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PHYSICAL FITNESS

Physical fitness implies not only the absence of disabling deformity or disease, but also a reasonable capacity for physical exercise. The value of athletic training to the athlete has been appreciated for more than 2,000 years, but the importance of adequate physical exercise for the health and welfare of the non-athlete has been generally appreciated only within the last century. With the development of urban civilization and the increasing proportion of sedentary workers, ever-increasing numbers of men and women are now exposed to the dangers of physical inactivity.

The excessively sedentary individual tends to become obese, unless the diet is correspondingly reduced, and is therefore liable to all the known complications of obesity, including arterial hypertension, coronary artery disease, diabetes mellitus, cholecystitis and arthritis. Recent surveys in the USA have shown that obese individuals have a much shorter expectation of life than those whose weight is below the mean for the community.[1] Very many cases of obesity are due to subnormal physical activity rather than to overeating.[2] Regular physical exercise is of value, not only in combating obesity, but also in maintaining muscle tone and so promoting normal function of the circulatory, respiratory, and alimentary systems. Lack of exercise may leave the individual incapable of the sudden physical efforts sometimes required even in a sedentary existence.

If physical fitness is important, it is useful to be able to estimate it. Fitness for physical exertion may be tested by determining the individual's ability to perform some standard exercise, which may range from walking upstairs to mountaineering or cross-country running. Usually a battery of tests is employed, involving a number of activities, such as running, jumping, throwing a ball, and lifting a weight.

More delicate tests involve a study of the physiological reactions to the performance of a standard laboratory exercise, such as stepping up and down on to a bench, walking or running on a treadmill, or pedalling a stationary bicycle. The responses studied may be the heart rate, arterial blood pressure, rate of oxygen consumption, or concentration of lactic acid in the blood; these parameters are less altered by exercise in the physically fit individual than in the less fit. From tests on large groups, appropriate standards may be established for each age and sex.

Physical fitness is related to mental and also to social fitness. This does not imply that the best athlete is also the most brilliant scholar and an outstanding social success, but there is a positive correlation in school children between athletic and scholastic ability, and the more athletic children achieve better social adaptation.[3]

Physical training should start in childhood and should be planned to develop strength, agility, and neuromuscular coordination. To hold the child's attention, the training must be interesting and a competitive element is usually desirable, though this must not be allowed to discourage the weaker children. Active participation in sport and regular physical training are important throughout school life, the period when the foundations of adult physical fitness are being laid, and sufficient time for these activities must be allowed in the syllabus. For older children and young adults who have access to a gymnasium, some planned gymnastic activity, such as circuit training,[4] which allows of progressive achievement in the individual's own time and within his capacity, is valuable. Older people may find social enjoyment as well as physical benefit in the activities of some organized physical training group, such as is available for women in the League of Health and Beauty. Obviously the intensity of the effort should be graded according to the individual's physical capacity, but authorities are agreed that frequent moderate exercise is more beneficial than infrequent more active exertion.

Physical training is of even greater value to the disabled than to the normal individual. Its place in rehabilitation after injury is now well established, and even patients with a permanent disability, such as paraplegia, may attain a high standard of general fitness for all forms of exercise not involving the paralysed muscles.

The communal as well as the individual aspects of physical fitness are important. Even in times of peace no community can afford to carry a large proportion of individuals who cannot perform the physical tasks of everyday life. In war the survival of a nation depends to a large extent on the physical fitness of its young men and women. The importance of this has been stressed in the USA by President Kennedy.[5] According to his report, almost 50% of young Americans who were called up during the Korean war were found to be unfit for military service.

The problem has been approached in the USA by creating a Council on Youth Fitness at Cabinet level. In the Republic of South Africa a National Fitness Council was formed this year to advise the Government on the legislative and administrative action required to promote national health through physical and mental fitness. This Council should serve a useful purpose in improving facilities for physical education and recreation, but the responsibility still rests on the individual to make use of the facilities, organized and natural, which South Africa provides for healthful and enjoyable physical activity. In doing so he may have the satisfaction of knowing that he is contributing not only to his own well-being, but also to that of the nation.

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2. Mayer, J. and Bullen, B. (1960): Physiol. Rev., **40**, 369.
3. Clarke, H. H. (1958): Education (USA), **78**, 460.
4. Adamson, G. T. and Morgan, R. E. (1954): J. Phys. Educ., **46**, 1.
5. Kennedy, J. F. (1960): *Sports Illustrated*, **13**, 26 December, p. 15.

DIE FINANSIËRING VAN MEDIESE DIENSTE

Almal wat direk of indirek by die hedendaagse mediese praktyk betrokke is, weet dat die koste van die versorging en behandeling van pasiënte gedurende die afgelope paar dekades geweldig gestyg het. Dit is 'n verskynsel wat dwarsoor die wêreld voorkom. Dit is, verder, 'n verskynsel wat op alle vlakke van die mediese praktyk voorkom, naamlik die van persoonlike mediese dienste, hospitaaldienste, en die gebruik van medisyne.

Om hierdie rede is die koste van mediese dienste in die algemeen 'n onderwerp van bespreking waar geneeshere en lede van die publiek ook al ontmoet. Om hierdie rede het ons ook byvoorbeeld onlangs die omvattende Snyman-ondersoek en verslag gehad wat die hele probleem teen 'n breë, perspektiewe agtergrond benader het. Hierdie verslag is nou 'n tyd lank al as 'n basis van bespreking beskikbaar, en dit het 'n groot bydrae gemaak ten opsigte van die stelling van die probleem en van positiewe aanbevelings.

Vir ons in hierdie land sal die jaar 1963 'n belangrike jaar wees omdat ons binnekort 'n formule sal moet vind vir die daarstelling van doeltreffende mediese hulpfondse wat dit vir alle mense moontlik sal maak om, as hulle siek is, dié soort mediese dienste te ontvang wat hulle nodig mag hê — en dit sonder om inbreuk te maak op die tradisionele soort dokter-pasiënt verhouding wat ons hoog ag. Hierdie verhouding berus op die uitgangspunt dat die pasiënt 'n vrye keuse van dokter moet hê, en dat die dokter besoldig word ooreenkomstig die kwaliteit van die dienste wat hy lewer.

Dit is nie maklik om só 'n formule te vind nie. Dit is moeilik omdat die hele ekonomiese struktuur sodanig is dat alles nie net duurder is nie, maar baie duurder. Ook is daar die feit dat ons basiese kennis, sowel as ons kennis en gebruik van tegnieke, prosedures en apparaat, sodanig toegeneem het dat dit nou baie duurder kos om 'n pasiënt grondig te ondersoek en te behandel as wat dit voorheen die geval was.

Verskeie benaderinge is in verskillende lande beraam om hierdie sentrale probleem die hoof te bied. In Brittanje, byvoorbeeld, het 'n volledige staatsmediese diens ontwikkel as deel van die sogenaamde welsynstaat. In ons land, omrede van die ekonomiese samestelling van al sy bevolkingsgroepe, en ook omrede van die basiese inslag van ons praktiserende geneeshere, sal hierdie soort stelsel nie maklik inslaan nie.

In lande soos Amerika en Kanada word die grootste deel van die bevolking gedek deur planne soos die Blue Shield en Blue Cross, aan die organisasie waarvan die geneeshere self deel het, en deur kommersiële versekering.

In Suid-Afrika het ons ons eie kenmerkende patroon ontwikkel. Die boonste klas van gegoede persone moet self betaal al kos die dienste ook al wat. Die laere klasse van mindergegoedes kan gratis of naby-gratis dienste ontvang van private, provinsiale of staatsbronne. En die middelste klasse kan gedeeltelik self betaal en/of gehelp word deur mediese hulpfondse, bystandsfondse, mediese hulpplanne of versekering deur kommersiële maatskappye.

Ons het tot dusver nog nie daarin geslaag om 'n algemeen aanvaarde en bevredigende oplossing te vind nie. Spruitende uit die ondersoek en die aanbevelings van die Snyman-verslag is die Reinach-raad nou egter aangestel met die opdrag om metodes te probeer vind waardeur soveel persone as moontlik (om mee te begin alle Blanke landsburgers) deur vooruitbetaalde mediese hulp gedek kan word.

Hierdie ontwikkeling moet ons in essensie as gesond verwelkom. Alhoewel daar nog nie 'n groot mate van ooreenkoms tussen al die betrokke partye is nie, het hierdie ontwikkeling die hele vraagstuk van vooruitbetaalde hulp weer vloeibaar gemaak.

Ons pleidooi hier is om versigtig maar tog daadwerklik op te tree. Die heel belangrikste stap is en sal altyd bly om op die basis van volle vertroue volledige medewerking te probeer verkry en te behou tussen die Reinach-raad en die Mediese Vereniging as mondstuk van die professie.

Die hele probleem is groot en van oorwegende belang vir ons toekoms. Nie alleen moet ons 'n formule vind waardeur dit moontlik sal word om alle Blanke inwoners teen siekte te dek nie, maar ons moet ook planne beraam waardeur ons aan alle bevolkingsgroepe die soort mediese dienste sal kan verskaf waarop hulle geregtig is.

Hier is 'n taak — die fundering van die ekonomiese en praktiese aspekte van ons mediese praktyk van die toekoms — wat groot genoeg en belangrik genoeg is om ons beste kragte en oordeel te verg. Laat ons met wysheid en verstand te werk gaan in die wete dat wat ons nou beplan die patroon gaan word van die soort van mediese dienste wat ons aan onsself en ons nageslag gaan beskikbaar stel.

UROLOGICAL CONTRIBUTIONS

The issue of the *Journal* for 16 March 1963 was devoted to a number of papers presented at the Fourth Congress of the Urological Association of South Africa (M.A.S.A.), which was held in Cape Town from 19 to 23 November 1962. Owing to limitations of space we were unable to publish all the contributions submitted from the Urological Congress in that issue of the *Journal*. This week we are happy to present a further seven papers from that congress, several of them again by overseas guests of the Urological Association.

By devoting two full issues of the *Journal* to these papers, we highlight the importance of the congresses arranged by various groups within the Medical Association. By keeping the spirit of scientific enquiry alive in this way, our members continually add to the sum of medical knowledge. By inviting a number of British urologists to their congress, the Urological Association went further, and infused into our midst important points of view from some outstanding workers in this field.

Publication of these communications in the *Journal* of the Medical Association enables not only all urologists, but also other specialists and general practitioners who may have an interest in this subject, to keep in touch, in their own *Journal*, with many of the latest trends in this particular branch of medicine.