HEALTH SERVICES IN THE UNION

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INTRODUCTION.

While it is true that the different racial groups in the Union do not receive medical and health services in proportion to their needs, this fact is the consequence of their differing economic status and even of their cultural differences and is an outgrowth of the country's social and economic structure rather than of deliberate legislative and administrative discrimination. The increasingly non-racial approach to national health needs was notably exemplified in the terms of reference of the National Health Services Commission (1942-44), which were that it should report and advise upon "the provision of an organised National Health Service..... for all sections of the people of the Union of South Africa". The Report of the Commission, from first to last, concerns itself with the requirements of the people as a whole, without distinction of race, colour or creed.

Not only for this reason is it inevitable that mention should be made of the "Gluckman" Report ø, at the very outset

ø So-called, as is customary, from the name of its Chairman, Dr. Henry Gluckman, M.P., who, in 1945, became Minister of Health.

of an article on Health Services in the Union. For not only did the Report set its seal upon the non-racial approach to national health needs which had prevailed in the past, but it also devised a classification of an ideal system of health services more comprehensive and scientific than any which had been authoritatively given before, in the Union or in any other country.

This classification will be followed in the present survey and evaluation of the services affecting the health of the people of the Union. Its principal feature is that it adds to the old-standing categories of curative and preventive health services two more, which the Report named promotive health services and rehabilitative health services.

(1) The Promotive Health Services include "adequate wages; nutrition; general and health education; physical exercise and recreation; industrial welfare and hygiene, etc."

(2) The Preventive Health Services are subdivided into non-personal and personal.

(a) Non-personal Health Services.

These are identical with the sanitary services, using that term in its widest sense to include housing, the provision and pro-

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tection of communal water supplies, the disposal of refuse and wastes, the control of animal vectors of disease, and the hygiene of the food-handling trades.

(b) Personal Preventive Health Services.

These are services based upon the periodic medical examination of apparently healthy individuals - infants, pre-school children, school-children, expectant mothers, workers in industry, contacts of known cases of infectious disease - with a view to the detection, at the earliest possible moment, of errors susceptible to correction without special medical, dental or nursing care. They include also such services as active immunisation against infectious diseases and the treatment of latent venereal disease. Obviously, for the reason that the onset of ill-health is often so insidious, no hard and fast line can be drawn between this group of services and the next.

(3) The Curative Health Services are medical services as ordinarily understood. They may be divided into in-patient (hospital) and out-patient services. The latter may be further divided into services

rendered at patients' homes (domiciliary), at doctors' consulting-rooms, and at out-patient clinics associated with or detached from hospitals.

(4) The Rehabilitative Health Services merge into other social services. Accident or illness may result in psychological and economic as well as purely physical injury. Medical services alone can at best repair only the physical injury. Even when they can, and more often when they cannot, the psychological and economic consequences of ill-health may necessitate vocational retraining and labour replacement of the injured individual. In an effective over-all rehabilitative service there should be the closest co-operation between the health services proper and the authorities in control of education and of labour.

7 SURVEY OF PROMOTIVE HEALTH SERVICES.

(1) Wage Regulation.

While there have been marked increases, during the war years, of wages among all groups in the population, there has been a simultaneous decrease of the purchasing power of money.

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The statement of the Gluckman Report remains true: "Vast numbers of people in this country do not earn enough to purchase the minimum of food, shelter and clothing to maintain themselves in health". Unless and until this position is remedied "the health and social services maintained by the State will be tantamount to a perpetual system of poor relief". The position of the poverty-stricken town-dweller, of whatever race, is particularly unfortunate, as he is completely dependent upon his cash wage. He cannot, as he might in the country, eke out his cash income through the home-growing of field crops and the keeping of cattle, poultry, and so on. Among all races, there is a natural tendency for those who are endeavouring to rise in the cultural scale to reduce their expenditure on the protective and even the purely calorific foods in order to have more to spend upon the material appurtenances of civilisation. In this connection the Union is unfortunate in that high, even extravagant, standards with regard to mere externals have been established by a wealthy minority; and that in the endeavour to get as near as possible to those standards there are many who, no doubt unconsciously, sacrifice the personal health needs of themselves and their children.

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(2) Nutrition.

Adequate nutrition is the very foundation of good health. The most deplorable single fact with regard to the health of the Union is that the majority, at least of its child population, is malnourished. This statement is supported by the findings of sample surveys made from 1938 to 1942. Among European schoolboys (urban and rural) 40% were found to be malnourished; among Coloured children (urban) 57% were malnourished; among Indian families (urban) 57% were malnourished; among Bantu school children (rural and urban) 69% were malnourished.

The reasons for the high incidence of malnutrition are well-known. Not only is there a lack of purchasing power on the part of the consumers, but there is also grave shortage of production measured against essential requirements, and there are inefficiencies in the system of the handling and distribution of foodstuffs. In respect of only two commodities - maize and sugar - does the Union produce sufficient to feed itself. Imports in respect of other foodstuffs do not meet the shortage. In drought years there may be a shortfall even with regard to maize. The latter is a food for stock as well as for human beings, and thus there develops a competition

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between human and animal requirements in which the humans have sometimes been at a disadvantage; although, in saying this, it must be remembered that the feeding of stock is a step in the production of certain foodstuffs for human consumption. The bulk of these, however, go to feed Europeans, who thus obtain protective foods (meat, milk, eggs, etc.) at the expense of the Natives whose staple diet is maize.

Not only is the annual production of "protective" protein and vitamin-containing foodstuffs - meat, milk and milk-products, fruit and vegetables - inadequate, but this basic inadequacy is accentuated by marked seasonal fluctuations due fundamentally to maldistribution of rainfall. Gluts and shortages alternate. Moreover, the Union is a land of vast distances, and the areas of dense population are not always near the areas of maximum food production. Transportation of perishable foods in hot weather and over long distances is beset with many difficulties. Some of the most densely-populated areas - the Native territories - are very poorly provided with railways and roads, so that in times of famine the importation of food is slow and costly.

Added to all these adverse factors are the widespread ignorance and the prejudices which prevail among masses of the people with regard to the selection and utilisation of

foodstuffs. These are due to the lack of general and health education.

However, undoubtedly the most auspicious aspect of the situation today is the ever-increasing public consciousness of the importance and urgency of the nutritional requirements of all sections of the people. In 1940 the National Nutrition Council was statutorily established under the chairmanship of the Minister of Health. In this body are brought together the highest officials of the social service departments of State - Health, Agriculture, Native Affairs, Labour and Social Welfare - and experts from the universities and other scientific institutions. Although its functions are purely investigational and advisory, the findings and the advice of this Council have been influential in drawing attention to nutritional needs and in indicating practical policies for the meeting of those needs.

It has been reliably estimated that the over-all production of food within the Union has increased by 30% to 40% during the war years. Plans are afoot for still further increase, while at the same time the land is to be guarded against uneconomic exploitation and soil erosion. Large irrigation schemes are projected, and special attention is being paid to the agricultural development of the Native

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territories. Facilities for the storage and processing - including dehydration - of foods are being developed, and these will assist in the smoothing out of seasonal and geographical maldistribution. Moreover, steps are being taken to prevent the recurrence of the situation described above, whereby there is competition between animals and humans for the same foodstuffs.

Further, and even more important in relation to the meeting of the immediate problems, schemes have been established for the assistance of consumers. The first of these originated as schemes for the distribution of "surpluses" - meaning surpluses to effective economic demand, not surpluses to nutritional requirements - among low-income groups at prices below current market prices.

In 1935 the Department of Agriculture, in order to dispose of surplus dairy products, initiated the distribution of butter in a number of centres at reduced prices under the State-aided milk and butter scheme to Europeans and Coloureds with incomes below specified levels. Concurrently milk or cheese was supplied free under the scheme to a proportion of European and Coloured school-children; Native children are not included, but some municipalities supply Native schools with

milk at reduced prices and operate milk depôts in the locations.

In 1941 some grapes were offered for state-aided distribution by the Koöperatiewe Wynbouers Vereniging. In 1942 the scheme was taken over by the Deciduous Fruit Board, which decided to include other deciduous fruit. The scheme was particularly popular with owners of factories, who ordered fruit for distribution to their workers. In 1941 an offer of 1,200 tons of unsaleable oranges was received from the Citrus Board. When these were disposed of, no further action was taken, until distribution was renewed in May, 1944, through public and private channels.

The distribution of surplus chilled or fresh eggs began in 1944. Food depôts are maintained in a number of centres by the Department of Social Welfare. In addition to these official schemes, financed by the State, there are many voluntary agencies at work, notably the South African Red Cross Society

In 1943 for all school children, irrespective of economic class, the principle of free school meals was introduced and applied on a national scale. Approximately £537,000 for Europeans, £114,000 for Coloureds and £87,000 for Indians. The cost of Native school-feeding is met from

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the Union Treasury in conjunction with the allocation for Native education. In 1946-47 the allocation for school-feeding was £860,000. In Natal the Province administers and itself meets the cost of administration of the scheme; in the other three Provinces the Union Department of Education administers and meets the cost thereof.

There are obvious inherent anomalies in school-feeding schemes. They include among their beneficiaries some children who are not in need of such assistance. They do not include children not at school, which means about half the Bantu children and a considerable proportion of the Coloured and Asiatic children. During the school holidays the meals officially supplied are in abeyance, although in several places the Red Cross Society and other voluntary agencies have recently undertaken the financial and administrative responsibility of continuing the meals throughout the holiday period. A more serious criticism is that, as the actual organisation of school feeding is in many cases left to local voluntary effort, the best use is not being made - partly through ignorance, and partly through the tremendous difficulties in procuring the desired kinds of food - of this splendid potential opportunity for remedying the deficiencies of the

home dietary of many of the children. To exploit this opportunity to the maximum requires expert guidance in the selection of foods and a high degree of organisation in the procuring of supplies. These points are receiving attention in some Provinces, and no doubt will receive increasing attention as the schemes develop. No accurate assessment has been made of the effect of school feeding on the nutritional state of the child population, but it stands to reason that the schemes cannot but be beneficial.

No summary of nutrition services in the Union would be complete without a reference to the activities of the Health and Welfare Organisation of the Railways Administration among its own employees, which have done much, chiefly through stimulus to self-help, to improve the nutritional state of a considerable section among the lower-income European groups, whilst recently steps have been taken to develop similar activities among non-European employees; the efforts of some local authorities and of voluntary agencies to improve nutrition among residents of Native locations through distribution of milk at cost, feeding of pre-school children at crêches and nursery schools, encouragement of vegetable gardening, co-operative buying, and so forth; and the scheme developed in the Ciskei during 1945 by the Department of Native Affairs, for

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the feeding of Native pre-school children during a period of drought and famine.

Mention must also be made of organised services provided by certain industrial employers. First and foremost there is the feeding of Native mine workers living in compounds. The ration scales for these workers have been prescribed by law ever since 1911, and provide an adequate balanced dietary. It is an illuminating commentary on the general shortage of food in Native reserves that many of the new recruits require a preliminary fortnight of feeding on the official dietary, during which they gain in weight, before being put to work at all. And, it must be remembered, ~~that~~ they have in the first place been recruited on the basis of physical superiority over their fellows left behind in the reserves. In industries other than mining there is no statutory compulsion, but an increasing number of employers provide, or co-operate with committees of their employees in organising, milk-bars, canteens, vegetable and fruit purchasing clubs. In this connection the experience of the Johannesburg Municipality which at one time provided food for many of its Native employees is of interest. Under a wage determination it was decided to pay cash in lieu of rations. The result was a deterioration of the physical condition of their employees

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owing to their inability to purchase, on an individual basis, as nutritive a diet as that provided by the municipality.

(3) General and Health Education.

Ignorance is one of the principal enemies of health in South Africa. Even among Europeans, lack of education renders them an easy prey to quackery and many false ideas regarding health and ill-health. Among non-Europeans, so many of whom are totally illiterate, errors and superstitions abound. It is clear then that the most effective type of health education, based on an appeal to minds disciplined by general education, cannot yet be undertaken among the non-European masses. Fortunately, even among illiterate people much can be done through verbal and visual appeal. Many voluntary agencies have been and are active in these fields, and the South African Red Cross Society in particular, has been subsidised by the Department of Health in order to enable it to produce and distribute films, posters and illustrated leaflets dealing with health topics. As has been indicated, health education is most urgently required in the nutritional field. The Department of Health has recently established a Special Division of Nutrition and Health Education which, in co-operation with existing agencies, will pay special attention to this important promotive health service.

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General education is also important, particularly in relation to health services for non-Europeans, because upon its adequacy depends the supply of recruits for training as health personnel. Generally speaking, at the present time, the number of recruits available is sufficient to utilise fully the facilities for training - of doctors, of nurses, of nursing assistants, of health assistants, of health inspectors - which are today available. Possibly, however, this would not be so were it not that the facilities themselves are inadequate in relation to the over-all needs for health personnel.

(4) Physical Education and Recreation.

The importance of physical education and recreation, from both the educational and the health viewpoints, including that of mental health, was recognised in the establishment of the National Advisory Council for Physical Education and in several large-scale experiments carried out under Government auspices to bring about the reconditioning of physically unfit or undeveloped adolescents. Hitherto, most of the work of the National Council has been for Europeans, and the only non-European scheme is one for Coloured youths at Kimberley. Some of the larger municipalities employ non-European social workers who, in addition to other activities, organise physical recreation among non-Europeans.

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(5) Industrial Hygiene and Welfare.

(a) On Mines.

Comprehensive regulations made under the Mines and Works Act of 1911 include provisions relating to ventilation, lighting, prevention of dust (which is the cause of miners' phthisis), change-houses, sanitation, and first aid. These of course apply to all races. They are enforced by inspectors employed by the Department of Mines. The feeding, housing and medical care of Native mine-workers is controlled by regulations made under the Native Labour Regulation Act and administered by the Director of Native Labour in association with health officers of the Department of Health.

(b) In other Industries.

Working conditions are controlled by the Factories Act (brought up to date in 1941) and regulations made thereunder, the Shops and Offices Act and other Acts. The Acts are administered by the Department of Labour, which appoints male and female factory inspectors. Hours of work, with special reference to juveniles and women, are laid down in the Factories Act, and apply equally to

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all races. The Department of Labour carried out 37,396 inspections of factories in 1944. The regulations prescribe measures for cleanliness, safety, and preservation of health; accommodation facilities during work, resting and eating; protective clothing and other safety devices. Generally speaking, it may be said that in most large factories the working conditions are good, and in many of them excellent. There are some employers who go far beyond the statutory requirements of the Factories Act by providing or assisting to provide recreational facilities for their employees and, as already noted in the sub-section on nutrition, by assisting in measures for better feeding.

There are, however, numerous small and a few large factories in which conditions are poor or definitely bad.

An interesting and important development is the increasing employment of personnel managers. These are now being trained in the Union, at the Leather Research Institute, Grahamstown. Personnelmanagers can do much to promote the physical, mental and social health of employees in industry.

The National War Memorial Health Foundation deserves special mention at this point. It was founded, on the initiative of South Africans on active service, and with the blessing of the Government, as the Union's memorial to those who served in World War II. Its chief aim is to stimulate, guide and assist voluntary effort in the field of promotive health. To this end it will establish "People's Centres" throughout the Union, to become the foci of activities organised and supported by the people themselves for the promotion of physical and mental health.

SURVEY OF PREVENTIVE HEALTH SERVICES.

There is no sharp dividing line between promotive and preventive health services. The former are concerned with social welfare generally, whereas the latter are more specifically concerned with the prevention of ill-health. They comprise the classical functions of "public health" departments as established during the nineteenth century and the early twentieth century, which were dominated by the desire to combat pathogenetic micro-organisms wherever found in man's environment. Although historically the services which deal with the isolation and treatment of sufferers from infectious diseases had their genesis in the desire to prevent the spread of infection in the community, rather than in the

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desire to cure the individual, nevertheless in this chapter these services will be considered in the survey of curative services.

A. NON-PERSONAL PREVENTIVE HEALTH SERVICES.

(1) Administration and Finance.

Under the provisions of the Public Health Act (passed in 1919) this group of health services is specifically the primary executive responsibility of the local authorities, that is, the already existing general-purpose local authorities with powers derived from pre-Union legislation and from post-Union provincial ordinances. The general functions, and particularly the finances of the local authorities are under the control of the Provinces; but the central Department of Public Health, which was created under the Public Health Act, exercises inspectoral and advisory powers over the health functions of local authorities. A local authority which defaults in respect of its health duties cannot be coerced by the central health authority without prior reference to the Provincial authority. This cumbersome arrangement is an essential weakness in the administration of public health services in the Union.

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In the Transkei (Cape) and the three northern Provinces there were, until three or four years ago, no constituted rural local authorities.[x] In the malarial areas of the Transvaal and Natal, however, there are malaria committees, which are not local authorities for the general purposes of the Public Health Act, but are co-operative committees of land-owners undertaking measures for the prevention of mosquito breeding. In the Native reserves and in other rural areas where there are no malaria committees the Department of Health undertakes mosquito-control. The Department also undertakes measures for the prevention of plague in the rural areas of the Cape, Transvaal and O.F.S. The divisional councils in the Cape, which are rural local authorities for the general purposes of the Public Health Act, are generally so weak financially that - with the notable exception of the Cape Divisional Council - they can do very little in the way of public health services.

Generally speaking, therefore, throughout the rural areas of the Union each landowner or householder is responsible for the sanitation of his own domain, with no assistance from

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[x] In Natal there is now a Local Health Commission which is the local authority for several 'rural areas becoming urbanised' and, in the Transvaal, a Peri-Urban Areas Health Board which is the local authority for a considerable portion of the central Transvaal lying outside urban local authority areas.

any public authority. The standards attained vary widely, being dependent upon the economic status as well as the degree of enlightenment of the individual concerned. Throughout the Native reserves, on the alluvial diggings, and in many rural areas becoming urbanised the standards are deplorably low. Fortunately the generally sparse distribution of the population in the reserves, together with the abundant sunshine of South Africa, diminishes the risks to health consequent upon insanitation; but in the more densely populated areas - occupied by members of all races - these risks are very considerable. On European-owned farms there is also wide variation in standards, depending upon the degree of enlightenment of the owners, but generally speaking they are low, particularly in relation to non-Europeans permanently resident on farms.

In urban areas there is also wide variation in sanitary standards, not only as between the areas of different local authorities, but also within one and the same area. The policy of racial segregation undoubtedly tends towards the acceptance of dual standards by local authorities. This tendency is to be observed even in public health legislation itself. Thus, in section 130 of the Public Health Act, permission is given for the lowering, in respect of Native

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housing only, of the ratio of window area to floor space from one-twelfth (the general standard) to one-fourteenth. In the Slums Act, Native compounds (erected in terms of the Native Labour Regulation Act) and locations (established in terms of the Natives (Urban Areas) Act) are expressly excluded from the purview of the Act.

The principle of a self-balancing Native revenue account, adopted by the vast majority of local authorities,(1) means in practice that no more can be spent on the sanitary and health services of locations than can be raised from the residents thereof. The resultant contrast between the sanitation and general amenities of locations, as compared with European-occupied portions of the same local authority area, is an all too obvious feature of most South African towns. Fortunately, there is now a tendency on the part of progressive municipalities to abandon the principle of the self-balancing Native revenue account and to provide, from general revenue, if necessary, health services according to needs instead of according to the capacity of the separate account. The fact that non-Europeans have no Municipal franchise rights militates against speedy progress in this direction.

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(1) See Urban Areas

A few remarks may be made, from the health angle, regarding the municipal monopoly of the brewing and sale of Native beer. It is at least doubtful whether the additional social services provided from the profits derived from this monopoly balance the social and economic ills which result from the consumption of beer; and it is noteworthy that the local authority - Port Elizabeth City Council - which has provided the best location housing and health services in the country has not exploited this power of monopoly at all. It is also doubtful whether the establishment of municipal beer-halls reduces the volume of illicit brewing. It has been claimed that Native beer has a high 'food value'; but food of equal nutritive value could be provided, in other forms, for at least half the price. Moreover, it is adults who drink the beer and not children who are most in need of nutriment generally and vitamins in particular.

(2) Housing and Town-planning.

This subject is dealt with in the section on Urban Areas, and only points of special bearing upon health will be discussed here. Lack of planning and bad planning, together with the policy of territorial segregation, often places non-Europeans so far from their places of work that they have to

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spend much time, energy and a disproportionate part of their incomes in travelling to and from work every day either on bicycles or in overcrowded trains. The rentals, even of sub-economic houses, are often so high that they absorb an unduly large percentage of the European or non-European tenant's income, so that there is too little to spend on food and clothing. The overcrowding which is a feature of all non-European housing is an important contributory cause of the spread of "crowd diseases", particularly tuberculosis. As affecting Natives, it often means a crowding together of adolescents of both sexes which does not obtain under conditions in the Reserves, where separate huts are provided; and this herding together is undoubtedly a factor in the spread of venereal diseases.

(3) Water Supplies.

Throughout the rural areas water supplies are generally inadequate and frequently polluted. Even water drawn from boreholes is not without risks to health, for in many areas such supplies contain an excessive amount of fluoride. The latter causes mottling of the teeth in children, which in severe cases renders the teeth more susceptible to decay, and the fluoride may also cause extreme stiffness on the

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spine in middle and old age. In many urban areas there is often a basic inadequacy, although the supply can be and usually is purified. Even where the supply available to the town as a whole is adequate, the supply made available to the location is often very inadequate. It is only of late years that any attempt has been made to provide every Native dwelling with its own piped supply of water. For the majority of dwellings there is still only a standpipe available, often a considerable distance from the dwelling. "It is unreasonable", says the Smit Report, on the Conditions of Urban Natives, "to expect any people to keep their dwellings and their persons clean unless they are provided with reasonable facilities for so doing". Uncleanliness favours the multiplication of disease-carrying vermin and bacteria.

(4) Disposal of Wastes.

As with housing and water supplies, so with the disposal of the waste products of human activity, there are wide variations in the standards adopted, from area to area, and within one and the same area. In the Native Territories and even on many farms, in respect of Native labourers, no special provision at all is made. Waste matters, including human ordure, are deposited on the bare veld to be disposed

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of by sun, wind and rain. Consequently most streams are polluted, and some of them are little better than open sewers. Another important consequence is that there is a very high degree of infestation of cattle and pigs with the bladderworms which, when the beef or pork is eaten, produce tapeworm in the human being.

In urban locations likewise very low standards are all too frequently tolerated. For example, earth closets are often found in a location although the remainder of the town is sewered. The minimum standard laid down in the Slums Act - one latrine to every eight persons - is frequently not attained, even where the local authority itself is the landlord. The Smit Report (1942) says - "Many houses in the locations are entirely without what in the remainder of the urban area is regarded as an essential adjunct to any dwelling, however humble, namely a latrine. The absence of household latrines necessitates the provision of those aesthetically repulsive and hygienically dangerous structures known as communal latrines. They are never (quoting from the Second Schedule to the Slums Act) "accessible to all the occupants (of the dwellings served by them) with reasonable convenience", for example, at night, in wet weather, or during illness."

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The disposal of household rubbish from locations is usually very unsatisfactory. Says the Smit Report - "Rubbish is all too frequently allowed to accumulate in the open in yards or even on the streets, thus attracting and providing a breeding place for flies and rodents, both of which are carriers of disease. Lidded receptacles for the storage of rubbish are the exception rather than the rule. A refuse removal service is not always provided, and even when it is, removals rarely are made at sufficiently frequent intervals. Similarly, the storage and regular removal of slop waters is far less common than their crude disposal by throwing them on to the plots or running them into the streets. Neither houses nor streets are properly drained except in a very few instances. The dust which blows about the average location must then, from these various sources of pollution, harbour an exceptionally rich flora of septic and other pathogenic germs; and it is not surprising that sore eyes, skin diseases, tuberculosis and bowel infections are as common as they are".

(5) Food-handling Control.

The unhygienic handling of foodstuffs which are consumed raw, particularly milk, may result in the transmission of the germs of diseases such as enteric, dysentery,

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tuberculosis, and various throat infections. This happens if the food is handled by a person who is a "carrier" of one of these diseases and is at the same time unhygienic in his personal habits. Herein lies one of the most serious threats to the health of Europeans occasioned by the inadequacy of health services, including health education and propaganda, among non-Europeans. For in many food-handling trades, particularly dairies, the auxiliary personnel who perform the actual work are non-Europeans. In many towns special measures are taken to test the personnel of dairies for the enteric-carrier state; but in smaller towns and throughout the rural areas there is rarely any control at all. There are no easily applied tests for the carrier state in respect of the other diseases mentioned. In a somewhat different sphere, the inspection of meat by persons competent to detect bladder-worm and other diseased conditions is carried out only in the towns.

B. PERSONAL PREVENTIVE HEALTH SERVICES.

Except in a few minor matters, there is no specific statutory obligation upon public authorities to provide any of the personal preventive health services described in this

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sub-section. There is merely a general obligation, in terms of section 10 of the Public Health Act, upon every local authority, in respect of its district, "to safeguard and promote the public health". It is to the credit of local authorities that so many of them have interpreted this obligation so generously. Moreover, when local authorities as such have failed to provide personal preventive health services, local charitable organisations have often stepped into the breach and established - usually with the assistance, in cash or in kind of the local authority - infant clinics and the like, often associated with district nursing services.

(1) Maternity and Child Welfare Services:

All the large and many of the small local authorities provide antenatal clinics for members of the several racial groups within their areas. These clinics are making a very valuable contribution to the betterment of maternal health, mainly through education in regard to nutrition and personal hygiene. A specially valuable procedure, carried out as a routine at nearly all antenatal clinics, is the examination for syphilitic infection - latent or active. In most towns some 25% of Native women are found to be infected. Treatment is given free and, if started in time, is generally effective in preventing the birth of congenitally syphilitic children.

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Maternity services are included among the preventive services not only because they prevent maternal and neo-natal deaths, but also because they prevent the gynecological ill-health which is a common sequel of unskilled midwifery. Maternity hospitals or wards are regarded as a sub-division of "general" hospitals, for which the Provinces are responsible. Most general hospitals, however, provide only for abnormal or emergency cases. For all races, the provision made at private maternity homes is in excess of that made by public authorities. These homes vary enormously in size and quality. They are all registered and inspected by the Department of Health or authorities acting on its behalf. For Natives, the provision is mainly at mission hospitals, notably the Bridgman Memorial Hospital in Johannesburg and the McCord Hospital in Durban.

District midwifery services, that is, the provision of midwives to attend parturient women in their own homes, are undertaken, frequently in combination with district general nursing services, by provincial administrations and hospital boards, by local authorities, and by voluntary associations. The Department of Health provides financial assistance, in the case of the Provinces and Public Hospital Boards one-half of the total cost of the service, and in the case of the

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other agencies one-half of the cost of the midwives' salaries and allowances (exclusive of travelling allowances) only. Further, the Department of Health subsidises some district nurses and midwives direct, in order to encourage them to practise in areas where otherwise they could not make a living. In 1946 the Department of Health reported that under these part-refund and subsidy schemes there were 280 European district nurses and midwives, 48 Coloured and 245 Native. In 1935 the corresponding figures were 30 European, 1 Coloured and 16 Native. It is impossible to differentiate district midwifery from district nursing services, as they are nearly always combined in practice.

Infant welfare clinics for all races have also been established by the local authorities of many towns in the Union. Here, in addition to advice on dietetics and management generally, active immunisation against smallpox, diphtheria and whooping-cough may be provided. Vaccination against smallpox is compulsory (except upon formal declaration of conscientious objection) but is often neglected or deliberately avoided, particularly by the followers of quasi-religious cults which are fairly widespread among the Bantu. These evasions account for not a few of the outbreaks of smallpox which have occurred among Native

communities. Immunisation against diphtheria and whooping-cough is not compulsory.

Crêches and nursery-schools, which are very few in number relative to the child-population, provide preventive health services incidental to their main purpose which is custodial. Generally speaking, preventive health services for pre-school children (ages two to seven) are lacking for all races. Nursery schools are maintained here and there, for the several racial groups, by local authorities and by voluntary agencies.

The financial arrangements with regard to maternity and child welfare services are complex, partly because the services themselves merge into other services presently to be described. No direct charge is made to individuals using them (except at crêches and nursery-schools, in respect of their custodial functions only), and the cost is met in the first instance by the local authority or voluntary agency as the case may be. Thus the cost is a charge upon local rates or local charity. The central Department of Health gives advice and technical guidance, but its subsidies to maternity and child welfare services are limited to those in respect of district midwifery services, described above.

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(2) School Medical Services.

The medical inspection of school children has been accepted for many years by the provincial councils as an obligation arising out of their constitutional responsibility for education services, although neither the constitution nor any other law imposes it specifically upon them. Owing to staff shortages - medical inspectors of schools and school nurses - the routine medical inspection of European, Coloured and Indian children is inadequate. There are no medical inspectors of Native school-children, but a very few Native school nurses have been appointed. The curative services available for the remedying of defects discovered at routine examinations will be described below.

(3) Industrial Personal Preventive Health Services.

In the gold-mining industry there is routine examination of employees - of all races - for the express purpose of early detection of miners' phthisis. This service is highly organised and efficient, and is conducted by the Miners' Phthisis Medical Bureau, the cost being borne by the mining industry. In other industries there is sometimes a medical examination of entrants, merely with a view to rejecting candidates physically unsuited, but thereafter no further examinations are made of those who are accepted. Natives

entering /...

entering urban areas to look for work of any kind are usually subjected to a medical examination designed merely to spot those suffering from communicable diseases. Any such persons are sent to isolation hospitals. Those suffering from non-communicable diseases, even though physically handicapped thereby, do not automatically receive remedial care. The system applies only to males, despite frequent demands for its extension to females.

(4) Routine Medical Examinations of the General Public.

A small beginning has been made with this, the rational basis of a system of effective personal health services, in the health centres now being established by the Union Department of Health. The family rather than the individual is being taken as the clinical unit of this "family welfare service". Pioneer health centres have already been established among European, Native, Coloured and Indian communities. (See page)

SURVEY OF CURATIVE HEALTH SERVICES.

A bewildering variety of agencies participate in the provision of curative medical services, which are the traditional sphere of medical, dental and nursing practice. Private practitioners cater, on an individualistic basis,

for "those who can afford to pay" - a class which, owing to the ever-increasing costs of medical diagnosis and treatment, forms an ever-diminishing proportion of the community as a whole. Even today, private practitioners vary their fees according to their estimate of the patient's ability to pay and may even undertake pro Deo work, apart altogether from incurring bad debts. However, provision has always been made for the medical treatment of paupers - "those who cannot afford to pay" - at public expense, through the district surgeoncy system and the public hospitals. The very large class in between - "those who can afford to pay something" - are catered for increasingly by voluntary (or even compulsory) insurance schemes organised as benefit societies, sick funds, etc.

A. MEDICAL SERVICES OUTSIDE HOSPITALS.

(1) Unorganised Private Practitioner Services.

These are carried out by registered medical practitioners, dentists, nurses, midwives, masseurs and physiotherapists; and also by large numbers of unregistered practitioners (osteopaths, herbalists, etc.) and, in Natal, Native herbalists who are actually licensed by the Government. The distribution of private practitioners throughout the

Union is not in accordance with the medical needs of the people, but according to their economic status. Thus there is a much higher proportion of doctors, etc., in the towns than in the Native rural areas. Generally speaking, and particularly in rural areas, medical practitioners (the vast majority of whom are Europeans) attend persons of all races. The converse is also true, that is to say most non-European registered medical practitioners (of whom there is a steadily increasing number although very small in proportion to the whole) have some European patients; and, significantly enough, it is by no means rare for Europeans to patronise non-European herbalists and even witch-doctors.

Considerable sums in the aggregate are paid by Natives, particularly in rural areas, to European practitioners; and sums probably still larger are paid by them for medicines purchased from chemists over the counter and through the post. The services received in return are on the whole of little value, being in the main merely palliative.

Private ~~general~~ dental practitioner services are barely adequate to meet the demands of Europeans and, for non-Europeans, are practically non-existent.

(2) / .....

(2) Organised non-State Services.

(a) Organised by Beneficiaries alone:

Strictly, these are rarely, if ever, more than contributory insurance schemes - medical benefit societies, friendly societies, etc. That is to say, they do not provide an organised medical service, but merely establish an insurance fund against medical expenses. The actual services are rendered by private practitioners - chosen by the insured person from a panel, or without restraint. They rarely provide complete cover against all the costs of medical care. The membership of these societies is restricted in practice to Europeans and a few Coloureds.

(b) Organised by Beneficiaries assisted by Employers:

These schemes differ economically from the preceding in that employers contribute to the funds - usually on a basis of fifty-fifty or thereabouts - in return for which they usually insist upon a share in the management. The employers' contribution is voluntary, that is, not made under statutory compulsion; but agreements between employers and employees made in terms of the

Industrial Conciliation Act (which may provide for the establishment of sick funds) are legally binding. The outstanding examples of schemes jointly maintained are the South African Railways and Harbours Sick Fund, the Mines Benefit Society, and the Iscor Benefit Society. In this group of schemes there is a stronger inclination toward the closed panel and the appointment of full-time medical practitioners.

(c) Organised by Employers alone:

Under statutory compulsion (the Native Labour Regulation Act of 1911), employers of Natives housed in compounds are obliged to provide medical services for them. This is done on the gold mines, the coal mines and a few others by the appointment of whole or part-time mine medical officers. Certain public servants - members (of all races) of the permanent defence force, policemen and prison officers - are entitled to free medical services, which are provided through the district surgeoncy system and, in the case of the defence force, officers of the South African Medical Corps. An increasing number of employers - notably Iscor and the larger municipalities -

voluntarily/....

voluntarily provide medical services, at least of the out-patient type, for their Native employees: it pays them on economic grounds so to do.

(d) Organised by Philanthropic Agencies:

Out-patient and domiciliary services are provided not only by medical missions, operating among non-Europeans, but also by numerous district nursing associations employing district nurses and midwives and operating among all races. The former have been assisted by grants mainly from the Department of Native Affairs and the latter by part-refunds mainly from the Department of Health as explained at page 32 above.

(3) Organised State Services.

(a) Local Authority Services:

Mention was made earlier in this chapter of the preventive personal health services provided by local authorities. These services merge imperceptibly into and are combined with curative services. A difficulty arises here. The provision of curative services by a public authority is an encroachment upon a long-established private

interest / ....

interest, namely, general medical practice. Accordingly, it has always been understood that, with certain exceptions, curative treatment will not be undertaken at municipal infant welfare clinics, ante-natal clinics, etc. However, in respect of venereal diseases and tuberculosis, the treatment of which is important in the interests of public health (to prevent spread) as well as of the individual sufferer, curative services are provided, for all who want them, by local authorities. In respect of other forms of ill-health, while advice and even treatment may be given for the milder cases, full curative services, if they are provided at all, are provided only for those too poor to pay for them. In practice, this usually means non-Europeans. Most of the large municipalities provide fairly comprehensive out-patient medical services in their Native locations. Moreover, many local authorities provide domiciliary - "district" - nursing and midwifery services, either directly or by subsidies to local hospital boards or voluntary associations to assist them to do so. The assistance given by local authorities to dental clinics will be mentioned later.

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The Union Government gives the following assistance to local authorities: in respect of V.D. services, 100% refund of approved cost together with free drugs and free laboratory services; in respect of T.B. services, 62½% refund of approved cost (to which another 25% is added by the Province); in respect of general out-patient services and district nursing and midwifery services, 50% refund of approved cost.

(b) Provincial Authority Services:

At all the larger public hospitals (but not at the smaller) there are departments which provide, free or at low charges, general out-patient medical services. Some public hospitals also conduct "detached" or "decentralised" out-patient clinics or "dispensaries" at points geographically separate from the hospital itself. Mention must also be made of curative services for school-children, the necessity for which became apparent in consequence of the medical inspectoral services undertaken by the Provinces in their capacity as education authorities. These are provided at special clinics or as part of general out-patient

services/....

services. Specialised offshoots of school medical services are the dental clinics, usually under ad hoc boards, towards the expenses of which local authorities also contribute; and the Transvaal Bilharzia Committee which undertakes mass treatment of (European) school-children as well as propaganda. Provincial Administrations and Hospital Boards in some places maintain district nursing and midwifery services, mainly in respect of Europeans.

The Union Government specifically assists provincial out-patient services as follows: in respect of detached out-patient services, 100% of approved net cost; in respect of district nursing and midwifery services, 50% of approved net cost; and a grant of £1,250 per annum to the Transvaal Bilharzia Committee. In respect of services not specially assisted, the Union Government meets half the cost as part of the general subsidy given to each Province in terms of the Financial Relations Act.

(c) Central Authority Services:

Although general poor relief was the statutory responsibility of the Provinces from 1913 to 1940

(and / ....

(and is so still in Natal), the principal cost of the provision of out-patient (including domiciliary) medical services for indigents - namely, district surgeons' salaries and drug allowances - has always been met entirely by the Union Government, on the Vote first of the Department of the Interior and, since 1919, on the Vote of the Department of Health. Travelling and detention charges and the cost of certain surgical operations are met, in Natal, by the Province, but the district surgeoncy system is controlled there as elsewhere by the Department of Health.

The services provided by district surgeons, as such, are restricted to cases of serious illness among paupers. There is no legal definition of a pauper. The decision is left in each case to the magistrate of the district. Magistrates are instructed to have regard to whether the sick person has relatives who could assist him to pay a private medical practitioner. In the rural Native territories generally, this provision has been interpreted in practice to mean that no Native is entitled to the free services of the district

surgeon / ....