A Health Service Plan for South Africa*

IN THE AUTUMN OF 1942, the Government of the Union of South Africa appointed a Commission on National Health Services to inquire into all aspects of national health from general medical practice to hospital services, medical training, nutrition, and housing. Since that time the Commission has been hearing evidence, with a view to legislation, and has received recommendations and proposals from various political and professional groups.

A comprehensive proposal has been put forward by the Medical Association of South Africa, which has a membership of more than 2,000 doctors or about two-thirds of the registered practitioners. The plan envisages a national health program providing both medical care and general health services to all members of the community. It would be financed by the State, directed by a unified authority, and the medical and allied professions would have primary responsibility for the technical aspects of the program. While recognizing that the system would have to be introduced gradually, because of the immediate lack of sufficient medical personnel, the Medical Association nevertheless urges that first steps be taken as soon and as rapidly as possible.

The proposed plan was drawn up by the Medical Association's Planning Committee, appointed in April 1941 to outline the broad objectives of an ideal health service and to recommend a particular program which would command the unanimous approval of the Association members. Early in 1942 the Committee published a statement of certain general principles which should underlie the Association's proposals. In December a questionnaire was sent to the members of the profession, accompanied by a preliminary draft of the Planning Committee's proposals and summaries of other proposals put forward by branches or individual members.

From the replies to the questionnaire, the Committee drew up a draft of recommendations embodying the basic principles and a detailed plan. Before its presentation to the National Health Services Commission, this draft was in turn submitted to the members of the Medical Association and approved by more than nine-tenths of the 785 members who voted. The Federal Council of the Medical Association assumed[1] that unexpressed views could be ignored; the members who did not reply were either indifferent or felt that a change was inevitable and that they would be "fitted in somehow" in the new system.

Basic Principles

The general principles formulated by the Planning Committee and approved by the Federal Council stressed, first, that mere "doctoring" will not solve the health problem. The curative services must of course be increased and improved, but prevention is basic. Freedom from want and poverty will do more to build up a healthy community than any amount of medical treatment. The medical profession must take the lead in planning for the "future progressively-democratic medicine." The *British Medical Journal* quotes the authors of the plan as saying "We are prepared on our own initiative to surrender some of our independence and to become to the extent hereunder laid down 'socialized.' . . . We are only prepared to do this, however, if we are satisfied that the State, as representing the people, will carry out its obligations for the successful working of a health service." Among these obligations, they include nutrition, research, housing, and public health services.

The other principles are that a good health service can be evolved only under unified direction—that is, direction should be centralized but activities decentralized; that such a health plan can be carried out only by State financing and by close cooperation between the Ministries concerned and the medical and allied professions; and that these professions must have a direct voice in the organization and control of the service.

Organization and Control

The Planning Committee proposes a National Health Advisory Council which will plan and initiate the program and lay down the broad lines of policy. Probably its first work would be to draft a new health act to coordinate present agencies. The Council is to consist of 28 members: 9 to be nominated by Government Departments; 3 to represent the public, of whom one would represent native interests; and 16 to be technical members—8 of them medical practitioners elected by the Association and the others to include dentists, nurses, pharmacists, and medical auxiliaries.

The policies determined by the Council would be carried out by a National Health Corporation, in which doctors and other health workers entering the service would be enrolled, under the authority of a board of Governors. The Board of Governors, with the Minister of Health as chairman, would be the executive body; its members—4 medical and 4 representing the other professions—would serve for a specified term and be eligible for reappointment for one further term only. The work of the Corporation would be subject to 5-year scrutiny by Parliament, and its charter to a 10-year renewal.

The Board would be responsible for providing a comprehensive health service and for spending national health funds appropriated to it in the form of block grants. It would be empowered to acquire, build, and own hospitals, clinics, and health centers, and to make contracts with any State, provincial, or municipal authority for carrying out the social and environmental health services. It would also be the appointments board for senior central and regional officers of the Corporation. There would be close relation between the Board of Governors and the Advisory Council; in fact, all professional members of the Board would be members of the Council.

*This summary, prepared in the Division of Publications and Review, Executive Director's Office, is based on the following sources: Supplements to the *British Medical Journal*, Jan. 1, 1944, pp. 1–2, and Jan. 22, 1944, pp. 14–16; *International Labour Review*, Vol. 49, No. 3 (March 1944), pp. 392–394; Inter-American Committee on Social Security, *Provisional Bulletin* No. 4, pp. 25–29; *A National Health Service*, Cmd. 6502, London, 1944.

[1] Supplement to the *British Medical Journal*, Jan. 1, 1944, p. 2.

Regional Administration

For administrative purposes the country is divided into 19 regions, each of about half a million population, large enough to justify a major general hospital of 1,000 beds with a full-time specialist staff, as well as smaller auxiliary hospitals, strategically placed and staffed by general practitioners, with consultant specialists. Each region would have two regional directors, one for the protective or general health services, one for the curative or medical-care services. They would be assisted by an advisory technical commitee. A regional public relations committee, comprising representatives of local authorities, and possibly employers' associations and trade-unions, would deal with problems of coordination within the area. The function of the regional administration would be to see that the central plans were carried out in the area, and to forward plans, suggestions, and criticisms to the central administration.

Health Centers Based on Hospitals

The protective and curative services are focused in health centers throughout the country. In rural areas a center may require only one practitioner; centers in cities may require a dozen doctors, including general practitioners, dentists, and pharmacists, as well as the doctors administering the general health services for which the general practitioner is not responsible. The centers would be linked closely with the nearest auxiliary hospital, to which the doctors working in the center will be attached. Buildings of a considerable size are contemplated; each doctor would have his own consulting room, and a separate consulting room would be available for the visiting specialist. A small theater for minor surgery, an X-ray room, a pathological room for simple diagnostic work, and a pharmacy should be included. The health center is visualized as a hospital without in-patients. However, if there is no hospital within a reasonable distance, the center might have a few beds for emergency and observation cases and possibly for normal confinements. In the country, mobile medical, dental, and laboratory vans may be used. At each center the medical staff, sitting as a technical committee, would arrange hours of work, night calls, holidays, and other details.

Relationship of Doctor and Patient

The patient should have free choice of doctor among the general practitioners attached to the center, and the doctor the right to decline to accept the patient. A limit must be set, however, to the number of patients any doctor can accept. Only in exceptional cases should a patient be allowed to choose a doctor at a center outside his own area, and home visits by the doctor (always to be discouraged except in case of necessity) should be strongly deprecated if not actually forbidden outside the area.

The plan gives the bulk of the curative work to the general practitioner. Arrangements are suggested whereby the general practitioner, when he has reached the limit of his skill or when the patient requests, even though the doctor thinks it unnecessary, must refer the patient to the appropriate specialist and must cooperate in carrying out the treatment when the patient leaves the specialist's hands. This is not to be construed as unfair discrimination against the general practitioner. His role is not only that of "family guide, philosopher, and friend" but that of an expert in diagnosis and treatment of a wide variety of conditions.

Status and Qualifications of Practitioners

Doctors working for the health center are to be employed by the National Health Corporation. They are to be free to come into or leave the Corporation as they wish and while in the service are free to express opinions and give advice or criticism. They must be adequately remunerated and housed, with sufficient off-duty time, regular holidays, and a "refresher vacation" every 5 years. Within their general field they must have opportunity for acquiring and utilizing special skill and be able to keep in contact with their colleagues at the health center and the hospital.

The *British Medical Journal* comments that "a study of the South African proposals shows that the Medical Association has done its best to secure a proper recognition of the doctor's place in the community, as interpreted by remuneration and status, but has also been concerned to develop the newer conception of the duty of the profession to the community, alike in the emphasis on positive health instead of the mere remedying of ailments, and in the movement away from the competitive and towards the cooperative ideal." [2]

A salary scale of three grades is proposed, ranging from £900 to £3,000.[3] At the outset, appointments at all grades will have to be made; when the service reaches its normal level, recruitment is to depend largely on apprenticeships. To meet the problem of obtaining the same quality of service in rural areas as in towns or cities, it is proposed that the rural practitioner should receive, in general, a higher grading than his town colleague.

Qualified medical-school graduates joining the service must serve a 3-year apprenticeship. The first year will be spent in a general or auxiliary hospital. If at that time the apprentice wishes to specialize, and his wish is approved, he will spend the next 2 years in hospital appointments in his special field. Those going into general practice will spend the second year in clinics and departments in the preventive service and their third as assistants in a health center. Beginning at an entrance salary of £200, apprentices will advance to £300 the second year and £500 the third year; board and lodging, or an allowance therefor, are to be provided.

The doctor will be retired at age 65, with a pension equal to one-sixtieth of his salary at the time of his retirement for each year of service up to a maximum of 40 years. It is suggested that 10 percent be deducted from salaries for the pension fund, which will also include provision for sickness and disability, and for dependents if the doctor dies or becomes disabled.

Discipline and Education

It is proposed that the Medical Association of South Africa should be reorganized as a chartered society, with compulsory membership for all members of the profession. This new society should be charged with the disciplinary and other authority now

[2] Supplement, Jan. 22, 1944, pp. 14–15.
[3] A pound is approximately $4.

vested in the South African Medical Council. The society would promote research in medical science and reforms and improvement in medical practice, encourage the study of medicine, ensure the regular conduct of examinations, provide for the amicable settlement of disputes, and suppress dishonorable conduct or practice.

Comparison With the British Government's Proposed Health Program

The similarity in general pattern of the proposals of the medical profession of South Africa, as represented in the Medical Association, and the British Government's proposals in the recent White Paper on a National Health Service (summarized briefly in the May 1944 BULLETIN) is evident. Both emphasize that a national health service must include not only medical services but improvement of all the environmental factors—housing, sanitation, conditions in school and at work, diet and nutrition, economic security—which create the conditions of health and prepare the ground for it. The Medical Association of South Africa declares flatly that freedom from poverty and want will do more to build up a healthy community than any amount of medical treatment—a theme developed even more fully in earlier proposals of British groups, especially Medical Planning Research.[4]

In South Africa, as in Great Britain, the Governments are developing plans for a comprehensive national social security program, into which the health services are to be integrated. The South African Social Security Committee, appointed in January 1943, has published its recommendations, which include provisions for old-age and invalidity pensions, sickness, maternity, and unemployment benefits, and dependents' allowances. Another appointed group in South Africa, the Social and Economic Planning Council, has submitted two reports which deal with measures supplementing the social security program and providing extension of education and industrial training, proper housing, improved living conditions, subsidized food for the needy, and institutional facilities for individuals with personal handicaps.

The British Government has announced a forthcoming White Paper on social security, which will include also the preventive and environmental services omitted from the national health service proposals because their proper place was "in the wider pattern of Government policy and of post-war reconstruction."

Both health systems would make the facilities available to the entire population; poverty would no longer be a barrier to necessary medical aid. Both stress freedom of choice. The patient is to be free to come into or remain outside the service; if he comes in, he may choose his physician. The individual doctor can join the system or remain in private practice or combine both types of practice; if he joins, he has freedom to reject a patient. Both stress the importance of the family doctor as the first line of defense in the fight for good health; both emphasize the need for increasing the numbers of available specialists and consultants and making their services available more widely. The White Paper terms the hospital services the keynote of the system; the Medical Association ties the health centers closely to the hospitals.

The main divergence between the two proposals is in the administrative structure proposed. This divergence is undoubtedly due in part to the different stage of development of the health services in the two countries. South Africa has no existing health insurance or medical care program for the whole country. In Great Britain, on the other hand, national health insurance was established in 1911. The problem of creating a national health service for Britain, says the White Paper, "is not that of destroying services that are obsolete and bad and starting afresh, but of building on foundations laid by much hard work over many years and making better what is already good." The present services represent "a complicated patch-work pattern of health resources," evolved at intervals over a century or more and representing mainly the attempt to meet particular problems, one by one. The White Paper proposals have been prepared and put forward against this background of development and of "constructive thinking and discussion during the last quarter of a century."

The services proposed for Britain are grouped into three main categories—a general medical service, hospital and consultant services, and local clinic and other services. Health centers are linked with the general medical service. Quoting the draft *Interim Report* of the Medical Planning Commission[5] that "the principle of the organization of general practice on a group or cooperative basis is widely approved," the White Paper declares that, while undoubtedly grouped practice would find its best expression in the health centers, time is necessary for experimentation as to the best type of center and the extent of the public's preference for the group system. At the beginning, therefore, a combination of grouped practice and separate practice, side by side, is suggested.

The plan for South Africa centralizes all services within each of the regions throughout the country. These services are focused in the health center or centers, which are in turn closely linked with hospitals in that the doctors in each center would be attached to the nearest hospital.

The administrative structure proposed for the South African system is simpler than that for the British plan, just as the outline of the services is less complex. The South African National Health Corporation, through its Board of Governors, would have complete responsibility for administration. Though the Minister of Health would be chairman of the Board of Governors, the other eight members would be elected from the members of the Corporation and would therefore represent directly the medical and allied professions.

The White Paper, on the other hand, would place central responsibility for administration on the Minister of Health. For the general practitioner services, however, much of the actual administrative responsibility would fall on a Central Medical Board, predominantly professional. This Board would be appointed by the

[4] See the *Bulletin*, March 1943, pp. 43–48, for a brief summary of that report.

[5] Organized by the British Medical Association; a brief statement of some of the proposals in this report, published in 1942, was carried in the *Bulletin*, December 1942, pp. 11–21.

Minister but in close consultation with the profession.

In proposing a public-utility corporation of members of the medical and allied professions, to administer the system, the Medical Association of South Africa was following the preference expressed by a majority of the members who responded to the Association's questionnaire, according to the *British Medical Journal*.[6] "By a majority of something like twelve to one they declared against a medical service on the lines of the Civil Service or the Army. On the other hand, there was a majority of five to two in favor of a service under the Minister of Health . . . with an elected council, and the problem has been to reconcile a comprehensive national health service initiated and organized by the State with, so far as possible, the administration by the profession of its own affairs."

The Medical Association of South Africa was also in close agreement with the British Medical Association, its parent body, which has demanded that the central administrative authority for the British health service shall be vested in a corporate body rather than a Government department.

In addition to the central administrative authority, both plans recommend an advisory council, to consist of members of the medical and allied professions. The White Paper proposed a Central Health Services Council of some 30 or 40 members, who would be appointed by the Minister of Health in consultation with the appropriate professional organizations. The Council would select its own chairman and regulate its own procedure. Of the 28 members of the proposed National Health Advisory Council in South Africa, only 9 would represent and be nominated by the Government; 3 would represent the public, and the other 16 would represent the professions, half of them being nominated by the Medical Association. There would be close liaison between this Council and the Board of Governors.

At one important point the proposals of the South African Association diverge sharply from the recommendations of the Representative Body of the British Medical Association and are more specific than those in the White Paper. In the plan for South Africa, all doctors joining the service, whether as apprentices or on full appointment, would receive a specified salary, varying with the quality and kind of work they do. The salary scale allows for promotions within the grades specified as well as from one grade to another.

The Representative Body of the British Medical Association favors "a method of remuneration which relates remuneration to the amount of work done or the number of persons for whom responsibility is accepted," that is, a continuance of the capitation system of reimbursement. "In the opinion of the Representative Body the creating of a whole-time salaried State medical service is not in the best interests of the community. (This was carried by 20 votes to 10.)"[7]

The White Paper offers alternative proposals. In discussing the remuneration of general practitioners, the White Paper says that, while "the Government do not contemplate the introduction of a universal salaried system . . . they propose that doctors taking part in the public service should be remunerated on a basis of salaries or the equivalent in any part of the service in which this form of payment is necessary to efficiency. They contemplate also that it may be possible in certain other cases to offer remuneration by salary where the individual doctors concerned would prefer such an arrangement."[8]

[6] Supplement, Jan. 1, 1944, p. 2.

[7] Supplement to the *British Medical Journal*, Oct. 30, 1943, p. 75.

[8] White Paper, op. cit., p. 80.

*The Second Actuarial Valuation of the Railroad Retirement Act**

"AT INTERVALS not longer than 3 years the Board shall make an estimate of the liabilities created by this Act and the Railroad Retirement Act of 1935 and shall include such estimate in its annual report."[1] In accordance with this statutory mandate, the Railroad Retirement Board has issued the second actuarial valuation, along with its recommendations and a statement of the Actuarial Advisory Committee, as an appendix to the annual report for 1942–43.

The first valuation covered the period ended December 31, 1938. The experience and data accumulated in the 3 succeeding years provided a more complete basis for the compilation of mortality, disability, withdrawal, and retirement rates and salary scales. They also permitted a far more accurate determination of the liabilities for years of service before 1937 which, although prior to the date of enactment, are credited toward benefits under the retirement system.

The second valuation as of December 31, 1941, employed methods generally similar to those used for the first and, whenever possible, compared original estimates against actual experience. The report also took into account amendments to the law since 1938 which, except for the military-service provisions, were administrative and had slight effect on coverage and other features. By amendments in 1940 and 1942, credit toward benefits is allowed on account of specified past, current, or future military service. Since the Federal Government bears the cost entailed, these provisions were not taken into account in the valuation. The actuary's report, summarized below, was approved as to method and presentation by a three-member Actuarial Advisory Committee consisting of actuaries recommended by employees, carriers, and the Secretary of the Treasury.

The First Valuation and Actual Experience

Annual costs of benefits based on estimates of the first valuation compared with the experience during the past few years showed that the estimated disbursements exceeded the actual expenditures by a steadily in-

*Prepared by the Office of Director of Research, Railroad Retirement Board. The actuarial valuation was conducted by Robert J. Myers, now lieutenant, AUS.

[1] Section 15 (d) of the Railroad Retirement Act, as amended (Public, No. 162, 75th Cong.), approved June 24, 1937.