income category, i.e. no members earn more than £2,500 gross *per annum*, the average income of members is £1,100 gross *per annum* or less, and not more than 3% earn between £1,750 and £2,500. If, in addition, the society undertakes to pay the doctor's account direct and in full if charged according to the preferential tariff for approved medical aid societies, the name of the society will probably be added to the list of approved medical aid societies. Most societies are run by commercial and industrial concerns which also attend to the business organization of their own society, but the Medical Association does not insist on this arrangement and is not greatly concerned about who carries out the bookkeeping of a society. It does insist that no directors or shareholders should make profits out of a doctor's work or a patient's misfortune and is concerned that a member should get a fair return in benefits for his subscription.

There are a number of examples of composite medical aid societies which are approved by the Medical Association, and the best known of these is probably the United Banks Medical Aid Society. In this society any organization which is registered under the Banking Act is elegible for membership and the society is really a central office which attends to the business of the medical aid society members who form the staffs of all the registered banks. The Chamber of Mines Medical Aid Society is another example, and deals with the office staffs of a number of mining houses and their many subsidiary companies. In Johannesburg the employees of a number of firms are banded together in approved societies and employ a firm of secretary/accountants to attend to their business affairs, while in Natal the Chamber of Industries Medical Aid Society conducts the affairs of its members belonging to a number of separate companies.

The Federal Council has recognized that there are a number of groups of persons in commercial and industrial organizations who fall within the income limits laid down by the Association but who, for various reasons, have not formed their own medical aid societies. If they had done so, they would no doubt have been approved by the Association. The demand for social security, which is world-wide today, has led these groups to seek the assistance of others to provide the organization and experience necessary. They have turned to the mutual, non-profit insurance companies to help them, and the insurance companies have asked that we treat these groups of persons as if they were organized like any other approved medical aid society.

It is to this that the Federal Council has agreed. The group so approved will be known by its own name and the member will have a card bearing the name of his firm under which approval has been given. As far as we are concerned the mutual, non-profit insurance companies will merely be the business managers of a number of new approved medical aid societies—neither more or less—and all those persons who fall outside the groups we have approved will be private patients, who may or may not have had the foresight to provide for their own assistance by means of indemnity in times of illness. As private patients they should be charged fees in accordance with their financial standing as is usual practice.

It should be repeated that it is not the insurance companies themselves that are to be approved, but only separate organized groups of persons who have sought help in managing their medical aid affairs and who, in all respects, conform to the Association's rules for approval. The resolutions of the Federal Council cover a wide field in an endeavour to assist persons who fall within the lower and middle income groups, and envisage approval for 'all groups' of persons who conform to our rules, whether it be a mutual, non-profit insurance company, the Medical Services Plan or any other organization which administers them on a mutual, non-profit basis. The two resolutions of the Council are as follows:

1. 'The Medical Association of South Africa agrees to cooperate with insurance organizations which provide prepaid medical care, in order to enable them to provide an adequate medical service to the public,' and

2. 'That the preferential tariff as amended from time to time be granted to all groups which can conform with the rules laid down for approval as a medical aid society, on the understanding that the organization administering them will in their turn undertake to pay the accounts of doctors direct and in full.'

There are a number of medical aid societies which were formerly approved by the Association and which chose to be taken over by mutual, non-profit insurance companies for administration purposes. By resolution of Federal Council these ceased to be approved by the Association and the members were no longer entitled to the preferential tariff. This resolution was rescinded at the recent meeting of the Council and it is possible that some of these former societies may be among the first to be recognized under the resolutions quoted above.

It should be stressed that even though a considerable number of new groups may be approved, there will always be some who will fall outside the scope of the 'medical aid society' arrangement even though they may insure themselves

against illness under one of the insurance schemes. This form of insurance, as has been mentioned, is a contract between the insurance company and the member (or patient) and there is no obligation for the company to pay the doctor, but only to indemnify the member to the extent of his cover. The Association will have no agreement in respect of these insured persons in terms of the resolutions quoted, and doctors will have to look to the patients for their fees as is the case generally in private practice. Only in the groups which are approved will there be an obligation to pay the doctor direct and in full according to the preferential tariff.

At the time of going to press, no new groups (or societies) have been approved in terms of the Council's resolutions. As soon as any are approved their names will be published in the *Journal* for general information.

,ONBELANGRIKE SIEKTES'

Daar bestaan ongetwyfeld 'n aansienlike aantal toestande wat 'n mens dikwels by pasiënte aantref, maar wat nie in enige standaard handboek beskryf is nie en wat geensins die lewensverwagting van die pasiënt beïnvloed of sy normale aktiwiteite beperk nie. Die meeste pasiënte verwag egter tog altyd 'n naam vir hul siekte en baie verwag ook 'n elementêre verklaring van wat aan die gang is.

In die tweede Lettsomiese lesing[1] vir 1959 het Richard Asher die gehoor gevra dat almal hulle hande moet opsteek wat al 'n kort, skerp, naaldagtige pyn naby die punt van die hart ondervind het wat skerp gelokaliseer is tot een plek binne die borskaswand en wat voel asof iets daaraan vaskleef. Asemhaling verskerp die pyn en die persoon voel nie geneë tot 'n diep asemhaling nie. Die pyn verskyn skielik en verdwyn binne enkele minute en, hoewel akuut, is dit nie in die minste onrusbarend nie. Meer as een derde van die gehoor het hulle hande opgesteek. Hy het voorts beweer dat die toestand nie 'n naam het nie, en dus nie 'n kliniese bestaan het nie.

Kort na die publikasie van die lesing het die Briewerubrieke in die betrokke tydskrif (*Lancet*) die aandag daarop gevestig dat die toestand wel beskryf is deur Miller en Texidor,[2,3] en in 'n latere brief bevestig Asher[4] dan ook hierdie mededeling, en verwys hy na 'n voller bespreking deur Miller en Texidor[3] in 'n onlangse publikasie. Asher[4] stel dan in die brief voor dat die naam ,Texidor's twinge' gou populêr sal wees onder die publiek en as alternatief kan ,precordial catch' gebruik word.

'n Ander toestand wat ook onlangs die aandag getrek het, is ,sluimer-rukkings' (,drowsing jerks'). Hierdie toestand van nagtelike miokloniese trekkings kom algemeen voor, en die meeste mense ondervind dit op die een of ander tyd. By sommige persone kom die toestand egter meer dikwels voor en kragtiger trekkings vind plaas. Sommige neuroloë, onder wie Symonds,[5] beskou laasgenoemde groep as 'n vorm van epilepsie—'n opvatting wat ondersteun word deur die voorkoms van duidelike epileptiese aanvalle by sommige van hierdie persone, die verbetering wat intree met antikonvulsiewe middels en die, weliswaar seldsame, elektro-ensefalografiese abnormaliteite in enkele gevalle. Oswald,[6] daarenteen, het vier gevalle tot in fyn besonderhede ondersoek en vind geen punte van verskil tussen die enkele ruk by ,normale' persone, en die trekkings wat in 'n ergere graad en meer dikwels by sommige persone voorkom nie. Hy stel voor dat geestesspanning verwant mag wees aan die veelvuldige voorkoms van hierdie trekkings, en dat dit net so wel psigogeen as epilepties mag wees. Die E.E.G.-studies in hierdie gevalle toon dan ook 'n gewysigde ontwakingspatroon eerder as 'n epileptiese ontlading.[6]

In die oorgrote meerderheid van gevalle is hierdie trekkings waarskynlik nie epilepties van aard in die kliniese betekenis van die woord nie. Die feit dat die toestand soms in aansluiting aan epilepsie voorkom, mag slegs dui op 'n groter neiging tot sinkronisasie van neuronale ontlading in epileptici as in normale persone.

Daar bestaan ongetwyfeld baie sulke verwante verskynsels waarvan die meganisme onbekend of onseker is en, omdat die verskynsels nie benoem is nie, kan ons nie van hulle praat nie en bestaan hulle dus nie as kliniese begrippe nie. Ons luister na die pasiënt se beskrywing van sy toestand, maar veronagsaam dit dan as iets wat van geen belang is nie en ons konsentreer op bestaande kliniese toestande wat wel name het. 'n Toestand wat geen naam het nie beteken (in kliniese en praktiese terme) 'n dokter wat geen raad het nie.

1. Asher, R. (1959): Lancet, 2, 359.
2. Miller, A. J. en Texidor, T. A. (1959): J. Amer. Med. Assoc., 159, 1364.
3. *Idem* (1959): Ann. Intern. Med., 51, 461.
4. Asher, R. (1959): Lancet, 2, 735.
5. Symonds, C. P. (1953): J. Neurol. Neurosurg. Psychiat., 16, 166.
6. Oswald, I. (1959): Brain, 82, 92.