Social Justice or Grandiose Scheme?

'People come to us with a cough and we give them cough syrup. But if we listen, they tell us stories of poverty, injustice, exploitation. Is the cough syrup enough?'

Ravi Naryan - People's Health Movement

In June 2012 the SAHJ carried two 'revisionist' articles on the 1942-44 South African National Health Services Commission (the NHSC or Gluckman Commission, after its Chairman, Dr Henry Gluckman), the first by the eminent African economic historian, Bill Freund, the second, by the much-published medical historian, Anne Digby.¹ The Commission’s specific remit was to report and advise upon 'the provision of an organized National Health Service, in conformity with the modern conception of "Health" for all [sic] sections of the people of the Union of South Africa'.² After exhaustive enquiries across the Union and from all sections of the population it recommended the establishment of a National Health Service, with health centres as its foundation at the local level.

As we all probably know, this did not happen: Smuts, then Prime Minister refused to take on the provinces which controlled regional hospitals and thought the entire venture far too expensive; the handful of health centres came under attack from members of the medical profession who feared they were taking away their patients, and were allowed to atrophy were by the Nationalist government. As Freund and Digby point out, however, there has been relatively little detailed historical analysis of this Commission, despite a number of general accounts, mainly by its medical admirers. At a time when South Africa is implementing its National Health Insurance scheme, such an endeavour could be welcome and timely.³

Freund begins by placing the NHSC among the inquiries and committees 'set in motion by the Smuts

³ Unfortunately, both these texts contain a number of errors of fact. Here is not the place to show this in a line by line analysis. I will try to show some of the more egregious examples in an appendix which I hope to make available at the seminar.
Not for citation

ministry (1938-48) during its early progressive phase'. As the title of his article suggests, for him the appropriate context for such revision is South Africa's 'developmental agenda' in the late 1930s, an endeavour which was in line with that of many other modernising states in the late 1930s. In South Africa, the developmental agenda necessitated greater consideration of the relationship health to the efficiency of workers, as a number of Commissions suggested and this rationale, he argues, provides a framework for understanding the establishment of the Commission and its Report. Indeed, he asserts (but without providing any evidence) that 'The Gluckman Commission was aimed at fitting in to this process deliberately' [my italics].

While it is undoubtedly true that the Commission was appointed and took its evidence in the early war years when 'a developmental agenda' characterised many of the South African state endeavours, the description does not get one very far. Indeed Freund partly recognises this. Thus, he maintains that the Commission should be understood in relation both to 'a growing demand' for administrative reform 'from those involved in the health system for 20 years', and to changing medical practice internationally'(p.170). By 'recontextualising' the Commission 'to its own time' in this way, he also promises to render 'the transition' between the policies of the Smuts and those of its National Party successor 'more complex', a view echoed by Digby. Now, while it is extremely easy to find statements at the time linking health to worker efficiency, and even liberal and radical doctors were wont to do so beyond the shores of South Africa – arguably to get government to listen – it is reductionist to suggest that this was the raison d’être of the Gluckman Report.

The radicals in the Department as well as Gluckman had to step warily around the colour line: nothing would have destroyed a proposal to establish a national health service more quickly than an explicit defiance of the colour bar in 1944. We should remember that Sidney Kark was denounced in terms of the Suppression of Communism Act in the 1950s, apparently because he allowed white doctors to smoke in front of [black] nurses at the Institute of Family and Community Health! It is intriguing to note the contrast Freund draws between Gluckman and the 'more liberal reformers during the era of 'the developmental state'. 'Highlighting this second, somewhat different group, albeit mainly very much Smuts loyalists,' he notes, 'provides a shading to the view of the developmental

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4 My italics. Freund's reference to this assertion is revealing and appropriate: 'It is really in the course of work on the Union of South Africa as a developmental state in progress that the point of an article on the Gluckman Commission occurred to me as I make no claim to be a historian of public health or medicine' (fn 28, p.?).
state vision as one-dimensional or all-pervasive. They were probably most important in the social rather than the economic impulse of the time. Quite so – but this was equally, possibly even more true, of Gluckman! They were, after all, mouthing the 'common sense' clichés of the time.

Most bizarrely, Freund concludes: the 'Gluckman's Report' was what Smuts wanted. Indeed, as we shall see, the Commission was coming from the left, and, as Freund himself points out, Smuts baulked at the central tenets of the Report. Indeed if anyone destroyed the prospect of improving the health of all the people of South Africa it was probably Smuts, who seems to have had little time for the medical profession or their patients. In this he was perhaps – for all his intellectual prowess – expressing a more common popular attitude towards doctors. As the forthright (and reactionary) Dr Isaac Frack remarked, at a time when two percent of white women in the rural areas were dying in childbirth unnecessarily the country's parliamentarians were unmoved:

Imagine the revolution in this country if 2 per cent of cows were to die. Why, no member* of Parliament would be safe. ... The Government has it in its power to put a stop to the terrible toll of women's lives, if it could be induced to divert its attention for one brief moment from a consideration of locusts, veterinary diseases, boll weevil and foot-and-mouth disease.

If Freund looks at the broad context of the Commission, Anne Digby looks more closely at 'the testimony' given before it, which as she rightly says provides 'unrivalled detail on the fragmented state of South Africa's healthcare structures and on the variety of its personnel' as well as on 'the social attitudes and prejudices related to health and medicine in a racially segregated society on the eve of apartheid'. Digby uses H.M. Clokie and J.W. Robinson's analysis of Royal Commissions of

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5 This quotation has been drawn from Bill Freund’s paper, ‘A Ghost from the Past: The South African Developmental State of the 1940s’, Paper given to a conference in Scandinavia in 2011. Cited on 11 June 2013 at www.nai.uu.se/eca5-panels/41-60/panel.../Bill-Freund-Full-paper.pdf. He lists them as Biesheuvel, Gale, Cluver, Gear, EW Lowe, Herbert Cooke, Holloway, Ivan Walker, Harry Lawrence and Walter Madeley, but shows little evidence of how they were different to Gluckman. This has now been published in Transformation: Critical Perspectives on Southern Africa, Number 81/2, pp.86-114, but I have not yet been able to check this version against the original. Nuber 81/2 pp. 86-114.]

6 It is telling that although Smuts was briefly Minister of Health (albeit with many other ministerial duties) in 1910-11 there is nothing in his published correspondence or the Hancock biography to suggest he had any interest in health. In 1910 he deliberately refused to create a separate portfolio for health or appoint a highly qualified Secretary of Health, despite the attempts by the medical representatives of all four provinces. Indeed when Dr DF Malan became Minister of Health in 1924, many members of the profession found him far more sympathetic.

7 Isidore Frack, A South African Doctor Looks Forwards – and Back (Central News Agency, 1943).
Inquiry\textsuperscript{8} to decide whether the Gluckman Commission was either 'packed' or 'relatively expert and impartial'. As she decides that the NHSC lacked 'defined ideological motivation or government manipulation', she argues that in its origin it appears to fall into the second category of an expert commission, a somewhat surprising conclusion in view of the role of members of the Department of Health in advising it, and Report's explicit espousal of social medicine. On the other hand, she believes that in its treatment of evidence the NHSC fell into the first category of 'packed' Commission. This is based on her view that 'the massive scale of the evidence' meant that there was only a 'tangential relationship between the evidence and the radical reform' of the health services recommended in its Report, a criticism which, not surprisingly, could as well be leveled against her own analysis of the relationship between the 12,000 pages and 3.5 million words of evidence and the Commission Report. She concludes by stressing the contrast between what she chooses to call the Commission's 'grandiose recommendations and its modest effects'.\textsuperscript{9} Contrary to Freud, who argues that Gluckman represented the views 'of a great many doctors', she believes that the Commission's recommendations were doomed from the outset because Gluckman failed to prepare the politicians and doctors for his 'grandiose schemes,' and ignored the views of 'political and professional interest groups'.\textsuperscript{10} Thus, she argues – as if it were a new discovery\textsuperscript{11} - that its main recommendations were foiled even before the electoral victory of the National Party in 1948.


\textsuperscript{9} Readers might find this reminiscent of Churchill's response to plans for a comprehensive Health Service in Britain: 'The idea of establishing a unified comprehensive health service was sometimes dismissed as an unrealisable, utopian objective. This was certainly the response to schemes evolved in the context of post-war reconstruction in 1918. When the reconstruction exercise was repeated during WWII and the health scheme was again introduced, Churchill warned his colleagues against deceiving the people with "false hopes and airy visions of Utopia and Eldorado". (Charles Webster, \textit{The Health Services Since the War}. I. \textit{Problems of Health Care: The National Health Service Before 1957} (London: HMSO, 1988), p.16. Smuts also dismissed the NHSC recommendations as 'utopian'.

\textsuperscript{10} But cf Freund, who states categorically that 'Gluckman did represent the ideas of a great many doctors'.

\textsuperscript{11} Digby seems to think she is the first to point this out, but see Shula Marks and Neil Andersson, 'Industrialization, Rural Health and the 1944 Health Services Commission in South Africa' in S Feierman and J M Janzen eds. \textit{The Social Basis of Health and Healing in Africa} (Comparative Studies in Health Systems & Medical Care) (University of California Press, winter 91-spring 92) pp.131-161 and 'South Africa's Early Experiment in Social Medicine: Its Pioneers and Politics' \textit{American Journal of Public Health}, Vol. 87, No. 3, March 1997, p.454, where I state explicitly 'Long before the National Party came to power, the South African government had surrendered two "fundamental " aspects of the commission's vision: "that all health services be administered by the same authority", and "that all health services be paid for from taxation." Regarding the first, even before its report was published, Field Marshal Smuts, the then prime minister, had given way to the clamor of the politically powerful provincial authorities, who were responsible for running curative services, and allowed hospital services to remain in their hands despite the recommendation that these services some directly under the Department of Health.... the electoral unpopularity of increased taxation made a direct health tax also too radical a recommendation for a beleaguered war-time government ...'
Although Freund and Digby seem to approach the National Health Services Commission from diametrically opposite directions – Freund from the elevated perspective of the 'developmental state', Digby from 'the bottom up', in many respects their accounts suffer from similar shortcomings. Both authors acknowledge the gravity of the crisis in health and health care afflicting all sections of the population especially in the rural areas, and that South Africa's system of health administration was totally dysfunctional in the 1930s. Yet somewhat bizarrely neither seem to link this evidence – given by very many of the witnesses to the Commission - to its recommendations for an integrated national health service.

These omissions are not especially surprising. There is little evidence that the authors have systematically consulted either the voluminous Department of Health records in the South African archives, or even the *South African Medical Journal*, where the editor, Dr Louis Leipoldt, created space (under the title, 'The Future') for a host of articles from doctors debating the issues involved in the early 1940s, the majority of whom favoured a radical shake up of the health services. Indeed what is striking is that the support for a radical reshaping of the profession came from its top echelons. Perhaps more seriously, neither author recognises the enduring significance of the health centre at Pholela, which the Commission saw as the model for primary health care in an integrated health service. This is not surprising as neither of them seem to have read the Karks’ own account of Pholela’s practice. The inevitable result is that their articles are superficial and misleading.

For a start, both Freund and Digby make the mistake of thinking that the National Health Services Commission was solely the work of its chair, Dr Henry Gluckman, and pay scant attention to what the other commissioners brought to the table. Yet as FR Luke, a Commissioner nominated by the Cape Western Branch of the South African Medical Association of which he was President, later recorded:

> Never in the history of this country had a Commission worked so hard, so continuously, or with such zeal and application. ... We travelled the length and breadth of this country in order to see conditions ourselves. We acquired a deep knowledge of health conditions in this country, and our survey forced us to the conclusion that present conditions in no way approached the ideal contemplated in our terms of reference, and that under the existing

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12 On the crucial role of the Department of Health in suggesting the appointment of a Commission, see below
system of multitudinous agencies and divided control the attainment of such an ideal was impossible ... All of us contributed to the scheme, and almost all of us to the actual setting forth of the scheme on paper [my italics].

Fixated on Gluckman, though for different reasons, the authors virtually ignore the vital contribution of members of the Department of Public Health who supported the establishment of the Commission, shaped its remit, and helped to draft its final report. A letter from Geoge Gale to Sidney Kark is particularly illuminating here:

I was not sure at all who of the NHS Commission went to Pholela, and Henry himself couldn’t remember! Luke and Albertyn were both keen on social medicine, and influential in writing the report. .... David [Landau] supplied most of the ideas for the memo. The Health Officials Association put to the Commission and I think they took more from that, than from the also very good, memo of the Medical Association, inspired mainly by Harvey Pirie and Eustace Cluver .... I’ve never told anyone this before, so keep it under your hat, that David and I spent an entire weekend with Henry, the three of us alone, at Zagaran (his farm near Evaton), and formulated the main outlines of the Report: Henry sold the lot to his Commission! – he was a first class salesman, with a keen eye for what was essential and must be preserved, and what could be given away if any mollification was necessary. There is no need to tell you what a grievous loss when David left us so suddenly.

As a result of their fixation Freund and Digby both exaggerate and misunderstand Gluckman's role, and underestimate the political skills he brought to the task of chairmanship. Nor do they seem to

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13 F.R.Luke,  SAMJ, 27 Jan 1945 vol.19, 1, p.376. See also Gale's account in Abiding Values, p. 'From first to last their chairman led the commission. He was a firm adherent of the democratic method. Each of the many contentious issues with which the commission was faced was debated fully, not only with appropriate witnesses, but also within the commission itself.'

14 Landau was Medical Officer of Health to the Local Health Commission at the time. When the government established the Social Medicine Division of the Department of Public Health in Natal he was appointed to head it, and acted as locum for Sidney when the Karks went on study leave to Britain. He died in August 1948, at the tragically early age of 42. According to his obituarist, he was 'one of the outstanding pioneers in the newly conceived practice of Social Medicine in South Africa'(SAMJ, 11 December 1948).

15 Gale Papers, Gale to Sidney Kark 15 Feb 1968 from Malaysia where he was appointed by the WHO as Professor of Social and Preventive Medicine to help establish the new medical faculty in Kuala Lumpur.'

16 cf Gale's account in Abiding Values, p. 'From first to last their chairman led the commission. He was a firm adherent of the democratic method. Each of the many contentious issues with which the commission was faced was debated fully, not only with appropriate witnesses, but also within the commission itself.'
be aware of the pressures from within the Department of Public Health and from the medical profession on the department, pressures which led to the appointment of the Commission, a product of the perhaps surprising but explicable radicalisation of many leading members of the profession during the war, but which faded quite rapidly after 1945.\textsuperscript{17}

As Freund notes, the idea of a national health service had been mooted a number of times in the South African House of Parliament before the appointment of the Gluckman Commission. The two most recent attempts were in 1935, by Dr E.P. Bauman, the SAP MP for Rosettenville, and in 1940 by Dr Bremer, a Hertzog supporter,\textsuperscript{18} both had made similar attempts in the past, without eliciting support from either the government or the department. However, in February 1942 when, on behalf of Gluckman, Harry Lawrence, then Minister of Health and Home Affairs put forward a motion in Parliament, 'That the Government be requested to take into consideration the advisability of appointing a commission to investigate and recommend, the best measures to be adopted for ensuring adequate health services for all sections of the population of the Union', it was adopted by MPs on both sides of the House. As importantly, the Department of Health itself sat up and took notice for the first time.\textsuperscript{19}

There were a number of reasons for this change. A shift in the composition of the Health Department's staff in Pretoria when Eustace Cluver replaced Sir Edward Thornton as Chief Secretary of Health in 1938 was important, especially as he made three crucial new appointments in that year. They were the epidemiologist Harry Gear, George Gale, a former mission doctor, and the somewhat younger Sidney Kark.\textsuperscript{20} They all made a notable contribution to rethinking health care delivery in South Africa, and all had stellar medical careers after they left South Africa. Gear, trained as an epidemiologist at the London School of Hygiene and Tropical Medicine, had recently

\textsuperscript{17} Digby is incorrect in suggesting that the 1948 election was proof of this. As is well-known, the Nationalists won the election on the basis of a majority of seats but a minority of votes. The majority of doctors were still English-speaking and lived in the urban areas, so that they were unlikely to have voted for the National Party.

\textsuperscript{18} Dr. Baumann, Hansard, 27\textsuperscript{th} March 1934, column 1852 and House of Assembly Debates, Hansard, 5\textsuperscript{th} Feb 1935 Columns 1123-1146; Dr. Bremer, Hansard, 13-5-1940, 7516, cited in GES 1756 2/95/33 Department of Health memo on Gluckman's motion, Order No. 1, House of Assembly, 17th February, 1942

\textsuperscript{19} See GES 1756 2/95/33 Department of Health memo on Gluckman's motion, Order No. 1, House of Assembly, 17th February, 1942. (See below, pp.),

\textsuperscript{20} HS Gear joined the DPH as an Assistant Health Officer in May 1935, appointed by Cluver’s predecessor, Edward Thornton, and was promoted to Deputy Chief Health Officer by Cluver in Jan 1939. Gale joined the Department in Nov.1939 as an Assistant Health Officer; he was promoted to Secretary of Health on 1 July 1946 - over Gear’s head and directly from his AHO post. (Dave Duncan, The Mills of God: The State and African Labour in South Africa, 1918-1948. Witwatersrand University Press, 1995, pp269-70)
returned from China, where he had worked at the Lester Institute for Medical Research between 1932 and 1935. During this time he conducted a survey of morbidity and mortality in Chinese hospitals, which became his MD thesis at the University of the Witwatersrand. He could not fail to be aware of the impact of the health centre movement at Ding Xian under Dr CC Chen, and of the crucial role in its creation of John B Grant Professor of Public Health at the Rockefeller's Peiping University Medical College.

Gear was particularly taken with Rockefeller’s developing rural health work in Ding Xian where, he wrote, a 'most enterprising and bold experiment' was in progress, utilising methods and practices of rural sociology, education, agriculture, administration and health and medical services. Methods of nursing, sanitation, and of providing medical care are being tested and gradually there is emerging a general administration including all aspects of social life.

.... in this area a simple system of birth and death registration has been evolved, school medical inspection is a routine procedure, dispensary and clinic records are collected and, finally, a health survey of a thousand families is in process of analysis.

According to the Karks, on his return to South Africa Gear 'had many innovative ideas about the provision of health services for the South African populations, more especially the Africans living in the "Native Reserves," and they credit him, together with Eustace Cluver, then Chief Secretary of Public Health (1938-41) with being responsible for Sidney's appointment to head the 'Polela Health Unit', as Gear termed it, and thus to the Department of Health in 1939; and, last but not least, George Gale, a former mission doctor (hardly simply the 'radical civil servant' Freund thinks him) recruited specifically because of his knowledge of the health of rural Africans, and the publication at his own expense of a pamphlet, *A Suggested Approach to the Health Needs of the Native Rural Areas of South Africa*, which he published at his own expense in 1938. It was this pamphlet that led the Secretary of Public Health, Eustace Cluver, to invite Gale to join his department and help
develop rural health services.\(^{25}\)

Sidney Kark's work at Pholela in the 1940s and at the Institute of Family and Community Medicine in the 1950s, was to become renowned internationally – and still is. Gear and Gale have been largely forgotten, although their contribution to the success of Pholela was in many ways crucial.

Gale had spent the first ten years of his medical profession working at the Gordon Memorial Hospital and Tugela Ferry; had left mission work to join the new scheme to train Africans as medical aids at Fort Hare – he resigned when he realised that by raising the entrance level to matriculation (it was originally meant to be JC) the five-year training the scheme was unlikely to train medical aids in sufficient numbers to make a difference to health in the rural areas. Furthermore, despite their educational qualifications, the medical aids were barred by the South African Medical Council from practising as doctors or even using stethoscopes. Many of the medical aids left Fort Hare embittered by the experience.\(^{26}\) Gale was to become the most effective spokesman on behalf of the Commission and probably wrote most of its Report, together with David Landau.\(^{27}\) After Gluckman became Minister of Health in November 1945, he appointed Gale as Chief Medical Officer and Secretary for Health, and he became the departmental member responsible for the implementation of the health centre scheme.

The most important factor, however, was undoubtedly the ferment in the medical profession in the 1930s and especially during the early years of the war. As a departmental memo records, 'The past year has seen great activity among medical men on the question of the provision of improved, medical services and sickness insurance'.\(^{28}\) There were serious socio-economic reasons for this. The 1930s found many of South Africa's doctors unable to scratch a living as 'a devastating combination of depression and drought ... traumatised South African society in the first half of the 1930s'.\(^{29}\) In introducing his 1935 motion in parliament requesting the Government to appoint a

\(^{25}\) Gale, 'The medical education'.

\(^{26}\) For the Fort Hare scheme see Karin Shapiro, 'Doctors or medical aids? The Debate over the Training of Black Medical Personnel for the Rural Black Population in South Africa in the 1920s and 30s', JSAS, vol. 13, number 2, 1987. For Gale's dissatisfaction with the Fort Hare scheme see my 'Doctors and the State: George Gale and South Africa's Experiment in Social Medicine' in S.Dubow (ed), Science and Society in Southern Africa (Manchester University Press, 2000) pp.194-5. The scheme was abandoned in 1942.

\(^{27}\) According to Sidney Kark, his close friend, Landau's personality was one of 'brilliant excitement'. (Interview with Sidney and Emily Kark, Jerusalem, 29 Sept. 1982).

\(^{28}\) GES 1756 2/95/33 cited in fn 12.

commission to 'enquire into the urgent necessity of establishing a whole-time salaried State Medical Service', the MP, Baumann acknowledged that when he raised the issue three years before the profession was 'on the whole antagonistic'. By 1935, however, he thought that 'conditions have changed, and ... that if a plebescite [sic] were taken among the medical profession today 90 per cent would be in favour of such a service', largely as a result of the dire straits doctors found themselves in as a result of the depression. He believed that doctors had grown to approve 'the security of tenure offered, ...regular leave, opportunity for sleeping at night and ... assurance of a pension.\textsuperscript{30}  

Baumann was a long-time advocate of a nationalised health service, so that his views of the profession are to be taken with a pinch of salt, but there is no doubt that an influential lobby, including many of the country's most eminent physicians were in favour of a national health service in the early 1940s.

Behind this transformation was the visit of the charismatic Henry Sigerist to South Africa in the last months of 1939. He came to South Africa at the invitation of the Wits Medical Students Visiting Lecturers' Fund. The leading medical historian of his day, and 'a spokesman for the left-wing of the medical profession, Sigerist was an impassioned advocate of socialized medicine, and an enthusiastic supporter of socialism and the Soviet Union'. And he 'wowed' medical students, physicians and lay audiences across South Africa.\textsuperscript{31}  

Largely as a result of his visit, the topic of a national health service moved to the top of the agenda of the South African Medical Association.

His intervention led to a flurry of correspondence in the SAMJ on the pros and cons of 'socialized medicine' in 1940-1. In April 1941, the Federal Council the Medical Council set up a Planning Committee 'to consider and put forward' a health policy for South Africa. Louis Leipoldt, the editor of the SAMJ, invited contributions from the profession. According to the Commission, this was in large measure as a result of Sigerist's visit.\textsuperscript{32}  

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\textsuperscript{30} 'The average medical income in South Africa is surprisingly low', he remarked, '... probably under £500 pa. Very much medical work is unpaid or at least underpaid. ... This has been particularly the case of recent years during the depression.' He believed that 'under the present system' doctors were 'constantly under great strain'(House of Assembly Debates, Hansard 5\textsuperscript{th} Feb 1935, Column 1133 and 1126).
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\textsuperscript{32} According to the NHSC Report, 'A series of brilliant addresses led to the formation in 1940 of the Planning Committee of the Medical Association of South Africa (B.M.A.) , which has played a leading part in ascertaining, expressing and, to some extent, in influencing South African medical opinion on the advisability of
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scheme for a 'Democratic Health Service' inviting its readers to set out what kind of health service they wanted which set the fox among the pigeons. 'A "Democratic Health Service" as outlined in the pamphlet', members of the Department complained,

... is in essence a proposal that the health services of the country be handed ever "lock, stock and barrel" to the medical profession .... The published scheme contains principles of a far-reaching character e.g. the control of what is essentially a responsibility of the State by “outside interests”, the state to finance the scheme but to have no say in the appointment of personnel, the nature of the services to be provided etc. except, presumably, by a refusal to make funds available for projects of which it does not approve. ... It is inadvisable that any scheme such as is referred to paragraph 4 should be allowed to crystallize since once it is put forward as the considered view of the M.A.S.A., it will be infinitely more difficult to secure general acceptance of any alternative scheme which it may be within the capacity of Government (from political and financial angles) to give effect to.

It was for this reason that the Department came round to thinking that 'The appointment of a. Commission ... would, have many advantages', and gave its blessing to Gluckman's initiative. Its own control was at stake and neither the conservatives in the Department nor the more radical new members wanted to see this undermined.

Not only do Freund and Digby fail to explore the reasons for the appointment of the Commission, they also completely misunderstand the nature of its recommendations. While they assert it needs to be understood in an international context, they both construe this very narrowly as meaning British practice. While, however, the Beveridge Report, the Peckham Health Centre and Socialist Medical Association (the last is barely mentioned) were undoubtedly important influences, other examples of health practice – the USSR, China, the League of Nations Health Organisation – were at least as important, if not more so. What is fascinating about the Commission's report is the extent to which its draftsmen (and they were all men) were influenced by the international development of specifically social medicine in the 1930s. This was manifestly the most important

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33 See below,
ideological influence on the Commission; it is, indeed, what the Commission's protocols referred to as 'the modern conception of health' and what Digby (p.200) scornfully refers to as 'an international pantheon of modernity'.

It is perhaps helpful here to sum up what the 'modern conception of health' meant in the period from World War I until well into the 1950s, when it was generally known as 'social medicine'. As Iris Borowy has shown, in these years 'an understanding of health not as a medical but as a social condition reached its apex'. Its roots were in 19th century Europe but it became 'a key strand of the public health discourse next to bacteriology and eugenics' in the interwar years. And because its advocates stressed the social determinants of health and disease, and saw health status 'as a function of policy decisions that determined social conditions', it undoubtedly also had a political, usually left-wing, dimension. It is no accident that in Britain its adherents were generally to be found in the Socialist Medical Association. From its foundation in 1930 the SMA advocated of a national health service, preventive rather than curative medicine, and health centres rather than hospitals. The example of the Soviet Union's organisation of health was also important: Sigerist had visited Russia in 1937 and his book Socialist Medicine in the Soviet Union, 'created a sensation'.

At least as important – certainly so in the long run – was the influence of social medicine on Sidney and Emily Kark in establishing the Pholela Health Centre. Here we come back to the role of China and Harry Gear in the evolution of ideas. It is no coincidence that the account of the Karks work both at Pholela and in the Institute for Family and Community Health in Natal was called A Practice of Social Medicine. It is revealing that neither Freund nor Digby see fit to cite the writings of Sidney Kark and his associates before dismissing the health centre project. (Freund seems to see

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34 Union Government 1944. Report of the National Health Services Commission. 1942-44, p.1: They were appointed 'to enquire into, report and advise upon ... an organized National Health Service, in conformity with the modern conception of "Health", which will ensure adequate medical, dental, nursing and hospital services for all [sic] sections of the people of the Union of South Africa'.

35 In fact the Commission (p.8) explicitly spelt this out in Chapter III, paragraph 14 which explicitly draws attention to the recently established Institute of Social Medicine in Oxford.


health centres as an inferior form of health service designed to fit apartheid South Africa; Digby fails to see any difference between it and the three or four other 'health centres' in South Africa at the time) Vague as the term may now seem, however, in the years between the two world wars and well into the 1950s 'social medicine’ embodied four or five key ideas which both its advocates (and its opponents) saw as a specific ideology.

First and foremost, its practitioners believed then – as their successors believe now - that much ill-health is social in origin, and is rooted in individuals' social, economic, cultural and political environment. The South African Medical Association addressed this very explicitly in its evidence to the Commission, and again in its resolutions taken after the Report appeared, when it 'insisted that the mere provision of “doctoring is not enough to ensure health for all the people of South Africa". These services were defined by the Commission as “adequate wages”; nutrition; general education; physical exercise and recreation; industrial welfare and hygiene, etc.” The Report went on to say that while these services could not be 'under the direct control of a health service', the central health authority had to be 'in a position to influence profoundly the policies ... of the Departments directly in charge'.\(^{39}\) Thus the health service had to be multi-sectoral.

Secondly, their mantra was – and is – 'prevention is better than cure'. This does not mean they were uninterested in cure or 'hostile' to hospitals (as Freund believes Gluckman was)– simply that it was better to catch illness earlier rather than later – better for both the patient and the health service. It also meant that ill-health had to be treated holistically – another key word in the interwar period. This applied in two ways. First, the patient had to be seen in the context of his or her family and community and that it was incumbent on health practitioners to understand the customs and beliefs of the people they worked among.\(^{40}\) And secondly, that the health service itself had to be delivered at local level by a multi-disciplinary team of health workers working amongst and at least in part drawn from the community. This made the health centre the basis of both preventive and curative health care delivery, especially, but not only, in rural areas. In

\(^{39}\) See George Gale, 'Health Centre Practice, Promotive Health Services and the Development of the Health Centres Scheme', *SAMJ*, 22 June 1946, pp 326-330. Gale was then the Secretary of Health and Chief Medical Officer for the Union.

\(^{40}\) According to the medical anthropologist, James A. Trostle, perhaps the most important contribution of the Institute of Family and Community Health established by the Karks to train health workers for the health centres planned by the NHSC, was its emphasis on teaching its staff – and one might add its students – of the importance of anthropological understanding. He thought Kark and his co-workers like John Cassell
addition, health centre staff were expected to conduct epidemiological surveys, promote health education in the schools and in the community, work with mothers and infants, address psychological problems, plant vegetable gardens, help build community activities. Epidemiology was an essential tool, and was explicitly used by the Karks both to ensure that they were addressing the most significant threats to health in their area and to measure outcomes. Indeed the Commission was so impressed with Pholela is because they were able to show a dramatic decline in the death rate and infant mortality.41

Social medicine was built up out of all kinds of everyday practices born of local exigencies. Medical 'science' is built of universalizing these practices which have, nonetheless, to be adapted constantly to new circumstances. Thus, Helen Tilly argues persuasively that a number of British colonial doctors in Africa in the interwar years were early practitioners of forms of social medicine. She maintains that their practice was in advance of that practiced in the UK, not least because they were forced to respond to a new ecological environment and to African health practices, which they discovered were often more successful than those imported from the UK.42

And it was in part their recognition of the local circumstance that made the Karks practice of social medicine at Pholela so successful. Another of the most significant features of the Karks's practice, both at Pholela and when they moved to Durban to set up the Institute of Family and Community Health was their growing recognition that to develop a community health service accepted by all the people of South Africa they had to adopt a more culturally sensitive and respectful approach towards African medical practice and come to terms with indigenous healers, even if they did not accept their underlying premises. It was a respect born of dialogue and empathy – and, importantly, contact with progressive anthropologists:

As Kark described it in 1981:

'An important focus of the health center's practice was that of education for healthy living. As a health project that had an educational orientation, it was concerned with what the

41 According to George Gale, from 1942 and 1946, in the intensive area the death rate fell from 38.33 to 13.11 and the infant mortality from 275 to 155; scabies and impetigo, which were very widespread in 1942, had almost completely disappeared by 1946’ (Government Health Centres’, p.634).

42 Africa as a Living Laboratory: Empire, Development, and the Problem of Scientific Knowledge (Chicago, 2011).
people in the community felt, thought and did about health. ... A common subject was, as expected, ... sickness and its nature, with doctors, medical aides, nurses and community health workers encouraging the individual or group to express attitudes and worries. In this way, the varying concepts of the people were discussed and related to modern knowledge. A relationship of mutual respect between the health center team and the community developed, and it was common for patients or families to discuss their worries, family problems or the nature of illness, whether thought to be due to natural or supernatural causes.\footnote{Cf (Sidney L. Kark, \textit{The Practice of Community-Oriented Primary Health Care} (New York: Appleton-Century-Crofts, 1981), pp. 230-1). This was not unique in the rest of Africa where a number of colonial medical officers also recognised that they would have to work with and not against indigenous healers but they were the first to try to implement this beyond their own health centre – something that the NHSC made possible.}

Neither of these authors appear to have any understanding of the importance of social medicine beyond the shores of the metropole and of its continuing relevance and practice in numerous countries across the globe. The range of influences on progressive medics in the 1930s was, however, far wider and far more rooted in the experience of countries much closer to South Africa's situation: by Andrija Stampar in war-wrecked Yugoslavia in the 1920s, by Dr Chen and John Grant in the 1930s (before the Japanese invasion and the Communist take-over), in the Dutch East Indies also in the 1930s where the Health Organisation of the League of Nations held a conference in Bandoeng which medical historians view as the stepping stone to the famous Alma Ata Declaration: itself premised on the ideas of social medicine. It characterised the approach of the League of Nations Health Organisation under Ludewyk Rajchman and its recommendations for rural health in Europe as well as in Asia. Many of these initiatives were supported by the Rockefeller Foundation in the 1930s and 1940, if less generously than academic medicine. Indeed it was the RF which paid half of George Gale's salary as Dean of the Durban Medical School, and supported the Institute of Family and Community Health headed by Sidney Kark in the 1950s when social medicine was being attacked as 'socialist medicine' during the Cold War.\footnote{It also supported the London School of Hygiene and Tropical Medicine which was widely regarded as teaching social medicine in the 19302 and paid for the first Professors of Social Medicine in Edinburgh, Birmingham Manchester; and it supported both the League of Nations Health Organisation and the WHO.} It remained a key – if not always constant – aspect of WHO policies for developing countries after the war, and remains so. Stampar indeed was the first director of the WHO, and it was the most distinguished of the WHO Directors after Stampar, Dr Halfdan Mahler, who became its champion in the 1970s and 80s – and remains
Nor do they have any concept of the continuing influence of the Karks and their health centre practice beyond the shores of South Africa. Their ideas continue to inform progressive health care in many parts of the world. Contrary to Digby’s assertion that the Gluckman report had no effect on post-apartheid South Africa, Sidney and Emily helped devise the community health curricula at the Medical Schools at Wits and in Durban. Their ideas were rediscovered by radical doctors in South Africa in the 1970s and 80s, and informed the ANC’s Green Paper on Health issued before the 1994 elections. In contemporary South Africa, the current Minister of Health, Dr Aron Motsoaledi, clearly embodies and practises Karkian ideals. Internationally, too, recent years have seen a revival of its principles as health practitioners have realized that much ill-health could be prevented and the new epidemics from AIDS to diabetes and obesity could be avoided by health education and early detection in community health centres.

Despite – or because of – the marvels of modern surgery and the beginnings of genetic medicine the role of community health centres is probably more not less important. The fundamental tenets of social medicine are embodied in the 2008 WHO Commission Report on the 'social determinants of health'. For its Chairman, Sir Michael Marmot, an internationally renowned epidemiologist, 'Reducing health inequities is, for the Commission on Social Determinates of Health ... an ethical imperative. Social injustice is killing people on a grand scale.'

Shula Marks
August 2013

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