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CENTRAL COUNCIL FOR MEDICAL SCHEMES

The year 1963 bids fair to be one of the most important for the medical profession in South Africa. During the past two or three years two commissions have been gathering evidence on various aspects of the whole field of medical practice in South Africa — they were popularly known as the Reinach and the Snyman Commissions. These Commissions have now both completed their work and have made known their recommendations to the Minister of Health.

We are not in a position to comment authoritatively on the contents of the report of either Commission, for these reports are not yet generally available, and the Snyman Commission report, a three-volume document, will need a good deal of study when it is finally released in a form that can be usefully examined.

Flowing out of the work of these Commissions is the desire of the Government to bring uniformity into prepaid medical care and to lay down certain minimum standards for medical aid schemes.

Indeed, a Central Council for Medical Schemes has already been set up, with Dr. N. Reinach as chairman, and with ten members appointed from medical, dental, pharmaceutical, medical aid, social welfare and other interested professions and bodies. These members have been appointed by the Minister of Health in their personal capacities and not as representatives of any bodies with which they may be officially associated.

The Central Council will have the duty of bringing about a measure of uniformity among all medical aid schemes, and the professed aim is to enable all White persons to join these schemes irrespective of income.

In order to implement these far-reaching recommendations and others which it may wish to put forward, the Central Council will have to have the full cooperation of the medical profession.

We said on a previous occasion[1] that the formation of the Central Council offered a golden opportunity to put the whole problem of prepaid medical care on a sound footing in this country. As we pointed out then, for various reasons the story of the attempts to find a formula to suit all interested parties in South Africa has been an unhappy one. We strongly urged, and we reiterate this now, that there must be mutual confidence between the Medical Association (as the official voice of the medical profession) and the Central Council for Medical Schemes, so that the pitfalls of earlier attempts at organizing medical aid in its widest sense may be avoided.

In recent weeks, since rumours and hearsay evidence of the Central Council's plans accumulated, and following a somewhat tactless statement by its chairman, there has been much perturbation in medical circles. Many doctors feel or believe that the end of all private practice as we have known it is in sight. Others consider that the profession will be dictated to by the Council which, as a statutory body, will have far greater powers than the present medical aid societies or even the insurance companies which have ventured into the medical insurance field.

We believe that these signs of worry on the part of the profession are healthy in one respect — that they show that doctors are alive to possible dangers to established medical practice. On the other hand, many of the statements that have been made and have sometimes found their way into print, have been based on complete misconceptions or unfounded rumours. A case built up on the basis of such information will be shaky indeed.

There is no question, with the increase in the cost of medical services, with the very many necessary expensive special investigations, and with the high charges for nursing-home and hospital accommodation, that some form of help to the average patient in meeting these costs is required. It may well be that the Central Council will supply the answer. That answer must be found, however, in conjunction with the medical profession, on whom the success of the venture will in large measure depend.

We were therefore pleased to receive a letter from Dr. Reinach recently, which was published in the *Journal*.[2] In that letter Dr. Reinach made the point that the full cooperation of the Medical Association was sought, that no dictation as to fees or anything else was contemplated, and that 'there must be consultation and cooperation' all the way. We hope this letter has cleared the air to some extent.

A confidential draft Bill relating to legislation to make effective the changes in the medical aid system has since been sent to all Federal Councillors and to all Branch Honorary Secretaries. A special meeting of the Federal Council has been called for 29 March, at which a full and free discussion of the draft Bill (which is exactly that — a draft and subject to much modification) will take place, and an opportunity will be afforded for the Federal Council to meet Dr. Reinach and other members of the Central Council, who will answer any questions about this matter.

We hope that before the 29th of this month all Branches will have taken the opportunity of holding meetings of their members, with their Federal Councillors present, so that the views of all members of the Association can be fully expressed at the special Federal Council meeting. Obviously, there will be many points of view and many opinions, but it is hoped that as democratic a summing-up of each Branch's point of view as possible will be presented. We are sure that all will make use of this opportunity of analysing the draft Bill and the whole question of medical aid control in a constructive and responsible manner.

What the final outcome of these talks and negotiations will be, no one can forecast, but we are sure that if the spirit of consultation and cooperation asked for by Dr. Reinach is forthcoming on both sides, progress will certainly be made towards better organization of prepaid medical care and a better deal for doctors and their patients than many envisage at the moment.

This is why 1963 may be such a momentous year for medicine in South Africa. If the Central Council is able to satisfy all the parties involved in prepaid medical care, not least of whom are the doctors, then the way will be open to a solution of many of the problems of private medical practice in the context of modern society. We hope that this solution will be forthcoming and that, after this preliminary step, ways and means will be found to extend the provisions of prepaid medical aid beyond the confines of the White section of the community to those members of the non-White races who are financially able to support and make use of medical aid schemes.

Now is the time for us, as members of the Medical Association, to deliberate, in a clear-minded and responsible way, all aspects of this problem. Our Federal Council, as one of the last acts of its three-year life, can do much to pave the way for future happy relations between the profession and the Central Council. To do this will indeed be a great valedictory achievement.

1. Van die Redaksie (1963): S.Afr. Med. J., **37**, 22.
2. Correspondence (1963): *Ibid.*, **37**, 182.

AKTIEWE IMMUNISASIE TEEN TETANUS

Die doeltreffendheid van deeglike immunisasie teen siektes soos pokke, difterie en pertussis word treffend weerspieël deur die konstante afname van gevalle oor die jare heen. Uiteindelik kan gepoog word tot algehele uitwissing van hierdie siektes omdat hul voortbestaan epidemiologies van kliniese gevalle afhanklik is. Maar in die geval van tetanus is dit anders. Nooit sal ons volkome van die bron van besmetting ontslae raak nie omdat tetanusbasille in die spysverteringskanaal van diere, hoofsaaklik hoefdiere, en ook mense, voorkom. Dié hitte- en droogteweerstandige spore is wyd verspreid in die boonste lae van die grond, asook in die stof van 'n land se strate en paaie. Dit is 'n bekende feit dat veral in ons burgerlike bevolking, wat die meeste by motorongelukke betrokke is, daar nog geweldige gapings in die immunisasieskemas teen tetanus bestaan.

Uit die oogpunt van publieke gesondheid word deur heelparty lande in die wêreld vandag, veral die met groot landbougemeenskappe, ernstige pleidooie gelewer vir beskerming teen tetanus. In Ceylon word jaarliks ongeveer 1,000 pasiënte met tetanus tot hospitale toegelaat, terwyl studies, wat in 'n sekere gebied in Indië gedoen is, aantoon dat tetanus een van die 10 hoofoorsake van sterftes is. Tetanus neonatorum kom ook voor in meer as 1% van alle geboortes buite hospitale in die Dakar area van Senegal.[1] In Suid-Afrika is weinig syfers beskikbaar, maar te oordeel aan gevalle wat behandel is in opleidingshospitale in Wes-Kaapland, is die sterftesyfer aan tetanus jaarliks aansienlik hoog.

Die antwoord op so 'n probleem van volksomvang is natuurlik aktiewe immunisasie wat begin in die vroeë lewensjare en wat op effektiewe vlak gehou word met versterkerdosisse (*boosters*) wanneer skoolgaande ouderdom bereik word en wanneer die skool verlaat word. In die geval van tetanus neonatorum is die voor-die-handliggende antwoord immunisasie van alle swanger moeders, wat natuurlik sou beteken dat voorgeboortelike fasiliteite in hierdie rigting uitgebrei moet word. Tetanus toksoïed is 'n kragtige en goedkoop antigeen wat reeds langer as 4 dekades deur die werk van Ramon beskikbaar gestel is, en wat vandag met ander vaksienes soos vir difterie, pertussis en selfs tifoïed toegedien kan word. Teen die passiewe immunisasie van toediening van 1,500 - 3,000 eenhede tetanusantitoksien na besering kan egter verskeie besware geopper word:

1. Serumsiekte kan ontstaan asook 'n noodlottige anafilaktiese skok.

2. Na een dosis antitoksien sal 'n tweede dosis binne 1 of 2 jaar min of geen uitwerking hê nie, inteendeel, so 'n pasiënt is 'n goeie kandidaat vir allergiese anafilaktiese skok.

3. Sekere gevalle van tetanus ontstaan na 'n onbeduidende besering, sodat die pasiënt nie dadelik deur die geneesheer behandel word nie.

4. Vervaardiging van antitoksien is duur.

5. Dikwels is dit prakties onmoontlik om te bepaal of 'n beseerde aktief geïmmuniseerd was of nie, sodat die ongevallebeampte verplig is om 'n dosis tetanusantitoksien toe te dien.

Om 'n volledige kursus in vaksinasie aan te dui, is 'n betroubare sisteem (soos die notering op die persoonskaart, dra van 'n metaalplaatjie om die nek, of 'n klein tatoëermerkie op 'n onsigbare deel van die liggaam) nodig.

Daar is dus goeie argumente vir aktiewe immunisasie met toksoïed op groot skaal vir alle bevolkingsgroepe. 'n Pasiënt kan beskou word as immuun vir 'n periode van 6 maande na 2 inspuitings, of vir 5 jaar na 3 inspuitings. Nadat 5 - 10 jaar verloop het sonder 'n versterkerdosis, moet so 'n persoon as nie-immuun beskou word en potensieel vatbaar vir die siekte. Ons verstout ons om te sê dat die grootste persentasie van ons bevolking nie-immuun is en dat hierdie belangrike feit van gereelde versterkers vergeet word, waarskynlik omdat dit so 'n doodeenvoudige proses is! 'n Goeie skema sou wees om na immunisasie van die vroeë lewensjare, voor- en na skoolverlating, weer gereelde versterkers op 25 jaar, 30 jaar, 35 jaar, ens. te gee. Word 'n besering dan opgedoen, is slegs 'n dosis toksoïed nodig. 'n Gerusstellende feit is dat lede van die Suid-Afrikaanse leër 'n aktiewe tetanus-vaksinering ontvang. (Word hier ook aan die later noodsaaklike versterkerdosisse gedink?) Uit statistieke van gewonde troepe van die Tweede Wêreldoorlog leer ons hoé effektief hierdie vorm van immunisasie is — 'n insidensie van minder as 0·1 per 1,000 gewondes.[1]

Die voorkoms van 'n bewese geval van tetanus in die aktief-geïmmuniseerde persoon is so seldsaam dat dit publikasie regverdig.[2] Hierdie skrywer meen dat so 'n diagnose slegs met sekerheid gemaak kan word nadat onomwonde vasgestel is dat die pasiënt wel toksoïed ontvang het, dat die kliniese diagnose absoluut korrek is, en dat die moontlikheid van 'n agammaglobinemie uitgeskakel is.

Tetanustoksoïed is, saam met die vaksiene teen geelkoors, een van die mees effektiefste middels bekend, en allergiese reaksies daarteen is seldsaam. Waarom sou ons nie op groot skaal van so 'n goeie middel gebruik maak om ons teen 'n siekte wat so letaal soos tetanus is, te beskerm nie?

1. Cruickshank, R. (1961): *The Role of Immunization in Communicable Disease Control*. Geneva: W.H.O.
2. Edsall, G. (Correspondence) (1962): New Engl. J. Med., **267**, 520.