The National Health Services Commission, 1942 - 1944 — its origins and outcome

D. HARRISON

Abstract **An analysis of the origins and outcome of the Gluckman Commission is relevant to the current health service debate in South Africa. Fundamental to the report's recommendations was the establishment of a unitary health service responsible for all health care functions within the Union of South Africa. On this proposal rested the success of the other key recommendations.**

The sequence of events following the publication of the report demonstrated that piecemeal restructuring, determined primarily by political considerations, failed. Unless policy-makers today are committed to a unitary health system with democratic control, current initiatives to restructure health services will probably remain parochial, contributing little to the improvement of health care for all South Africans.

S Afr Med J 1993; **83:** 679-684.

Nineteen ninety-two marks the fiftieth anniversary of the appointment of the National Health Services (Gluckman) Commission. Its report was released in 1944 and is widely regarded as the most comprehensive overview of the South African health services and health status yet published.

While the details of the report are obviously dated, it remains a valuable resource document for two reasons: (*i*) an analysis of the origins and impact of the National Health Services Commission helps place current health policy in historical perspective; and (*ii*) the report attempted to move beyond broad policy guidelines and offer concrete proposals for transformation of the health service from local to national. Today, many of the recommendations would be considered impracticable, but they do provide a springboard to help breach the gap between generally accepted principles and detailed implementation.

The Gluckman Report's fundamental proposal was that a unitary national health service (NHS) be established in South Africa. Such an NHS would ensure *free* provision of health services to all people in the Union, and would be financed by a national health tax. It further envisaged the creation of a separate Ministry for Health whose functions would be exercised by a national health board (department) with strong regional powers. The foundation of the NHS would be health centres that provided complete primary health care to the communities they served. Democratic interests would be protected by representation of the community and non-government organisations in health service management at local, regional and national levels. Similarly, health personnel would be represented at all three levels of policy-making. Local authorities would be responsible for non-personal health services, but would answer to provincial authorities.[1] This paper explores the origins of the National Health Services Commission and its impact on South African health policy in the light of each key recommendation.

Centre for Epidemiological Research in Southern Africa, South African Medical Research Council and Child Health Unit, Department of Paediatrics and Child Health, University of Cape Town

D. HARRISON, M.B. CH.B.

Accepted 4 Jan 1993.

NHS

A state health service

The South Africa Act of 1909 failed to provide for centralised public health administration. Almost three decades later, the Deputy Chief Health Officer of the Union, H. S. Gear, reflected that 'confusion, inefficiency, inertia and extravagance are all to be laid at the door of this illogical division of public health duties'.[2]

Some co-ordination of preventive health measures was achieved through the Public Health Act of 1919, although public health would have become from 'A to Z, a Union responsibility' had the Public Health Bill of 1919 been passed 'without material mutilation'.[3]

In 1920, George Hills, M.P., proposed to Parliament that a Select Committee be appointed to consider a comprehensive free state medical service. But, following hot on the heels of the influenza epidemic, the proposal was coldly received by an assembly preoccupied with the control of contagious diseases (*Cape Times*, 13 July 1920). Public health officials, however, continued to agitate for a state health system which brought 'preventative and curative medicine . . . together and practised in harmony'.[4,5]

The cause received a significant boost in September 1931 when the president of the MASA, Francis Napier, made an impassioned plea for a unitary medical service administered by the State. He argued that it would 'meet the needs of the whole population, rich and poor' and allow for co-ordination of preventive and curative

services.[6] The editors of the *Journal of the Medical Association of SA*, while declaring themselves 'radically opposed to the views enunciated', acknowledged that Napier spoke for a small, but growing, section of the population.[7]

In 1935, Dr E. P. Baumann moved in the House of Assembly that the government appoint a commission to inquire into the establishment of a full-time salaried state medical service, arguing that 'entirely fresh machinery is necessary to provide for the health of the country as a whole, urban and rural, rich and poor, employed and unemployed, without distinction of race or colour by the State Medical Service'.[8] Once again, the motion was 'fobbed off on financial grounds'.[9] But the issue had generated a great deal of discussion, and the *South African Medical Journal* published numerous articles on the subject in a section devoted to the 'Future of Medicine in South Africa'.[10-14] The publication of an anonymous pamphlet entitled *Co-operative Medicine* caused a flurry of responses in 1941. In that pamphlet, the authors analysed South African health services and concluded that: (*i*) medical education was orientated towards curative rather than preventive care, which encouraged competitive private practice; (*ii*) doctors were maldistributed throughout the Union; and (*iii*) the Public Health Service was hamstrung by inadequate finance. They argued that: (*iv*) health and health care were rights to which all people were entitled; (*v*) there should be no direct fee-for-service; (*vi*) the cost of health services should be met from general state revenue; (*vii*) a medical co-operative should be contracted to provide health services and execute health policy; and (*viii*) the formation of health policy should be in the hands of a democratically elected advisory committee.[9,15] The pamphlet was severely criticised by many who regarded its sentiments as communist, but praised by others for its democratic, if nebulous, approach.[16,17]

Three other proposals for health service re-organisation attracted support; these were described by the Gluckman Report as the 'bureaucratic', 'technocratic' and 'insurance' types of national health authority.

The first evolved from the proposal to convert the military medical service to a civil service after the Second World War, and mirrors the organisation of the current Department of National Health and Population Development. The second proposal emanated from the Planning Committee of the MASA and proposed the delegation of powers of a separate Ministry of Health to a health supply commission administered by superintendents and commissioners of various health departments.[18,19] The third proposal was based on the recommendations of the Second Report of the Commission on Old Age Pensions and National Insurance (1928), which called for the introduction of a scheme of health insurance to include all employed people in urban areas whose incomes fell below an annual minimum, and which would provide medical, maternity and funeral benefits out of funds contributed by both employer and employee. It further proposed the extension of district surgeon services in rural areas and the creation of a separate medical service for blacks.[20] But in the words of Gluckman, 'the 1928 report got no further than some departmental pigeon-hole'.[21]

In 1935, the Public Health Department appointed a Committee of Enquiry into National Health Insurance, which submitted similar recommendations to those of the 1928 commission.[22] The MASA responded by resolving to support a national health insurance scheme if introduced by the Government.[23,24] Even Gluckman himself gave qualified support to the findings of the departmental inquiry, provided that adequate state provision was made for health services for black people.[20] But 3 years later he described it in parliament as 'an obsolete scheme of the past'.[25]

It was against this background of numerous and conflicting suggestions for the organisation of a national health authority that Gluckman called for a health services commission appointed by the Government. Both the medical profession and the Government were far more receptive to his far-reaching proposals than at the time of the previous parliamentary motions in 1920 and 1935. In its lead editorial of 27 January 1945, the *South African Medical Journal* welcomed the report and commended it to the profession as a 'workman-like, feasible scheme which it may safely accept'.[26]

A unitary health service

A debate which paralleled and overlapped with that of a state health service had to do with the provision of health care for black people. During the nineteenth century, Western medical care for blacks was provided primarily by missionaries and a few private practitioners scattered throughout rural areas. But by the turn of the century, there was growing recognition of the 'pressing problem of Native medical needs'.[27] McCord, doyen of medical missionary work in Natal, advanced the debate by calling for the appointment of a government commission to investigate the 'medical needs of the Natives of South Africa'.[28]

A call by Campbell-Watt for a 'specific Native Medical Service' was taken up by the editors of the *South African Medical Record* in June 1918.[29] They favoured a separate state medical service for blacks administered by the Department of Native Affairs, but supported McCord's suggestion of an investigative commission.

Despite the lack of political will and apathy on the part of most South African practitioners, the subject of an organised health service for blacks remained alive, motivated not entirely by selfless concern.[30] For example, the 1925 Committee of Inquiry into Public Hospitals and Kindred Institutions argued that 'at present there are hordes of natives in many centres who have little chance of medical treatment, and (that) the untreated sick become a menace to the rest of the community'.[31]

Sir Edward Thornton, Secretary for Public Health, revived the debate in 1926 by proposing a health service similar to that in French West Africa, i.e. black medical auxiliaries under the authority of a white medical officer, operating in approved geographical areas. Thornton's publication seems to have been an attempt to pre-empt the findings of the Loram Committee appointed to inquire into 'the training of natives in medicine and public health'. It recommended the establishment of a government medical service for blacks which incorporated all mission hospitals, and the training of fully qualified black practitioners in addition to health assistants and nurses.[32] Publication of the committee's report was delayed for over a year following its completion, and although never officially explained, it is clear that Thornton was vigorously opposed to the concept of identical medical training for black and white students.[33]

The issue appeared to assume a new urgency during the first few years of the 1930s, but continued to be clouded by a circular debate about the level of medical training of blacks.[30,34-36] One of the major factors confounding progress was the lack of clarity concerning the form that such health care should take. P.W. Laidler,[37] medical officer of health for East London and later medical historian, reflected that 'top-heavy expensive (health) services' were pointless in a country which denied black people access to economic power. He emphasised environmental upliftment and economic reform, with gradual extension of rural health services. Despite discussion about a state health service, few individuals suggested a unitary NHS. The most notable

exceptions were the President of the Medical Association, Francis Napier (1931), Dr A. Hay-Michel (1931) and Dr E. Baumann, M.P. (1935). In a concise and persuasive letter to the *Journal of the MASA*, Hay-Michel outlined a scheme for a *unitary* health service for the country. But in the mid-1930s, this was very much a minority viewpoint, even among the pioneers of rural health care.

The Public Health Amendment Act of 1935 cleared the way for better provision of services in 'native territories'. In 1936, the Government proposed the formation of a 'native medical service', and the expansion of training of 'native medical aids' at Fort Hare.[38] In accordance with government policy, the Department of Public Health decided in 1938 to establish a completely segregated health service for blacks, administered jointly by itself and the Department of Native Affairs. By 1940, 'an embryo Native Health and Medical Service' had been created. The Gluckman Commission was appointed just at the time when the fluidity of the 20-year-old debate had eventually crystallised into a plan of action.

Gluckman would have no problem getting departmental support for the concept of health centres — a separate health service could readily accommodate that idea. But a unitary health service flew in the face of accepted government policy. The government's antagonism toward the recommendations of the Gluckman Commission intensified with the death of the Minister of Health, A. J. Stals, in 1951. Disillusioned, the Secretary for Health, George Gale, resigned to become dean of the new medical school for black students in Durban in 1952.

The Tomlinson Report, initially presented to the government in 1954, marked the end of attempts by the Department of Health to create a unitary health service, and entrenched a separate 'Bantu Health Service'.[39]

The 'provincial issue'

Sidney Kark describes Gluckman as a 'man who knew everybody's corns and how to avoid them' (personal communication — S. L. Kark, 2 April 1992). But Gluckman found it necessary to tackle the issue of provincial control of hospitals head-on. During the nineteenth century, hospitals were established primarily as charitable institutions for the sick poor, but by 1910, virtually all hospitals were subsidised or supported completely by the colonial governments. In most institutions, however, medical practitioners provided care to patients without payment, and hospitals were still regarded as primarily for paupers.[40] Consequently, the provincial administration of hospitals provoked little controversy at the time of Union. The promotive and preventive emphasis of the Public Health Act of 1919 overshadowed the issue of curative health services, and left the prevailing system of hospital control intact.

By 1922 however, there was growing dissatisfaction with provincial control of hospitals. In a strongly worded editorial, the *South African Medical Record* contended that 'the provincial administration of hospitals has proved an expensive and calamitous failure'.[41]

Drs Ronald MacKenzie, Superintendent of Johannesburg Hospital, and Helen Moffat spearheaded the drive for Union control of all hospitals. In an address to the MASA in 1923, Dr MacKenzie argued forcibly for unitary control of all public health services, and called on the medical profession to 'press for general hospitals in South Africa to be placed under a saner form of government'.[42]

On 26 August 1924, Morris Alexander, M.P., moved in the House of Assembly that the Government appoint a commission to report on the best hospital policy for the Union. The motion was unanimously supported by the House.[43] The Report of the Committee of Inquiry into Public Hospitals and Kindred Institutions (Vos Report) was published in mid-1925. Its recommendations were confusing, but included the proposal that all large hospitals be transferred to Union control.[51] Dr D. F. Malan, then responsible for the public health portfolio, caused outrage by declining to give effect to the recommendation. It later became clear that Malan himself had favoured the acceptance of the committee's recommendation, but that he had been overruled by the treasury and overwhelmed by the 'strength of the spirit of provincialism'.[44]

Because Union control had been so central to the recommendations of the 1925 committee, the Government appointed a further commission early in 1927 with a similar brief, but with the distinct understanding that provincial control of hospitals was non-negotiable. This committee, chaired by the Secretary for Public Health, Edward Thornton, found its hands tied with this directive, and concluded that there was no alternative to unitary, central control of all curative services.[45]

The issue simmered though the 1930s, but erupted again in 1942 with the appointment of the Pentz Commission of Inquiry into the feasibility of free hospitalisation in the Transvaal. The Federal Council of the MASA (BMA) refused to co-operate with Pentz on the grounds that the Gluckman Commission was considering the national re-organisation of health services, and that the Pentz Report was 'not only inopportune but likely to prejudice and vitiate the object of such a commission'.[46]

As early as 1911, the editor of the *South African Medical Record* had commented on Smuts' 'obsession' with provincial council control of public health, and before the Gluckman Commission's recommendations had even been released to the public, Smuts issued a statement reassuring the provinces that the Government would not disturb provincial control of general hospitals.[47] On 6 February 1945, the Minister of Welfare and Demobilisation accepted the report's recommendations with the reservations that the Government would work within the limits imposed by the constitution.[48] Ever the politician, Gluckman sought ways to implement as much of the report as possible within the confines of prevailing legislation, but remarked that 'the decision to leave hospitals with the provinces has increased the formidable task of achieving an effective plan for meeting our national health needs'.[49] Dr F. R. Luke, a member of the commission, was less diplomatic. Soon after the submission of the commission's report to the Government, he noted that 'it is regrettable if the Government is finally committed on the provincial issue; if that is so, no organised national scheme is possible'.[50]

Ministry of Health

At the time of Union in 1910, medical opinion was almost unanimously in favour of centralisation of health administration in the hands of a minister of public health.[47] During the first session of the Legislative Assembly, Dr J. C. MacNeillie moved that a minister for public health be appointed. The proposal was met with indifference by the Minister of the Interior who thought that 'the country was already blessed with too many portfolios', while the Minister of Lands objected on the grounds that he had had 'dozens of cups of coffee in the country districts, and had never suffered any evil'.[51]

The Public Health Bill of 1919 provided for a separate ministerial portfolio.[52] But the omission of this provision from the final act ensured that public health remained under the Ministry of the Interior. The Gluckman Commission's recommendation regarding

a separate health ministry was finally accepted by the Smuts Government in February 1945, and in November of that same year Gluckman became Minister of Health and Housing.

Health centres

In 1920, a consultative council on medical and allied services appointed by the British Government issued a report with startling and revolutionary recommendations. The proposed scheme for health services was based on a system of 'primary health centres', which would provide comprehensive health care. A group of primary health centres would be associated with a secondary health centre which would in turn be attached to a teaching hospital. The Assistant Medical Officer of Health of the Union of South Africa, L. G. Haydon, described the recommendations of the consultative council at the 16th Medical Congress of the MASA, but met with little enthusiasm from a gathering concerned more immediately with the control of infectious diseases.[52]

Sir Edward Thornton, enamoured with his experience of health services in French West Africa, proposed a system of health centres for black areas in his 1927 hospital report. His concept of health centres was rather vague, and he certainly failed to provide motivation for a comprehensive primary care service. His concern was the establishment of a cheap, extensive service for blacks which would pose no threat to white practitioners. But despite some ill-conceived ideas and questionable motivation, Thornton provided the framework on which the South African health centre concept was built.

The Loram Committee (1928) supported Thornton's proposal of health centres as the basis of the 'native medical service', but failed to articulate the precise function and scope of practice of the village health centres. By 1930, leading medical practitioners, such as Park-Ross and McCord, were proposing the establishment of health centres in rural areas along the lines suggested by the British consultative committee a decade before. Park-Ross, Assistant Officer of the Union Health Department, suggested one or two experimental comprehensive health centres under the control of a full-time medical officer.[34,36]

In 1934, an inter-departmental committee highlighted the poor social conditions in the George-Knysna forest area, and proposed the establishment of a combined health and social centre. A year later, Harry Gear returned from China to take up the post of Assistant Health Officer of the Union Health Department. He was particularly impressed with the comprehensive health services developed for rural populations in India and China, and soon committed the Department to a system of 'health units', intended to form the basis of the 'native medical service' and provide comprehensive health care to rural black people.[53]

In April 1940, the first health centre in South Africa was established by Drs Sidney and Emily Kark in Bulwer in the Natal midlands, under direction of the Union Health Department. Initially, its intended function was mainly curative, but the pressing realities of poverty and malnutrition soon changed the nature of the project to one which included community development and prevention of illness.

The detailed statistics kept by the centre allowed for documentation of the dramatic improvements in health over the first decade, accompanied by growing interest and active co-operation of the people served by the project.[53-57] Two other health centres were established before the appointment of the Gluckman Commission: one at Bushbuckridge in the eastern Transvaal and one in Umtata, Transkei.

The health centre was described in the commission's report as 'the foundation of the NHS', and it recommended the establishment of about 400 centres, or 1 per 25 000 people in the Union. Even before the completion of the report, the Government consulted the commission with a view to 'taking some small steps even now towards the initiation of the national health services scheme'. Fifty thousand pounds were made available from the treasury for the establishment of health centres in 1944 - 1945. A special Health Centres Advisory Committee was appointed in June 1944, with Dr Gluckman in the chair.[58] By June 1946, 6 additional centres were operational, including those at Knysna, Grassy Park, Newlands (Durban) and Alexandra.[59]

The appointment of Gluckman as Minister of Public Health and Housing in November 1945 and Gale as Chief Health Officer in 1946 injected tremendous enthusiasm into the project. The health centre service expanded rapidly, from 8 centres in June 1946 to over 40 by the time of the United Party defeat in 1948.

Initially, all health centre personnel were trained at Pholela, but it soon became impossible to accommodate all those who required training. The rural African nature of the Pholela Health Centre was also felt to be inappropriate for all 'racial and socio-economic backgrounds representative of the Union'.[60] Consequently, a training scheme for health personnel was established at Springfield, Durban, in 1946. This evolved into the Institute of Family and Community Health at Clairwood, headed by Kark.

Gluckman's immediate successor, A. J. Stals, was sceptical of the basic tenets of the health centre concept, but allowed development to continue during his term of office. His death a couple of years later signalled the end of either government support for, or ambivalence toward, the health centre service. The institute came under increasing pressure from the Government, which withdrew financial support after the resignation of George Gale. In 1953, the Rockefeller Foundation agreed to provide a 5-year grant to the institute, but refused to renew it in 1959 on the grounds that the money was wasted under a government directly opposed to the concept of community health (personal communication — S. L. Kark).

By 1960, most of the peripheral health centres had been forced to close, and were handed over to the provincial administrations for conversion into detached outpatient departments. A few of the medical officers in the outlying areas persisted for a few years, but by the mid-1960s all health centres had closed. The institute continued until January 1961. The greatest travesty was that it too was converted into an outpatient department practising curative medicine only.

The South African health centre experiment failed for several reasons. Firstly, the key elements of the Gluckman Report were rejected. Just as a NHS was stillborn as a consequence of the failure of the Smuts Government to accept key recommendations of the Gluckman Commission, so effective implementation of health centres was thwarted.

Secondly, legislated apartheid was in direct conflict with the commission's proposals. Gluckman had been committed to equity and a 'comprehensive and progressive public health policy'.[61] Without his vision, and in the presence of a government averse to socialism and committed to white progress, the health centre scheme was doomed to failure.

Thirdly, the scheme lacked the support of the MASA and private practitioners. The MASA underwent a remarkable regression of thought in the years following the Second World War. Gluckman's impression was that most South African medical practitioners were staunchly behind the concept of a NHS, but by 1952 the MASA had dismissed a 'drastic revolutionary NHS

based on the NHS Commission's Report (as) impractical and undesirable'.[62] The reasons for the about-face are murky, but the report was rejected at a time when every initiative was being carefully scrutinised for socialist tendencies. Gluckman had taken great pains to reassure private doctors that health centres would not be established in competition with their practices.[63] Despite this, resistance to proposed health centres emerged rapidly.[64,65] Gale found himself increasingly compromised by the fact that health centres remained an addition to the public health service and not its foundation, as envisaged by the Gluckman Report.

Fourthly, there was inadequate support and training for medical officers working in health centres. The rapid expansion of the service between 1946 and 1948 stretched the training capacity of the Institute of Family and Community Health to its limit. Because of the immediate need, some medical officers were sent to health centres with inadequate training and orientation.[66] The lack of support, and even obstruction from the Ministry after 1948, compounded the isolation of medical personnel at health centres.[67]

A democratic health service

Democratisation of the health services had been given scant regard throughout the 30 years of Union preceding the Gluckman Commission. With the notable exception of Helen Moffat, women had not been vocal regarding a future health service. A 'health service for natives' had been debated and eventually established without consultation, although a few black medical practitioners had commented on the proposals in the *Journal of the Medical Association of SA*.[68,69] In proposing a health centre service for blacks in 1930, the Assistant Health Officer of the Union, Park Ross, called for the community to be given a share in the management and financial control of each centre. But the first real call by members of the medical profession for creation of democratic mechanisms for the entire health service was encapsulated in the pamphlet *Co-operative Medicine*. It suggested tripartite control of health services in an 'advisory committee' that comprised representatives of the central government, the medical profession, and the national public. For Gluckman, democratic control of the NHS was fundamental. He recommended the appointment of representative national, regional and local health councils.

The first National Health Council, established by Act 51 of 1946, convened on 11 August 1947. It comprised over 50 members representing government departments, the professions and various voluntary organisations. In reality, it served little purpose because of its unwieldy size. The composition and functions of the National Health Council were modified by an amendment to the Act in 1952, and the reconstituted Council was never called together.[70]

Protection of professional interests

The medical profession had played a prominent role in lobbying for the appointment of the National Health Services Commission. By 1942, the Ministry was pressurised into appointing a commission by a vocal sector of the profession adamant that health services should no longer meander along, oblivious to the country's health needs. Not surprisingly then, professional personnel expressed 'great fear' to the commission that the health service bureaucracy would 'muzzle' individual opinion. The report's plan for technical advisory committees at local, regional and national level satisfied the MASA, which applauded the fact that a personnel commission would be appointed independent of the Public Service Commission. However, this did not materialise and instead, the Central Health Services and Hospitals Co-ordinating Council were established, which sought to co-ordinate central and provincial functions. The repeal of the Public Health Act in 1977 abolished this council.

Non-personal health services

The South Africa Act of 1909 provided for provincial administrations to act as ministries of local government. This relationship had been left intact by the Public Health Act of 1919, despite the petitions of the Secretary for Public Health, J. A. Mitchell.

Clearly, Gluckman favoured the combination of the ministerial portfolios of health and local government, as in Great Britain. But in a rather blunt trade-off, and in an attempt to appease the provinces, the report recommended that local authorities relinquish all personal health services and expand their non-personal services such as sanitation, housing and water. Local authorities were to remain under provincial control. Even this proposal met with resistance, and Gluckman was forced to concede that some local authorities could provide personal health services, albeit under departmental supervision.[71] His gamble did not pay off. Not only did the provinces retain their power, but the health system of local authorities remained a hotch-potch of personal and non-personal services.

Conclusion

In many ways, the appointment of the National Health Services Commission in 1942 was expected and inevitable; the health service debate had been floundering ever since it became clear that the Government had no intention of implementing a national system of health insurance. The Department of Public Health, the medical profession — and, in Gluckman's view, the general public — demanded that health services be directed at and become responsive to national needs.

Most of the recommendations of the report were also expected, and consistent with the thinking of the time. The establishment of a NHS was really taken for granted by 1942. The debate centred around its form and organisation.

The emphasis on non-personal health services and intersectoral collaboration reflected the Public Health Department's justifiable preoccupation with infectious disease control. The vast body of opinion, outside of the political arena, insisted that provinces should relinquish control of the hospitals. A separate ministry of health was a logical step and had been mooted since Union. The health centre concept had been accepted as the basis of the 'Native Health Service' 5 years before the report. Its extension to the entire health service was neither startling nor revolutionary.

Gluckman's placation of medical personnel by the establishment of local, regional and national technical committees was a fairly unimaginative option which satisfied the MASA at the time but would, one suspects, have proved unwieldy and expensive. It has already been argued that the proposals regarding local authorities effectively meant no change. In short, the Gluckman Report delivered few surprises.

But two implications of the report were powerful and contrary to popular thinking. Firstly, the report was dogmatic that the changes envisaged could only be effected within a *unitary* NHS. This implied not only integration of provincial functions, but also the incorporation of the 'Bantu Health Service' into the NHS. Although the Department of Native Affairs was unlikely

to resist the changes, the recommendation challenged the conventional assumption of a separate health service for blacks.

Secondly, the creation of mechanisms for democratic control of the health services represented a giant leap beyond the thinking of most of the medical profession. Admittedly, the National Health Council was cumbersome and proved to be poorly constituted, but it was a monument to the commission's progressive and holistic understanding of health. For the first time, public representatives had a direct say in the formulation of health policy.

The National Health Services Commission was not a commission ahead of its time. Its appointment and most of its recommendations were rooted in the prevailing health service debate. Its outstanding innovative feature was its commitment to a unitary health system and democratic control of health services.

Since the mid-1980s, there has been a resurgence in the call for a unitary NHS as part of an enlightened social policy for South Africa.[72,73] Today, there is renewed government interest in many of the recommendations of the Gluckman Commission. There are moves to bypass, if not undermine, the power of the provinces. The idea of comprehensive primary health care centres is once again attracting attention. Technical co-ordinating committees have been established at regional level and in the homelands. But in the light of the above, these initiatives may also be regarded as parochial unless they form part of a broader commitment to a unitary health system and democratic control of these services.

REFERENCES

1. Union Government 30 - 1944. *Report of the National Health Services Commission, 1942 - 1944.* Pretoria: Government Printer, 1944.
2. Gear HS. South African public health services. *S Afr Med J* 1937; **11:** 12-17.
3. Editorial. New public health bill. *South African Medical Record* 1919; **17:** 1-3.
4. Mitchell JA. The public ill-health. *Medical Journal of South Africa* 1922; **18:** 59-63.
5. Mitchell JA. Public health in the Union. *South African Medical Record* 1921; **19:** 390-391.
6. Napier FH. A plea for state medicine. *Journal of the Medical Association of SA (BMA)* 1931; **5:** 587-591.
7. Editorial. The presidential address. *Journal of the Medical Association of SA (BMA)* 1931; **5:** 585-586.
8. Baumann EP. Union of South Africa debates of the House of Assembly. *State Medical Service* 1935; Col. 1124-1137.
9. Napier FH. State medicine. *S Afr Med J* 1941; **15:** 294-297.
10. Editorial. Axiomatic principles of a democratic health service. *S Afr Med J* 1941; **15:** 422-425.
11. Alabaster GH. Towards national health. *S Afr Med J* 1941; **15:** 351-352.
12. Albertyn CJ, Pirie JH. The future of medical practice. *S Afr Med J* 1941; **15:** 395.
13. Brink V. Health service. *S Afr Med J* 1943; **17:** 231.
14. Communist Party of South Africa. A planned health policy for South Africa. *S Afr Med J* 1943; **17:** 295-298.
15. Drury EG. Co-operative medicine. *S Afr Med J* 1941; **15:** 163-164.
16. Cluver EH. The future of medical practice in S.A. *S Afr Med J* 1941; **15:** 292-293.
17. Lundie C. Co-operative medicine. *S Afr Med J* 1941; **15:** 353-356.
18. MASA Memorandum from the Planning Committee. *S Afr Med J* 1942; **16:** 261-266.
19. Montgomery SK. National health service. *S Afr Med J* 1943; **17:** 207-212.
20. Union Government 50 - 1928. *Second Report of the Commission on Old Age Pensions and National Insurance.* Pretoria: Government Printer, 1928.
21. Gluckman H. National health insurance and an improved rural medical service. *S Afr Med J* 1939; **13:** 39-40.
22. Department of Public Health of Union of SA. *Report of the Departmental Committee of Enquiry: National Health Insurance.* (Reprinted in *S Afr Med J* 1937; **11:** 260-326.)
23. Editorial. National health insurance. *S Afr Med J* 1936; **10:** 247-256.
24. Editorial. A health service for South Africa. *S Afr Med J* **16:** 425-429.
25. Gluckman H. *Abiding Values.* Johannesburg: Caxton Press, 1971: 419.
26. Editorial. The Health Commission's Report. *S Afr Med J* 1945; **19:** 15.
27. MacVicar N. The Native Health Society. *South African Medical Record* 1913; **11:** 406-407.
28. McCord JB. The Zulu witch doctor and medicine man. *South African Medical Record* 1918; **16:** 116-122.
29. Editorial. A native medical service. *South African Medical Record* 1918; **16:** 161-164.
30. Thornton E. A medical and nursing service for natives in South Africa. *Journal of the Medical Association of SA (BMA)* 1930; **4:** 507-510.
31. Union Government 30 - 1925. *Report of the Committee of Inquiry re Public Hospitals and Kindred Institutions.* Pretoria: Government Printer, 1925.
32. Union Government 35 - 1928. *Report of the Committee Appointed to Inquire into the Training of Natives in Medicine and Public Health.* Pretoria: Government Printer, 1928.
33. Editorial. Medical training of natives. *Journal of the Medical Association of SA (BMA)* 1928; **2:** 657-658.
34. McCord JB. A native medical service in South Africa. *Journal of the Medical Association of SA (BMA)* 1930; **4:** 511-514.
35. Loram CT. The training of natives in medicine and public health. *Journal of the Medical Association of SA (BMA)* 1930; **4:** 515-517.
36. Park-Ross GA. A medical and nursing service for natives in South Africa. *Journal of the Medical Association of SA (BMA)* 1930; **4:** 517-519.
37. Laidler PW. The relationship of the native to South Africa's health. *S Afr Med J* 1932; **6:** 617-628.
38. Gale GW. The rural hospital as an agent in native health education. *S Afr Med J* 1936; **10:** 541-543.
39. Report of the Commission for the Socio-Economic Development of the Bantu Areas within the Union of South Africa. *S Afr Med J* 1956; **30:** 869-876.
40. MacKenzie RP. The hospital question in South Africa. *African Medical Record* 1909; **7:** 250-253.
41. Editorial. Hospitals: union or provincial control. *South African Medical Record* 1922; **20:** 161-162.
42. MacMenzie RP. Hospital control. *Medical Journal of South Africa* 1923; **18:** 164-167.
43. Editorial. Medical matters in parliament. *South African Medical Record* 1924; **22:** 410-411.
44. Editorial. The hospital question. *South African Medical Record* 1924; **22:** 392-393.
45. Union Government 25 - 1927. *Report of the Hospital Survey Committee.* Pretoria: Government Printer, 1927.
46. G.P.S 31066 - 1942. Report by HF Pentz on a Scheme of Free Hospitalization.
47. Editorial. Centralised public health administration. *South African Medical Record* 1911; **9:** 129-130.
48. Medical Association of SA. National health services. *S Afr Med J* 1945; **19:** 222-223.
49. Gluckman H. Address to the S.A. Medical Congress, 9 November 1946. In: Gluckman H. *Abiding Values.* Johannesburg: Caxton Press, 1971.
50. Luke FR. The National Health Service. *S Afr Med J* 1945; **19:** 18-21.
51. Editorial. Medical matters in parliament. *South African Medical Record* 1910; **8:** 324.
52. Haydon LG. Some public health problems, as viewed from a South African standpoint. *South African Medical Record* 1920; **18:** 449-461.
53. Gear HS. The South African native health and medical service. *S Afr Med J* 1943; **17:** 167-172.
54. Kark SL. A health service among the rural Bantu. *S Afr Med J* 1942; **16:** 197-198.
55. Kark SL. The management of an enteric fever outbreak in a 'native territory'. *S Afr Med J* 1943; **17:** 87-88.
56. Kark SL. A health unit as family doctor and health adviser. *S Afr Med J* 1944; **18:** 39-46.
57. Kark SL, Cassel J. The Pholela Health Centre: a progress report. 1952; **26:** 101-104, 131-136.
58. MASA. National health services. *S Afr Med J* 1945; **19:** 222-223.
59. Gale GW. Health centre practice, promotive health services and the development of the health centres scheme. *S Afr Med J* 1946; **20:** 326-330.
60. Gluckman H. Address at the opening of the National Tuberculosis Conference held in Durban on 29 April 1947. *S Afr Med J* 1947; **21:** 322-326.
61. Gluckman's Election Manifesto (1938). In: Gluckman H. *Life's Rewards.* Johannesburg: Caxton Press, 1977: 246-247.
62. MASA News. National medical services. *S Afr Med J* 1952; **26:** 118-119.
63. Gale GW. Health centres: a memorandum for the information of government officers. *S Afr Med J* 1950; **24:** 426-427.
64. Gluckman H. Health centre at Sandflats. *S Afr Med J* 1947; **21:** 376-377.
65. MacQuillan CJ. Health centre practice and the general practitioner. *S Afr Med J* 1948; **22:** 502-503.
66. Chesler J. Health centre services. *S Afr Med J* 1953; **27:** 996.
67. Luke FR. Health services in South Africa: their defects and a suggestion for their reform. *S Afr Med J* 1955; **29:** 51-59.
68. Xuma AB. Notes on a native medical service in rural areas. *Journal of the Medical Association of SA (BMA)* 1931; **5:** 39-43.
69. Mahlangeni MR. A medical service for natives in South Africa. *Journal of the Medical Association of SA (BMA)* 1931; **5:** 37-38.
70. Cluver EH. *Medical and Health Legislation in the Union of South Africa.* Johannesburg: Central News Agency, 1960.
71. Gluckman H. The National Health Council (Speech delivered at the first meeting of the National Health Council in Bloemfontein, 11 August 1947). *S Afr Med J* 1947; **21:** 643-648.
72. Benatar SR. A unitary health service for South Africa. *S Afr Med J* 1990; **77:** 441-447.
73. Owen CP, ed. *Towards a National Health Service* (Proceedings of the National Medical and Dental Association Conference, March 1987). Cape Town: NAMDA, 1988.