

# 'Vision and Vested Interests': National Health Service Reform in South Africa and Britain during the 1940s and Beyond

Anne Digby\*

**Summary.** Both Britain and South Africa considered major health reforms during the 1940s and there was mutual interest in the ideas being generated. In South Africa, the *Report* of the National Health Services Commission of 1944 advocated a national health service based on health centres that would integrate curative, preventive and promotive work. Parallel with this were plans by the provinces for free hospital treatment. Scarce finance, together with political and medical vested interests, meant that the health centre ideal only survived in minor form. In Britain, a free national health service was created in 1948, in which a reformed structure of hospitals was central, and early plans for health centres were marginalised. In each country, limited financial resources and vested interests—in the form of powerful medical professional associations or (in the case of South Africa) of provincial administrations—delayed, scaled down or reshaped the original reforming vision.

**Keywords:** free treatment; health centre; hospital reform; national health service; medical professional association; social medicine; South Africa; Britain

The 1940s offered an environment of possibility for varied reform and reconstruction in both Britain and South Africa, and it was within these contexts that schemes for new national health services were formulated.<sup>1</sup> Some of those involved in these innovative healthcare policies were conscious of parallels between their endeavours. In each country, bold visions produced idealistic plans, but these were then shaped by vested interests and limited by resource constraints. Both countries had pronounced defects in their healthcare systems that stimulated reformers' efforts. In Britain, these included the deficient finance of voluntary hospitals, the exclusion of many women and children from the national health insurance scheme, variable standards in healthcare offered by general practitioners, and complexities in multiple healthcare administrations. In South Africa, there were even greater disparities, with a conspicuous failure to provide adequate public facilities in rural areas where the black population was concentrated. There was also a division of responsibilities between the Union government whose efforts focused mainly on public health, provincial bodies with responsibilities for hospitals, as well as municipal administrations looking after maternity and child welfare. This included advancing preventive health through improving sanitation, water supply, or

\*Centre for Health, Medicine and Society, Oxford Brookes University, Gypsy Lane, Oxford OX3 0BP, UK.  
E-mail: [adigby@brookes.ac.uk](mailto:adigby@brookes.ac.uk)

<sup>1</sup>Dubow in Dubow and Jeeves (eds) 2005.

hygiene. In each country there was a pronounced urban geographical concentration of hospitals and private medical practitioners.

In this article, attention will be given mainly to reform during the mid-twentieth century, focusing on health centres, hospitals and free treatment: topics that stimulated interesting discussion and attempted reform. South Africa is discussed first, and given lengthier coverage because of its relative unfamiliarity to most readers. Then comes a shorter overview of the better-known intellectual terrain of the NHS in Britain, before the two are placed in a longer-term perspective, and a final comparative assessment is made.

## South Africa

It might be said that our proposals are bold and far-reaching. They may perhaps be described as revolutionary by those who look to tradition and precedent as their guide. Even so, we are in good company. 'A revolutionary moment in the world's history', says the Beveridge Report of 1942, 'is a time for revolutions, not for patching'. There has been far too much patchwork in the past development of health and medical services in the Union. We have been instructed to plan *nationally* for a service in conformity with the modern conception of health.<sup>2</sup>

Charged in August 1942 with re-planning the post-war health services of South Africa, and reporting two years later, the National Health Services Commission (NHSC) under its chairman, Henry Gluckman, uttered this confident statement. It makes clear that one of its multiple sources for inspiration was the British Beveridge *Report*, with its radical blueprint for a visionary welfare state. With comparable spirit, the South African *Report* acknowledged that the establishment of a national health scheme would 'call for vision in planning and decision in action. Neither resolution nor ability is lacking in this country'.<sup>3</sup> Resolution had certainly been necessary for the commissioners who acquired extensive evidence in the course of three and a half months field work and three and a half million words of testimony from more than 1,000 witnesses. Their forceful interrogation could overstep the mark, as when one witness accused a commissioner of 'almost taking up the position of a prosecuting counsel'.<sup>4</sup>

The Gluckman *Report's* authors described how services were the antithesis of their reforming ideal: provision was disjointed, haphazard, provincial and parochial, and thus 'very inadequate'. Services were not 'in conformity with the modern conception of health' but instead were curative rather than promotive, and were 'poorly supplied to the under-privileged sectors who require them most'.<sup>5</sup> Adopting a messianic tone, the *Report* argued that a national health authority's efforts should be directed not towards 'the provision of more and more hospital beds, but towards the provision of more and more health centres with periodic examination of *all* members of the population'.<sup>6</sup> Introduction of health centres had been floated for African areas by an earlier Commission in

<sup>2</sup>Union of South Africa, UG 30-1944, *Report of the National Health Services Commission* (hereafter *NHSC*), para. 75.

<sup>3</sup>*NHSC Report*, para. 74.

<sup>4</sup>Evidence to NHSC, 8 February 1943.

<sup>5</sup>*NHSC*, chapter XIX, summary, para. 3.

<sup>6</sup>*NHSC*, chapter XIX, para. 5.

1927, but were hardly the staple discourse of reformers so that this was a radical proposal.<sup>7</sup> The NHSC proposed 400 health centres under 20 regional health organisations, each looking after roughly 25,000 people.<sup>8</sup> Provision was envisaged in socialistic terms as ‘personal health services for all sections of the people, as a citizen right . . . according to needs rather than means’.<sup>9</sup> A new world of opportunity was envisioned.

The NHSC was self-confident in evaluating its role as ‘one of the most important investigations’ by government since the Union of South Africa in 1910. It hoped to achieve ‘the fuller welfare, the greater happiness of South Africa as its goal and reward’.<sup>10</sup> Eschewing a ‘mere expansion of their several component parts’ in reform of existing health services, it concluded that adequate health services for all sections of the population required national uniformity under a centralised authority.<sup>11</sup> ‘The place of the hospital in modern society is no longer one of splendid isolation’ commented Gluckman later in explaining why the NHSC had tied up its proposals with ‘highly-controversial constitutional issues’ of provincial responsibility for such tertiary institutions.<sup>12</sup>

How was such far reaching change to be effected in the face of vested interests whose narrow concerns might impede the attainment of wider national ones? The Commission attempted to forestall opposition from one of these powerful sectional interests—the medical profession—by emphasising that there were ‘many details requiring to be worked out and settled in collaboration and consultation with all parties concerned’.<sup>13</sup> As a qualified doctor, Gluckman was well aware of the medical profession’s sensitivities and the Commission’s report spelled out patients’ rights to a free choice of doctor in the new health centres, as well as the fact that there would be no compulsion for medical practitioners to enter the national health service.<sup>14</sup> But although the Medical Association of South Africa (MASA) had signalled its ‘preparedness to cooperate wholeheartedly in a national health service for the prevention and treatment of disease’, this was conditional on the implementation of the scheme as a whole, on the preservation of personal relationships between doctors and patients, and on the right of doctors to engage in private practice.<sup>15</sup>

In practice, however, the Commission opted to make ‘a practical beginning’ in establishing health centres, before ‘delicate and important negotiations’ had been accomplished and in advance of what it termed a ‘comprehensive solution’.<sup>16</sup> The Commission prevailed on the government to provide £50,000 in the estimates for 1944–5 to effect the early establishment of health centres, and government then set up the first ones by administrative process.<sup>17</sup> The government was signalling what

<sup>7</sup>Official Publications of South Africa, UG 25–1927, *Report of the Hospital Survey Commission*, para. 81.

<sup>8</sup>NHSC, chapter XIX, paras. 7–8.

<sup>9</sup>*Ibid.*

<sup>10</sup>NHSC, chapter II, para. 4.

<sup>11</sup>NHSC, chapter XX, para. 3.

<sup>12</sup>*Abiding Values* 1970, p. 468.

<sup>13</sup>NHSC, chapter IV, para. 62.4.

<sup>14</sup>NHSC, chapter IV, para. 47; chapter XIX, summary, para. 19.

<sup>15</sup>*Abiding Values* 1970, pp. 463–4, 466.

<sup>16</sup>NHSC, chapter IV, para. 65.

<sup>17</sup>NHSC, chapter IV, para. 65; chapter XXXV, para. 16.

later became explicit—that reform would be introduced by a series of measures and not by major legislation, as was to be the case in Britain.

Health centres were to be ‘the basic unit’ in the national health scheme where ‘the actual personal health service will be rendered’.<sup>18</sup> The NHSC promised that they would be:

the focus of all personal and preventive and curative services carried on outside institutions. They will replace the present system of uncoordinated private practice. The entire country will be served by health centres, and every family will have a centre to which it will look for health services.<sup>19</sup>

Making such centres the ‘very foundations’ of the national scheme was a remarkably bold step, as there were few South African precedents on which to build, and even these were of recent foundation. But external precedents—including socialised medicine in Russia, Dutch practice in Java, as well as the Peckham experiment in England—had already influenced the centre at Pholela.<sup>20</sup> The centres established in South Africa before the Gluckman *Report* were heterogeneous. The Umtata rural clinics in the Transkei focused on minor ailments, with ante-natal and home visits from district nursing stations, and with the health of local school children the focus of attention by two medical aids.<sup>21</sup> At Bushbuckridge, in the Transvaal, an uphill task was envisaged in trying to inculcate ‘new and progressive ideas into a conservative and simple people in whom tradition and custom are deeply ingrained’. Here African health assistants were deployed to ‘exert their influence on their own people’, with emphases on prevention of disease, dietetics, hygiene, and ‘on the need for the natives to help themselves’.<sup>22</sup> The Alexandra Health Centre in Johannesburg was linked to the Witwatersrand Medical School and offered a general clinic to the township population.

In contrast, at the much better-known Pholela (later Polela) Health Unit in Natal, a dynamic set of initiatives was pioneered by Sidney and Emily Kark and their colleagues. During the first years of its existence the unit was better staffed, expanded its remit more swiftly (to include a feeding plan for schoolchildren, a welfare clinic for women and children and a pre-school child centre), and made more rapid progress in extending its activities than did other centres. The healthcare team developed an intensive family health service in which the home visit, and not the clinic, was seen as the basis for activity. Health assistants acted as field workers in compiling detailed records of domiciliary visits. Interestingly, the terms preventive and curative healthcare were stated to have gradually merged into ‘a more comprehensive outlook best described by the title of social medicine’.<sup>23</sup>

<sup>18</sup>NHSC, chapter XXVIII, paras. 1, 6.

<sup>19</sup>NHSC, chapter XXX, para. 3.

<sup>20</sup>UG 6–1946, *Report of Department of Health* (hereafter *DH*), p. 40.

<sup>21</sup>UG 8–1943, *Report of DH*, p. 14.

<sup>22</sup>UG 8–1945, *Report of DH*, p. 17.

<sup>23</sup>South African Official Papers, UG 8–1943, p. 10; UG 8–1944, p. 14; UG 8–1945, pp. 16–17; UG 6–1946, pp. 36–41; UG 18–1947, pp. 47–50; UG 53–1948, pp. 18–23; Kark and Cassel 1952.

The future work of staff in health centres more generally was envisaged as being 'to act as the practitioners of social medicine'.<sup>24</sup> This was an innovative concept in both South Africa and Britain.<sup>25</sup> It was one that challenged the existing order, so that in Britain, the opportunity to change medical education to train doctors as practitioners of social medicine was frustrated.<sup>26</sup> A prominent British exponent of social medicine, John Ryle, argued that social medicine was concerned with man in relation to the environment and dealt with all diseases, as distinct from public health that focused on communicable disease in the environment.<sup>27</sup> In 1948, Ryle was invited by the South African government to review its early health centres.<sup>28</sup> Despite the fact that Sidney Kark had trained with Ryle, the latter pronounced himself in favour of much larger health centres than were present in South Africa, and suggested they should be linked to universities, thus giving ammunition to critics.<sup>29</sup>

The first 'Gluckman' health centre began in December 1945 at Grassy Park, in Cape Town, followed by Lady Selborne and Tongaat in 1946, whilst Cradock and White River were set up in 1947. Early centres possessed variety in institutional origins, in clientele and in range of services.<sup>30</sup> Knysna had the government district surgeon acting as medical officer, whereas at two Transvaal health centres, close links with missions were fostered by them being located in mission premises. Grassy Park catered predominantly for a coloured or mixed race population, Lady Selborne for Africans, Cradock directed its activities both to coloured people and Africans, while Newlands and Tongaat treated Africans and Indians. Most stressed promotive health education (through ante-natal clinics, mother and baby clinics or the examination of school children), as well as preventive measures (through improved nutrition, immunisation and vaccination), but the importance of curative medicine in the treatment of disease (through the out-patient clinic or district nursing station) varied considerably.<sup>31</sup>

The extent to which the health centre would offer curative care—thus posing a threat to private medical practice—affected the medical profession's attitude. Gluckman had become Minister of Health in November 1945 and thought it necessary to reassure the profession. He stated that those receiving curative care at health centres would not have been able to afford a private doctor, and that centres had only been set up 'in those areas where there are large numbers of people so poor that they cannot afford to engage the services of private practitioners'.<sup>32</sup> But the environment of political possibility narrowed drastically in 1948 with the change to an apartheid government. Alan Jeeves has written aptly of 'the window that briefly opened for a more innovative approach' and of the multi-racial health teams in the health centres that were antithetical to apartheid.<sup>33</sup>

<sup>24</sup>UG 6–1946, *Report of DH, year ending 30 June 1945*, p. 40.

<sup>25</sup>Kark in Cluver (ed.) 1951, p. 664.

<sup>26</sup>Oswald 1991.

<sup>27</sup>Ryle 1948.

<sup>28</sup>Porter 1992.

<sup>29</sup>Jeeves 1998, pp. 10–11.

<sup>30</sup>UG 53–1948, *Report of DH, year ending 30 June 1947*, pp. 18–22.

<sup>31</sup>UG 53–1948, *Report of DH, year ending 30 June 1947*, pp. 18–23.

<sup>32</sup>Gluckman 1948; *Abiding Values* 1970, p. 488.

<sup>33</sup>Jeeves 1998, pp. 3, 8.

**Table 1.** 'Gluckman' Health Centres in the Four Provinces, 1952

Cape	Natal	Orange Free State	Transvaal
Adelaide*	Institute of Family Health, Durban, Clairwood*	Bethlehem	Bloemhof
Cradock*	Botha's Hill		Bosbokrand
Fort Beaufort*	Gcilima (Port Shepstone)		Bushbuckridge
George*	Ixopo		Evaton
Gordonia	Newland, Durban		Lady Selborne
Grahamstown	Nottingham Road		Randfontein
Grassy Park (Cape Town)	Pholela		
Krystna*	Springfield, Durban		
Mossel Bay*	Tongaat		
Sandflats (Alexandria)*			
Stellenbosch*			
Umtata*			
Walmer (Port Elizabeth)*			
Zwelitsha (King William's Town)			

Note: Asterisks mark those catering in the early years for both European and non-Europeans.

Source: UG 40–1954 and UG 23–1956, *Reports of Department of Health*.

The momentum of change continued for a time, if at a diminishing pace. In 1953, more than 30 centres existed, as Table 1 indicates, and by 1960 this had grown to more than 40 health centres.<sup>34</sup> Health centres had 864 posts in 1953, but with few professional, technical or nursing positions with four out of five personnel designated temporary, 'other' or non-European.<sup>35</sup> Staffing problems were endemic since more than one in five staff left, transferred or had their services terminated, whilst 'considerable difficulty' was experienced in staffing rural or remote centres.<sup>36</sup> Training the personnel who would practise social medicine in health centres was undertaken first at Pholela, but later at Clairwood where, in 1945, an Institute of Family and Community Health linked to a group of Durban health centres had been set up.<sup>37</sup> It was envisaged that a new medical school training black doctors would be established nearby and that its students would participate in its team practice. The Rockefeller Foundation helped the Institute with generous funding, and a galaxy of practitioners—Sidney Kark, George Gale, John Cassel and Guy Steuart—led this pioneering establishment. Unfortunately, within a few years, peripheral centres closed or had been handed over to the provincial administration whilst, discouraged by hostile apartheid government policies after 1948, the pioneers emigrated.<sup>38</sup>

In 1952, health centres were devolved from the national Department of Health to regional offices.<sup>39</sup> Thereafter, not only were they subject to greater vagaries of control and funding, but information became less accessible. What follows takes the story up

<sup>34</sup>Gale 1970, p. 508.

<sup>35</sup>UG 23–1956, *Report of DH*, p. 6.

<sup>36</sup>UG 53–1948, *Report of DH*, p. 21; UG 40–1954, *Report of DH*, p. 21.

<sup>37</sup>Kark and Steuart (eds) 1962, chapters 20–23.

<sup>38</sup>Gale 1970, pp. 506–7, 514–17.

<sup>39</sup>UG 40–1954, *Report of DH*, p. 21.

to the 1960s.<sup>40</sup> In Natal, only six of the nine health centres continued, in the Orange Free State one centre was listed as a clinic for non-whites, whilst in the Transvaal none of the six early centres were found in later provincial reports, although other evidence indicates that at least one of them survived. The *Reports* of the Cape Director of Hospital Services indicated that the province took over nine health centres.<sup>41</sup> To summarise: little more than half of the original health centres of 1952 listed in Table 1 were documented a decade later: the building blocks of a new national health system envisaged by the NHSC had been absorbed into an existing provincial system based on hospitals.

### Hospital Care

The Gluckman *Report* had referred to the Cape provincial administration's recent proposal that free hospitalisation should be introduced as a citizen right. The *Report* had preferred a centralised system that would give uniformity, so that hospital responsibility would cease to reside with the four provinces, but such a takeover was deeply unpopular in provincial administrations.<sup>42</sup> Cape representatives in evidence to the NHSC pronounced provincial administration of hospitals as being 'the most efficient system', and argued forcefully that there should be a 'clear mark of demarcation' between province and Union in hospital administration.<sup>43</sup> Earlier, Mr H. F. Pentz, Secretary of the Transvaal Administration, had warned the NHSC that 'the provinces say that what is entrusted to them is their business' and that 'any attempt to make any inroad upon the powers and functions of the provinces, is to invite failure for any scheme'.<sup>44</sup>

The Union Government acknowledged provincial vested interests in recognising the hospital as their responsibility, stating that it would not amend the constitution against their will. It then gave such substantial grants to the hospital sector that the nascent health centre sector was starved of funds. It took a positive stance towards provincial plans for free hospitalisation in financial legislation of 1945 that enabled the government to assist these.<sup>45</sup> A meeting of MASA representatives at the Ministry of Health in January 1946 found officials reiterating that the ministry had no constitutional authority to interfere with the provincial/Union demarcation of functions. Following on from this, the government effectively ruled out major change by making clear that in relation to healthcare 'without making radical changes to the present allocation of functions, there is, and for some time will be, quite enough to do in filling in the gaps to keep us fully occupied'. Demarcation was along the lines of 'whether or not the services are performed inside or outside an institution', with provinces responsible for the former (i.e. hospitals) and the Union for the latter (i.e. public health).<sup>46</sup>

<sup>40</sup>Information from provincial reports on hospitals and from MOH reports for major urban centres.

<sup>41</sup>Continuing centres were Pholela, Clairwood, Botha's Hill TB Centre, Ixopo Christ the King, Newland and Tongaat (Natal); Bethlehem (OFS); Adelaide, George, Grassy Park, Knysna, Mossel Bay, Sandflats, Stellenbosch, Walmer and later Cradock (Cape).

<sup>42</sup>NHSC, paras 19, 32, 66. Views of Cape Provincial Council reported in *Cape Times*, 30 May 1947.

<sup>43</sup>Evidence of B. Muller and G. M. H. Barrell, members of Executive Committee of Cape Provincial Council to NHSC, 8 February 1943.

<sup>44</sup>NHSC, pp. 19, 63, 406.

<sup>45</sup>Financial Relations Consolidation and Amendment Act, 1945.

<sup>46</sup>'Government Statement of Policy', 9 September 1944, reported in *South African Medical Journal (SAMJ)*, 20, p. 538.

Gluckman had to acknowledge provincial control of hospitals as a powerful obstruction by stating that this departure from the NHSC recommendations 'has increased the formidable task of achieving an effective plan for meeting our national health needs'.<sup>47</sup> MASA also deplored continuing provincial control of hospitals and feared that it 'may render a unified national health service impossible'. It stated that it was 'in favour of and will support a scheme for free hospitalisation' but only on condition that it would be introduced gradually and that 'the conditions of service of the medical profession in public hospitals shall be compatible with the honour and interests of the medical profession'. Significantly, these conditions resulted in later medical opposition.<sup>48</sup>

The Transvaal's proposals to establish free hospital care had preceded the NHSC, both in the unpublished report by the Craib Commission on free hospitalisation and then in the significant Pentz Report of 1942, which used evidence given to Craib to formulate bold recommendations.<sup>49</sup> Beginning with the fundamental issue of free hospital admission, the Pentz Report advocated its extension to all classes in the community, stating this was both 'advisable and feasible'.<sup>50</sup> It then extended its remit into proposals for what was a form of provincial health service where hospitals would possess a network of clinics for Europeans and non-Europeans. The clinics would also be 'the main gateway of admittance to hospitals', but the treatment was to be exclusively curative.<sup>51</sup>

The Pentz Report's recommendations—for a hospital-led healthcare system with detached out-patient clinics in the community—were seen as such significant competition to the NHSC vision, based as this was in health centres, that Pentz became the Commission's first witness. In dramatic confrontations, the NHSC spent a week grilling Pentz while his 400 pages of replies and submissions reportedly depressed the spirits of the commissioners.<sup>52</sup> Pentz interpreted his prior proposals on hospitals as 'not a solution, but it is a beginning' for South African healthcare reform. In a remarkable statement Gluckman rejected this because 'our job is to formulate a plan where hospitals would be kept empty'. He stated that the Pentz proposals would perpetuate the 'faults with the old system', and that mere correlation between central and provincial government over a national health service—of which free hospitalisation formed a part—would be impracticable.<sup>53</sup> As well as focusing NHSC firepower, Pentz also alienated the organised Transvaal medical profession with the Report's forthright proposals to abolish honorary medical appointments to public hospitals, and fill hospital medical posts with salaried full- or part-time staff.<sup>54</sup> Nor did the Report's comments—that 'the practice of medicine is becoming too commercialised' and that honorary hospital posts are 'regarded as "open sesame" to a good practice'—further endear it.<sup>55</sup>

<sup>47</sup>'Address' to Medical Congress, 9 November 1946, reproduced in *Abiding Values* 1970, p. 484.

<sup>48</sup>Special issue on medical profession and the new order, *SAMJ*, 20, 1946.

<sup>49</sup>H. F. Pentz, *A Scheme of Free Hospitalisation*. Appointed in 1939, the Craib Commission had not finished its work because of unpropitious wartime conditions.

<sup>50</sup>Pentz 1942, ch. XXVII, para. 1.

<sup>51</sup>Pentz 1942, ch. XV *passim*, ch. XX, para. 21.

<sup>52</sup>Evidence in late October and early November 1942; Gale 1970, p. 496.

<sup>53</sup>Pentz's submission to NHSC, pp. 404, 407, and Gluckman's response, pp. 405, 407.

<sup>54</sup>Pentz 1942, ch. XXVII, paras 6 and 17.

<sup>55</sup>Pentz 1942, ch. XIX, para. 8 and ch. XX, para. 6; *SAMJ*, 16, 1942, 409–12; 17, 1942, 29–31, 33–8.

In July 1946, the Transvaal was the first province to adopt a Public Hospitals Ordinance with free hospital care to take effect in April 1947. Pentz had postulated a rival popular mandate to that of the NHSC, 'the Transvaal public have in no uncertain voice, and quite unequivocally demanded of the Provincial Legislature to deal with the question of free hospitals now'.<sup>56</sup> The eventual provincial ordinance was 'a very different document' from that envisaged by Pentz because doctors' pressure led to a number of hospital beds being set aside for private practitioners' patients, as well as for medical membership of new hospital boards.<sup>57</sup> Similar schemes were envisaged in the Cape, Free State, and Natal, although anxieties about financial implications delayed their implementation.<sup>58</sup> Indeed, Natal failed to introduce free general hospitalisation at the time it was enacted elsewhere, although Natal doctors supported the oppositional stance taken by militant colleagues elsewhere.<sup>59</sup> And, although medical criticism of health centres had been muted, moves for free hospitalisation were vigorously critiqued because these impinged directly on private practice.

The Transvaal and Cape Ordinances created centralised, authoritarian provincial health administrations as well as providing for free treatment.<sup>60</sup> That they were reproduced in full in the *South African Medical Journal* indicated the importance given them. Doctors expressed varying concerns. One thought that the authorities had 'pulled a fast one' on us, and that there was a need to 'weigh fairly the general good against the sectional interest'.<sup>61</sup> A second referred to the policy as the course of 'a dictator', whilst 'revolting' doctors saw the value of 'a free and liberal profession' defending private practice against the subsidised competition of publicly-funded doctors.<sup>62</sup> Another practitioner struck the same note by writing that 'the very thought of state control makes any free democrat shiver'.<sup>63</sup> But one doctor, with a less narrowly sectional focus, considered that MASA was neglecting the more important issue of health centres by targeting hospital provision.<sup>64</sup>

The process of setting up a national health scheme involved 'complex negotiations', as Henry Gluckman admitted, after having become Minister of Health, a position he held only until May 1948.<sup>65</sup> He also hoped to facilitate the growth of health centres through accepting the chairmanship of the new Health Centres Advisory Committee that was to select their sites. He told a Medical Congress that 'as a profession we would do well to lead and guide. ... I plead for patience, understanding and cooperation'.<sup>66</sup> But the extent of doctors' objections to free hospitalisation had already become obvious two months previously, as MASA awkwardly linked its defence of the

<sup>56</sup>Pentz evidence to NHSC, p. 406.

<sup>57</sup>Woolf 1946.

<sup>58</sup>*Cape Times*, 5 July and 5 September 1946; 29 May 1947.

<sup>59</sup>Hellmann 1949, p. 406; *Cape Times*, 14 October 1948.

<sup>60</sup>Reproduced in *SAMJ*, 20, 1946, 539–52, 552–8.

<sup>61</sup>Downes 1946.

<sup>62</sup>Alabaster 1946.

<sup>63</sup>Du Preez 1946.

<sup>64</sup>Anning 1946.

<sup>65</sup>Gluckman also accepted key positions as chairman of the National Health Services Advisory Committee, of the Central Health Services and Hospitals Coordinating Committee and of the National Health Council.

<sup>66</sup>Gluckman 1946.

profession's sectional interests to the universalist rhetoric of the NHSC in stating disingenuously that, since free hospitals would be beyond the financial capacity of the provinces, the proposals would 'perpetuate and aggravate the unbalanced and uncoordinated patchwork of health services in South Africa without achieving any appreciable improvement in the health of the people'.<sup>67</sup> A central concern was that the free hospitalisation plan 'would tend to deprive the bulk of them [i.e. doctors] from sharing in hospital work'.<sup>68</sup>

The vested interests of the medical profession were soon obvious in their opposition to hospital ordinances in the Cape and Transvaal. When the hospital bill was being discussed in the Cape Provincial Council, the Cape Western Branch of MASA organised a meeting of 1,000 people in Cape Town to protest against the allegedly indecent haste and lack of consultation in its introduction, as well as the bureaucratic control that would result, and which was seen as bearing no relation to Gluckman's proposals.<sup>69</sup> Later opposition in the Free State and the Transvaal was more formidable. The part-time medical staff of the National Hospital in Bloemfontein resigned in protest against the free hospitalisation clauses in the Free State's hospitals ordinance, as they considered that 90 per cent of their patients fell into this category, so that their incomes would be adversely affected. However, a settlement was reached after it was agreed to pay doctors who treated these free hospital patients, although proposals envisaging the implementation of an entirely free hospital service in the Free State renewed medical anxieties.<sup>70</sup> The Free State disagreement was dwarfed by that in the Transvaal where there was a much larger medical fraternity and a more developed hospital sector. A general 'walk-out' of honorary staff—effectively a strike—occurred at Johannesburg General Hospital in October 1948, when only the casualty department was left operational.<sup>71</sup> The practice of honoraries withholding their services spread to other Transvaal hospitals, and even full-time medical staff threatened a walk-out.<sup>72</sup> The doctors wanted a means test to be inserted in the province's ordinance because, without this, free hospital treatment was alleged to threaten doctors' livelihoods since only a minority holding paid appointments were to be employed in new staffing arrangements.<sup>73</sup>

The fee issue was an equally explosive issue. In the Cape, the fees paid by patients at public hospitals were to be halved by the Cape Hospital Board from 1 January 1948, as an interim measure before free treatment came into effect in 1950. In reality this may not have been a particularly significant extension of free hospital care as 70 per cent of patients already received free treatment, while Cape hospitals took a lenient view over patients' ability to pay.<sup>74</sup> Similarly in the Transvaal, patients' fees constituted only 29

<sup>67</sup> *SAMJ*, 20, 1946, 537.

<sup>68</sup> *SAMJ*, 20, 1946, 538.

<sup>69</sup> *Cape Times*, 4 June 1946.

<sup>70</sup> *Cape Argus*, 21 April 1947; *Cape Times*, 21 June 1947; *Cape Times*, 28 August 1947; *Friend*, 12 October 1948.

<sup>71</sup> *Cape Argus*, 2 October 1948; *Cape Times*, 6 October 1948.

<sup>72</sup> *Cape Argus*, 7 October 1948; *Cape Times*, 15 October 1948.

<sup>73</sup> *Cape Argus*, 9 October 1948; *Star*, 12 October 1948.

<sup>74</sup> *Cape Argus*, 9 December 1947; evidence of Dr D. A. van Binnedyck (Medical Inspector of Hospitals) to NHSC, Q. 5892.

per cent of hospitals' revenue.<sup>75</sup> Nationally, however, many doctors were hostile to the reform of fees, as had been shown earlier in a national MASA plebiscite of 1946 when 88 per cent of votes cast were against hospital ordinances' provision for free hospitalisation. Doctors were also opposed to the related issue of a continued division of powers in healthcare between provinces and Union. However, the doctors' stance was weakened by the fact that little more than half (54 per cent) of MASA members voted.<sup>76</sup> On patients' fees, the Transvaal Branch of MASA had pressed for a referendum on a means test for patients but had finally agreed to accept the appointment of Judge H. de Villiers as mediator. Villiers proposed the seemingly obvious formula that those who could not pay should receive free hospital treatment, and that those who could pay should be treated by private practitioners.<sup>77</sup> Indirectly, this met MASA's fundamental point that free services would have deprived those in private practice 'in a large measure of their ability to earn a living'.<sup>78</sup> The hospital dispute ended with the Transvaal hospital ordinance suspended for three years, so that in the interim period only patients who were unable to pay would receive free treatment.<sup>79</sup>

As in Britain where the British Medical Association (BMA) whipped up anxiety that a socialised occupation would be created, so MASA increased tension in South Africa by envisaging 'that all members of the professional division will be civil servants'. Comparability of professional anxiety between professional associations in the two countries was also evident in MASA's fears that a patient's right to a doctor of their own choosing would be interfered with. However, an explicit contrast was drawn between the more favourable financial settlement achieved by British doctors compared with the less auspicious financial position faced by their South African colleagues. This was because South African colleagues perceived the principle of compensation to be an integral part of the British NHS scheme.<sup>80</sup>

## Britain

In comparison with South Africa, a more unified national health service emerged from British reforms advocated during the 1940s, and these were embodied in integrated legislative measures rather than in the separate initiatives by state and province in South Africa. However, there were strong similarities not only in timing but in the vision of health centres offering more than a narrowly defined curative medicine, in a reformed structure of hospital care, as well as in free treatment at the point of access. In both countries the existence of powerful sectional interests reshaped the original visionary blueprint.

The most conspicuous change in Britain was reform of the hospital sector with the result that critics of the National Health Service (NHS) called it the National Hospital Service. Replacing the segmented tertiary sector of the interwar years where voluntary,

<sup>75</sup>Evidence of Pentz to NHSC, p. 65.

<sup>76</sup>*Cape Times*, 11 December 1946.

<sup>77</sup>*Cape Argus*, 29 October 1948.

<sup>78</sup>*Friend*, 12 October 1948.

<sup>79</sup>*Cape Argus*, 29 October 1948.

<sup>80</sup>*SAMJ*, 20, 1946, p. 538; Bartrip 1990, pp. 271–8.

municipal and public assistance institutions operated independently was a nationalised, regional hospital service. In effecting this change, the Labour government's Minister of Health, Aneurin Bevan, had been assisted by the lack of opposition from local authorities (many with Labour administrations) and by financially weak voluntary hospitals (which could look forward to the substantial autonomy of teaching hospitals in the new scheme). Even more significant was a divided British medical profession operating in a tense coalition of varied, vested interests. In contrast to the South African situation where the same professional association represented the interests of both specialists and generalists, and hence were able to put up a strongly unified opposition to hospital reform, in Britain the specialists were represented by the Royal Colleges and the generalists mainly by the BMA. In this situation the consultants made their own deal with the government. This safeguarded specialists' interests by providing the option of a part-time contract that enabled them, for only a small reduction in remuneration, to do private practice as well as hospital work. The provision of private pay beds in NHS hospitals, together with generous distinction awards for specialists, made this a deal so advantageous that these elite doctors could hardly refuse it.<sup>81</sup>

Hospitals became the 'cuckoo in the nest' as far as healthcare resources were concerned.<sup>82</sup> Huge strides in medical progress involving impressive advances in specialist expertise, technology and pharmaceuticals made increasing hospital expenditures a worldwide phenomenon. British hospitals were increasingly voracious consumers of funds, at first taking up 54 per cent of NHS funding, but three decades later as much as 70 per cent.<sup>83</sup> In South Africa, 60 per cent of the Cape Province's healthcare budget was taken up by three specialist Cape Town hospitals by the 1990s.<sup>84</sup> But whereas in Britain a universalist service was created, in South Africa there were racially-differentiated services, except in the Cape Province.

Another institutional reform envisaged in the NHS was that of health centres, but whereas hospital reform was swiftly brought about, this was attenuated and delayed. The concept of the health centre had entered health service planning earlier in Britain than South Africa, starting with the Dawson Report of 1920. Although a somewhat amorphous concept, the health centre ideal was differentiated from the individualistic, curative model then dominating general practice. Instead it envisaged collective provision by a variety of personnel and with greater emphasis on preventive and promotive activity. By the 1930s, the Socialist Medical Association, the Medical Practitioners Union and the Labour Party had embraced its desirability.<sup>85</sup> During the interwar period, health centres had featured in municipal health services as maternity and child welfare clinics, as well as in post-natal clinics. And a few local authorities had already set up pioneering institutions of a more ambitious type, notably the Peckham Health Centre.<sup>86</sup>

<sup>81</sup>Webster 1998, pp. 15–26, 38.

<sup>82</sup>Email communication by J. Stewart, 24 June 2008.

<sup>83</sup>Webster 1998, p. 38.

<sup>84</sup>The three hospitals were Groote Schuur, Red Cross Children's, and Tygerberg (Digby *et al.* 2008, ch. 4).

<sup>85</sup>Stewart 1999, p. 184; Digby 1999, p. 328

<sup>86</sup>Lewis and Brookes 1983.

When planning for post-war reconstruction was begun during the early 1940s, the potential of the health centre was recognised in the Labour Party's plans for a comprehensive and publicly-financed system of health centres under local authorities, with much of this thinking shared by Ministry of Health officials. The 1946 White Paper stated that 'a main feature of the personal practitioner service is to be the development of health centres'.<sup>87</sup> However, the mainstream BMA was opposed to the kind of salaried doctor operating within a group practice that was envisaged in this health centre scenario. Pressure from this powerful sectional vested interest meant that the activity of general practitioners was substantially untouched in the creation of the NHS. However, future provision of health centres was envisaged in the NHS Act of 1946 (section 21) for England and Wales and the NHS (Scotland) Act of 1947 (section 15) where the health centre was a 'key feature'. But as early as December 1947 and January 1948, circulars from the Ministry of Health began to backpedal on the desirability of devoting resources to health centres, so that local authorities were instructed to submit plans only for 'urgent new projects'. The rationales for this revisionism were scarce resources and the conservative, oppositional stance of the BMA to a reform with such a radical potential to destabilise the existing small businesses of GPs.<sup>88</sup>

During the initial wartime plans for a new health service, municipal health services had seemed central, but this was not carried through to the final NHS reform so that some compensation was the promise to local authorities of a positive new function in a provision of health centres to 'be developed as fast and as widely as possible'.<sup>89</sup> Health centres under the early NHS offered the potential to unify primary health care so that progressive local authorities retained their interest in their potential. But resource constraints, tensions between the medical profession and other bodies, as well as lengthy, often unsuccessful planning negotiations between local authorities and the Ministry of Health meant that expansion was modest. In this unpropitious environment, the failure rate was high, with even the Peckham Centre reconfigured as a mere recreation centre.<sup>90</sup> Indeed Charles Webster, the official historian of the NHS, refers to 'the virtual death of the health-centre concept under the early NHS', and that 'as a vehicle for promoting cooperation, or for revitalising general practice, health centres were thus a catastrophic failure'.<sup>91</sup> Bucking the trend, however, was the New Town of Harlow where all primary health care doctors worked in new health centres and hence were not encircled by the usual, competitive general practices. George Gale, a commentator with a good knowledge of both South Africa and Britain, remarked that the health centres set up under the NHS:

were far removed in concept from the health centres established in South Africa. They provided facilities at one and the same geographical point which could be used in common by practitioners of curative medicine and the practitioners of preventive medicine who, however, remained quite separate functionally.<sup>92</sup>

<sup>87</sup>Webster 1988, pp. 24, 381.

<sup>88</sup>Webster 1988, pp. 24, 38, 381–3.

<sup>89</sup>Webster 1998, pp. 10–12, 20.

<sup>90</sup>Webster 1988, pp. 382–3, 386.

<sup>91</sup>Webster 1998, p. 50; Webster 1988, pp. 386–7.

<sup>92</sup>Gale 1970, p. 500.

He concluded that in 20 years much less than half the 40 centres set up in South Africa had been created in Britain.<sup>93</sup> By 1965 there were still only 33 British health centres.

### Longer-Term Perspectives

British reform of primary healthcare was delayed for a generation; general practice was substantially unreformed under the NHS legislation so that GPs persisted as independent contractors, many in under-funded practices.<sup>94</sup> Substantive later reform occurred only after 1966 with financial inducements given for GPs to establish group practices in new premises. As a result, the number of so-called health centres rose dramatically to 654 by 1974. This constituted a substantial advance in primary healthcare since doctors had the opportunity of working in teams with other healthcare professionals. In practice, this teamwork was seldom realised and the focus was still on curative rather than preventive care.<sup>95</sup> The full potential of the health centre to give holistic care that was promotive, preventive and curative was seldom realised.

Institutional attrition of South African health centres continued during the 1960s, 1970s and early 1980s: some health centres were amalgamated with out-patient services of provincial hospitals. This was a fate suffered in the Cape by six centres.<sup>96</sup> At the same time, the original emphasis on preventive services morphed into a stress on curative ones so that the Cape Administration admitted that they would be 'similar to that provided by the Administration's out-patient departments and district services'.<sup>97</sup> Howard Phillips has analysed perceptively how the original rationale of providing promotive and preventive medicine at the Grassy Park Health Centre was effectively strangled. This was because of the provincial administration's reluctance to continue employing health assistants whose work had been to assemble the family data on which such health centre work was predicated, as well as by a provincial directive that 'the health centre should function as a detached out-patient clinic where curative services are rendered'.<sup>98</sup> Statistics for attendances at Cape health centres from 1958 to 1980 indicated that more than nine out of ten attending patients were seen in the health centre clinic and thus that there was only a small minority of domiciliary visits. A decline in healthcare for the black population under the apartheid regime was also evident in the fact that only two-thirds of attendances at Cape centres were made during the 1970s as had been the case during the 1960s.<sup>99</sup> This information confirms George Gale's earlier assessment of the outcome of the health centre experiment. This was that centres had closed down or been handed over to provincial administrations, which then converted them into 'detached out-patient clinics practising curative medicine only'.<sup>100</sup> In South Africa, the changed values and priorities of an apartheid government after 1948 had meant a

<sup>93</sup>*Ibid.*

<sup>94</sup>Digby 1999, pp. 331–40.

<sup>95</sup>Webster 1998, pp. 50, 131–2.

<sup>96</sup>These were at Cradock, George, Knysna, Mossel Bay, Stellenbosch and Grassy Park.

<sup>97</sup>*Report of the Director of Hospital Services, Provincial Administration of the Cape of Good Hope, 1957*, p. 2.

<sup>98</sup>Phillips in Dubow and Jeeves (eds) 2005, pp. 119–20.

<sup>99</sup>*Reports of Director of Health Services in the Cape Province, 1958–1980.*

<sup>100</sup>Gale 1970, p. 515.

diminished status for the health centre away from it being the fundamental building block of a new healthcare system. A diminishing number of centres could do little to redress the poor distribution of healthcare resources from urban to rural areas or to extend modern healthcare to a disadvantaged black population. And the free hospital care that was introduced proved an unsustainable expense for the provinces, which later reintroduced fee scales, as in the Cape in 1957.

In Britain by the 1970s there was recognition of the failure within a national health service adequately to redistribute healthcare resources away from well-endowed geographical areas. Even after the Resource Allocation Working Party (RAWP) initiative in 1975, progress remained slow. In 1980, the Black Report graphically depicted a two nation scenario, where poor areas suffered a disproportionate amount of ill health, with a skewed resource distribution not greatly altered during three decades.<sup>101</sup>

In South Africa, little was salvaged of Gluckman's bright vision until the concept of a national, more equitable health system resurfaced during the closing decades of the twentieth century. A renewed interest in primary healthcare was discernible in the establishment of community health centres. For example, in the northern 'homeland' of Gazankulu a health plan of 1977 envisaged health centres replacing clinics, although only one was actually initiated.<sup>102</sup> In 1980, the Cape Province also set up six such centres in areas not having had a health centre previously.<sup>103</sup> The pace of reform quickened after 1994 as the democratically elected government formulated plans for a national health system predicated on an expansion of primary health care (PHC) in decentralised district health authorities. But time horizons were short so that these plans were formulated without explicit reference to the experiments of half a century before. Nevertheless, the congruence of vision was striking.

*Restructuring the National Health System for Universal Primary Healthcare* (1996) had 'the aim of developing an equitable and efficient national health system for the country'. It noted that, despite devoting a higher proportion of GDP to healthcare than most developing countries, South Africa's health status was relatively poor. In seeking explanations for this, the 1996 Report—like the Gluckman Report half a century earlier—focused on historical disparities in provision, such as the under-resourcing of PHC compared to hospitals (with more than nine-tenths of healthcare expenditures going to acute hospitals) and on the need to improve access to basic PHC.<sup>104</sup> Like the Gluckman Report, this healthcare plan emphasised that 'health is seen as more than the absence of disease; health services encompass promotive, preventive and curative services' and it also advocated that there should be a 'symbiotic relationship' between different healthcare sectors.<sup>105</sup> But, as in the earlier experience of health centres, there was recognition of a severe problem in staffing healthcare facilities in remote areas.<sup>106</sup>

<sup>101</sup>Townshend and Davidson 1982; Webster 1998, pp. 84–6.

<sup>102</sup>Buch and Stephenson 1984, p. 1.

<sup>103</sup>These were at Albertina, Beaufort West, Calitzdorp, De Aar, Lambert's Bay and Pacaltsdorp (*Report of Director of Hospital Services, 1980*, p. 1).

<sup>104</sup>*Restructuring the National Health System for Universal Primary Healthcare*, January 1996, part 1, paras 1, 2.1–2.3, and 3.

<sup>105</sup>*Restructuring*, paras 4.1.4 and 4.1.5.

<sup>106</sup>*Restructuring*, para. 4.3.9.

## Conclusion

'This is a report that shows us what we should be doing', exclaimed a British civil servant on reading the South African Gluckman Report.<sup>107</sup> The 1940s had given an environment of possibility in both countries: reforming visions were put forward, notably in the health centre concept, but the realities of vested interests and resource constraints meant that such reform was soon downgraded in a hierarchy of practical possibility, with the radical health centre option taking second place to mainstream hospital reform. In focusing on parallel health reforms and outlining the comparative dynamics of restructuring health systems in South Africa and in Britain, this article has highlighted the problems of transforming reforming ideas into reality. In South Africa, Pentz's more limited view of free hospitalisation recognised the boundaries of feasibility, whereas Gluckman's idealistic vision of national reform based on health centres tested the limits of healthcare possibility almost to destruction. As Minister of Health, Henry Gluckman had intended to introduce a new health bill in the 1948 session of parliament.<sup>108</sup> But the victory of the National Party at the polls in that year resulted in an apartheid government unsympathetic to idealistic plans for improving the lot of the black population, while a diminishing 'poor white' problem among Afrikaners removed any remaining rationale for healthcare reform. Although the Gluckman Report had appealed to a popular mandate, in that 'the people are thoroughly dissatisfied with the inadequacy and incoordination [*sic*] of the health and medical services', the majority population had no empowering vote to support such a mandate.<sup>109</sup>

In 1948, the new health minister, Dr Stals, was able to signal that he was sympathetic to the doctors' stance in remarking that 'it would be short-sighted in the present zeal to bring about a socialisation of services', and that 'complete uniformity within a single framework would lead to mediocrity and inferiority'.<sup>110</sup> The earlier inclusive, universal health vision was downgraded as Stals envisaged 'a practical health scheme' and a reasonable provision for a reasonable state of health. 'I use the term reasonable state of health because I am not of the opinion that we in South Africa can provide an ideal scheme. We can only have the scheme for which we can pay.'<sup>111</sup>

In contrast, the swing of the political pendulum in Britain was modest by comparison with South Africa. In Britain, a broad bi-partisan consensus had soon emerged in favour of an NHS perceived as an untouchable national institution. In addition, initial reform in 1948 was facilitated by strong elements of bureaucratic continuity, as the complex administrative framework of the British national health insurance scheme (built up since 1911) enabled the NHS scheme to be grafted on it.<sup>112</sup> In contrast, the South African constitution safeguarded the independent responsibility of provinces for hospitals, thus making the creation of an integrated national health scheme problematic. And in Britain, the economy and tax base was much larger so that resources could be

<sup>107</sup>Quoted in Henry Gluckman's obituary, *SAMJ*, 72, 1987, p. 303.

<sup>108</sup>Speech to Medical Congress, reported in *Cape Times*, 12 October 1946.

<sup>109</sup>*NHSC*, chapter IV, para. 73.

<sup>110</sup>*Cape Times*, 27 July 1948.

<sup>111</sup>*Natal Mercury*, 22 October 1948.

<sup>112</sup>Digby in Bloor (ed.) 1998, p. 14.

made available for compensation for medical practices. The editor of the *South African Medical Journal* saw 'very close analogies between the terms of the National Health Service Act in Great Britain and the proposals of the National Health Services Commission in this country' but contrasted the settlement received by doctors by lamenting that 'we in South Africa might be very satisfied if we could obtain such generous terms'.<sup>113</sup> The relative power of medical vested interests in modifying healthcare reform in the two countries had similarities in so far as both MASA and the BMA had some success—the former in postponing free hospitalisation and the latter in keeping the independent contractor status of GPs. But both professional associations were criticised for their perceived failure to defend members' interests adequately.<sup>114</sup> Since MASA had just achieved independence from its erstwhile parent body, the BMA, their equivalence was perhaps unexceptional.<sup>115</sup> Although the politics, resources and divided vested interests of Britain gave greater momentum for integrated healthcare reform, arguably the vision of reformers in South Africa had wider, long-term influence. Gluckman's view of positive health anticipated by three years the preamble of the World Health Organisation's constitution, South African reformers such as Gale and Kark worked for the WHO, whilst Karkian principles have been interpreted as an inspiration for the WHO's landmark Alma Ata Declaration on primary healthcare in 1978.<sup>116</sup>

### Acknowledgements

I am most grateful for the able research assistance of Kirsten Thomson and for the helpful comments of Howard Phillips and John Stewart.

### Bibliography

#### Primary sources

- Government Papers of the Union of South Africa, 1943–56. South African National Library, Cape Town and the Government Publications Department in the Library of the University of Cape Town.
- Orange Free State Provincial Administration, Report of the Director of Hospital Services. 1956–85.
- Report of the Director of Hospital Services, Transvaal Provincial Administration, 1958–9.*
- Report of the Director of Hospital Services, Natal Provincial Administration, 1956–85.*
- Reports of the Director of Hospital Services, Cape of Good Hope Provincial Administration, 1958–9.*
- Cape Argus*
- Cape Times*
- Friend*
- Alabaster G. 1946, 'Family Doctor and the State', *South African Medical Journal*, 20, 565–6.
- Anning C. C. P. 1946, 'The Provincial Ordinances and a National Health Service', *South African Medical Journal*, 20, 558–9.
- Downes J. C. 1946, 'Social Planning versus Free Enterprise', *South African Medical Journal*, 20, 559–60.
- Du Preez C. J. 1946, 'Reorganisation of Medical Services', *South African Medical Journal*, 20, 566–7.
- Gluckman H. 1946, 'National Health Service', *South African Medical Journal*, 20, 655–63.
- Gluckman H. 1948, 'Health Centre Practice in Relation to Private Practice', *South African Medical Journal*, 22, 370–2.

<sup>113</sup>Editorial 'The British NHS Act', *SAMJ*, 22, 1948, p. 117.

<sup>114</sup>*SAMJ*, 21, 1947, p. 623; Digby 1999, pp. 329, 335–7.

<sup>115</sup>Digby 2006, pp. 156–7.

<sup>116</sup>Gale 1970, p. 500; Marks 1997, p. 453; Marks in Dubow (ed.) 2000, p. 189.

- Hellmann E. 1949, *Handbook on Race Relations in South Africa*, Johannesburg: Oxford University Press.
- Kark S. L. 1951, 'Health Centre Services', in Cluver E. H. (ed.), *Social Medicine*, Johannesburg: Central News Agency, 661–700.
- Kark S. L. and Cassel J. 1952, 'The Pholela Health Centre', *South African Medical Journal*, 26, 101–4, 132–6.
- Kark S. L. and Steuart G. W. (eds) 1962, *A Practice of Social Medicine*, Edinburgh and London: E. S. Livingstone.
- Pentz H. F. 1942, *A Scheme of Free Hospitalisation. Report to the Administrator of the Province of Transvaal*, Pretoria: Government printer.
- Ryle J. A. 1948, 'The History and Modern Concept of Social Medicine', *South African Medical Journal*, 22, 436–7.
- Woolf E. B. 1946, 'Comments on the Transvaal Hospitals Ordinance, 1946', *South African Medical Journal*, 20, 567–8.

### Secondary sources

- Abiding Values. Speeches and Addresses by Henry Gluckman*, 1970, Johannesburg: Caxton.
- Bartrip P. W. J. 1990, *Mirror of Medicine. A History of the BMA*, Oxford: BMJ and Clarendon Press.
- Buch E. and Stephenson D. 1984, 'Reviewing the Health Centre Policy', unpublished paper to Second Carnegie Inquiry.
- Digby A. 1998, 'Continuity or Change in 1948? The Significance of the NHS', in Bloor K. (ed.), *Realism and Reality in the National Health Service: Fifty Years and More*, York: University of York, 4–17.
- Digby A. 1999, *The Evolution of British General Practice, 1850–1948*, Oxford: Oxford University Press.
- Digby A. 2006, *Diversity and Division in Medicine. Health Care in South Africa from the 1800s*, Oxford and Berne: Peter Lang.
- Digby A., Phillips H. with Deacon H. and Thomson K. 2008, *At the Heart of Healing: Groote Schuur Hospital*, Johannesburg: Jacana.
- Dubow S. 2005, 'Introduction', in Dubow S. and Jeeves A. (eds), *South Africa's 1940s. Worlds of Possibilities*, Cape Town: Double Storey Books, 1–19.
- Gale G. 1970, 'The Gluckman Report', in *Abiding Values. Speeches and Addresses by Henry Gluckman*, Johannesburg: Caxton.
- Jeeves A. 1998, 'Public Health and Rural Poverty in South Africa: Social Medicine in the 1940s and 1950s', unpublished paper, Wits Institute for Advanced Social Research, 1–11.
- Lewis J. and Brookes B. 1983, 'The Peckham Health Centre', *Medical History*, 27, 151–61.
- Marks S. 1997, 'South Africa's Early Experiment in Social Medicine: Its Pioneers and Politics', *American Journal of Public Health*, 87, 452–9.
- Marks S. 2000, 'Doctors and the State: George Gale and South Africa's Experiment in Social Medicine', in Dubow S. (ed.), *Science and Society in Southern Africa*, Manchester: Manchester University Press, 188–212.
- Oswald N. T. A. 1991, 'A Social Service without Social Doctors', *Social History of Medicine*, 4, 295–315.
- Phillips H. 2005, 'The Grassy Park Health Centre: A Peri-Urban Pholela?', in Dubow S. and Jeeves A. (eds), *South Africa's 1940s*, Cape Town: Double Storey Books, 108–28.
- Porter D. 1992, 'Changing Disciplines: John Ryle and the Making of Social Medicine in Britain in the 1940s', *History of Science*, 30, 137–64.
- Stewart J. 1999, *The Battle for Health. A Political History of the Socialist Medical Association, 1930–51*, Aldershot: Ashgate.
- Townshend P. and Davidson N. 1982, *Inequalities in Health. The Black Report*, Harmondsworth: Penguin.
- Webster C. 1988, *The Health Services since the War*, vol. 1, London: HMSO.
- Webster C. 1998, *The National Health Service. A Political History*, Oxford: Oxford University Press.