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EDITORIAL : VAN DIE REDAKSIE

THE EXTENSION OF PREPAID MEDICAL SCHEMES

The Central Advisory Council for Medical Aid Schemes was established by the Government to investigate the possibility of extending medical aid to all Whites (to begin with) in the Republic, irrespective of income, and to control these schemes. In addition to this, legislation was contemplated in which the principles on which the extension of medical aid membership to all Whites is to be based, were to be embodied.

In view of the fact that it is necessary to have a tariff in order to administer an Act of this nature, this problem was discussed at length by Federal Council at its meeting in Johannesburg in July 1963. Federal Council then decided to inform the Minister of Health that it accepted the principle of submitting both a single tariff and a dual tariff to the Government and leaving it to the Government to decide which would be adopted. The Minister subsequently made it clear that he favoured the adoption of one standard tariff.

In order to draw up an acceptable standard tariff of fees which would be applicable to all members of prepaid medical schemes, irrespective of income level, a Central Schedules Committee was appointed. A report of the activities of this Committee was published in the *Journal* of 21 November 1964, on page 903. A large number of problems relating to the standard tariff of fees arose and were discussed widely subsequent to the establishment of the Schedules Committee. The fact that this standard tariff, if it was adopted, would have been applicable to all members of the community irrespective of income level, means that a radical change in the pattern of private practice would have resulted inevitably. It would have been possible to charge private fees only for people who are not covered by any of the schemes.

Moreover it was felt, among many other considerations, that the adoption of a standard tariff would militate against the rendering of the best quality of service to all patients at all times and that it would limit the scope for the professional recognition of doctors with special skills and/or extraordinary experience—in a word, that it lacked the built-in safeguards of the private doctor-patient relationship as we have known it through the years. It is therefore not astonishing to find that the Schedules Committee has been unable at this stage to produce even a skeleton schedule.

The whole problem of the applicability of a standard tariff was again discussed by the Executive Committee of Federal Council at its recent meeting in Pretoria in November 1964. In view of the considerations mentioned and of various other developments, the Executive Committee felt that its basic approach to this problem should be changed so as to make it possible for the Minister to incorporate the principle of *a tariff* into the contemplated Bill, while at the same time accepting the principle that the tariff should only be applicable to members whose incomes are below a certain figure (to be agreed upon), and the members with incomes above that figure will be regarded as private patients subject to private fees *but that they may be indemnified as members of their schemes.* The resolutions taken by the Executive Committee of Federal Council read as follows:

'1. That the Executive Committee, having considered the urgent necessity to assist the Minister in bringing the Medical Schemes Act into force as soon as possible, is prepared to depart from the policy previously determined by Federal Council, i.e. that a *standard* tariff of fees be applied to all insured persons regardless of income.

'2. That the Minister be informed that the Association is prepared to agree that the tariff as defined in the Act, shall be the *preferential* tariff, as amended by agreement with the medical aid societies at the forthcoming joint meeting, provided however that:

(a) this tariff shall only be applicable to those members of schemes whose *taxable* incomes are below a certain figure to be agreed upon;

(b) members of schemes whose *taxable* incomes are in excess of the figure agreed upon shall be regarded by the profession as private patients subject to private fees, but may be indemnified as members of their scheme;

(c) the tariff as initially agreed upon shall not remain in force for a fixed period but shall be subject to annual review; and

(d) before any regulations are promulgated in terms of the Act, the Association be consulted in regard to the principles contained in these regulations.

'3. That the Minister be further informed that in its future requests for an amendment to the tariff the Association will utilize as a basis the standard tariff at present being devised by the Association's Actuarial Committee.'

These resolutions have been circulated to members of Federal Council, who have been requested to indicate whether or not they agree with this decision. The resolutions have also been conveyed to the Minister of Health, who has indicated that the formula contained therein is acceptable to him.

KOMITEE VIR ONDERSOEK NA DIE ONOORDEELKUNDIGE GEBRUIK VAN GEHOORAPPARATE

Soos aangekondig word in 'n brief wat in die Briewerubriek in hierdie uitgawe van die *Tydskrif* verskyn, het Sy Edele die Minister van Gesondheid besluit om 'n Komitee aan te stel om ondersoek in te stel na die onoordeelkundige gebruik van gehoorapparate. Op grond van sy bevindinge moet die Komitee dan besluit of hy voel dit geregverdig is dat beheermaatreëls oor die verkoop van sulke apparate ingestel behoort te word. Die Komitee is angstig om so veel moontlik feitlike inligting oor hierdie aangeleentheid te versamel, en met hierdie

doel voor oë word 'n uitnodiging aan alle belanghebbende partye gerig om so gou as moontlik, maar nie later nie as 20 Januarie 1965, met die sekretaris van hierdie Komitee in verbinding te tree. Sy adres is Posbus 386, Pretoria.

Die aanstelling van hierdie Komitee is 'n stap wat sonder enige twyfel die algemene goedkeuring van sowel lede van die mediese professie as van die algemene publiek sal wegdra. Die probleme van hardhorendheid en doofheid is van besondere groot belang, want die gebruik van doeltreffende hulpmiddels wat die gehoor van hardhorendes verbeter, maak 'n radikale verskil aan die hele persoonlikheid van sulke persone. Hulle word weer aktief en intellektueel betrek in die gewone alledaagse omgang, met die gevolg dat hulle in staat is om 'n meer bevredigende lewe te lei, om deel te hê aan alle voordele en genietinge wat afhanklik is van 'n goeie gehoor, en om gevolglik nie die risiko te loop van voortydige verstandelike agteruitgang nie.

Nou is dit egter 'n bekende feit dat daar 'n groot verwarring heers en ook uitbuiting voorkom ten opsigte van die koop en gebruik van gehoorapparate. Hierdie hele veld is eintlik nog ongekaart. Handelaars in gehoorapparate wat 'n goeie integriteit het en wat met geneeshere saamwerk, lewer gewoonlik betroubare dienste op hierdie gebied. Maar dit is ook bekend dat daar as gevolg van die nood van die pasiënt, aan die een kant, en die behaal van finansiële voordeel van die verkoper, aan die ander kant, dikwels uitbuiting plaasvind. Ons is almal bekend met hardhorende en dowe persone wat in die besit is van drie, vier of meer stelle gehoorapparate, geen een waarvan bevredigend vir hulle spesifieke gehoorgebrek is nie. Ook is daar 'n groot aantal persone wat gehoorapparate koop en dra op advies van handelaars—sonder dat hulle in die eerste instansie medies ondersoek is. Sommige van hierdie persone moet 'n ander soort apparaat kry as wat hulle het, en andere weer behoort glad geen apparaat te dra nie omdat hulle in die werklikheid eerder 'n operasie (byvoorbeeld vir otosklerose) moet ondergaan.

Die inligting wat op hierdie gebied beskikbaar is, is in die meeste gevalle van 'n onbetroubare en onwetenskaplike aard. Om hierdie rede is dit van die allergrootste belang om hierdie saak op 'n verantwoordelike manier te benader. Langs hierdie weg wil ons dus 'n beroep doen op alle lede van die mediese professie om so veel as moontlik en so volledig as moontlik met hierdie Komitee van ondersoek saam te werk en om hulle ook te help om enige inligting wat ter sake mag wees uit enige (selfs nie-mediese) bron te bekom.

HIGH BLOOD PRESSURE AND EMOTIONAL STRESS

In an experimental study[1] on the relation between hypertensive vascular disease and emotional stress, rats in whom emotional stress was introduced, were studied. Changes in their blood pressure values were studied in rats who were daily confronted with cats. These experiments, lasting over a period of 20 weeks, showed that emotional stress was by itself not sufficient to cause high blood pressure in rats. At the same time it was shown that a high salt diet (1·0 - 3·5%) encouraged and accelerated a hypertensive state in rats subjected to stress.

In another experiment[1] both patients with essential hypertension and normal control were used as subjects for examination of autonomic function, which is closely related to emotion. Consideration was given to the degree of emotionality of the subjects. A cold-pressure test, a mecholyl test and a Wenger-Okinaka test were administered.

The results are summarized:

1. Findings based on the results of the cold-pressure test and emotional pressor reaction established that hypertensive subjects showed a higher sensibility than the normals in their vascular reactivity.

2. The mecholyl test did not indicate that there existed a direct relation between hypertensive vascular disease and the tensions or excitability of the sympathetic nervous system.

3. It is therefore difficult to conclude that vascular hyperactivity, which is seen in hypertension, comes from the strain and acceleration of the sympathetic nervous system.

4. It was also shown that emotionality, or autonomic nervous factors, do not play an important role in the cause of chronic hypertension in patients.

1. Kanda, Yasuo (1963): Jikeikai Med. J., **10**, 200.

STERFTES AAN KROONAARSIEKTE BY PERSONE VAN 50 JAAR EN JONGER

Alle bewese gevalle van sterftes weens kroonaarsiekte van die hart by persone van 50 jaar en jonger is oor 'n tydperk van 12 maande bestudeer in King County, Washington, VSA.[1] Daar was 122 mans en 11 vroue in die reeks. Onder die mans het die dood binne een uur na die aanvang in 63% van gevalle ingetree en in 85% binne 24 uur. Van dié wat binne 24 uur oorlede is, het 41% geen simptome gehad wat na die hart verwys kon word nie. Slegs 23% het lank genoeg geleef om gedurende hul terminale siekte mediese behandeling van enige aard te ontvang. Moontlike bydraende oorsake is in slegs 16% van gevalle aangemeld. Nie baie van die slagoffers was in beroeps- of besturende hoedanighede werksaam nie.

Die algemene opvatting dat die persoon wat kroonaarhartsiekte opdoen die gespanne, ambiseuse, dryfkragtige tipe is wat 'n verantwoordelike posisie beklee, word nie gestaaf deur die feite nie. In hierdie studie was hulle meerendeels 'n trae, hipokinetiese groep.

Tien van die mans en drie vroue was volslae alkoholiste. Nog 23 mans het gewoontelik 30 of meer onse whisky, of 'n ekwiwalent daarvan, weekliks gedrink. Die geloof dat alkohol 'n profilakse teen kroonaarsiekte is, is dus nie bevestig nie.

Van die 11 vroue in die groep het die meeste geen voorafgaande siekte getoon nie en 9 het nog gereeld gemenstrueer ten tye van hul infarksie. By die nadoodse ondersoek van 2 vroue wat vantevore 'n histerektomie ondergaan het, is gevind dat hulle ovariële weefsel oorgehad het.

1. Rainton, C. R. en Peterson, D. R. (1963): New Engl. J. Med., **268**, 569.