# Public Health Then and Now

## The 1945 Gluckman Report and the Establishment of South Africa's Health Centers

*Harry T. Phillips, MD, DPH*

In times of crisis, national leaders often plan for a better world. During World War II, the Beveridge Plan outlined a welfare state (including a national health service) for postwar Britain while political leaders in the Union of South Africa dreamed up a progressive proposal for a health program for the people of that country. In South Africa there was a special reason for this political strategy. The nation was deeply divided on the question of participation in the war on the side of the British because a significant part of the White population fostered strong anti-British sentiments. Postwar reforms with promises of benefits for all sections of the people were seen by the prowar party in South Africa's Parliament as a strategy with potential unifying effects.

In 1942, by order of the governor-general (South Africa was still a member of the British Commonwealth at that time), a commission was established to inquire 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.

Ten people prominent in the political, health, and social fields were appointed to serve on this commission, and Dr. Henry Gluckman, a member of Parliament, was appointed its chair.

The commission reviewed the long list of previous proposals and programs (dating back to the formation of the Union in 1910) for improving the health and general well-being of various groups of the population. Studies and recommendations had been made by bodies organized by government health officials, the Dutch Reformed Church, the Carnegie Foundation, and voluntary and labor organizations, among others. Attention had been given in the past, for example, to the need for services to control tuberculosis and malaria and to provide medical care for Black mine workers and poor White communities. While all these were being reviewed, health services in several other countries were also being studied. The commissioners directed special attention toward preventive medicine, noting descriptions of programs such as the Peckham Health Center in England, the Life Extension Institute in America, and the Institute of Social Medicine at Oxford University.

Members of the group conducted a 3½-month tour to learn firsthand—through observation, evidence, and discussions—about the various conditions that prevailed around the country. They paid special attention to pioneer work being done in existing health units established in three rural areas. Then, after 2 years of diligent work, the commission presented its report—219 legal-size pages of densely printed material generally referred to as the Gluckman Report. This report included the following statements:

> We determined at the outset to evaluate the past and present, and to plan for the future, having regard neither to varia-

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**Editor's Note.** See related editorial by Geiger (p 946) in this issue.

The author on leave during World War II, with his wife, Eva Salber, who also became a member of the Institute staff. Reprinted with permission of the Special Collections Library, Duke University, Durham, NC.

tions of political creed within the orbit of democracy, nor to rival social theories, but simply to the modern scientific conception of health . . . which indicates not only absence of disease but a maximum degree of physiological and mental efficiency. It embraces the evolution of our knowledge regarding the factors which make or mar human health and happiness. Its aim is economic prosperity, social contentment and creative power. The attainment of this positive ideal must be the primary objective. . . . Neither in this country, nor, as far as our knowledge goes, in any other, has a Commission ever been appointed by the State to make a *nation-wide* survey of existing health needs and services, and to produce a plan for a national health service designed to promote and preserve the health of *all* sections of the people in accordance with modern standards.[1]

The report set out numerous ambitious and far-reaching proposals. It emphasized the need at the national level for coordination of policies and programs in departments of government that affect well-being, such as town planning, housing, education, and the environment, as well as personal health services, both inside and outside of institutions. It recommended a comprehensive reorganization of the administrative structure of health services with policy-making and programming units at the national, provincial, regional, and local levels. Basic to the delivery of personal health care was the concept that action needed to be taken on four levels: promotion of health; prevention of ill-health; cure or alleviation of disease or injury; and rehabilitation of the disabled. For each kind of care services, the report named agencies and personnel.

The commission recommended the establishment of a national health service, administered by a ministry of health under the direction of a minister of health responsible to Parliament. The heart of the recommendations was the establishment of a workable program based on the "modern concept of health," the health center, which is

> the practical expression of two of the most important, and universally accepted, conclusions of modern medical thinkers. The first is that the day of individual isolationism in medical practice is past, and that medical practitioners and their auxiliaries can make their most effective contribution to the needs of the people through group or team practice. The second is that the primary aim of medical practice should be the promotion and preservation of health.[1]

The health center was to be the basic unit for the delivery of care. Functions, staffing, physical plant, and other characteristics were spelled out in detail and emphasis was placed on combining and integrating health education and preventive care with curative medicine. An epidemiological approach for assessing community needs and identifying appropriate interventions was to be applied. (The South African model for this ecological approach to health had been initiated in 1940 in Pholela, a rural area in Natal, under the direction of Drs. Sidney and Emily Kark. This health unit provided the prototype for future health center practice.)

A special feature in the operation of health center practice was the employment of auxiliary personnel. Some of these staff members, medical aides, had received college-level education that equipped them to work in rural areas under the supervision of fully qualified doctors. In the health center they acted as physician extenders, trainers of junior personnel, and supervisors of health assistants. The latter were recruited from the ethnic groups in which they were to work in various roles—health education, rural sanitation, child-rearing, vital statistics maintenance, laboratory work, and so on.

What was the practical impact of the Gluckman Report?

The establishment of health centers was the only area of the proposed reforms that reached any level of implementation. In the last year of the war, the Institute of Family and Community Health was established to train professional and other per-

sonnel in health center work and to conduct relevant research. By 1949, 44 health centers had been established around the country; a few more were operating by the time the National Party government was reelected in 1952. This event was the beginning of the end of an exciting experiment in the delivery of *health* care, as distinguished from medical care.

In those brief years, the establishment of new health centers provided excitement and inspiration, accompanied by an almost missionary zeal. It is difficult to assess the long-range effects of the South African Health Centre program after its demise. Without question, visitors and departing staff took with them ideas that influenced the development of programs in Israel, the United States, and other countries. For many of those who participated in the program, the experience shaped their orientation to health care for the rest of their lives. □

## Reference

1. *Report of the National Health Services Commission on the Provision of an Organised National Health Service for All Sections of the People of the Union of South Africa 1942–1944* [The Gluckman Report]. Cape Town, Republic of South Africa: South African Government Printer; 1945.

# A South African Odyssey in Community Health: A Memoir of the Impact of the Teachings of Sidney Kark

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This memoir celebrates the accomplishment of Sidney Kark as I personally experienced it. His accomplishment is to have made primary medical care an instrument in and for public health. Kark assembled the girders on which, at some remove, the famous declaration of Alma-Ata rests. At this meeting in 1978, 40 years after Kark began his work, the World Health Organization and the United Nations Childrens Fund endorsed community-oriented primary health care as policy.[1]

Almost from the beginning of his medical studies (which in South Africa normally follow immediately after high school), Sidney Kark seems to have had a comprehensive view of health in society. He was an outstanding student at the Witwatersrand University Medical School, where the education provided was strictly for Whites. Students were taught about the medical disorders that the dominant White minority shared with the more developed world. That was the medicine that their teachers had learned abroad and that the students continued to learn from British and US texts and journals. The configuration of disease peculiar to the majority but fiercely segregated Black population was seldom if ever mentioned. That configuration, where it was not idiosyncratic to the local cultures, was better described in the texts of a half-century earlier, before rising productivity and public health measures had begun to ameliorate the living conditions of the developed world.

Despite the blinkered life and education normal to medical students in that rarefied setting, some, under the guidance of a few remarkable members of the faculty like Raymond Dart and Joseph Gillman, did not neglect the broader issues of a multilayered society. Thus, before graduating in 1935, Kark and Emily Jaspan (later his wife and lifelong collaborator) had founded the Society for the Study of Medical Conditions among the Bantu (then the polite and "scientific" way to describe Black Africans). With fellow students, they carried out a health and nutrition survey of African schoolchildren in Johannesburg and its environs. And in 1938, Kark was recruited by H. S. Gear, the deputy chief medical officer of the government, to carry out a Bantu nutrition survey, together with Harding le Riche as anthropometrist and John Sebonyone as assistant. Their report on this 1-year national survey covered 1000 children in each of nine urban centers.[2]

In 1940, Gear gave the newly married Karks the chance to initiate a plan for a health center at Pholela in rural Natal. This center began with primary care as the

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