THE NATIONAL HEALTH SERVICES COMMISSION REPORT OF 1944: LESSONS FROM THE PAST FOR THE RECONSTRUCTION OF SOCIAL SERVICES IN A POST-APARTHEID SOUTH AFRICA

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1. INTRODUCTION.

The National Health Services Commission Report (NHSCR) of 1944 has recently regained popularity and is frequently cited as the first such study that compiled a comprehensive report on the need for a national health service in South Africa. It has been described as an "enlightened" (De Beer, 1984) and "visionary" (Benatar, 1990) report. While these perceptions of the Commission's report may be contested, indeed it has been criticized by Marks (1987) and Packard (1989), the report (to the best of knowledge of the author) has not been evaluated in terms of its findings and recommendations with respect to social services.

The issue that the Commission researched in the late 1930s and early 1940s is indeed relevant today - given the numerous calls for a unitary health service (e.g., Coovadia:1987); and Benatar:1990). The current literature on the transformation of South African health policy has tended to, with a few exceptions, ignore the issue of "social services" (this concept, popularized by the Organization of Appropriate Social Services of South Africa, is preferred and includes practices that are usually labelled mental health and social welfare). This paper attempts to revisit the NHSCR to evaluate its treatment of the role and location of social services in a national health service and to explore its possible lessons for current health and social service policy analysts.

2. CONTEXTUALISING THE REPORT.

The appointment of the NHSCR and its recommendations may be regarded as surprising given the repression and politics of exclusion that has plagued the history of

South Africa since the arrival of the Dutch in 1652. How then can the publication of this "enlightened" and "visionary" report be understood?

One way to understand the development of health policy is Navarro's (1974) suggestion that the health system of a country mirrors the distribution of power and that to understand the health system of a country (i.e., the "tree"), it is necessary to analyse its economic, political and social components (i.e., the "forest"). This suggestion is also supported by Korpi (1983) who argues that social policy is the outcome of the relationship of the distribution of power resources in society and state intervention. He defines "power resources" as those "characteristics which provide actors-individuals or collectivities with the ability to punish or reward others" (p14). In addition he distinguishes two types of power resources, i.e. capital and control over the means of production and human capital (which includes labour power, education and occupational skills).

It may be instructive therefore to contextualise the National Health Service Commission (NHSC) in terms of the correlation of class forces or power resources of the late 1930s and early 1940s. This may also assist in understanding both the "promises" and the "problems" of the report.

The United South African Nationalist Party (popularly known as the United Party), which was a coalition formed in 1934 of Smuts's South African Party and Hertzog's National Party, had taken the Union into the Second World War much to the displeasure of Hertzog's National Party. South Africa's entry into the war led to crisis in the government, one consequence of which was that the war time cabinet did not include members of the National Party.

The Smuts government, while willing to make some concessions in terms of political participation of the black majority, was unwilling to grant the latter anything approaching universal franchise. Instead, Smuts believed that the "... native policy would have to be liberalized at modest pace but public opinion has to be carried with us ..." (quoted in Davenport, 1987:343).

Beside his concern for white public opinion, it may be argued that Smuts had to implement policies that were acceptable to his constituency in the business arena, especially the industrialists who supported the party (Stadler, 1987). Secondary industry, at this time, was fast becoming the mainstay of the South African economy. Whereas commercial farming and mining produced the major portion of the gross domestic product (GDP) prior to 1930, O'Meara (1983) suggests that the contribution of manufacturing outstripped that of agriculture in 1930. If the capitalist state is dependent on the market and the extraction of surplus for its survival, as suggested by Esping-Andersen (1990), then the state has to implement policies that would maximise the extraction of surplus.

In the transition from an agrarian to an industrial society, successive South African governments had to rely on coercive labour policies to satisfy the needs of the commercial farmers and mine owners for cheap, unskilled labour (Callinicos, 1984). However, with mechanization and the increasing importance of secondary industry, there was a need for more semi-skilled and skilled labour. Industry's need for semi-skilled and skilled labour which resulted from the labour-power shortages caused by

the war and the increasing degree of industrialization could not be met entirely from within the ranks of the white population. Hence the interest of industry in training blacks and having a permanent and stable urban black population (Marks, 1987).

The argument that the appointment of the NHSC was not a moral response to the levels of disease and inadequacy of access to the health services the part of those in power but rather an indication of a wider crisis is supported by De Beer (1984). He suggests that the appointment of the Commission should be viewed as part of a reform process, initiated by "Commercial and industrial interests and their political representatives in government (which)...through reform aimed at undermining the growing militancy of the urban proletariat" (p23).

The growing militancy of the working class was related to a significant increase in the number of industrial workers in the period 1933 to about 1950. O'Meara (1983) suggests that the number of white workers increased from 32 718 to 104 913 (an increase of 320%). The proportion of blacks in the industrial work-force was also on the increase: while they constituted 64.1% of the industrial work-force in 1933, by 1950 they accounted for 75.6% of the work-force. In addition, during the World War II the state allowed capital to violated the laws that had previously restricted blacks from doing various skilled jobs (O'Meara; ibid).

This period also saw an increase in union membership and levels of militancy. This is an important issue to consider in terms of understanding what "drives" social policy. Navarro (1989) suggests that there is a temporal relationship between the exercise of working class power, as measured by union membership and level of militancy (indexed by the number of strikes) and the creation of welfare states in Europe. While this argument may not be entirely relevant in the South African case, given the lack of access of the black working class to state power, increasing levels of black working class militancy may have forced the state into health reforms as concessions.

Despite the repression of black trade unions in the 1920s, unions were again established in the late 1930s. By 1941 a trade union council was formed, the Council of Non-European Trade Unions (CNETU) which claimed to have 119 affiliates and a membership of 158 000 in 1945. This increased level of organisation was reflected in the increase in the number of strikes recorded during this period, 24 in 1940 as compared to 63 in 1945 (Fine and Davis, 1990).

It may be suggested that there is a need to explore the behaviour of the various professional players in terms of their contributions to and influences on the Report, specifically that of psychiatrists and psychologists. However, it is argued one should be cautious in attempting to understand the development of policy from perspective of the history of "interest groups" only. This may lead to the mistake of not viewing these "interest groups" as part of classes. Navarro (1989) labels this type of theorization the "power group" explanation of health policy and is critical of it as it focusses on visible actors and not the "invisible actors" (i.e., a class analysis): "The visible interest groups are parts of broader categories of power such as classes that give them an ideological cohesiveness that explains their basic agreements on the parameters upon which their interaction, power competition, and discourse take place" (ibid:387).

In summary, it is argued that the appointment and recommendations of the NHSC should be understood as the result of the needs of capital and the outcome of working

class struggles during this period. This type of theorization is rooted in a neo-Marxist understanding of the state, that is, as an institution through which the class struggle (primarily between the working class and their political organs and the capitalist class and its organs) is played out (Therborn, 1986).

3. THE NATIONAL HEALTH SERVICES COMMISSION REPORT: MEMBERS, MODUS OPERANDI, FINDINGS AND RECOMMENDATIONS.
(a) Members and Modus Operandi.
The Commission's Report was the result of a two year long investigation by the chairperson, Dr. H. Gluckman and nine others who were appointed by the Governor-General of the Union in August 1942. The Commission was asked to "... enquire into, report and advise upon -
(1) The provision of 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* sections of the people of the Union of South Africa.
(2) The administrative, legislative and financial measures which would be necessary in order to provide the Union of South Africa with such a National Health Service." (Report of the National Health Services Commission, 1944:1; emphasis in original).

The demographic profile of the Commission was as follows: all White; two females; two members of Parliament; one Senator; one lawyer; and four persons with medical qualifications. Given the above profile it would not be unreasonable to suggest that the Commissioners were (at minimum) all members of the upper middle class and represented the interests of that class.

The Commission collected data from various sources: they listened to evidence presented by some one thousand witnesses; were presented with five hundred and five memoranda; and visited various sites in a period of three and a half months. The extensive public and professional interest, in the issue with which the Commission was charged, is reflected in the wide range of individuals and organizations that presented evidence. These included (an incomplete list is provided to illustrate the various racial, professional, gender and class interests that were represented): the political organs of the working class (e.g., Food and Canning Workers' Union, South African Trades and Labour Council, the Communist Party of South Africa, the African National Congress, and the African People's Organization); representatives of commercial farmers (various Agricultural Unions); representatives of commerce and industry (e.g., Chambers of Commerce, and Associated Pharmaceutical Societies of South Africa); mining interests (e.g., De Beers Consolidated Mines, Ltd); the health professions (Dental Association of South Africa, Medical Association of South Africa, Non-European Nursing League, and the South African Trained Nurses' Association); representatives of the Representative Council of Medical Aid Societies in Southern Africa; and the state (various departments).

(b) A Summary of the Findings and Recommendations.

(i) General Findings.
Briefly, the following were the major findings of the Commission: (1) Poverty, overcrowding, poor wages, ignorance and illiteracy were reported to be the main causes of "... economic and pathological casualties ..." and a drain "... upon national productivity and prosperity" (p12);

(2) health services and personnel were produced and distributed according to the economic laws of supply and demand and not the need of the people;

(3) health services were not equitably distributed but were distributed according to: race ("Europeans" had superior services compared to the other race groups, with the "Natives" having the most inferior); class (the rich experiencing "over doctoring"); and geography (the rural areas being under-served compared to the urban areas);

(4) health outcomes were differential by race e.g., infant mortality rates (per 1000 live births) were found to be: whites = 50 (which was better than several European countries e.g., Germany, UK, Portugal and Italy); Coloureds = 176; Asians = 88; and "Natives" between 150 and 600;

(5) the lack of adequate coordination between the various levels of government and the manner in which responsibility for various health maintenance functions were allocated was inefficient; and

(6) of the total health expenditure only 1% was spent on preventive health.

(ii) General Recommendations.

The Commission made several recommendations (those that relate to social services will be listed in the next section) to the government. The recommendations included:

(1) that the modern definition of "health" include the following components: environmental health; health promotion; prevention of ill-health; curing of diseases/injuries; and rehabilitative services;

(2) the creation of a National Health Service, to be funded by a National Health Tax and that health is a right which the state should protect and promote;

(3) that the National Health Service provide free (at the point of service) and adequate medical, dental, nursing and hospital services to all South Africans on the basis of need and not ability to pay;

(4) that all national and regional hospitals be owned and operated by the central government;

(5) that a National Health Council be established to assist and advise the Minister of Health and "for the protection of democratic interests" (it was to be made up of various Regional Health Councils which in turn should comprise of representatives of local and provincial authorities);

(6) that health centres be created at which families and individuals would be able to receive both preventive and ambulatory care;

(7) that doctors would not be forced to join the National Health Service and that those who did would not be forced to treat specific families or individuals (the Report did not make explicit if health workers could object to treat members of other race groups but this was possible given that the Report endorsed the position that people should be treated by health personnel of their own race group where possible);

(8) health care consumers would have a choice of doctor (from amongst those employed at a health centre);

(9) that general practitioners be allowed to treat their patients in hospitals (with the assistance of specialists);

(10) that there be an increase in the quantity and quality of all types of health personnel; and

(11) it was preferable that members of the various race groups provided health services to members of their own race groups (there was also implicit support for racially separate health services e.g., hospitals).

(iii) Social Service Findings and Recommendations.

An inspection of the list of centres and institutions visited by the members of the Commission (Annexure C of the Report, pp201- 202) reveals that they visited a child guidance clinic, a child welfare clinic, a welfare centre and a mental hospital.

The Commission found the following with respect to social services:

(1) that the South African National Council for Mental Hygiene coordinated mental hygiene societies which were responsible for the supervision of the mentally ill on discharge from state institutions;

(2) that some of these mental hygiene societies held regular clinics (one had the services of a regular state psychiatrist whilst others had to rely on volunteer psychiatrists) and some had established child guidance clinics (there is no information on what services were offered and by whom);

(3) that there were nine mental hospitals and two institutions for the mentally retarded which were under the control of the sub- department of Mental Hygiene in the Department of the Interior because the patients were detained by statutes that restricted their freedom (the sub-department of Mental Hygiene was transferred to the Department of Public Health in 1943);

(4) that there was an increase in the number of certified patients, a shortage of beds for the mentally ill and that this shortage was greatest for "non-Europeans" (Europeans = 295/100 000; /non- Europeans = 97/100 000);

(5) two social workers were employed in general hospitals (Groote Schuur and Pretoria);

(6) there was a shortage of "mental" nurses - the South African Medical Council reported that as of 31 December 1943, 346 mental male nurses and 78 female mental nurses were employed in state run services but that there were 459 female vacancies;

(7) gross overcrowding in the mental hospitals;

(8) psychologists, employed by the Departments of Education in Natal and the Transvaal (1 in each), were responsible for selecting backward white children who were considered good candidates for special classes; and

(9) there were 29 psychiatrists and neurologists registered as specialists in January 1939, the vast majority of whom were thought to be in state employment.

In terms of the social service recommendations that the Commission made, the following appear to be the most significant:

(1) there was a perceived need to keep the Ministry of Health separate from that of Welfare and Demobilisation as a merger may "... cause the general public to underestimate the importance of health as a function of the government" (p110);

(2) that mental illness was "... so intimately bound up with the general health of the people that it is impossible and undesirable to separate them ..." (p79);

(3) it was recognised that mental hospitals and mental hygiene services were specialised and needed to be placed under a separate Division of Mental Hygiene, under the direction of the Director of Mental Hygiene;

(4) that special mental wards be attached to general hospitals for the treatment of acute cases and for teaching purposes (this was to be used to relieve the pressure for beds in the mental hospitals);

(5) feeble-mindedness should be decreased by "... prohibiting marriage between persons descended from stocks in which there has appeared feeble-minded or any other undesirable quality, at any rate within the few preceding generations" (p27);

(6) psychiatric wards be attached to all national and regional general hospitals;

(7) the appointment of almoners (hospital social workers) was suggested to: act as a liaison between the hospital and the services offered by the Department of Social Welfare; be responsible for investigating the living conditions of in-patients; and for the social after-care of the discharged patients (1 social worker per 100 in-patients was recommended);

(8) "mental" nurses be well trained and that this branch of nursing be made more attractive (probably as a way of decreasing the number of vacancies/shortages, however no concrete suggestions of how this could be achieved was given);

(9) medical officers who provided mental hygiene services, the Commission suggested, should receive training in psychology and psychiatry, should not practice exclusively in institutions but should be rotated through special psychiatric wards in general hospitals and be available to consult at the health centres; and

(10) that the training of occupational therapists should include psychology and psychiatry to enable them to work in either general or mental hospitals.

The next section will focus on a discussion of the social service recommendations of the Report. In addition, an attempt will be made to draw some lessons from the Report for the current critical period in the history of the development of mental health policy in South Africa.

(iv) Discussion of the Report's Findings and Recommendations.
While the Report has be argued to be "enlightened" it can be argued to have perpetuated racism as it accepted the prevailing notions of race and racism. It, for example, argued for the desirability for members of each race group to care for their own. In addition it accepted the need for a racially segregated, though equitable, health service. It also questioned whether "non-Europeans" should and could be trained as mental nurses: "... it is questionable whether their *development* generally is of such a nature as to make their training desirable" (p79; emphasis added).

Despite perpetuating racism in various ways the Commission's findings can be said to have be fairly exhaustive. While it did not report on incidence and prevalence rates of mental disorders, the types mental illness or treatment modalities used, the Report did suggest that the number of certified patients was on the increase and that there was a fairly significant shortage of both beds and personnel.

In terms of the training of health personnel, the Report stressed the need for medical officers, nurses and occupational therapists to be trained in both psychiatry and psychology. While this may be argued, by mental health specialists, to be problematic as it infringed on their specialty, it should be remembered that there was a shortage of mental health professionals during this period. The Report suggests that were only 29 psychiatrists for ten million people and a shortage of mental nurses.

The Commission did not appear to study the training and roles of psychologists too closely. Beside mentioning that psychologists were employed in Department of Education, no other mention is made of this profession. Possible reasons for this include: that the profession was not well organised and therefore did not make representations to the Commission - this possibility is supported by the fact that the first organisation to represent the interests of psychologists was formed in 1948 (Cooper et al, 1990); and that because departments of psychology in universities were still in their early stages of development, few psychologists were trained e.g., the

University of Cape Town's Child Guidance Clinic was only established in 1935 (Foster, 1991).

One of the major social service recommendations of the Commission was that the ministries of health and social welfare be separated. However then (like now) this issue was a highly contested one. The majority opinion of the Commission was that the decision of the cabinet to add the welfare portfolio to that of the Ministry of Health was problematic as is "... may cause the general public to underestimate the importance of Health as a function of Government" (p110). The minority opinion was that this was a progressive step that was based on "... scientific principles ... (and that) ... Experienced and qualified men and women with practical knowledge of social and health services have always stressed the necessity for close contact between the administrations of these respective services" (p113).

Indeed, this close relationship between health and welfare is reflected in the recommendations of the Commission. As noted in the previous section, the Commission stressed the need for social workers to be employed in various capacities in general hospitals, some of which would have required that they act as a liaison between the Departments of Health and Welfare.

The decision of the Commission to prioritise health, as illustrated by the following quotation: "The Commission recommends that there be established a Ministry of Health which *shall be regarded as one of the most important of Cabinet portfolios, as important as is that of Defence in time of war*" (p110; emphasis added), and recommend the creation of separate departments for health and welfare may be speculated to be the consequence of the power of the medical lobby (the Medical Association of South Africa had by far the most number of representatives who presented evidence to the Commission and there were many medical practitioners on the Commission) and the desire of big business to keep the definition of health narrow so as not to increase the pressure on them to increase wages and improve the overall working conditions of their workers - both of which will increase their costs and lower profits.

A remarkable feature of the Commission's report was the inclusion of sociologists in the health team. It is speculated that the inclusion of sociologists was influenced by their involvement in and the findings of the Carnegie Report on poor Whites. In addition the visit of Dr H E Sigerist (a visiting U.S. professor of medical history and medical sociology), who was referred to in the Report as a "foremost authority", may have been influential in the expansion of the health team to include sociologists and in the definition of health adopted by the Commission.

Readers, who are interested in social service policy development, will be aware of the similarities between the issues researched and recommendations made by the Commission and those that currently preoccupy policy analysts in South Africa. The next section will attempt to explore some of the possible lessons for the 1990s.

4. THE NATIONAL HEALTH SERVICES COMMISSION REPORT: POSSIBLE LESSONS FOR THE 1990s.

The NHSC can be criticised from various perspectives. Firstly, for being reformist in terms of not challenging capitalist relations of production which can be argued to be

the root of the health care problem. Secondly, for its failure to argue against racially segregated health services. However, it can be argued that despite these shortcomings there are lessons that can be learned from the work of this Commission. This section will attempt to outline some of these lessons which may be helpful to contemporary social policy analysts.

Any attempt to transform national health policy has to acknowledge that the definition of social problems (including issues affecting health) and responses to these problems are not objectively defined but that they depend on the correlation of class forces and the distribution of power resources. This acknowledgment is vital if we are to move beyond the formulation of policies that cannot be implemented because they are not "politically feasible". In addition, this acknowledgment may force us to confront, directly, those forces that may prove to be obstacles to the implementation of policies that the majority of South Africans need, want and deserve.

The attempt to contextualise the appointment of the NHSC in 1942 is also instructive in answering the question: why are there currently serious attempts to transform social policy in South Africa? As in the late 1930s and early 1940s, current responses by the state and the ruling classes cannot be viewed as moral responses to the inequities in health services and health outcomes between blacks and whites. Neither should it be viewed as part of a process by the F W de Klerk to democratise the polity. A more comprehensive understanding of the reasons for this "window of opportunity" must include an analysis of the following: the changing needs of the economy; the changing political constituency of the National Party; and the strength and militancy of the black working class and their political organs. In other words one should examine the changing correlation of class forces in contemporary South Africa to understand what possible policy changes can be implemented.

The recently published policy guidelines of the Department of National Health and Population Development (Slabber, 1992) should be seen within this context. The Director General of Health would like to believe that the principles that underlie the policy guidelines are new. However, even a brief review of the NHSCR would reveal that these principles are at least forty eight years old. Many of principles adopted by the new guidelines were both implicitly and explicitly articulated by the NHSC in 1944. A few examples will be cited for purposes of illustration. The NHSC called for: a unitary health care system; a focus on primary health care; and an efficient and equitable health system.

Current attempts to define health can borrow from the definition adopted by NHSC. The Commission acknowledged the need for a broad definition of health, including all the components of the biological, psychological, social, political and economic. Even though an all-encompassing definition is desirable, the Commission noted constitutional impediments to its implementation. While it perceived the advantages of including, within the Department of Health, the portfolio of local government (given that the latter was responsible for environmental health) this required a change in the constitution of the Union which was thought to be unamenable to change. Issues of a constitutional nature were to resurface later - one of the reasons given for the non-implementation of the major recommendations of the Commission was that the provinces were guaranteed control over hospitals by the constitution (De Beer, 1984; Marks, 1987).

Another issue that the Report raised was the desirability of keeping the Ministries of Health and Welfare together or separating them. While the majority opinion was that they should be separated, the minority suggested that they should be incorporated into a single ministry. This debate has resurfaced in the 1990s. While many social welfare workers appear to support a separation of the ministries, others favour a single ministry. In their survey, Letsebe and Loffell (1992) found that the majority of the key social welfare practitioners that they interviewed supported the idea of a separate ministry. The major reasons for this included: fear of being dominated by the social status and power of the medical profession and concern that social problems would become medicalised; fear of losing resources to the medical health sector; and the need for social welfare to develop its own identity.

Freeman (1992), on the other hand, using the mental health and social welfare needs of a mentally ill person to illustrate the degree of overlap between the two types of services, makes a plea for both health and welfare to be in one ministry. He argues that a progressive definition of mental health and the provision of a broad spectrum of services to mentally ill patients makes it imperative for health and welfare to be located within a single ministry. While the NHSC supported the idea of separate ministries it recommended that mental hygiene services should be located within the Ministry of Health but in a sub-department headed by a Commissioner of Mental Hygiene.

The decision of the NHSC to include such non-traditional professionals as sociologists into the health team can also be instructive to those concerned about the transformation of mental health policy in the 1990s. Any expansion of members of the health team should also focus on the possibility of including indigenous healers into a future national health service. This was not addressed in any way by the NHSC and given that the Report contains explicit references to "non-Europeans" being developmentally inferior to "Europeans" it is not surprising that a role for indigenous healers was not considered at all.

The Report also emphasised the need to increase both the quantity and quality of health practitioners. This issue has special relevance for social service practitioners who are currently few in number and largely located in urban areas. This is especially true of psychologists and psychiatrists. There is a need to confront issues of quantity and quality together as issues of production relate directly to issues of distribution. In other words, the mechanisms that determine who is selected for training, how training occurs, what conceptual frameworks influence training models, what levels of personnel are trained and where trained personnel work, are related.

While the Report did not specifically emphasise the importance of primary mental health care, the emphases on primary health care and training in psychology and psychiatry for medical officers and nurses could have, unintentionally, led to the development of the practice of primary mental health care. The importance of the appropriateness of training and the need for an emphasis on primary mental health are beginning to be discussed by contemporary mental health policy analysts (e.g. Dawes, 1986; Pillay and Subedar, 1992; Freeman, 1992).

Finally, the need for wide ranging consultation (with all possible constituencies) was emphasised by the Commission and is a lesson for those interested in developing social

policy. However, there is a need for a Commission that is democratically elected (or appointed by a government that was elected democratically) and accountable to the majority of the citizens (unlike the NHSC which was selected by an undemocratic state and therefore accountable to those whom that state represented). This issue is explored by the author is another paper and does not need to be repeated here (see Pillay, 1992).

5. CONCLUSION.

This paper has attempted to summarise the general findings and recommendations of the National Health Services Commission. This is considered useful because of the recent increase of its citation in the South African literature (principally literature that has argued for the need for a unitary national health system in South Africa). The paper also attempted to highlight some of the findings and recommendations that were specific to the social services. This was done in an attempt to tease out some of the lessons and issues that current social service policy analysts may find useful.

The paper emphasises the need for health policy analysts to take seriously the influences of the distribution of power resources in society on the development of health policy. There is a need to go beyond exploring the influences of interest or "power" groups in this regard and analyse health policy within the context of the matrix of power resources that are a result of the current correlation of class forces in South Africa.

Note. This article was written while I was a Kellogg Doctoral Fellow in the Department of Health Policy and Management, School of Hygiene and Public Health, Johns Hopkins University, Baltimore, MD, USA.

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