Naval Wireless

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Health Reform a Present Need

HIGH DEATH-RATE AMONG BABIES

Dr. Cluver's Startling Facts

JOHANNESBURG, Wednesday.

DR. E. H. CLUVER, director of the South African Institute of Medical Research, discussing the "Development of Our Human Resources," said South Africa was making very poor use of its human resources, which had been allowed to degenerate, and in large measure to become not an asset but a liability.

Reviewing the evidence to support this statement Dr. Cluver said that close on 3,000 babies born in the Union died before they were a year old. Although the death-rate per 1,000 births had fallen in two decades from 82 to 50 it was still deplorably high, and compared unfavourably with that of many other civilised countries, where the rate was calculated for the whole population, "and not, as with us, for the favoured upper European section of society only."

HYGIENIC NEGLECT

Infant mortality, which was almost entirely due to under-feeding and other hygienic neglect, could be reduced to a negligible figure by proper diet and medical and nursing supervision.

The maternal mortality rate was still shockingly high, having dropped only from 4.9 per 1,000 births in 1921 to 3.4 in 1940, and obviously preventible diseases, like typhoid and diphtheria, continued to take heavy toll of life and health. Tuberculosis was actually increasing among the non-European population as an inevitable result of increasing malnutrition. Attempts to combat this evil by increased hospitalisation were but a "costly confession of failure of our social organisation."

The methods introduced to South Africa by Dr. E. Jokl had made possible a scientific examination of the degrees of physical efficiency among various groups of the population.

The most convincing evidence of the low actual and high potential physical efficiency of South African youth had been supplied by a study of the results produced in the Special Service Battalion. That experiment by the State had demonstrated that, by a relatively small public expenditure, the physical efficiency of largely unemployable young men could be raised so that they became valuable citizens.

Discussing nutrition, Dr. Cluver said the preponderant section of the population, which had to earn its living by manual effort, was compelled to subsist on the "malnutritious diet" of bread and mealie-meal porridge. A "daily intake" of protective foods had to be insisted on.

BETTER FARMING METHODS

"To make this possible a complete reorientation of our farming policy is necessary. Not only must we produce vastly more food on the farms, but the relative proportion of crops must be altered. For larger crops better farming methods are needed.

"Irrigation and anti-soil erosion projects must be developed to an extent hitherto unthought of; the tractor must replace the ox for ploughing, and generally modern scientific methods must be introduced."

A policy of internal consumption of farm products, subsidised, if necessary, would repay the country to an extent hitherto unimagined through reduction in hospitalisation costs and a vast increase in fit industrial manpower.

Some ghastly mistakes in housing policy had to be corrected, chief among them being the herding of hundreds of thousands of young native men into mine compounds away from their families.

If the industries which are being planned for the future are to get the best value from the employes provision will have to be made for homes, not barracks, where the workers can enjoy normal family life.

A MIGHTY ARMY

A mighty army of Europeans and non-Europeans was at present economically unemployable, not because of inherent biologic inefficiency, but because of remediable factors. If this army were properly fed and housed, and had its minor ailments corrected, it could, by accepted methods of physical education, be made employable.

Dr. Cluver then outlined the value of vaccination in preventing diseases like diphtheria, typhoid fever, typhus and plague, and said that in this field also some measure of compulsion might be needed initially in the interest of general welfare.

Medical services, as at present constituted, were of relatively little value in conserving human resources, because the bulk of the medical profession was required in the present social order to earn its living by curative work, and had little or no part in preventing disease and promoting positive health.

"The only satisfactory solution will be the introduction of salaried medical services, in which the members are not compelled to exploit ill-health to make a living. In such a service competition will be replaced by co-operation, and there will be every inducement to apply preventive measures."—S.A. Press Association.

Health. 2) Mr. Ngubane

3) Library

BUILDING A HEALTHY NATION.

STATE AND LOCAL SERVICES IN SOUTH AFRICA

ADMINISTRATIVE BASIS EXPLAINED.

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PRETORIA. November, 1953.

HEALTH SERVICES AND HEALTH CENTRES IN SOUTH AFRICA.

FUNDAMENTAL PRINCIPLES OF PUBLIC HEALTH ADMINISTRATION.

The fundamental principle of the Public Health Act, the legislative basis on which most of the health services of the Union of South Africa have been built, is one of decentralization, by which is meant that each local authority is responsible for the public health of its area. There is of course a strong advisory and supervisory central authority, the Union (Government) Health Department, which guides general policy, exercises a measure of control and subsidizes the work of the local authorities as well as carrying out a large number of executive functions itself, such as the provision of mental, tuberculosis, venereal disease and leprosy institutions, of district surgeon services, pathological services etc. However, each unit of local government (municipality, village council, etc. - the nomenclature varies in the different provinces) is responsible for the public health of its area and all the larger local authorities maintain a number of clinics of various sorts - ante-natal, child welfare, tuberculosis clinics, general clinics for outpatient treatment of minor ailments and so forth - but these clinics are not health centres. In fact, although clinics of all sorts are a prominent feature of local authority health services, and many local authorities have polyclinics, no local authority in the Union has a health centre in the specific sense in which the term is used in the Union, which will be explained later in this article.

LOCAL SERVICES ARE FREE.

The pattern of local authority health administration in the towns follows closely that which is to be found in the United Kingdom, the United States or in Canada, except that the clinics in the Union form a more important and prominent feature than they do in the other countries mentioned. This is perhaps partly due to the fact that we have so large a Native and Coloured population, the majority of whom are socially and economically much less advanced than the Europeans and therefore in need of these services which are rendered by public bodies. Most of our large local authority health departments provide curative medical and nursing services (both at clinics and in the people's homes where necessary) to the inhabitants of their Native locations. The so-called preventive medical services, by which we mean ante-natal, child welfare, tuberculosis and venereal disease services are even more widespread and in most cases have been longer established. All these services are rendered free of charge to the patients.

HEAVY STATE SUBSIDIES.

The municipal health services are heavily subsidized by the Central Government. The basis on which the subsidies are paid is somewhat complex and has been altered from time to time by amendments to the Public Health Act. Speaking generally the subsidies on the various services have been increased greatly during the thirty odd years since the passing of the original Public Health Act, in 1919 and are now very generous: they assist local authorities greatly in providing comprehensive and efficient health and medical services for the people of all races in their areas.

MUNICIPAL/.....

MUNICIPAL AND VOLUNTARY EFFORT.

Health centres are not to be confused with these municipal health services which form the basis of the health organization of the Union. Nor in the past have health centres had anything to do with the other much longer established medical and nursing services which are provided by public authorities and in some cases by voluntary organizations for the poorer people of all races. Reference is made here firstly to the district surgeoncy service, a very old established Government service operation in both urban and rural areas in every district throughout the country and providing medical attention for the sick poor (or medically indigent) both at the doctor's surgery and by visits to their homes - serious cases of course being hospitalized at public expense - and secondly to the district nursing services which are maintained by both local authorities (already referred to in connexion with municipal health departments) and voluntary organizations, in both cases heavily subsidized by the Central Government.

PROVINCIAL HOSPITALIZATION.

In addition to the services referred to above, it may be as well to mention that general hospitals are provided throughout the country by the Provincial Administrations each of the four Provincial Governments being responsible for the provision of general hospital services in its area. The Provincial Governments are subsidized to the extent of 50% by the Central Government. These hospitals have since their establishment provided, at public expense, free accommodation and treatment for those unable to pay and this of course includes the vast majority of the non-European patients. The position varies somewhat in the different provinces but there is a general tendency everywhere towards free hospitalization, by which is meant extending the facilities which are provided at Government expense to the other economic groups to an increasing extent.

An out-patient service (including, in the larger towns, specialist out-patient attention where required) is provided at all the major general hospitals. Neither the hospitals themselves nor their out-patient departments have any direct connexion at present with health centres but they are mentioned here in order to complete this very brief sketch of health and medical services provided by public authorities in order to indicate the background against which health centres have been developed.

SPECIAL SERVICES FOR RURAL NATIVES.

The concept of a health centre, as we know it in the Union, originally arose out of a particular need which it was felt existed for a special type of service for the Native population living under tribal conditions in rural areas. Broadly speaking the idea was a constructive approach to health and medical services with a view to combining preventive and health educational services with curative services - the aim being to replace primitive ideas regarding disease, such as those of witchcraft, by modern concepts of sanitation and health, by improving nutrition to build up the health of the people in a positive way, to encourage periodical medical examinations as well as carry out ante-natal, maternal and child welfare work. The family was taken as the unit and an attempt was made to build up the family health in a positive way rather than the treatment of established disease in individuals.

DECENTRALIZATION THE KEYNOTE.

Two health centres working on these lines were established in Native rural areas shortly before the war. The first was at Polela, in a rural Native area in Natal. After the establishment

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of Polela and another initial health centre, further development was delayed by the outbreak of hostilities. In 1944, however, the idea received a great impetus when the National Health Services Commission recommended that all personal health services should come under the centralized control of the Government and that health centres, of which it was recommended that some 400 should be established throughout the country, should form the basis of the health services. For certain reasons, however, health services did not become centralized - in fact, the fundamental principle of the Union's Public Health Act is one of decentralization and this has not been departed from although a number of health centres were established and are maintained by the Central Government. Thus the health centre services came to be super-imposed upon the normal structure of health services in the country as a whole.

To render the type of service which is described as being given in the intensive family area of the Polela Health Centre to the whole community would, of course, involve great demands on both financial and manpower resources and for this and other reasons it is felt by most health administrators that a more extensive and less intensive application of the available resources of the Union would be more appropriate, at least for many years to come. This point of view was strongly supported by the late Prof. Ryle, the very well-known professor of social medicine at Oxford, who in effect expressed the view that the country was not yet ready for the very advanced and expensive type of service being rendered to a relatively small portion of favoured people in the intensive areas of the health centres.

INTEGRATION OF GENERAL PATTERN.

For these and other reasons it has been found necessary to review the whole question of health centre services with a view to their integration into the general pattern of health and medical services in the country as a whole. In fact at this stage the health centre service is in the process of being integrated with the other much older established and much more extensive Departmental district surgeon service.

It is considered that by developing these services in conjunction with each other, and of course in proper relation to the local authority health services, district nursing services and to provincial hospital and out-patient services, and by utilizing the available manpower and other resources to render somewhat less intensive services to greater numbers of people the needs of the community as a whole will be more adequately met. In other words, the lines along which we are thinking now are that instead of having small and very intensive areas of family welfare services we should spread the services more thinly over a wider area and integrate them with the much older curative medical, health and nursing services which have been in existence and have rendered very valuable service for many years.

It may be mentioned that a proposal is being investigated that the Health Department should make facilities available at selected health centres for research into promotive health and socio-medical problems by universities and other approved research institutions. The intention is that this research would serve as a guide in the future development of promotive health services at health centres and in other fields.

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RULES FOR SPECIAL GROUPS WITHIN THE MEDICAL ASSOCIATION OF SOUTH AFRICA.

1) Special Groups of members having a distinctive professional interest; but who, by reason of paucity of members and geographical distribution, are unable to achieve adequate representation of their special interests through the Branches and Divisions, may petition Federal Council for recognition of such Special Groups.

2) All members of such Special Groups must be members of the Medical Association of South Africa.

3) The membership of such a Special Group may not, at any time, be less than 11 (eleven) members.

4) Each Group shall appoint office bearers consisting of a Chairman, Honorary Secretary and Treasurer and an Executive Committee of three members to control the affairs of that Group. A list of such office-bearers, together with a complete list of members of the Group, shall be furnished annually to the Medical Secretary within 30 days of Election of such office bearers.

5) Each Group shall draw up its own Constitution which shall contain nothing contrary to the rules of the Medical ASsociation of South Africa and which must be approved by Federal Council. All subsequent alterations and additions to the Constitution must also be submitted to Federal Council for approval.

6) A levy may be made by a Group on its members toprovide funds for the carrying on of its work.

7) Independent action is allowed to Groups provided that the Association as a whole is not involved or pledged to any action, and that action contemplated by the Group is in conformity with the policy of the Association for the time being in force.

8) Groups may, if they think it desirable, request Federal Council to act for them (suggesting the line of action desired) although it may be in a matter affecting only the interests of the Groups and not the whole Association.

9) Federal Council, may if it considers it to be desirable, refer matters to a Group for opinion and/or action on occasions when matters affecting that Group have come before Federal Council directly.

10) It shall be competent for Groups to allow the formation of Sub-Groups within the framework of a Branch or Division of the Association. Such Sub-groups may be allowed powers of independent action in local matters provided that such action is not in conflict with the constitution of the Group and is governed by its rules.

11) Reports of work done by a Group during the year ending 30th June, together with a financial statement for the period shall be sub-mitted to the Medical Secretary within 30 days for submission to the next following meeting of Federal Council

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12) The Annual General Meetings of Groups shall be held, if practicable, during the Annual Congress and Scientific Meeting of the Association.

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