Mr Jones

BWT. 1/47.
CT. 8.1.47.

9,6,2,2

BANTU WELFARE TRUST.

THE POSITION OF MISSION AND OTHER SMALL HOSPITALS IN THE NATIONAL HEALTH SERVICES SCHEME.

1. There are very definitely no plans on the part of the Central Government for taking over control of hospital services from the Provinces.

2. In the Transvaal a satisfactory agreement has been arrived at between the mission hospitals and the Administration, whereby, in addition to subsidies on salaries, a flat-rate subsidy of 5/- is paid per patient per day, the mission hospitals retaining control of their own institutions.

3. In the Cape, the position is more complicated because of the comparative poverty of the Provincial Administration, which is extremely chary with its funds. It is probable that an agreement will be worked out between the missions and the administration, similar to that in the Transvaal. The Cape Administration is not, however, anxious to assume control over the mission hospitals, with the accompanying responsibility for their finances. The administration does not and will not subsidise capital expenditure for mission hospitals, although it is prepared to subsidise on maintenance. It would seem that those mission hospitals which are prepared to hand over full control to the administration will be eligible for full subsidies on all expenditure, but because of its poverty the administration apparently does not want this responsibility. Some mission hospitals in the Cape have indicated their willingness to hand over full control to the administration to use tact and discretion in making appointments. The majority do not appear to trust the administration in this respect and refuse to relinquish control; they must therefore continue to rely on donations for any capital expenditure. The administration does not see why it should subsidise capital expenditure on buildings and equipment which will be the property of some private body, often with headquarters in London, Paris, Berlin or Geneva.

4. Mission hospitals can by no means be said to be public hospitals in the sense that the Johannesburg General Hospital is a public hospital. Nor is the organisation, control and finance on all fours with that of public hospitals. The aim of the Provinces is eventually to provide free hospitalisation for all, but this aim cannot be achieved while there are nission hospitals which may be compelled to charge fees in order to make ends meet. (The charging of fees would further be contrary to the spirit of the Hospital Tax which is meant to provide free hospitalisation for all).

5. While the Provinces will be prepared to subsidise the mission hospitals on maintenance, they will not be prepared to include in their subsidy anything towards redemption charges. (For example, the Transvaal is paying a subsidy of 5/- per patient per day which may cover actual maintenance but does not cover any redemption on capital expenditure which may work out at, say, another 1/- per patient per day). The Province feel that capital extensions by mission hospitals are not made on loans but through gifts and donations.

6. It might be possible to force the Provinces to give £1 for £1 on money raised for capital extensions.

7. Dr. Gale recommends that the Trust therefore continues, where it feels it desirable, to subsidise mission and other private hospitals on capital expenditure, but only on the £1 for £1 basis.

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Duplicated by :
S.A. Institute of Race Relations,
P.O. Box 97,
JOHANNESBURG.

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CT. 8.1.47.

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