9, 12, 6, 2

FREE HOSPITALISATION COMMISSION

TRANSVAAL

1. The Advisability and feasibility of extending the existing field and scope of free hospitalisation so as to cover:

(a) all classes of the community
(b) certain classes of the community, these classes to be defined.

1(b) The Economic position of Natives.- is so low that (with perhaps the exception of a small fraction of 1%) no Native person could pay for hospital services without impoverishing his dependents. It is therefore necessary that free hospitalisation should be provided for the whole community.

At present the Transvaal Provincial Hospitals provide Non-European beds, Mission hospitals in the Transvaal beds, Mine Hospitals beds. There are Natives in the Transvaal. On the bases of one bed per 1,000 souls beds would be required. (Here actually I shall deduct all the mine numbers and treat of them differently) More beds are therefore necessary. It is important that these should be provided, not in the great urban areas, but in the rural areas. It must be realised that in the Native reserves the population is not sparse. The needs are not ordinary rural needs, but those of communities living a semi-rural life on small-holdings, but with no organised health and sanitary services. On the Western side since the Bechuana habit is to live in crowded villages or almost towns the health problems are even more concentrated. Hospitalisation problems/therefore not /are so difficult in Native reserves, as in the "European" rural areas. Hospitals provided in such Reserves will serve a

- considerable -

considerable community, and, while obviously some arrangement will have to be made for local transport of serious cases, transport will not be so difficult a matter, as it is in sparsely populated rural areas such as the bulk of the European farm areas.

To take one or two examples:

(1) In the Zoutpansberg Reserves and connected Native areas, there are approximately 300,000 souls. There is no Provincial Hospital dealing with this area, but there are two mission hospitals together providing beds. As

In the Eastern Transvaal on the Bushbuckridge there are approximately 75,000 souls. There is no Provincial or Mission hospital (a few Mission Clinics with no resident Doctor have a few beds for emergency).

In the Western Transvaal in the large Native area/the North West of Zeerust, there are /to approximately 45,000 souls. There is no Provincial or Mission Hospital. (N.B. There is a small mission hospital without a doctor in the Bechuanaland Protectorate across the border).

There are examples and are roughly typical of the whole.

The establishment of Provincial Hospitals presupposes local effort which is there subsidised by the Province, and a good deal of local reponsibility is being taken for upkeep. It is obvious that these areas cannot hope for such local preliminary or continuous effect, unless the responsibility should be taken by the Native

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Affairs Department. In general the local effort is undertaken by the well to do section of the community. In the case of Native Areas where there is no such well to do section, the Native Affairs Department could only finance the local side by taxation of a very poor community living something below the poverty line. It therefore remains for missions to undertake the responsibility, and to apply for subsidies. Missions are able to run hospital services much more economically than the Hospital Boards, and responsible authorities for the existing calculate that with a subsidy of 2/6 per pauper patient per day they could promise to meet the needs of their areas. If such a subsidy were abailable it would doubtless enable these and other missions to make provision for hospital facilities for the whole of the Native Areas. The absence of any regular method of subsidisation has deterred missions from the establishment and development of Hospitals.

The provision of hospital accommodation for the Natives on European farms is equally necessary. During the preparation of Native Evidence for the recent Farm Labour Committee, the absence of such hospital facilities was constantly stressed by Native witnesses. In some cases Native hospitals in the Reserves might serve a considerable such hinterland of rural farm workers. In other cases the hospitals in the small towns will need to provide the necessary beds if they are to be served. It will be a saving to have as much as possible of such accommodation in the more economical, but no less efficient mission hospitals.

In general for the sake of keeping people of tribal groups together for the provision

- of clinics -

of clinics subsidiary to the hospitals for the saving of transport expenses both for doctors and for patients, it will be well to have hospitals established wherever a 30 or 40 bed hospital would be justified. The doctor's time will be part occupied a t the hospital and part in district work, and clinics. One or even more doctors would therefore be justified, and the unit be satisfactory.

There is no doubt that Natives will make more use of doctors, clinics and hospitals, if they are available at a reasonable distance from their homes, and are well known to them.

The principle of free hospital services for urban Natives (other than those for whom employers have responsibility), is already established. At any rate in Johannesburg the accommodation is not adequate for the need, and I gather that this is so in other places.

I have no in this section considered the special needs of chronic-sick, and convalescents. There is no doubt that under both heads, due to the pressure of incoming urgent cases, patients are discharged from hospital who should be under care which cannot be given them in their homes, and they therefore relapse, and become a further burden on ordinary hospital accommodation.

I shall revert to this later.

1. (b) As has been said above the number of Natives rightly able to contribute to medical and hospital services for themselves is very small. There will, however, be a very small number of professional and business men, and of the richer Chiefs who would be in the same position as middle class Europeans, to make some contribution to special services.

3. What organisation, if any, should there be of decentralised clinics related to hospitals, particularly as regards Natives?

The Public Health Amendment Act of 1935, made provision under certain conditions for the subsidisation of district nursing services connected or not connected to hospitals.

In the case of Natives such nursing services have usually been partially used for clinics with or without the supervision of a doctor.

In the larger Urban Areas the Municipal authorities usually provide clinics of one kind or another within the Native locations, and finance the attendance of the doctor (when this is provided), and the salary etc., of the Nurse, and the building etc, for the Clinics. In general such medical and nursing services and clinics are not in direct connection with the local hospital, but naturally patients sent forward are accepted with as little delay as possible.

The existing town hospitals have out patients departments.

I can probably be said that in the larger towns, it is possible for indigent patients to have attention at a municipal clinic or hospital out patients Department. Except for V.D. work and casualities, however, the hours of attendance are usually difficult for wage-earners,

and many ailments are not attended to in the early stages, and cause more serious and more expensive trouble later.

Many smaller municipalities do not find themselves able to finance location medical, nursing and clinic services. In such cases, even if there is a local hospital its position usually prevents the outpatients Department being satisfactorily used.

There is no doubt that location clinics serve a very definite purpose relieving hospital services.

(a) In providing the necessary accommodation
(b) By providing the medical attention
(c) By providing the nurse's attention at the clinic.
(d) By providing the nurse's attention in follow up and therefore preventing relapse.
(e) By providing the nurse's attention in District visiting and thus dealing with cases before they become acute.
(f) By training in general health and preventive measures.
(g) By providing the dressings, drugs etc.

It would therefore seem right that where necessary these services should be financed from the same sources as hospitals.

Subsidisation would make it possible for the smaller municipalities to arrange for such services.

Alternatively such services and clinics might be established in direct connection with the hospitals. There is already provision for this for the nursing services in the Public Health Act.

In rural areas such clinics would serve the same functions of relief to the Hospitals.

They would even more greatly help the Native people by providing services for minor ailments at a reasonable distance from home.

At present such services are provided to a very limited extent.

(a) In out clinics from Mission Hospitals. In some cases grants for Nurses or Nurse Aids stationed at, or visiting such out clinics are paid by the Public Health Department, and by the Native Affairs Department.

(b) In out clinics visited or not visited by the District Surgeon, but with Native Nurses or Nurse Aids available. These are part financed by the Department of Public Health, and part by the Native Affairs Department, or Tribal funds.

The value of such clinics and services is naturally in direct relation to the regularity and quality of the attendance of doctor and nurse. There is no district where such services are adequate and in many large districts there is no such.

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