CUMANN BORD SLÁINTE IN ÉIRINN

(ASSOCIATION OF HEALTH BOARDS IN IRELAND)

in association with

THE INSTITUTE OF PUBLIC ADMINISTRATION

PAPERS PRESENTED

at

CONFERENCE

on

THE DEVELOPMENT OF CARE IN THE COMMUNITY

at

Hotel Blarney, Blarney, Co. Cork

13th - 15th May, 1986
CUMANN BORD SLÁINTE IN ÉIRINN

(ASSOCIATION OF HEALTH BOARDS IN IRELAND)

in association with

THE INSTITUTE OF PUBLIC ADMINISTRATION

PAPERS PRESENTED

at

CONFERENCE

on

THE DEVELOPMENT OF CARE IN THE COMMUNITY

at

Hotel Blarney, Blarney, Co. Cork

13th - 15th May, 1986
# CONTENTS

<table>
<thead>
<tr>
<th>Topic</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conference Speakers</td>
<td>1</td>
</tr>
<tr>
<td>A Summary of Proceedings</td>
<td>3</td>
</tr>
<tr>
<td>T. O’SULLIVAN</td>
<td></td>
</tr>
<tr>
<td>Summary of Points made at the Opening of Conference</td>
<td>8</td>
</tr>
<tr>
<td>CLLR. W. FARRELL</td>
<td></td>
</tr>
<tr>
<td>Current Trends and Developments in Community Health</td>
<td>10</td>
</tr>
<tr>
<td>PROF. J. P. CORRIDAN</td>
<td></td>
</tr>
<tr>
<td>Current Trends in Community Care</td>
<td>14</td>
</tr>
<tr>
<td>DR. B. O’HERLIHY</td>
<td></td>
</tr>
<tr>
<td>Transfer of Resources from Institutions to the Community</td>
<td>36</td>
</tr>
<tr>
<td>MR. E. HANNAN</td>
<td></td>
</tr>
<tr>
<td>The Contribution of Health Board Members to Policy Making</td>
<td>38</td>
</tr>
<tr>
<td>DR. R. O’HANLON, T.D.</td>
<td></td>
</tr>
<tr>
<td>Developments in Child Care – A Personal View</td>
<td>48</td>
</tr>
<tr>
<td>MR. P. KIERAN</td>
<td></td>
</tr>
<tr>
<td>The Development of Child Care Services</td>
<td>53</td>
</tr>
<tr>
<td>MS. A. MC CABE</td>
<td></td>
</tr>
<tr>
<td>Problems in Servicing Rural Areas</td>
<td>58</td>
</tr>
<tr>
<td>MS. A. O’MAHONY</td>
<td></td>
</tr>
<tr>
<td>Conference Dinner Address</td>
<td>75</td>
</tr>
<tr>
<td>CLLR. W. FARRELL</td>
<td></td>
</tr>
<tr>
<td>General Practice and its Contribution to an Expanding Community Care Service</td>
<td>77</td>
</tr>
<tr>
<td>DR. M. J. BOLAND</td>
<td></td>
</tr>
<tr>
<td>Nursing Services in the Community</td>
<td>89</td>
</tr>
<tr>
<td>MISS K. KEANE</td>
<td></td>
</tr>
<tr>
<td>Public Health Nursing Service in the Community</td>
<td>96</td>
</tr>
<tr>
<td>MISS J. STACK</td>
<td></td>
</tr>
</tbody>
</table>
CONFERENCE SPEAKERS

PROFESSOR JOHN CORRIDAN is Professor of Social Medicine in University College, Cork. He previously worked as a doctor in the public health services. He has had a major research interest in geriatric care and services. His present interests include the epidemiology of cancer in the Southern Health Board area.

DR. BRIAN O'HERLIHY is Director of Community Care and Medical Officer of Health in Community Care Area 8 in Dublin. He has written widely on issues related to community medicine in Ireland, has been active in medical organisations and is currently a member of the Eastern Health Board.

MR. EAMONN HANNAN is Chief Executive Officer of the Western Health Board. Previously was senior manager in Local Authorities and Manager of a major Dublin Voluntary Hospital.

DR. RORY O'HANLON, T.D. is Fianna Fail T.D. for Cavan/Monaghan and the party's spokesman on health. He is a General Practitioner in Carrickmacross and a member of the North Eastern Health Board.

MR. PETER KIERAN is a Senior Social Worker with the South Eastern Health Board working in the South Tipperary Community Care Area.

MS. AUGUSTA MC CABE, a social worker by profession, is Social Work Adviser in the Child Care Services Division of the Department of Health; was previously Senior Social Worker, Eastern Health Board (Kildare).

MS. ANN O'MAHONY is a Senior Researcher in the Rural Sociology Department of An Foras Taluntais. She has researched and published widely on Rural Areas and Services and is the author of a recent major study 'Social Need and the Provision of Social Services in Rural Areas: A Case Study for the Community Care Services'. This study was published by An Foras Taluntais in 1985.

MR. MICHAEL CONWAY is Administration Executive with a large Cork voluntary body, the Cork Polio and General After-Care Association. The Association has a staff of 450 and provides comprehensive services for the mentally handicapped adult and child in Cork City and County.

COUNCILLOR WILLIE FARRELL is a member of Sligo County Council, of the North Western Health Board, and is Chairman of the Association of Health Boards in Ireland.
DR. MICHAEL BOLAND is a General Practitioner working in Skibbereen. He is also currently Chairman of the Irish College of General Practitioners.

MISS KATHLEEN KEANE is Chief Education Officer with An Bord Altranais and has a particular professional interest in nurse training and education.

MISS JOAN STACK Superintendent Public Health Nurse in the Mid-Western Health Board region, is also a member of the Mid-Western Health Board.

PROFESSOR ROBERT DALY is Professor of Psychiatry and Dean of the Faculty of Medicine at University College Cork and Consultant Psychiatrist, Southern Health Board. He was a member of the group which produced the recent report on psychiatric services, Planning for the Future.
The development of care in the community was the theme under discussion at this year's annual conference of Cumann Bórd Sláinte in Éirinn (The Association of Health Boards in Ireland). The conference, which was organised in association with the Institute of Public Administration, was held at Blarney, Co. Cork from 13th to 15th May 1986.

ALDERMAN JOHN DENNEHY welcomed delegates to Blarney. He suggested that in Ireland at the moment we had a caring community but one which needed leadership. Community services were not getting adequate financial provision; if the government were serious about this area, he argued, they needed to devote more money to it.

In his opening address COUNCILLOR WILLIE FARRELL referred to the very broad WHO definition of health. Today we tended to forget that there was more to community health than the care of the sick, important though that might be. Community care must begin with and be part of the community itself; there could not be community care unless the community cared. He concluded by noting that community care which was properly organised, staffed and funded was not cheap. It might be better and more desirable for a whole variety of reasons but it would not be cheap. This theme was also taken up by MR. EAMONN HANNAN, who warned against seeing a transfer to the community as an easy solution to the real problem of the escalating costs of the health services. He noted that there was no reliable evidence that well developed community based services were less expensive than institutional services. "Pump-priming" funds would be required to develop community services.

MR. HANNAN said that the present position where health board allocations were reduced significantly in real terms each year allowed no scope to develop community services.

In his address after the conference dinner, COUNCILLOR FARRELL noted the enormous growth in services and in eligibility for them during the 1970s. Since 1981, there had been a major change, a new area of budgetary cuts. Though these cuts were being applied, no one was telling the Boards which of the services expanded in the 1970s should now be withdrawn; or which of
the departments opened then should now be closed. We had moved away from
direction by service priority into direction by finance only. The job of
ensuring uniformity of service provision around the country properly belonged
to the Minister and the Department but unfortunately they would not admit
that there was a problem in maintaining current services and standards.
COUNCILLOR FARRELL suggested that it was therefore now up to the Association
to develop clear policies and to coordinate service developments around the
country.

PROFESSOR JOHN CORRIDAN outlined changes in causes of death from the
19th century to the present day, and particularly the shift from infectious
to chronic diseases. Today heart disease and stroke together accounted for
nearly half of all deaths and care was more important than cure. While
community care was often a preferable alternative to hospital care, it ought
not to be examined uncritically; and the importance of coordination between
community and hospital services needed to be recognised. He turned to the
elderly in Ireland and the projected increase in their numbers in the next
two decades. The main challenge to public health in the next generation
would be the increase in numbers suffering from dementia. A high proportion
of the elderly in institutions were single; marriage was a clear protection
against ending one's days in an institution! PROFESSOR CORRIDAN also
referred to the phenomenal growth of home care in America and outlined the
services provided by the Southern Tumour Registry in Ireland.

DR. BRIAN O'HERLIHY emphasised the pressures on Governments internationally
to reduce spending. In the US, for example, Governments viewed health care
in the past as a social problem; now they saw it almost solely as a budget
deficit problem. This shift in perspective was linked to a desire for more
immediate solutions than in the past.

He noted the increasing demands today on the public health nursing service
with the nurses devoting significantly more time to curative nursing. If
basic trained nurses were available to do the public health curative nursing,
nurses could concentrate on a preventive/counselling role.

He examined the question of non-accidental injury to children, which had been
sensationallly treated in some media. Factors associated with parents who
battered children included: low income group; early marriage and parent­
hood; mother working; mother irritated by perpetual presence of small
children. The best hope for limiting the occurrence of non-accidental injury
lay in secondary prevention with early identification and action aimed at
limitation of morbidity. He spoke about the problem of child sexual abuse,
a part of non-accidental injury to children. There had been a marked increase
in the number of such cases coming to light in each of the last three years.
He suggested that there was a link between the vile material available from
many video lending libraries and the rise of child abuse.

DR. O'HERLIHY argued that there was little evidence from anywhere in the
world that health education was particularly effective yet there was great
resistance among health education bodies to evaluation of their activities.
In the future all preventive programmes should be clearly evaluated. It
would be vital to have one individual responsible for coordinating health
education programmes on a regional basis. GPs, he suggested, could be more
involved in preventive programmes.
He outlined the Measles Eradication Scheme and particularly the special promotion effort in Dublin funded by the Eastern Health Board with the co-operation of the Irish College of General Practitioners.

Turning to cancer of the cervix, DR. O'HERLIHY noted that repeated epidemiological studies had pointed to the overriding importance of early sexual experience with multiple partners in the aetiology of this condition. In addition, male sexual promiscuity may contribute to an increased risk in the female. While considerable effort and resources were expended on cervical smear screening in the country, the organisation was haphazard. Abroad, the most successful screening programmes had the following points in common:

- they were organised as public health cancer control programmes specifically directed towards a reduction of mortality;
- they repeatedly called the age groups at greatest and most immediate risk;
- a particular person was in charge and could be held to account.

Finally DR. O'HERLIHY stressed the importance of proper arrangements for the future of Community Medicine in Ireland and expressed concern about the current uncertainty in this area.

DR. RORY O'HANLON, T.D. begun by noting that in Ireland it is the Health Boards (and not the Minister, as in Britain) which are responsible for the delivery of health care on a statutory basis. He suggested that the establishment of the health boards was really the first attempt in Ireland to provide Government of any significance below national and above county council level.

He said that health board members were sometimes seen as parochial in outlook but his own experience of a health board was that rational decisions were made. One of the problems of the current system, however, was that there were not structures which allowed health boards per se to have a direct input to national policy. Nevertheless several important new developments since 1972 had originated with health boards, e.g. the development of a home help service, the development of the community psychiatric services, improved services for the elderly and the long term illness scheme. He noted that health boards tended to operate as corporate bodies rather than in the politicised, adversarial style of local authorities.

DR. O'HANLON stated that the health boards and their members had served the country well. He criticised recent centralising trends in Ireland in the health services. It would be unfortunate for local democracy and for access to services if the health boards were abolished or their number reduced.

He suggested that the proposal to abolish the post of Director of Community Care and Medical Officer of Health required further discussion. Rather than having the post abolished DR. O'HANLON suggested that doctors should be trained in administration.
MISS AUGUSTA MC CABE described developments in child care services over the years and particularly since 1981. She outlined the principles on which the Children Bill is based and the main provisions of the bill.

On any one day over two years ago, there were almost 2,700 children in care and 3,700 children passed through care annually. "A one parent family unable to cope" was the single biggest reason for admission to care. There were 767 reported and 304 confirmed cases of child abuse in 1985, including 128 confirmed cases of sexual abuse. In 1986, child care services cost £19½ million, or roughly 1.5% of the total health bill.

MR. PETER KIERAN suggested that the Constitution supported families but ignored any definition of the rights of children. He outlined what he saw as Irish "myths and notions" about family life, e.g. that home life was always better than children going into care; that parental instincts were automatic; that blood ties were paramount; that there were perfect parents; that a baby completed a home etc. Another 'myth', in his view supported by the Constitution, was that children were the possessions of their parents.

He felt that we had not yet had a proper debate about the rights and needs of children. The Pro-life Amendment debate, he claimed, was about morality, not children. The divorce debate was about adults not children. Children needed specific protection in the Constitution, which a Constitutional Amendment could provide. MR. KIERAN turned finally to the position of Social Workers. Their jobs, he said, involved a lot of responsibility and a lot of risk but not very much power.

MISS KATHLEEN KEANE stated that the total number of nurses to date on the public health nursing register was 1,770. She noted that a recent survey of the workload of public health nurses found that the mean percentage time given to home nursing was 44%.

She outlined developments in recent years, including the introduction of community psychiatric nursing services in the 1970s. This was remarkable in being largely a grassroots development, which extended the traditional role of psychiatric nurses.

She outlined training for public health nurses and examined a range of current issues, including the question of generalist v. specialist nurses.

MISS JOAN STACK asked whether community care was being seen as a way of off-loading patients and nurses from an over-crowded hospital service. She argued that health education was an integral part of every nursing activity. Crucial to its effectiveness was not so much its technique as the human relationships between the parties concerned in the educational process.

Among future needs, MISS STACK mentioned more public health nurses, more day centres for the elderly, a twilight nursing service for the terminally ill at night, holiday relief schemes provided by long-stay institutions for caring relatives and more equipment such as orthopaedic beds for the community services.
DR. MICHAEL BOLAND argued that since the mid-70s, explosive increases in the size of the acute general hospital sector had not been matched by similar increases on the community side. He also noted the relative cheapness of the GMS service. In 1982, the average total cost of an outpatient visit (rarely including medicines) was £25.00; of a hospital admission was £800; and of a GMS visit, including drugs, was only £10.75.

DR. BOLAND argued for the abolition of the global fee and the separation of fees and expenses in the GMS. He suggested that there should be incentives for doctors to invest in premises, staff and personal education, and that GPs should have direct access to some hospital facilities. He also argued the case for more public health nurses and for such nurses to be practice based.

MS. ANN O’MAHONY stated that the increased urbanisation and rural population decline had led to a retraction of services from rural areas and a concentration of these services in urban centres. An increasing centralisation of public services was evident in all modern western societies. Her research in Mayo suggested that rural areas in close proximity to urban centres had experienced a population increase whereas in the remote areas the population had remained static or was still declining.

MS. O’MAHONY highlighted problems of access to services in remote rural areas and the degree of disadvantage suffered by people in those areas. Agencies like the Western Health Board had to contend with scattered populations, more elderly populations, poor employment opportunities and high migration rates. If we wanted to provide proper access to services for all our citizens, we had to try to minimise the disadvantages associated with remoteness from an urban centre.

MR. MICHAEL CONWAY outlined the work and activities of a large voluntary organisation with a significant involvement in community care: the Cork Polio and General After-Care Association. He said that the Association emphasised education and training and championed the rights of the handicapped in society. There was a great voluntary effort in fund-raising, which led to a lot of grassroots communication with the population.

PROFESSOR ROBERT DALY examined the development of the community movement in psychiatry in the U.S. Among its guiding principles were the provision of comprehensive services and of treatment close to the patient, continuity of care, consumer participation and a multi-disciplinary team approach.

In Ireland, we had a very large number of psychiatric hospital beds and indeed topped an international WHO table in this area. First admissions were now tailing off but re-admissions continued to remain high.

In the GMS, at a conservative estimate, at least one third of patients had psychiatric disorders. PROFESSOR DALY suggested that GPs clearly needed to be trained to a high degree in psychiatry; and that there should be basic common training for general and psychiatric nursing.

In the psychiatric services, information was vitally important. Money and staff needed to be redeployed but PROFESSOR DALY stated in this concluding session of the conference, fairly modest changes would bring about a good service.
Community Care

What is Health?

The World Health Organization defines health as not merely the absence of illness but being a state of physical, mental and social well-being.

This means in practice:

- a sense of belonging to the community;
- having a feeling of dignity within the community;
- good housing;
- a good water supply, and nowadays hot water;
- good communications, road, transport, phone;
- social support;
- care and treatment when ill.

I have deliberately put 'sickness services' down the list because our first priority must be to maintain health, to support and cultivate good health for all, and then to look after those whose health has temporarily or permanently failed despite the good supports in the community.

However, nowadays we have gone the other way. We have equated health with doctors, drugs and dressings, we demand more and more pills and potions and we forget that there is more to community health than the care of the sick, important though that may be.

What is Community Care?

Community Care is all the ideas and the services which give practical effect to basic community health. It is far more than an alternative to hospitals for care of the sick. It is a comprehensive network of support for all, but especially for the frail and the needy.

Community Care must begin with and be part of the community itself. The community itself must care - you can't have community care unless the community cares. Put it that way and the question must be asked "How caring is our community today?"
Psychiatric Services

We have heard much in recent months in the debate about the psychiatric services as to whether the psychiatrically ill should be cared for in large institutions or in the community. One question that always intrigues me is what did we do before these huge hospitals were built. It was only in the second half of the last century, little more than a hundred years ago that most of the 'county asylums' as they were called were built. How did they manage before then? Did we have community care up to that time?

Since we built these huge institutions a large range of specialists and specialties have grown up within the walls. I fear that many of them could not survive or operate outside the walls. Their voice is going to be loud calling for the retention of the institutions. On the other hand, if we rely more and more on the community for the care of the mentally ill we will have to build up a new range of supports and services based on a caring community. Again, I ask, have we got a caring community? Or will this community, as it did in the past, reject the mentally ill and arrange for them to be locked up.

Cost

We are being constantly told by 'experts' who would not know anyway, as well as by politicians who should know better, that community care is a cheaper way of maintaining health.

Now firstly there are certain services and conditions which require a hospital back-up - major surgery, intensive care, coronary care, acute trauma. But let us look at, say, the care of the aged.

If 500 elderly people require comfortable accommodation, warmth, food, medical and nursing care it must be cheaper and more efficient to provide that by bringing them together under one roof than to provide the same services to those people scattered in their homes all over the country. The quality of life may be decreased, the sense of belonging to their own community may be impaired, their independence and dignity may be shattered, in fact, it may be quite indefensible on any other ground to do it - but it would be cheaper. Yet we are told that community care is cheaper and what's more this argument is being used as a pretext to cut health budgets. How often do we hear, close hospital beds, look after patients at home, provide community care, it will be cheaper, CUT BUDGETS.

Let me say loud and clear that if community care is properly organised and properly staffed and funded it is not cheap. It is better and more desirable for a whole variety of reasons but it is expensive.
The history of the development of community care was outlined as well as the reasons for same. Causes of death in the 1980's were contrasted with those of the 19th century. Chronic disease now predominated so that it was now much more a case of care rather than cure. The concept of community care however should not be accepted uncritically. Community care also had its problems but provided it is seen in perspective and not as an end in itself to be pursued at all costs, community care may in many circumstances be the better alternative. Some critics of community care aver that it has led to community neglect where an adequate community care structure does not exist. The main burden of community care always falls on families especially women.

The main challenge to Public Health within the next generation will, if population projections materialise, be in coping with a large increase in elderly demented people especially women. Teamwork within the community is necessary with the family doctor being the key person.

The phenomenal growth in Home Care in the United States was adverted to and in conclusion an outline of the services provided by the Southern Tumour Registry was described.
<table>
<thead>
<tr>
<th>Disease</th>
<th>1878</th>
<th>1900</th>
<th>1968</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scarlet Fever</td>
<td>2282</td>
<td>271</td>
<td>0</td>
</tr>
<tr>
<td>Diphtheria</td>
<td>1122</td>
<td>571</td>
<td>0</td>
</tr>
<tr>
<td>Whooping Cough</td>
<td>1372</td>
<td>815</td>
<td>3</td>
</tr>
<tr>
<td>Measles</td>
<td>1448</td>
<td>915</td>
<td>5</td>
</tr>
</tbody>
</table>
### MAIN CAUSES OF DEATH

<table>
<thead>
<tr>
<th>19th Century</th>
<th>1980's</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Infectious diseases 33%</td>
<td>1. Heart disease 35%</td>
</tr>
<tr>
<td>(\frac{1}{2}) of these TB</td>
<td></td>
</tr>
<tr>
<td>2. Respiratory 15%</td>
<td>2. Cancer 20%</td>
</tr>
<tr>
<td>4. Digestive 8%</td>
<td>4. Respiratory 10%</td>
</tr>
<tr>
<td>5. Circulatory 5%</td>
<td>5. Accidents etc. 5%</td>
</tr>
</tbody>
</table>
PERCENTAGE OF ELDERLY MEN AND WOMEN BY MARITAL STATUS IN COUNTY CORK AND IN COUNTY HOMES.

<table>
<thead>
<tr>
<th></th>
<th>MEN</th>
<th>WOMEN</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Cork</td>
<td>Homes</td>
</tr>
<tr>
<td>Single</td>
<td>26.4</td>
<td>63.6</td>
</tr>
<tr>
<td>Widowed</td>
<td>21.8</td>
<td>22.7</td>
</tr>
<tr>
<td>Married</td>
<td>51.8</td>
<td>13.6</td>
</tr>
</tbody>
</table>
CURRENT TRENDS IN COMMUNITY CARE

Dr. B. O'Herlihy,
Director of Community Care and MOH,
Eastern Health Board

When I was asked, about 10 days ago, to make a contribution to this Meeting, I was assured that I could interpret the title "Community Care/Current Trends" in its widest sense, the purpose being to touch on issues that might lead to discussion. I was also told that my talk need not be too long as individual health board members much preferred to do the talking themselves rather than have to listen to someone else.

I know that you are well aware of many of the current trends involving community care. There is emphasis in shifting the pattern of health care away from institutions to the community. The theory is to divert resources from hospitals and other institutions to the community care services and the development of primary health care. The reality appears to be somewhat different, for while hospital services are being reduced, there is little evidence so far of an equivalent input of resources to the community. Initially this move to shift care from the hospital to the community was promoted as being for the good of the individual user of the health service. In reality, it is for economic reasons. Yet, there is no evidence that a comparable level of service can be provided in the community at a lesser cost than in hospital. In fact, an equivalent level of care may be more expensive in the community.

One must accept that if the Government is to reduce its budget deficit by cutting expenditure, it must cut health care spending.
Thurow, writing in the New England Journal of Medicine on the topic "Medicine Versus Economics (5th Sept. 1985) said of the situation in the United States and I quote — The Federal Government used to view health care as a social problem. Today it views it almost solely as a budget/deficit problem. The shift in perspective is important. Social problems can be left to fester; budget deficit problems require more immediate solutions — unquote. I, not being a political animal, would not like to comment as to whether that statement has any relevant in an Irish context.

Most developed countries are struggling to contain health expenditure. Bernstein, writing in Technical Review (November/December, 1984) on the subject of "The Misguided Quest for the Artificial Heart", put it rather well and again I quote — Modern Technology has made almost everyone a candidate for a "catastrophic" illness — unquote. In other words, modern technology makes it likely that everyone will die of an illness that requires immense amounts of money, except those lucky enough to die quietly in their sleep. Given medicines' potential ability to spend almost unlimited amounts of money on almost everyone before reaching the traditional "do no harm" stopping point, it is not surprising that Governments want to limit their liability.

Yet we should not forget that the modern hospital and high technology brings many benefits to the sick and saves many lives.
As a country we must decide whether we wish to have a health service appropriate to a third world country or similar to that of our European neighbours.

Studies in several countries have shown that a large number of beds in highly specialised hospitals are occupied by patients who could well be taken care of in less specialised institutions. In Ireland, this is very true in respect of many elderly and young chronic sick because in many cases, to this day, we have not provided more appropriate institutional care. In Sweden, the bold concept of "the lowest effective level of care" has been wisely advocated. A different concept altogether than the often stark choice between hospital and community care.

During the late 1950's, a clear need was felt to make health services more comprehensive, particularly by developing services that would reach out into the community. The hospital was considered to be the hub of the health care system, providing leadership and guidance to all other sectors and responsible for the entire spectrum of health services. It was conceded, however, at a W. H. O. Conference in Stockholm in 1958 that primary medical care might possibly expand enough to provide comprehensive care. It was suggested that studies be undertaken relating to home care by the family doctor supported by assistance from local health authorities, ranging from a simple home nursing service up to highly organised schemes that would employ
a wide variety of professional health workers and volunteers.

The 1970 Health Act, following from the McKinsey Reports, regionalised health services in Ireland with the establishment of 8 Health Boards. The action was influenced by the fact that the State had taken over the major share of the cost of running the services which were increasing substantially every year. It was therefore, thought desirable to have a new administrative structure. In addition, it was recognised that in order to develop the medical service itself, especially in relation to acute hospitals, it would be necessary to have an organisation on an inter-county basis as it was clear that the county as a unit was too small an area for hospital services. So even at that point in time, the thinking was predominantly hospital orientated. Also, at that time, the McKinsey Reports were influential in the decision to deliver health services on a fragmented basis with the creation of separate programmes for hospital services, special hospital services and community care.

I have referred to hospitals because what is happening in the hospital very much affects community health services. The reverse is also true. I suggest there is now an urgent need to integrate the delivery of health services. The programme system of delivery should
be scrapped and Managers should become responsible for the totality of health care within a given geographical area.

An integrated approach to delivery of health services is essential if we are serious about cost effectiveness.

Some of the following comments are based on my experience with the Eastern Health Board area. However, I suspect that they also describe the situation in many parts of the country.

In general I find there is often unreal expectations about the support services available in the community. Some people are now being discharged from hospitals earlier and sicker than before. They require more support in the community where additional resources have not been provided. There is increasing demands on the public health nursing service with the nurses devoting significantly more time to what is described as curative nursing. This would cover such things as dressings, injections and bathing. There is less time being devoted to the preventive, surveillance and counselling role of the nurse.

In general the community nursing service is one that provides the service of a nurse, for whatever reason, for a period ranging from
5 to 20 minutes at a time. It does not provide a service to the very ill or dying who might require a nursing service over many hours per day. In the Dublin area, at least, contact between the individual nurse and family doctor leave a lot to be desired. Perhaps these are matters that need to be rectified.

If more and more of the community nurses time is to be taken up with curative nursing, it raises the question; do we need highly trained and expensive public health nurses to do a task that underutilises their qualifications? A basic trained nurse could provide curative nursing just as effectively. Indeed, some of the tasks public health nurses now perform could be undertaken by nurse assistants. I am not advocating the extermination of public health nurses but rather suggesting they could be confined to a preventive/counselling role where they can be most effective. An application of the Swedish principle of the lowest effective level of care could provide a greater number of nurses in the community at a cost equivalent to that at present.

I move quickly from that contentious matter.

Child and baby battering have in particular aroused high emotions over the last few years. The matter has been dealt with sensationally in sections of the media. Official annual figures relating to the incidence of non-accidental injury to children have been disputed
and claims from unofficial sources, relating to the incidents of this condition, have ranged from the high to the ridiculous. Such claims have seldom been supported by facts.

Attempts to measure the incidence of non-accidental injury to children is fraught with difficulty. There is no accepted precise definition of non-accidental injury. In this country, the Dept. of Health has issued guidelines on the identification and management of non-accidental injury to children. However, this document ignores definition. Instead, it is stated that and I quote — Every injury (apart from Road Traffic Accidents) to a child, particularly a child who has not reached school going age, should be a cause of concern. The full history of how the injury occurred should be compared with the physical findings by the doctor treating the child. Where the account of the injury is not compatible with the physical findings the possibility of non-accidental injury must be considered, unquote.

In the United States of America, Professor Henry Kempe deliberately originated the emotive phase "Battered Child" in 1961 in order to shake public opinion. Later he formed the opinion that battering and ordinary abuse were not two quite separate things. This poses the question, what degree of "ordinary abuse" constitutes non-accidental injury.
Factors associated with parents who batter children include:

1. Low Income Group,
2. Marrying or co-habitating at a younger age than average.
3. Having the first child earlier than average.
4. Mother working.
5. Mother irritated by perpetual presence of small children.

Most research shows battering to occur mainly among the lower income groups. Unquestionably, the more severe physical battering which is likely to come to the notice of the Authorities occurs among the underprivileged.

Stress is inevitably a factor in battering. Unemployment, financial difficulties, alcoholism, drug problems, marital difficulties, and particularly a third person entering a sexual relationship, are frequent factors.

Typically, battering parents have immature personalities. Some come from broken homes or homes where there is/was a history of violence. A high proportion of fathers have previously committed minor crimes.
A significant proportion of those who batter, about 20%, are aggressive psychopaths. The actions of these people are unpredictable.

Factors associated with the child who is battered include:

1. Unwanted child,
2. Illegitimate child,
3. Marriage arranged due to unplanned pregnancy,
4. Difficult pregnancy,
5. Abnormal birth,
6. Premature or low birth weight,
7. Child separated from mother for a significant period after birth,
8. Illness or wakefulness which causes continual disturbance of parents' sleep.

Factors associated with cases of non-accidental injury are so numerous and commonplace as to make the task of primary prevention extremely difficult. The majority of parents, including the majority of those parents who might exhibit a number of associated factors do not physically abuse their children. Consequently, the best hope for limiting the occurrence of this condition, lies in secondary prevention with early identification and action aimed at limitation of morbidity.
I will show just two examples of child battering;

The first slide shows a baby who was brought to the casualty department of a hospital late: After an interval of 2 or 3 days, bruising is established. The black eye has formed, the abrasions are crusted.

The next slide, the tell-tale high water marks on the buttocks is evidence of dunking or forced immersion in extremely hot water.

Sexual Abuse, of course, is a part of non-accidental injury to children. There is a marked increase in the number of such cases coming to light in each of the last 3 years.

(Slide showing Garda Statistics)

A. Just a few points I would make about this: This form of abuse is occurrences of a sexual nature between a child and an adult or between two children where there is a marked difference in age between the victim and the abuser.
B. Where this form of abuse occurs within families, and where particularly the father is involved, the wife may be aware that sexual abuse is occurring but often does nothing about it or tries to hide the fact.

C. Neighbours, baby-sitters, friends and relations, can also be abusers.

D. Girls and boys can be subjected to sexual abuse but girls are more commonly victims.

E. Where this form of abuse occurs within the home, removing the victim from the home is only punishing that person rather than the culprit.

F. Abusers are often responsible for numbers of sexual abuse occurrences with different victims. They will go abusing unless caught.

G. In my Community Care Area, as a matter of policy, we always involve the Gardaí in these occurrences.
Having regard to some of the vile material that is uncontrolled and available from many Video lending libraries - should we be surprised that sexual abuse may be on the increase.

Health Education has been in vogue in this country for nearly a decade. Yet there is little evidence from anywhere in the world that health education is particularly effective. Admittedly, for many people in Western Society, cigarette smoking is losing its appeal. However, the influences bringing this about are multiple and cannot be attributed to health education alone. Females, the young and the poorer sections of society are still smoking in significant numbers.

There is great resistance among health education bodies to evaluation of their activities. They argue that the benefits of such education are long term and will not be seen for 20 or 30 years. This approach could prove to be very costly if they are wrong. Health Education is usually seen as central to any strategy for primary prevention. Its importance, together with growing doubts about the effectiveness of the traditional leaflet, poster and media advertisements approach is now the subject of much debate.
It is not my intention to denigrate preventive medicine or preventive programmes. Indeed it is encouraging to see a growing interest in preventive measures as a health strategy. Many general practitioners are now eager to be involved in this area. However, I suggest that we cannot afford to fund vague preventive health programmes. It should be mandatory of such programmes to have a clearly defined objective, set targets and measure the degree of achievement. In the future all preventive programmes should be regularly evaluated. It will be important to have 1 individual responsible for coordinating such programmes on a regional basis. If general practitioners are to be more involved in preventive programmes it will be necessary that they make returns of agreed information for individual cases dealt with. This is essential, if the effectiveness of such programmes are to be evaluated. This may involve a fee for each individual preventive intervention paid on the basis of returned information.

The Working Group in the United Kingdom on "Inequalities in Health" published its report in 1980 (The Black Report). It clearly demonstrated the marked gradient by social class in relation to mortality and morbidity. The situation in Ireland is no different. Those people in the lower social income group are the ones that take least interest in preventive services. If we are to be effective with preventive health measures they must be actively promoted particularly among the lower income groups. In this country,
medical card holders are readily identifiable. This group in particular should be targeted for prevention with a "reach out approach" rather than waiting for these people to present to the doctor.

In my Community Care Area, Area No.8 in Dublin, we carefully monitored the measles eradication scheme both for my area and other areas in the Eastern Health Board. We did this with the help of two computers.

You will recall this scheme commenced on the 1st October, last year with a major publicity campaign by the Health Education Bureau which started in late September.

The scheme was unique in a number of ways:-

1. The family doctors were to play a major role in a State Vaccination Programme for the first time.

2. They were paid a fee for the vaccination on the basis of agreed information returned to the Director of Community Care and Medical Officer of Health.

3. The long-term objective of the scheme is eradication of measles rather than control as is the case with other vaccination programmes.
You will recall that phase 1 of the campaign was to vaccinate all those children in the age range 15 months to 5 years who had not previously been vaccinated or had the measles.

The numbers in this target group were identified in the summer by various survey methods. Lists of the names and addresses of children covered by medical cards in the target age group were provided to the appropriate general practitioner.

Five weeks into the campaign, we identified that in the Dublin area at least, the health education campaign was having little effect. Proposals we then put to the Health Education Bureau also had little effect in the sense that they made little or no impact upon the Bureau's staff. Consequently, the Eastern Health Board funded, with the cooperation of the Irish College of General Practitioners, a special promotion effort. Within 7 days there was a dramatic improvement in the uptake of measles vaccine. Indeed, it was this arrangement that was responsible for, among other things, the Gay Byrne intervention.

From on-going close monitoring we could claim to have achieved success with over 94% of the target population in Community Care
Area 8 having been vaccinated against measles. However, when we breakdown our information between medical card children and private cases, we find that only 50% of the medical card target group have been vaccinated.

We have also identified about 40% of general practitioners who are just not interested in promoting the scheme.

As a "mop up" operation, we have identified individual medical card children who are still at risk of measles. Lists of names and addressed have been provided to their general practitioners who have then been urged to visit the homes and vaccinate the children. Less than 45% of general practitioners are willing to do this.

In regard to the measles vaccination scheme we shall achieve a significant degree of success because we are monitoring very closely what is happening. This is being done on a week to week basis. We are identifying the problems. We are identifying the population groups and small geographical districts, using electoral wards, where our programme is having least impact and we are constantly adjusting our strategies to deal with these matters.

There is one individual with responsibility for coordinating the programme. This is the strategy that should be used with all future preventive schemes.
I show this slide, not to spoil your stay in Blarney, but to introduce a comment or two on screening or smear testing aimed at preventing cancer of the cervix of the uterus. As many of you will be aware, there is an ever growing demand from Women's Groups for this test to be widely and freely available.

Papanicolaou developed a practical test for the early detection of carcinoma of the uterine cervix in 1928. However, it was not until around 1960 that the "PAP Smear Test", as it became known, received universal recognition and widespread use. Since the 1960's cervical cytology has been widely acclaimed as a screening technique for large numbers of women to identify those with suspicious cells for further study. Although screening by cervical cytology has been widely practiced for 20 years, it is only recently that convincing evidence of its potential benefit has been published.

Deaths from cancer of the cervix peak between 55 and 65 years of age. Mortality from cancer of the cervix is much higher among working class women than among other social groups. Repeated epidemiological studies have pointed to the overriding importance of early sexual experience with multiple partners in the aetiology of this condition. In addition, male sexual promiscuity may contribute to an increased risk in the female.
Currently in Ireland in excess of 100,000 of these tests are done annually. An examination of the situation shows that while there is much well meaning activity in this area, the impact in relation to mortality statistics has been virtually nil. While considerable effort and resources are expended on cervical smear screening in this country, the organisation is hap-hazard. There appears to be a total lack of data in relation to what is happening.

While an estimate can be made of the total number of cervical smears carried out in this country per annum, there is little or no data available to indicate the number of women screened, their age or socio-economic group. It is not known how many of the tests carried out are for diagnostic reasons as opposed to general screening.

Nor is there information available on which to determine how many of the tests carried out per annum were repeat tests on women already tested. The present situation in this country as regards cervical smear testing is of questionable value. Maybe that a select group of low risk women are over-utilising the service.

It has been shown that where countries implement a properly organised cervical screening programme, the main objective, that is the reduction of mortality associated with cancer of the cervix, can be achieved.
Successful screening depends not only on reaching a high proportion of women at risk, but also on a high standard of smear taking and laboratory screening.

In the United Kingdom, it has been estimated that 40,000 cervical smears and 200 excision biopsies are made for every life saved and that is considered a previously poor cost/benefit ratio. However, such inefficiencies are not inevitable. In Finland, Denmark, Iceland, Sweden and the North-East of Scotland, with similar resources and expenditure, as in the U.K., mortality has been cut significantly and continues to fall. The most successful screening programmes have the following points in common:

1. They are organised as public health cancer control programmes specifically directed towards a reduction of mortality; that is, they have explicit objectives. They are not simply laboratory services for providing clinical investigation.

2. They call the age groups at greatest and most immediate risk (30+) and they keep on trying. They concentrate first upon women who have never had a smear at all. They use population registers.

3. Someone is in charge; he or she has a name and a phone number and can be held to account.
A comprehensive report on this matter, prepared by a committee of Directors of Community Care & Medical Officers of Health in the Dublin Area, has been presented to the Programme Manager. I understand it is to be made available to Eastern Health Board Members in the very near future and I am sure the Board would make the report available to people throughout the country who might be interested.

Mention of the Director of Community Care & Medical Officer of Health brings to mind an appending occurrence. It appears that the Minister for Health has decided to abolish the post of Director of Community Care & Medical Officer of Health. Neither the Minister nor the Department of Health have given any indication as to what arrangements are to be made relating to the future of Community Medicine in this country.

Community Medicine is one of the newer specialties within the medical profession. It can be defined as the branch of the practice of medicine which is concerned to determine the health status of human population and prescribe the means by which that may be optimally maintained. It is a practical specialty interested in the application of population based research findings on disease and its causation in an attempt to prevent or cure disease and to care for patients.
Community Medicine is concerned principally with:

1. Preventive Medicine,
2. Epidemiology,
3. Applied Epidemiology,
4. Environmental Health,
5. Medical Administration,
6. Development of Medical Information Systems,
7. Research.

I am sure you will agree that these are important matters that should not be neglected in Ireland. Most of these are self-explanatory. However, it is worth making the distinction between Epidemiology and Applied Epidemiology. The former is the study of the distribution and determinance of health and disease in population groups. While Applied Epidemiology is the application of epidemiological methods to the analysis, operation and planning of health services at whatever level.

One point I would make in relation to Environmental Health. We all know the excitement caused by radiation. Exposure to very heavy doses of radiation can cause death in a short time. However, exposure to lower levels of radiation have insidious effects over many years leading to cancers and genetic defects. There is no safe level of radiation.
It may surprise you to know that in this country we will never be able to say whether the recent accident in Russia or any future leak of radiation from anywhere in the World has had any affect on people in this country. The reason, we have no base line data on a national basis, relating to cancers and genetic defects in Ireland. I don't think that future generations will thank us for this deficiency.

NEEDES
PRIORITY
PLANNING
IMPLEMENTATION
MONITORING
EVALUATION

Reallocation of resources for development of new services.

Definition of needs.

Onion

Definition of planning.
It is appropriate and accepted that patients should receive treatment close to their homes and local community. Such service will be convenient for the patient and his family, and will also ensure that the places in the costly high technology acute hospitals are reserved for the more urgent cases.

In recent years, with greater pressure on resources, there is the danger that views on the location of services in the community may be unbalanced for a number of reasons.

Firstly, such a transfer of resources may be seen, without any great research or examination, as an easy and ready made solution to the real problem of the escalating costs of the health services.

Secondly, it may be pursued at the expense of very essential hospital services.

Thirdly, any shift in the emphasis in health services, to be effective, must be done in the context of an overall plan, duly costed, and reviewed on a regular basis, with due consideration of and determination of the priorities.

There is no reliable evidence that well developed community based services are less expensive than institutional services. Acute hospital services and further specialisation is necessary, if it is desired to meet all the needs of acutely ill people. Just as in trade and commerce, the management of change, and the problems created by the advances in medical science, create new demands for more resources and inputs in the hospital services.

The most effective method today to curb the ever rising costs of health expenditure has been through the limitation of the funds available. This is a crude weapon but produces results from the economists' point of view.

If there is a limit on the available funding, the only way that significant strides can be made to develop services in the community, is through the closure of hospitals or significant parts of hospitals and redeployment of resources.

When making comparisons, one must be careful to ensure that one is comparing like with like. In the first instance are we satisfied that our acute services are adequate? The transfer of resources must be done on a gradual (and planned) basis.

More home helps, public health and community psychiatric nurses, family doctors and better outpatient and diagnostic facilities do not all arrive overnight, and are very costly.
The objective must be that in the end, the patient in the community is better off than in the beginning, i.e. in an institution. The numbers seeking admission to institutions must be reduced by better facilities in the community, not less. Half the sum by which the Health Boards allocations have been reduced this year, i.e. £20 million, would make a significant impact in this regard. Two examples of recent health board plans which involve movement from institutions to the community, relate to the psychiatric services and the geriatric services. These are the key to the transfer of resources.

"Pump-priming" funds are required. The present position where health board allocations are reduced significantly in real terms each year allows no scope to develop community services. The funds are actually taken away - there is no re-investment in community health services. In the first instance, to facilitate the transfer to the community from the institutions, there must be investment, to a greater extent in the community facilities. Purpose built health centres with diagnostic facilities for shared group practice would be a step in this direction. Prevention as well as education have an important role to play. Indeed some of the glamour and high profile of the acute hospital side could usefully be moved to the community side of the health services.

In regard to the difficulties which arise, these require redeployment of permanent staff - avoidance of redundancy through natural wastage etc. Impact on total economy is a factor which can cause great emotion too. To avoid the major pitfalls I would say; hasten slowly, working to a well researched plan.
Dr. Rory O'Hanlon, T.D., Fianna Fail
Spokesman on Health, Member of the
North Eastern Health Board Addressing
The Association of Health Board Members
Conference in Blarney on the 13th of
May, 1986.

The Contribution of Health Board Members
to Policy Making.

The Health Act of 1970 specifies that for the administration of health care within the State there shall be a number of Health Boards, this point is sometimes overlooked that it is in fact the Health Boards who are responsible for the delivery of health care on a statutory basis and not the Minister, as pertains in the United Kingdom. For example: - a patient who goes into a hospital in any region in the United Kingdom is the direct responsibility of the Secretary for Health. If he goes into a similar acute hospital in Ireland he is the statutory responsibility of the local Health Board.

In Ireland the establishment of Health Boards was really the first attempt to provide Government of any significance below National and above County Council levels. The Irish Constitution is interesting in that it does not provide for Goverment per se below the Oireachtas, and our County Councils are a direct model of the old traditional County Council in England.

Previous to 1970 the Irish Tourist Association in 1964 was broken up into eight regions, this was dividing a larger National Association into smaller units where as the Health Boards were creating larger regional units from the local authorities, who formerly administered the Health Services.
ESTABLISHMENT.

Eight Health Boards were established by Health Board Regulations 1970 (S.I. No. 170 of 1970), made under Section 4 of the Health Act 1970.

In designing the Health Boards structure a number of factors were taken into account:—

1). Inter-county arrangements for other services were borne in mind, in particular the regions for local government planning and development. Roscommon and Meath are the only two Counties who are in a Health Board region different to that for planning and development.

2). The population served.

3). The number of Counties involved, and the extent of the area covered.

4). The convenience of the members attending meetings.

5). The rapid development of highly specialised medical services, which it would not be possible to place in every County.

Statutory consultations were held with the then Minister for Local Government, with the Local Authorities concerned and with the National Health Council, before decisions were made on the number and composition of the Health Boards.
ORGANISATION AND MANAGEMENT.

Each Health Board is required to have "a person who shall be called and shall act as the Chief Executive Officer to the Board". Under Section 17 of the Act a limited number of decisions (mainly relating to eligibility of individuals for services and to personnel matters), are reserved to the C.E.O. of a Health Board. Outside of these matters, he and the other Officers of the Board are required to "act in accordance with such decisions and directions (whether of a general or a particular nature) as are conveyed to or through the C.E.O by the Board and in accordance with any such decisions and directions so conveyed by a Committee to which functions have been delegated by the Board".

In practice Health Boards have recognised the need to delegate day to day management affairs to the C.E.O.'s and other officials.

The following illustrate the kind of matters on which Boards generally have reserved decisions to themselves:

- Approval of estimates or variations of estimates.
- Authorisation of capital schemes or the borrowing of money.
- Acquisition and disposal of land or premises.
- Programmes for development of services and review of such programmes.
- Decisions under Section 38 of the Health Act, 1970, relating to the provision or dis-continuance of premises - (a word on this later).

It is interesting to note that during a very lengthy Debate on the Health Act, 1970, going through the Houses of the Oireachtas, that there was very little discussion about the functions of the Health Board, or indeed, about Section 31 of the Health Act, which we hear so much about and which limits expenditure by Health Boards. Most of the discussion on the earlier Sections of the Bill were about the composition of the Board.
One of the suggestions made at the time was that only elected Councillors should be allowed to vote.

The roles of Government, the Health Board, and the various agencies that work in the Health Services have not been clearly defined in a policy context, and the extent to which policy is being defined is usually only in major terms, or in specific terms only when issues of some import arise.

Mc Kinsey envisaged that there would be an overall national policy and that the Health Boards would devise policies to meet objectives within this framework and provide for the needs of the people in their Board area. In otherwords, the Boards would have more freedom within the national guidelines set down.

This happened to some extent in the early years. However, as time has gone by and as resources have become scarce there has been a gradual move to the centre, now centralised to the extent that there was recently a suggestion that the Government were interested in one Health Board only, An Board Slainte for the entire Country. We would therefore have a situation where Health Services had been administered by twenty eight local authorities in 1970 and only one central authority in the mid 1980's. Current opinion appears to be that the number of Health Boards will be reduced to four.

The Health Board Member in my view has a role in implementing area policy and is acting as an advocate for the people he represents within the Health Board area. It is also his duty to ensure to the extent to which it is possible that resources in terms of money and staff which are made available are used to their best advantage.

There has been some criticism of Health Board Members that they have allowed vested interests and local interests to permeate considerations of what is in the best interests of the patients, or indeed, what could be justified in terms of cost. My experience as a member of the North Eastern Health Board region and from my knowledge of other Health Boards is that while occasionally an individual member of the Health Board maybe more parochial than necessary, at the end of
the day the Board as a whole have made rational decisions.

Board Members often request that more resources be put into a particular service or that services go in a specific direction. If we look at the proposals made by Health Boards over the years we can see the many of them have been carried through at Board level, although not always as quickly as the Board Member might have wished.

One of the problems of the current system is that there aren't structures for Health Boards per se to have a direct input to national policy. Nevertheless, the important new developments in the health services since 1972 originated with Health Boards, for example: the development of a home help service, improved services for the elderly and the long term illness scheme.

One of the examples that could be used in relation to the Boards role in policy formation is the psychiatric service in the North Eastern Health Board. Where the Board itself decided on a shift to community care long before anything of significance was written on the matter, developed hostels, day care centres, and promoted their policy to a point where Monaghan Co. Council agreed to provide a house in most new housing estates for the needs of the psychiatrically ill. This policy which originated in one Health Board area was accepted by the Eastern Health Board in the mid 1970's, and has become national policy in the 1980's as can be seen from reading the national policy document - the Psychiatric Services - "Planning for the Future". A further example can be seen from the use of the monies from the European Social Fund in each Health Board area for the rehabilitation of the handicapped.

The Devlin Report on the development of the Dept of Health did recommend a specific role for Boards and the Chief Executive Officer and I quote - paragraph 6.4.3. "for the Aireacht to obtain the co-operation of the Health Board and their staffs in implementing agreed policy, they and their Chief Executive Officers must be allowed to make a considerable input in relation to policy
making. The re-organisation of the Dept which we are recommending will facilitate we consider the development of these arrangements". While Health board Members per se have no direct input to national policy the Chief Executive Officers through regular contact with the Dept of Health have an opportunity to reflect decisions and wishes to Board Members.

Health Board Members particularly those who represent local authorities can be frustrated at the length of time taken for the implementation of some aspects of health policy, compared with their local authority experience where they make decisions about roads, housing etc.

Health Boards tend to operate as corporate bodies rather than in the politicised adversarial style of local authorities. In my experience having been a Member of a Board since its inception, I have seen no conflict of interest between various political groupings or between those elected representatives of the Board and those who represent professional interest. Each Member makes their contribution on any particular issue and in general consensus is reached representing the best interests of the people for whom the Health Board is responsible. Rarely is there a vote on any issue at Health Board meetings.

There is a good relationship between the C.E.O. and the Health Board Members. While the Members have delegated many of their functions to the C.E.O. they are still aware of the responsibility and authority.

The C.E.O. will normally give advice that is acceptable to the Board Members partly because he will anticipate the likely reaction of the Members to the Management Teams proposals. It is the responsibility of Members to review and where necessary challenge recommendations of the Team. Klein makes the point and I quote - "power of managers and professionals lies in their ability to define what is administratively feasible". He also make the point that policy should be formulated by a Dept or regional
authority and the means found to implement it, but in reality what happens is that what is possible becomes the policy.

CONSTRAINTS ON HEALTH BOARD MEMBERS.

There are many constraints on Health Boards mainly the lack of finance, lack of control over some health agencies in their area, and sometimes the relationship between the Board and central Government and the Dept of Health.

During the past five years the amount of money allocated to Health Boards has been less then their estimated requirements to continue existing services and cater for increasing needs.

The only options open to Health Board Members in this situation are to spread the available resources more thinly amongst existing services or to reduce the level of services in specific areas, for example:- the abolition of the Ad-Hoc Dental Service. If a new high priority service is to be developed it means further reductions in the available resources to existing services.

Another constraint in the administration of the services is the fact that Health Boards do not have a direct input into the administration of public voluntary hospitals. While I support the public voluntary hospitals, I believe there is need for closer co-operation between them and the Health Boards.

A major area of tension can be in the relationship between the Minister and his Dept with the Health Boards. It is interesting that the current Minister for Health doesn't differentiate as clearly as previous Ministers in the role of the Minister and the Board, and in many ways he has assumed responsibility to a greater extent than any of his predecessors, for example:- he refers to a sixty thousand staff, who are really the staff of the eight Health Boards and health agencies.
In his term of Office there has been a significant move to the centre in a number of areas:-

A). The selection of capital projects or works is now undertaken and decided upon by the Dept.

When Health Boards were established initially, each Health Board got a capital allocation or a capital budget.

B). A further move to the centre has been the placement of civil servants as head of a number of local bodies, as distinct from their being elected by the body, or nominated by a Health Board, e.g.

- the chairmanship of Tallaght Hospital Board.
- the Medico Social Research Board.
- the Hospital Joint Services Board.
- the St James's Hospital Board.
- the appointment of members to the E.E.C. Hospitals Committee.

The present Minister on three occasions convened meetings of the North Eastern Health Board in his own Dept in Dublin, and at the final meeting told the Board Members of the manner he was proceeding with hospital development in the region. I believe it is un-precedented in the history of the State for a Minister to bring a local statutory body to his Dept on three separate occasions to discuss the same issue.

In his Budget speech on the 30th of January, 1986, the Minister made the point -"that the organisation of the Health Services leads to un-necessary and un-workable conflicts in the loyalties of local managements in their reporting relationships to their Board Members and to the Minister for Health and his Dept."

In answer to a question later in Dail Eireann the Minister stated and I quote -"the proposals on the future structures for the planning
and delivery of health services which I will submit soon to the Government will seek to overcome the present difficulties".

Two proposals which will bring about change for the Health Boards are a Bill to amend Section 38 of the Health Act, 1970 - the Health Amendment Bill No 2., which will give the Minister power to discontinue any service or part of any service, or the maintenance of a premises or part of a premises or part of a premises, without the support of a Health Board., and the other proposal is to phase out the post of Director of Community Care and Medical Officer of Health.

I believe that these two proposals are worthy of full discussion before a final decision is made.

While no proposals have been made on the future of Health Boards, the Minister has stated on a number of occasions that he is submitting plans to Government for the re-structuring of the Health Services. He has stated in the Dail on the 25th of February, that our Health Board system is not working. In my opinion it would be un-fortunate if the Health Boards were abolished or the number of Boards reduced, as it is important in the interests of local democracy that there should be a regional administration where representatives of the people can stand up and publicly question Members of the Management Team. The abolition of the Health Boards in my opinion would lead to greater difficulty in making health services available and accessible to many people, particularly in the centre of large urban areas, and the more remote parts of rural Ireland.

It is interesting that while there are suggestions that the Health Board should be abolished and health services centralised, two other Departments of State are involved in re-structuring. The Dept of Education has published a Green Paper with proposals to set up thirteen Regional Education Boards., and the Dept of the Environment has made a positive commitment in a document published on the 30th of May, 1985, to revitalise local government " by devolving responsibilities and by improving structures and procedures so that Councils
and people are more involved in setting their own affairs and local democracy is strengthened."

As Health Board Members we must continue to work for a shift in emphasis from hospitals to community care, although, it is always easier to work up public support for the hospital setting. Klein makes the point and I quote - "if a ward has to be closed this is a highly visible (and controversial) issue, community services lack such dramatic visibility."

Health Boards must continue to monitor the service and plan for the future, it can be difficult in times of recession when so many decisions depend on what are priorities. Indeed, the question can be asked - whether the Health Boards are taking decisions or ratifying decisions already taken.

In conclusion, it is my view that the Health Boards have served the Nationa well since 1971.

The Health Boards composed of elected representatives, professional personnel, ministerial nominees, have combined with good Management Teams to provide a good health service, although, threatened by lack of national policy and finance.

It is important to remember that while we may differ on policy and on emphasis in particular aspects of the service, we are all on the same team - A) the Minister, b) his Dept, c) the Members of the Houses of the Oireachtas, d) the Health board Members, their Management Teams, and all those working in the Health Services, everyone endeavouring to provide the highest level of health care for those in need.

ENDS.
Association of Health Boards in Ireland - Annual Conference.


Developments in Child Care - A personal view by Peter Kieran, Senior Social Worker, South Eastern Health Board, South Tipperary.

In thanking you for your kind invitation to address this conference, I want to emphasize that my comments are not supposed to represent the South Eastern Health Board, or any other organization to which I belong. They are purely personal comments which I make after twelve years work in Community Care services. I don't expect you to agree with everything I say, but I would invite you to think about what I have to say.

I remember when in college, asking a lecturer could he explain heredity to me. In his usual jokey way, he made the remark that "if your parents never had any children, it's unlikely if you will either". However, your parents did have at least one child - they had you. And when you are thinking about services for children, about legislating for them, or planning or administering them, I think that it is important for you to try and get back in touch with being a child. Your experiences as a child may not have been always happy, but they are as important as any qualification or position you may have gained as an adult. Adults forget so easily what it is like to be a child.

Like a lot of things in Ireland, child care presents a few paradoxes. The most difficult and responsible job in the world is that of being a parent, yet so many children are conceived irresponsibly, and conceiving a child is one of the easiest things to achieve in this life. Again, in Ireland, we have a Constitution which emphasizes the primacy of family life, and the great importance of supporting and protecting families. Yet the same Constitution by it's failure to define the rights of children, poses severe problems in relation to making decisions about children's welfare in our courts. And the low status given to parenthood, especially motherhood in Ireland, and the insufficient support given to families dependent on our Social Welfare system are both factors which are leading to the breaking down of family life for many people.

Before looking at specific child care services I want to address some of the myths and notions which are in currency in Ireland about families and children. These myths and notions need to be scrutinized and debunked before progress can be made. I have identified ten, but I'm sure there are many more.

1. "No matter how bad a family's home life may be, it is better than children going into care". This has been shown to be untrue again and again in my own work experience. One example I can give you is of a couple who had four children, each of whom had to be removed from their care before reaching their first birthday, because each child in turn was physically assaulted by their father.

2. "Maternal instincts ensure good mothering". I'm not sure about how widespread maternal instincts are, but I am sure that they are not automatically called into action on conceiving a child. Quite a number of women become distressed because they do not experience the "instinctive" positive feelings of motherhood. I remember one woman who was so angry at having conceived a child, and she had many reasons for being angry, that she talked to the child in the womb often about how she was going to punish it when it was born. She broke this child's arm when she was three months of age.
3. "All families are worth preserving". I think that all families deserve as much opportunity as possible to succeed, as long as individuals within those families are not damaged in the process. In my experience, some families should never have been established in the first place, and do amazing damage to children. In a recent child sexual abuse situation, a priest operating according to this myth, convinced a mother to allow her offending husband return home, thus placing the four daughters in the house at considerable risk. Because of his status in the community, the priest was more persuasive than the social worker who was encouraging the woman to keep the husband out.

4. "Blood relationships are automatically more important to children than any other relationships". The most distressing situation in which I have been involved in my professional life was when a court, operating according to this myth, forced a couple to hand back a three year old child to the biological parents who she had never met. To that child, the only parents she knew were the couple with whom she had lived from the age of three months. Very detailed and weighty evidence was offered in court about the damage which would be done to the child if handed back, but this was insufficient to overcome the power of this particular myth which we have enshrined in our Constitution.

5. "There are such things as perfect families and perfect parents". This myth is well supported by advertising agencies who parade perfect, well off, happy families before us every day in magazines, and every night on television. Such image making is dangerous because it creates unrealistic expectations, and engenders guilt in all those who have not achieved such a lifestyle. I have never met any perfect parents - I am far from perfect as a parent myself. Children, because they are often noisy and demanding, and troublesome, and smelly, do not call out perfection from parents!

6. "Having a child is the most important way to feminine fulfillment". It may be for some women but is certainly not for many others. Again and again I come across young mother who feel cheated and trapped because they were misled by this myth.

7. "A child completes the home". It is true that most couples when they marry expect and wish to have at least one child. But children are to be wanted for themselves, not as another piece of the picture, like the freezer or the stereo. Disappointed parents whose child has not "fitted" into the picture account for a significant group of those attending child guidance services.

8. "Having a child will improve an unhappy marriage". Children are magic, but in a different sense to that implied by this myth. It is surprising just how many couples deliberately seek to conceive a child in the hopes that it's birth will lead to a new beginning. Again, in this situation the child is not wanted for themselves, but for what they can do for the adults. It does not work. Marital relationships need to be worked out by couples themselves with professional help if necessary.

9. "Children are their parents' possessions". This is not a statement that you will ever read as I have written it, or hear in these words. But it is very widespread and can be seen to be so in observing parents and listening to the way they talk about their children. The Dublin -ism "who owns that child" gives unintended expression to this truth. Owners of possessions feel justified in doing what they like with their own property. With children, this can mean beating them to a state of injury or death, it can mean raping them, it can mean enslaving them. And it
means all those things for a lot of Irish children.

10. "Pregnancy is a good reason for marriage". The Church tell us that this myth has been officially dropped but it has not. Priests are still encouraging couples to marry because they have conceived a child. So are parents. I can think of few worse reasons for becoming married. The I.S.P.C.C. some years ago in a small study in Dublin found that in over 70% of the families on their books, the eldest child had been conceived before the marriage.

All of these myths pose problems for social workers who are agents of society because they contradict the philosophies and principles on which social work intervention is based. And they are shared alike by makers of our laws, by judges in our courts, and by policy makers and service administrators.

To challenge and debunk these myths Ireland needs a debate about children. We have never had such a debate. The debate at the time of the abortion referendum was about morality. The divorce referendum debate is about the rights of adults. I predict that the debate on the Status of Children Bill will be about property. There are no votes in children and children have no votes. We may say that we cherish all the children of the Nation equally. But, like in many things in Ireland, what we say bears little relationship to what we do. The call "women and children first" remains a call for evacuating sinking ships!

What can we say about children? We know that they have common human needs: - The need for love and security. - The need for new experiences. - The need for praise and recognition. - The need to be given responsibility.

Unmet needs cause children to become either withdrawn or aggressive.

Children are dependent. They come into the world as a bundle of needs. Their self-image depends on how these needs are met by their carers. Children do best in a family, but not necessarily the family to which they are born.

Children need protection - they need to be protected by our Constitution, by our courts and by our laws, by our child care services. But we have major problems with our Constitution which does not recognise that children have rights independent of their biological parents. We need to rectify this, and to amend the Constitution to ensure the following:

(a) Parental rights should continue to be guaranteed but they should no longer be defined as imprescriptible or inalienable. The adoption of legitimate children with living parents should thus be made possible.
(b) A new balance should be established between parental rights and children's rights. This should ensure that in those exceptional cases where the exercise by parents of their rights (e.g. the right to custody of their child), would be clearly detrimental to the child, the interests of the child should prevail. In such cases the application of the principle of the primacy of the child's interests should not be conditional upon a finding that the parents have failed to discharge their duties.
(c) The protection of the rights of children should be recognised as a special responsibility of the State. In particular, there should be an obligation on the State to provide independent representation for their children where their interests require it.
(d) Discrimination between children based on parentage alone should be prohibited". (Quoted from Irish Council for Civil Liberties Report No. 2. Children's rights under the Constitution).

Discussion of the Constitution may appear to be far from the day to day concerns of child care workers and social workers, but it does provide the framework, both ideological and legal, within which we must work.

We have problems with our court system. Our judges have no training in how to be judges; especially so in relation to family matters. Of course, they would probably be highly insulted if anyone suggested that they should be so trained.

We have an adversarial system of decision making, which is not conducive to the making of agreements between people. We have dated structures, processes, buildings and law. There are signs of new moves towards a family court structure, and the provision of a mediation service. We must ensure that children's rights are given primacy in such a new situation.

We have problems in the absence of policy in relation to children at Department and Health Board level. And we have structural problems at the service delivery stage. We have yet to work out, fifteen years later, what we mean by Community Care - care for whom by whom? Is Community Care the care by professionals of the poor? Or should it be enabling communities to care for their own members? Are we satisfied with our efforts to ensure the maximum possible representation of people at decision making levels in our services? For instance, how well are women represented in your Association?

Within the Community Care structure management standards are low because of the lack of proper training and the overriding concern for financial matters.

There is a problem in the relationship between the Department of Health and the Health Boards for instance, how can the Department ensure that its policies are enacted at Health Board level?

Again at local level, there is interdisciplinary ignorance and rivalry. Community Care teams do not work because they have no serious remit or worse still, do not meet in some areas. And when all the money is spent, and the work done, there is little or no evaluation of our effort.

Much hope and expectation surround the publication of the new Children Bill. The policy reflected in the Bill is, correctly in my view, to keep children in their own families if possible, yet the section on prevention in the Bill is extremely slight and weak, and can, as phrased, be largely ignored by individual Health Boards if they so choose. In a situation of family breakdown when children need alternative care, the policy coming through the Bill is that foster care should be provided. But that will require providing major new resources in manpower, money and time to establish. This is highlighted more when we talk about the need for foster homes for children with handicaps, for adolescents, for children with behaviour problems and for sibling groups.

As a direct result of our change of emphasis to care in the Community, a crisis of identity has been created in the residential child care sector, and courage, honesty and imagination are required on all sides to plan for the future of residential care.

Before concluding, I would like to say something briefly about the job
of social workers. We have an awful lot of responsibility, but not very much power. Combined with the lack of organizational support for our work, this makes for a high level of emotional demands on social workers. The job involves a lot of risk - in the past year, I have been assaulted, and on another occasion, locked in a house against my will, both in the course of carrying out my duties. The other dimension of risk is the amount of risk taking involved in making decisions to leave children at home. The only way to be free of that risk would be to engage in wholesale admission of children to care, and their retention there, which of course could not be advocated. And we seem to be on the brink of a whole new scene in relation to child sexual abuse. The demands are hard to believe for those not involved in the work.

Finally, what can you do? I would encourage you to ask questions, a lot of questions about our child care system. A good yardstick to use would be how you would answer the question "would I be happy for my child to be cared for in my local child care service?" Get close to children - watch them, listen to them - keep them in mind when wearing your legislators, policy makers or administrative hat. Dust off your copy of the report of the Task Force Report on child care services. Unfortunately our new Children Bill is a very pale reflection of this report, but it is not too late. This Bill may never become an Act, for both Constitutional and political reasons, and the blueprint for a local, comprehensive, community child care service is contained in the Task Force Report. Seek out the opinions of social workers, child care workers, psychologists - you will not find them on your local health committees or on your local Health Board - but seek them out; they will talk to you. And a reminder - you were a child once, and that child is within you.
"THE LOST CHILDREN" is the title of a book written by Dr. J. Robins, Assistant Secretary in the Department of Health, based on his study of the plight of orphaned, illegitimate and abandoned children in Ireland between 1700 and 1900. This study tells the dreadful story of those children who were cared for, at public expense, in the workhouses of the eighteenth and nineteenth century.

So bad was the shocking poverty of Dublin children in the eighteenth century that Dean Swift issued his satirical pamphlet known as "A Modest Proposal" in which he suggested that young healthy babies from the lower classes might be fattened and reared at public expense for the tables of gentlemen of refined taste.

Campaigns for improvement in the lot of children brought about the passing in England of the Prevention of Cruelty Act in 1889, and in 1908, the Children Act of that year was introduced into Ireland. It gave the State the power to remove children from their parents if they abused them, through the Place of Safety Order, and the power to place such children in the care of a third party known as the Fit Person Order. This Act remains the backbone of our present day child care legislation.

In the 1950s two major developments took place in child care when legal adoption was introduced and regulations governing the BoardING Out of Children (Foster Care), were issued.

In 1974 the Government of the day set up the Task Force on Child Care Services to make recommendations on the extension of services for deprived children and children at risk, to update legislation in relation to children and to make recommendations on the necessary administrative reforms.

The Task Force reported in 1980 with a very comprehensive document covering a wide range of services for children, and setting out the principles which should underly future policy for child care services.
PRINCIPLES

1. Arrangements made for children must be consistent with their dependent status.
3. Normalisation.
4. Children's rights may, in certain circumstances, have to take precedence over the rights of their parents.

CHILD CARE AND FAMILY SUPPORT SERVICES

- Day Care
- Home Help
- Marital and Family counselling
- Self Help Group Work
- Supervision of Children at Home
- Community Development - e.g. Family Resource Centre
- Social Work Service

FAMILY SUPPORT

CHILD CARE SERVICES

- Foster Care
- Adoption
- Residential Care

DEVELOPMENTS IN CHILD CARE SINCE 1981

- Transfer of Adoption from Justice to Health
- Transfer of Children's Homes from Education to Health
- Introduction of the Children Bill - 1985 (Care and Protection)
- Introduction of Status of Children Bill
- Report of the Adoption Review Committee
- Report of the Social Work Review Committee
- Report of the Day Care Committee
- Report of the Social Work Review Committee
- Up-dating of Foster Care Regulations 1983
1. Every effort should be made to enable children to be reared in their own family.

2. A child should be removed from his family only as a last resort.

3. Where a child is removed, he should as far as possible be placed in a family rather than an institutional setting.

4. Children have rights which, in certain situations, take precedence over the rights of their parents.

1. New powers for health boards to provide child care and family support services.

2. Registration of nurseries, creches, pre-schools and playgroups.

3. Registration and inspection of children's homes.

4. Improved procedures for taking into care children who are abused or neglected.

5. New provisions for granting foster parents legal custody of children in their care.

6. Increased penalties for neglect or abuse of children.

7. Control of sale of solvents to children.

Day care services include nurseries, playgroups, pre-schools etc. It is estimated that about 1,500 services cater for 20,000 children. 233 services, catering for 6,200 children, are supported by health boards at the cost of £1.3m per year. The Children Bill will enable health boards to provide services direct to persons in need.

1. NO. OF CHILDREN IN CARE ON ANY DAY - 2,670

2. NO. OF CHILDREN WHO PASS THROUGH CARE EACH YEAR - 3,700

3. BASIS FOR ADMISSION

   Voluntary Care - 84%

   Court Order - 16%
MAIN REASONS FOR ADMISSION TO CARE

4. TYPE OF CARE PROVIDED

- Foster Care: 60%
- Residential Care: 40%

"One parent family unable to cope" = 38%
"Neglect of child" = 14%
"Short term crisis" = 13%
"Marital disharmony" = 9%
"Abuse" (physical, sexual* or emotional) = 9%
"Child awaiting adoption" = 6%

*Sexual abuse accounts for less than 1% of admissions.

CHILDREN'S HOMES

1. Comprises 24 residential homes (formerly industrial schools)
   - 17 approved homes
   - Total: 41

2. Provide accommodation for 1,100 children

3. Number of children in homes declining (due to greater use of foster care)
   - 1960 - 4,000
   - 1970 - 2,000
   - 1980 - 1,258
   - 1983 - 1,086
CHILD ABUSE SURVEY

<table>
<thead>
<tr>
<th>YEAR</th>
<th>REPORTED</th>
<th>CONFIRMED</th>
</tr>
</thead>
<tbody>
<tr>
<td>1980</td>
<td>271</td>
<td>90</td>
</tr>
<tr>
<td>1981</td>
<td>387</td>
<td>108</td>
</tr>
<tr>
<td>1982</td>
<td>405</td>
<td>112</td>
</tr>
<tr>
<td>1983</td>
<td>434</td>
<td>156 (37) +</td>
</tr>
<tr>
<td>1984</td>
<td>495</td>
<td>182 (33) +</td>
</tr>
<tr>
<td>1985</td>
<td>767</td>
<td>304 (128) +</td>
</tr>
</tbody>
</table>

+ Confirmed sexual abuse cases in ( ) .

PERSONAL FACTORS
- Immaturity
- Unrealistic expectations of children
- Adults abused in their own childhood
- People with low stress tolerance

ENVIRONMENTAL FACTORS
- Unstable employment
- Low income
- Poor housing
- Social isolation

1986 COSTS IN THE CHILD CARE SERVICE
- Adoption .53m (882 placements 1985)
- Day Care 1.3m (6,200 places/238 centres)
- Mother/Baby Homes 2m
- Foster Care 2.7m (1,650 placements)
- Social Work Service 4.5m (280 posts)
- Residential Care 8m (900 placements/41 centres)
Introduction

Access to the health and social services are important for all citizens of a modern society. Donnison (1975) refers to the social services as 'new forms of property' contributing vitally to the distribution of resources, status and 'life chances' in society. In this sense it is obvious that in a just society all groups including rural dwellers, must have equal access to services. However, there are additional reasons why some of the social services, for example, the health and personal social services, are of particular importance in rural areas. These reasons relate to the scenario of social and economic decline experienced in the Irish rural sector in the 1950s and 1960s. The decline in the rural population in the first half of the century resulted in a demographic imbalance in the population with the youngest and oldest age groups being disproportionately large.

The rural age dependency ratio(1) is high and proportionately more of the elderly live in rural areas. This, coupled with the economic structure of Irish agriculture characterised by persistent low incomes in a large section, suggests that the provision of social services is of central importance in any consideration of society's response to the problems of rural areas. Yet the emphasis in the literature and in public debate displays little awareness of the fact that our social problems are not exclusively confined to urban areas. There is little recognition that the modernisation process as it has unfolded in western societies had produced severe problems for rural areas also. The dominance of urban areas as centres of administrative decision-making has meant that official policy tends to be focussed on the needs and problems of the urban areas.

(1) The age dependency ratio is calculated as the ratio of dependent persons aged 0-14 years and 65 years and over to the rest of the population.
This paper focusses on the problems of providing the Community Care Services to rural communities. The research on which this paper is based consisted of a case study of the Mayo Community Care Area carried out by the Rural Sociology Department of An Foras Taluntais in co-operation with the Western Health Board during 1980 and 1981(2). The Mayo Community Care Area is one of 32 Community Care Areas located within the eight regional Health Boards. While it is not possible to generalise conclusions drawn from a single case study it is suggested that the problems identified in the provision of the Community Care Services in the Mayo setting seem likely to have considerable relevance in other Health Board areas with similar spatial and demographic characteristics, particularly those Health Boards operating within the "less favoured area" counties.

The paper argues that for a variety of environmental, social, economic and demographic reasons, agencies such as the Western Health Board face considerable problems in servicing their rural areas. The problems impinging on the provision of services to rural communities may be summarised under three headings:

(i) Environmental factors which present problems related to sparsity of population, dispersed settlement patterns, poor infrastructural services, in particular poor roads, inadequate communications and transport services.

(ii) Demographic factors resulting in an unbalanced population structure which has serious implications for the natural caring networks within rural communities and consequently for the demands made on the statutory services.

(iii) Social need factors which shape the pattern of demand for services.

(2) A full account of the case study can be found in O'Mahony, A, Social Need and the Provision of Social Services in Rural Areas: A Case Study for the Community Care Services, An Foras Taluntais, 1985.
Each factor will be given separate consideration but prior to examining these factors in detail the paper will set out briefly the main research findings of the case study in relation to the levels of service provision in rural areas.

The level of service provision: the research evidence

The study of the Community Care Services undertaken by An Foras Taluntais examines in detail the distribution of range of Community Care Services between Health Boards (inter-regional distribution) and within the Western Health Board area (intra-regional distribution). The services examined include the General Medical Services, Public Health Nursing, Social Work, Meals on Wheels, Laundry Service, Ophthalmic, Chiropody and Child Health Services. Using 1980 data on levels of service provision considerable inter-regional variation was found in service provision.

A general pattern emerges of the Eastern Health Board, serving Dublin and surrounding areas, and the Southern Health Board, serving Cork and Kerry, having the highest levels of provision. A fairly clear picture appears of the power of the country's two largest urban centres to attract resources. In addition intra-regional variation was found to exist in levels of service provision within the Western Health Board area which was the focus of the case study of Community Care carried out by An Foras Taluntais and no doubt this phenomenon also occurs in other Health Board areas also. The data showed that in some instances County Mayo as a whole had a lower rate of service provision than the Western Health Board average (in five of the nine services). There was also considerable within county variation. Castlebar was found to have higher levels of provision than either county or Western Health Board rates. Lowest levels of provision were found in Belmullet and Swineford Rural Districts, both remote rural areas.
These facts, of course, must be set against the considerable achievements of Boards such as the Western Health Board in laying the foundations of a modern primary medical and social care service. It should be remembered that Boards servicing the rural areas of Ireland started from a very poor resource base in 1972 and achievements have indeed been considerable. In addition any considerations of the level of service provision must be seen in the context of the increasing centralisation of public services evident in all modern western societies. Increasing urbanisation and rural population decline have meant in almost all cases, a retraction of services from rural areas and a concentration of these services in urban centres. In Britain a growing literature points to this phenomenon (Grant 1981, Moseley 1979, 1981) and a recent report by Age Concern (1984) notes the absence or low levels of provision of many services for the elderly in rural Britain.

The paper now considers each of the three factors which influence the level of service provision in rural areas.

Factors influencing the level of service provision

I. Environmental factors

A formidable task faces the Health Boards in providing services to rural areas characterised by low population density, and scattered settlement patterns coupled with poor infrastructural resources in terms of roads, and transport and communications. Increasing urbanisation and rural population decline have meant, in almost all cases a retraction of services from rural areas and a concentration of these services in urban centres. An increasing centralisation of public services is evident in all modern western societies. In Ireland in the last two decades we have witnessed a process of centralisation in many of our social
institutions ranging from education to the regionalisation of health services and agricultural advisory services. In the health services the trend has been towards a technologically based medicine with a concentration of resources in urban service centres. The implications of this model of service provision for rural areas can be seen when we consider some of the basic characteristics of County Mayo. Mayo is essentially a rural county with 71 per cent of its population living outside centres of population of 1,500 or more. For the state as a whole in 1981 the figure was 37 per cent. Only two centres in the county have populations in excess of 6,000 persons indicating a low degree of urbanisation. Table 1 examines the population density in the eight Health Boards, in Mayo county and in selected sub-regions of the county for 1981.

**TABLE 1: Density of population in the eight Health Boards, County Mayo and sub-regions, 1981**

<table>
<thead>
<tr>
<th>Health Board Areas</th>
<th>Persons per sq. km.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eastern</td>
<td>257.5</td>
</tr>
<tr>
<td>Midland</td>
<td>31.0</td>
</tr>
<tr>
<td>Mid Western</td>
<td>39.2</td>
</tr>
<tr>
<td>North Eastern</td>
<td>45.1</td>
</tr>
<tr>
<td>North Western</td>
<td>25.5</td>
</tr>
<tr>
<td>South Eastern</td>
<td>39.8</td>
</tr>
<tr>
<td>Southern</td>
<td>43.2</td>
</tr>
<tr>
<td>Western</td>
<td>17.5</td>
</tr>
</tbody>
</table>

Mayo county and sub-regions

| Mayo county                                 | 21.2                |
| Belmullet Rural District                    | 12.6                |
| Swineford Rural District                    | 26.6                |
| Castlebar Rural District                    | 23.0                |


Density of population is lowest in the Western Health Board's area and in Belmullet RD the density of population is considerably
lower than the Western Health Board average. This fact poses serious problems for the distribution of services and personnel. The implications of low population density for service provision can be seen clearly in the case of the Choice of Doctor Scheme. Some of the remote rural areas have low levels of provision of this service but under present circumstances it is unlikely that this could be improved because the low density of population would not provide remuneration for additional doctors.

The absence of any public transport in many low population density areas and its gross inadequacy in others, combined with a poor telephone service, makes the servicing of remote rural areas a formidable task. Given the particular model of service provision which we have adopted, i.e. the centralisation of services in centres of population, transport and communication are a vital consideration in relation to access to services for rural people. Moseley (1978) the British access expert, examining the situation in England, has stated that the lack of a car is probably the biggest single factor in identifying those rural people who are disadvantaged in terms of access to important services. As in other European countries car ownership levels are high in rural Ireland and public transport provision is low. However, evidence from research suggests that certain groups in the rural areas are more likely than others not to have a car in the household (Moseley 1981). Various studies indicate that elderly and low income persons are the least likely groups to have a car (Power 1980). In the absence of a car a telephone would enhance access to services. However, the Household Budget Survey found that, in 1980, only 23.6 per cent of
all rural households had a telephone. Again, research suggests that the elderly and those on low incomes in rural areas are significantly less likely to have telephones (Kelleher and O'Mahony 1984). The combination of these factors points to serious problems of access to services. The solution does not lie solely within the powers of any one agency.

II Demographic factors

This section of the paper examines the main demographic trends affecting rural areas in recent decades and the implications of these changes for the provision of the Community Care Services. The population decline characteristic of Irish demographic history from the mid-19th century was stemmed at national level in the 1960s and since then the aggregate national picture has shown a substantial reversal of the trend of decline. Between 1971 and 1981 the aggregate rural population increased by 10 per cent, ranging from 4 per cent in Connacht to 15 per cent in Leinster. The aggregate picture, however, masks a variation in the experience of different rural areas. Whilst there has been an increase in the population of some rural areas and a situation of stability has been achieved in others, there are also areas where population decline has not been stemmed.

The experience of County Mayo illustrates this. In the period 1926-1981 the county lost one-third of its population but since 1971 the pattern of decline has been reversed. Until 1979 the Urban District of Castlebar has shown constant expansionist trends and has achieved growth rates in excess of the national average. The Rural District of Castlebar has shown an increase in population of similar magnitude to the county growth rate since 1971. But when one examines this more closely it is the District Electoral Divisions in close proximity to Castlebar Urban District which mainly account for the growth in the Rural District. Swineford Rural District, which had lost more than 50 per cent of its
population between 1926 and 1981, has almost stabilised with a decline of 0.8 per cent between 1971 and 1981. Belmullet Rural District, on the other hand, continues to display a definite pattern of decline with a 3.4 per cent population loss in the same period. A clear pattern emerges therefore, rural areas in close proximity to urban centres experience population increase whereas in the remote areas the population remains static or is still declining. The most important social implications of the massive population decline in rural areas can be seen in the two summary statistics presented in Table 2. The highly selective effects of out-migration are evident from the age structure of the population. Migration mostly occurs among young adults and this has resulted in an unbalanced population structure, with the middle age groups being depleted and the older groups being disproportionately represented. The 15-44 year age group in County Mayo represents a smaller proportion of the population, particularly in the Rural Districts than in the State as a whole, while the 65 years and over group represents a higher percentage. The age dependency ratio is calculated as the ratio of persons of dependent age (0-14 years and 65 years and over) to the rest of the population. Table 2 indicates that the dependency rate for Mayo County is higher than for the State as a whole and the rates for the sub-regional areas within the county are considerably in excess of the national rate.
TABLE 2: Age structure of the population in selected areas 1981

<table>
<thead>
<tr>
<th>Area</th>
<th>0-4</th>
<th>5-14</th>
<th>15-29</th>
<th>20-44</th>
<th>45-64</th>
<th>65+</th>
<th>*Age dependency rate per 100 active persons</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mayo county</td>
<td>9.6</td>
<td>19.3</td>
<td>20.9</td>
<td>15.4</td>
<td>18.9</td>
<td>15.9</td>
<td>80.9</td>
</tr>
<tr>
<td>Belmullet RD</td>
<td>9.2</td>
<td>19.8</td>
<td>20.4</td>
<td>13.6</td>
<td>20.3</td>
<td>16.7</td>
<td>82.1</td>
</tr>
<tr>
<td>Swineford RD</td>
<td>8.6</td>
<td>18.6</td>
<td>19.1</td>
<td>14.7</td>
<td>20.1</td>
<td>19.1</td>
<td>86.3</td>
</tr>
<tr>
<td>Castlebar UD</td>
<td>8.5</td>
<td>16.6</td>
<td>23.7</td>
<td>15.8</td>
<td>17.8</td>
<td>17.5</td>
<td>74.6</td>
</tr>
<tr>
<td>Castlebar RD</td>
<td>10.8</td>
<td>18.6</td>
<td>22.5</td>
<td>16.0</td>
<td>17.9</td>
<td>14.1</td>
<td>77.5</td>
</tr>
<tr>
<td>State</td>
<td>10.3</td>
<td>20.1</td>
<td>24.6</td>
<td>17.2</td>
<td>17.1</td>
<td>10.7</td>
<td>69.6</td>
</tr>
</tbody>
</table>


As indicated in Table 3 the incidence of the elderly in the population is higher in the rural areas generally than in urban areas. In 1981 12.8 per cent of the population of the aggregate rural areas was over 65 years. The figure was nine per cent for the aggregate town areas. The aggregate figures often mask regional variation and this is so in the case of the distribution of the elderly. As can be seen from Table 3 the highest incidence of elderly persons is to be found in the North Western and Western Health Board areas, where the percentages of elderly people are considerably in excess of that found in the Eastern Health Board area. The 'elderly' elderly, i.e. those over 75 years, also have a higher incidence in the rural population. Again, the incidence of this group is highest in the North Western and Western Health Board areas.
<table>
<thead>
<tr>
<th>Health Board Areas</th>
<th>% of population aged 65 years +</th>
<th>% of population aged 75 years +</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eastern</td>
<td>8.5</td>
<td>3.0</td>
</tr>
<tr>
<td>Midland</td>
<td>10.8</td>
<td>4.0</td>
</tr>
<tr>
<td>Mid Western</td>
<td>11.1</td>
<td>3.9</td>
</tr>
<tr>
<td>North Eastern</td>
<td>10.4</td>
<td>3.7</td>
</tr>
<tr>
<td>North Western</td>
<td>14.5</td>
<td>5.2</td>
</tr>
<tr>
<td>South Eastern</td>
<td>10.5</td>
<td>4.0</td>
</tr>
<tr>
<td>Southern</td>
<td>11.7</td>
<td>4.1</td>
</tr>
<tr>
<td>Western</td>
<td>14.2</td>
<td>5.1</td>
</tr>
<tr>
<td>Mayo county and sub-regions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mayo county</td>
<td>15.9</td>
<td>5.7</td>
</tr>
<tr>
<td>Belmullet Rural District</td>
<td>16.7</td>
<td>6.2</td>
</tr>
<tr>
<td>Swineford Rural District</td>
<td>19.1</td>
<td>6.6</td>
</tr>
<tr>
<td>Castlebar Urban District</td>
<td>17.5</td>
<td>8.0</td>
</tr>
<tr>
<td>Castlebar Rural District</td>
<td>14.1</td>
<td>4.7</td>
</tr>
<tr>
<td>The State</td>
<td>10.7</td>
<td>3.8</td>
</tr>
</tbody>
</table>


These kinds of statistics are indicators of social facts which are likely to have important implications for the provision of the community care and other health services in rural areas. The continuing out-migration of young adults (there is a higher incidence of out-migration among females than males) to our own urban centres instead of those of Britain and the United States, as in the past, undermines natural caring networks within family and community groups. The elderly, especially those living alone are more likely in such situations to have to depend on the statutory services for support. The depletion of the vital young adult and middle age groups deprives rural communities of that section of the population by whose efforts the young and the elderly are maintained and supported. The potential for voluntary effort in such communities is likely to be greatly reduced and indeed the case study of the Mayo Community Care Area indicates that voluntary effort in the more remote rural areas was of a more limited nature than in the urban centres. There were clear
indicators of the kinds of community supports which the Health Board's nurses and social workers could mobilise for their clients in the rural areas were substantially less than those available to their professional colleagues in the urban centres particularly in relation to the elderly.

III Social need factors

In addition to the environmental factors outlined there are also deeply rooted socio-economic problems in some rural communities which will only be referred to briefly here. To a large extent these problems show a clear regional distribution being mainly concentrated in the less favoured western counties. Poor soils and small farm size result in a chronic low income problem among a substantial sector of the farming population. Family farm income in Connacht and Ulster persistently falls short of that in Munster and Leinster (Heavey 1977, 1978, 1982). Declining job opportunities in the non-farm sector contribute to a high incidence of low incomes in these areas. Using Medical Card coverage as an indicator of low income, the highest incidence of low incomes is to be found in the Western and North Western Health Board areas as can be seen from Table 4.
TABLE 4: Indicators of poverty by Health Board region

| The East- | Mid- | North | North | South | South- West- |
| State | Eastern | West- | Eastern | Eastern | Western | Western |
| % of population covered by Medical Cards | 1983 | 38.3 | 23.3 | 46.7 | 35.0 | 43.6 | 59.8 | 45.3 | 38.0 | 57.5 |


Demographic and socio-economic factors combine to shape the pattern of social need as presented to the Health Board's field staff at local level. The case study of social need and the provision of the Community Care Services in Mayo examined 540 referrals (i.e., requests for services) to the Health Board's public health nurses, community welfare officers and social workers. The complexity and diversity of the social needs presented to the Health Board staff can be seen from the fact that twenty different categories of problems were identified ranging from social and medical problems of the elderly to financial difficulties, poor housing conditions, marital problems and problems of excessive drinking. One third of all reasons for referral were classified by the fieldworker as problems of the elderly. All the fieldworkers in the rural areas indicated that the needs of the elderly were the most pressing problems they faced in their daily work. Substantial numbers of the elderly persons known to the fieldworkers were frail and incapacitated to such an extent as to be categorised 'at risk' by the public health nurses. Table 5 presents the distribution of the 'at risk' group in the caseloads of the public health nurses in Mayo.
TABLE 5: Distribution of the elderly at risk in the caseloads of the public health nurses, Dec. 30th 1980  

<table>
<thead>
<tr>
<th>Location</th>
<th>No. at risk</th>
<th>Per 10000 persons aged 65+</th>
</tr>
</thead>
<tbody>
<tr>
<td>Belmullet Rural District</td>
<td>17.4</td>
<td></td>
</tr>
<tr>
<td>Swineford Rural District</td>
<td>9.3</td>
<td></td>
</tr>
<tr>
<td>Castlebar Rural District</td>
<td>13.8</td>
<td></td>
</tr>
<tr>
<td>Castlebar Urban District</td>
<td>11.3</td>
<td></td>
</tr>
</tbody>
</table>

Source: O'Mahony, A 1985, Social Need and the Provision of Social Services in Rural Areas: A Case Study for the Community Care Services, An Foras Taluntais.

The response at national level

A serious problem faces the Health Board servicing rural areas in terms of ensuring equality of access to all its range of services in the more rural parts of its area. The uneven distribution of services within Mayo must be seen in the light of the substantial natural handicaps facing the Western Health Board in servicing remote rural areas. At a national level there seems to be little or no recognition of these difficulties or little priority accorded to devising strategies to minimise the disadvantage experienced by communities located at a distance from a service centre.

A basic factor which might enable the Health Boards to effectively tackle the problems of servicing remote areas is the financial resources they command. The basis on which the allocations are made to the eight Health Boards must surely include the notion of territorial justice which holds that the level of service provision in an area should be in proportion to the needs of the area and that in a situation where national resources are limited, the level of service provision would be in proportion to the relative needs of that area (Davies 1968).

Accepting the incidence of Medical Card coverage as an indicator of the 'need' for Community Care services the next Table examines non-capital
allocations from the Department of Health to the Health Boards in 1982. When the allocation is related to the incidence of Medical Card coverage the Eastern Health Board had an allocation substantially in excess of the State average and almost double that for the Western and North Western Health Boards(1). This pattern of allocation appears to take little account of the formidable handicaps facing the Western and North Western Health Boards.

**TABLE 6: Financial allocation to the eight Health Boards 1982 (non-capital expenditure)**

<table>
<thead>
<tr>
<th>The State</th>
<th>Eastern</th>
<th>Midland</th>
<th>Mid-Western</th>
<th>North Eastern</th>
<th>South Eastern</th>
<th>South-Western</th>
<th>Western</th>
</tr>
</thead>
<tbody>
<tr>
<td>IRE millions per 10,000 population</td>
<td>2.7</td>
<td>2.6</td>
<td>3.0</td>
<td>2.6</td>
<td>2.4</td>
<td>3.3</td>
<td>2.6</td>
</tr>
<tr>
<td>IRE millions per 10,000 persons with Medical Card cover</td>
<td>7.3</td>
<td>10.2</td>
<td>6.6</td>
<td>7.3</td>
<td>5.8</td>
<td>5.7</td>
<td>7.4</td>
</tr>
</tbody>
</table>

Source: Department of Health, unpublished data.

Note: Non-capital expenditure includes payments made by the Department of Health on behalf of the Health Boards.

**Concluding comments**

The data presented here indicate clearly the degree of disadvantage suffered by remote rural areas and there is nothing to indicate that people in such rural areas have less need of the social services than urban dwellers. The absence of services of comparable quality or low levels of provision of key services in rural areas compounds the basic social and economic problems of these communities. There is no doubt that considerable developments have occurred in the health services since the institution of the Health Boards in 1972. Yet the question of equality of access to services in the rural areas remains a formidable challenge to

(1) The special position of the Eastern Health Board area hospitals as providers of specialist medical services on a national basis is probably a factor in this together with the fact that the incidence of Medical Care coverage is lower.
health care administrators. Given the strong trend towards the build-up of large towns acting as centres for all services and the concentration of resources and personnel in these centres, there is little public debate as to how the statutory agencies might approach the problem of ensuring relative ease of access for all. The question of ensuring access to services is not the domain of any one agency. For example Transport and Communications has a vital role to play, yet the recent Green Paper on Transport Policy was sadly silent on the question of rural transportation. Neither is there any acknowledgement at national level of the problems that would be encountered in achieving this goal.

There is urgent need at national level for a recognition of the substantial handicaps faced by agencies such as the Western and North Western Health Boards in the provision of services in rural areas characterised by population dispersal over large geographical areas, demographic imbalances, poor employment opportunities and high migration rates. If the principle of territorial justice and equality of access to service is to be effectively enshrined in public service provision, then there must be a commitment towards identifying strategies which would minimise the disadvantage associated with remoteness from an urban centre. There is an alternative view that the cost of providing services to rural areas is exhorbitant and that the subsidisation of remote and sparsely populated areas is already excessive. But as a National Economic and Social Council Report (1976) has pointed out, such a view is incompatible with the notion of social justice and it actively undermines the concept of social citizenship, the only real basis upon which a cohesive and integrated society can be built (Parker 1975). It is alarming to consider that the services painstakingly laid down by the Western Health Board (and other Health Boards) in rural areas may be in jeopardy in the context of current cut-backs in financial allocations.
The problems of servicing rural areas are indeed complex and cannot easily be resolved in the short term. However, basic steps would indicate a serious approach on the part of policy-makers to these problems:

(1) Monitoring of standards of service provision at local level
(ii) Recognition of serious problems faced by agencies providing service in rural areas
(iii) A reconsideration of present patterns of resource allocation in terms of the relative needs of different regions
(iv) Promotion of research on cost effective means of minimising inequalities of access.
References

Age Concern 1984, A Profile of the Work of Community Health Councils in England and Wales in Connection with the Elderly, Age Concern, London.

Davies, B 1968, Social Needs and Resources in Local Social Services, Michael Joseph, London.


Kelleher, C and O'Mahony, A 1984, Marginalisation in Irish Agriculture, An Foras Taluntais, Dublin.

Moseley, M J 1978, Social Issues in Rural Norfolk, University of East Anglia, Norwich.


O'Mahony, A 1985, Social Need and the Provision of Social Services in Rural Areas: A Case Study for the Community Care Services, An Foras Taluntais, Dublin.


Conference Dinner Address

by

Cllr. W. Farrell, Chairman

Fifteen Years

This year marks the fifteenth birthday of the Health Boards, and it may be useful to see how these eight teenagers are behaving themselves. Are they acting like children, or are they experiencing the problems of adolescence and young adulthood? And how have they been treated parentally during these fifteen years? With consistency and responsibility or with directives and decisions which seem to indicate abrupt changes in policies and priorities?

The Seventies

During the 1970s there was an enormous growth in the health services under every heading, the range and availability of specialist hospital services, the services for the mentally ill, for the handicapped, new and improved community services. Each year saw a growth in both the size of the services and of the resources to provide them.

Eligibility for various services was greatly extended. We began with hospital services being available free to medical card holders, the lower income group, and with no obligation on Health Boards to provide for any others. This eligibility was then extended to the middle income group and later to the upper income group to make the whole population eligible. The resources were provided to back up these extensions.

Health Boards were urged to extend their social services, to employ social workers, to provide day centres, to provide home help. Specific services were analysed, and those Boards whose provision was under average were asked to come into line. Job creation programmes were used to provide more posts for Health Boards to carry out these service developments.

The Eighties

Then came 1981 and since then all is changed. Each year the budgets of the Boards have been cut and more cuts are being promised. The increase in health expenditure during the 1970s is being cited as evidence that Health Boards are extravagant, wasteful and spendthrift, that expenditure was out of control. No mention is made of the growth in service provision, of service eligibility, of the sheer volume increases during the 1970s. The cuts are now being applied, but nobody is telling the Boards which of the services expanded in the 1970s should now be withdrawn, which of the hospital specialties or departments opened then should now be closed, which of the social services initiated then should now be terminated. No Minister is retracting the eligibility provisions expanded during the 1970s.
No Central Lead

We have moved away from direction by service priority into direction by finance only. The only important directives now issued to Boards deal with the allocation. Boards are left to make up their own minds, to make their own decisions as best they can, as to how to deal with the budget cuts.

In this context one would expect a lead from the centre. One would expect the Minister or the Department to relate the budget cuts to a reduction or a retraction of service, as they related the budget rises to service developments in the 1970s. But no! Only popular service decisions are made by the centre. In the 1980s we are told, keep all the services going, ye are getting enough!

Role of the Association

But of course we are not getting enough to keep all our services going. And someone somewhere has to begin to relate budget cuts to the services we are providing and to decide which services are to be reduced or retracted. Someone has to decide where our priorities lie across the country. This is where our Association has a vital role to play. We are sharing our experience and problems, we are trying to develop clear and realistic policies on service development; above all we are trying to ensure that the public around the country do not experience huge discrepancies in the services they receive from various Boards.

The job of ensuring uniformity of service provision around the country really belongs to the Minister and the Department but unfortunately they will not admit that there is a problem in maintaining current services and standards. They will not admit that there is a problem of service variation around the country. It is left to us, to our Association, to develop clear policies, to coordinate service development around the country. And make no mistake we can and will accept this challenge.
GENERAL PRACTICE AND ITS CONTRIBUTION TO AN EXPANDING COMMUNITY CARE SERVICE

Dr. M. J. Boland,
Chairman,
The Irish College of General Practitioners

INTRODUCTION

The title I have been given is "General Practice and its contribution to an expanding community care service". The first question I want to consider with you is whether it is indeed an expanding service and what the evidence is for that. But before I do that I thought I should just say something about who I am and where I am coming from. The Irish College of General Practitioners was founded about two years ago, in March, 1984, and its objects are to encourage, foster and maintain the highest possible standards of general practice. The College has been very widely supported by the profession. We now have 1350 G.P.s' as members of the College and that is about 75% of all the family doctors in the country.

ROLE OF THE COLLEGE

I want to clarify the difference between the Irish Medical Organisation and the Irish College of General Practitioners because people sometimes get confused between the two. The I.M.O. is basically there to look after pay and conditions for doctors and is therefore primarily to look after the doctors' interest. That is their job. Our job is slightly different. We are interested in the quality of service the patient is receiving and we are therefore primarily there in the patients' interest. We will make suggestions as to how general practice should be organised and changed and reformed in order to improve the quality of the service and the I.M.O. will be there to make sure that doctors don't suffer as a result. On the other hand the I.M.O. make suggestions about changes to improve the lot of doctors and our job will be to see to what extent that might effect the quality of service as it applies to patients. So that is basically who we are and what we do.

EVIDENCE OF EXPANSION

If I could return now to the question as to whether or not community care services are really expanding. If we look at the growth of medical manpower between 1975 and 1984 and compare the number of consultants and the way it increased, the number of N.C.H.D.s' in hospitals and the way it increased, and the number of G.P.s' in the G.M.S. and the way that increased, you will see that the really substantial growth has been within the hospital sector. While these trends may have changed slightly in the last year or two the massive, explosive increase in the acute general hospitals is the major feature of the last ten years and community services have been relatively neglected.
Looking at the growth of hospital service staff overall, we see that this picture is repeated. There were 40,000 total hospital staff in 1974. By 1981 it had gone up to 58,000 - an increase of nearly 50%. Clerical staff went up by 72% in the same period, para medical staff up by a staggering 91% and medical and dental staff rose by 67%. Over the same period, the number of G.P.s' in the G.M.S. went up by 20%. So again we see a clear pattern of explosive increases in the size of the acute general hospital sector not matched by changes in the community.

SPENDING ON HEALTH

If we look at spending and compare acute hospital and community services growth in spending, between 1978 and 1982 the amount spent in the general hospital sector went up from £195 millions a year to £508 millions a year - an increase of £313 millions per year. While the amount that the community health sector went up was the same in proportion it was far less in absolute amount. If you look at the annual cost cost of G.P. fees and drugs taken together, it went from £40, millions to £81 millions. That is an increase of £41 millions in each year over the same period. If you take G.P. fees only the their cost went up by only £10 millions in each year and if you take finally the "expenses element" - that is what the revenue commissioners determine as the proportion of doctors' fees which are supposed to be going into the practice expenses and investment in general practice, the figure went up by £3 millions in each year. Now the point I want to make is that that £3 millions is supposed to be supplying all the costs within G.P. surgeries, all over the country in perhaps anything up to 1500 principal centres of practice and another 500 or so outlying surgeries. It is an infinitesimal figure when compared with the figure of £313 for the general hospital sector. That is the evidence of the expanding community care service.

INVESTMENT

If we look at capital investment and its growth between 1977 and 1982 the amount spent each year on the general hospital sector went up by 26 millions, where as on GP premises and equipment nobody knows what was spent. The government contribution to it is not listed but must be very small.
COST EFFECTIVENESS

If we look at the relative cost of treating people in the G.M.S. and in the general hospitals we see that the average total cost of a G.M.S. visit (including drugs) in 1982 was £10.75. The average total cost of an outpatient visit (and that rarely includes medicines) was £25.00 and the average total cost of a hospital admission was £800.00 in the same year. So again we see the enormous difference in the cost of the acute general hospital sector and general practice.

So what conclusions can we draw?

Well, yes, there has been some expansion in the community services, but I would suggest that it has been relatively very little, when compared with the hospital sector. Most people accept that resources are limited and therefore if we accept that total health spending in this country is not going to rise well then savings must come from the hospital sector and must be diverted. The transfer of care from hospital to the community must be accompanied by transfer of resources. We can see from the sort of staff numbers that that must include staff cutbacks. Treating patients in general practice is much cheaper and there has been very little spending and no investment in general practice over the period.

EFFECTS ON GENERAL PRACTICE

There is plenty of evidence of the effect of this relative situation on general practice. If we look at the present state of Irish General Practice as it was in a survey conducted in 1982, at that time there were about 1850 G.P.s' in the country, 23% of whom were in private practice only. It is interesting to note that at the same time there were 1176 public health nurses - not even one public health nurse to every G.P. The G.P. population ratio was one to 1800 people, whereas the Public Health Nurse population ratio was one to nearly 3,000 people.

The same survey showed that only 25% of GPs were working in purpose built premises, 45% had no staff whatever, 70% had no nursing assistance in their surgery, 50% had no regular working relationship with a social worker and 23% were offering no cervical cytology service at that time. 76% of them, (nearly three quarters) were single handed, and another 17% in only two man partnerships. Thus only 7% of them were in partnerships larger than two. You can see
from the survey, a pattern of low investment, under
capitalisation, very poor current level of current spending
on staff and facilities in general practice, and we have
plenty of evidence that that poor level of spending and
investment, in fact, is reflected in the standard that
pertains in general practice.

On the other hand we have, entering general practice in the
last ten years, 40% of doctors, so that there is a vast
influx of young doctors starting out, enthusiastic about
what their profession is and what it can do, keen to give
the best service they can to their patients. So it is a
time of opportunity. It is an opportunity which we should
be capitalising on.

So if the community care services are to expand where will the
expansion come from? As I have said I think it will come
primarily from the transfer of care from hospitals; also
from improved continuing care of patients; from the develop-
ment of a core team. It will come from the development of
prevention and screening services; from the involvement of
those in the community in training and teaching and in re-
training themselves, and in medical audit, from looking at
the quality of the work they are doing; and from some
expansion in manpower. But before coming on to consider
that list of areas, I want to put some general principles
to you.

SOME GENERAL PRINCIPLES

We in the CCollege, believe, that there should be incentives
built into the system for quality practice. We believe that
there are very few incentives operating at the moment and
there is ample evidence of this. The doctor who practices
at a lower quality is paid as much as the doctor who practices
well. In fact the doctor who takes time to have longer con-
sultations, who invests in his premises, invests in his own
education, or takes on extra staff, loses money by doing so re-
late to his colleagues. So there should be incentives rather
than penalties to induce people to practice in a better way and
to offer a better service.

Secondly we think that there should be an element of choice
and competition. Whatever we do with the community services,
we should make sure that we do not remove the element of
patient choice. It is absolutely crucial. I think that there
is already evidence in the hospital sector of declining choice.
If you look at the psychiatric services report you will see references to sectorisation and other proposals that will restrict patient choice. In the long run that it is the greatest guarantee of an efficient service that choice should be maintained.

At the moment there is equity in the system. By and large G.M.S. patients and private patients are treated in the same way, and attend the same surgeries. Payments are made in the same way. So whatever reform is made in the G.M.S. sector should be reflected also in the private sector. We should try and hold on to this concept of equity.

We need to look at patient incentive. We have an extraordinary situation at the moment where holders of hospital cards can go free to attend hospital outpatients departments, where as if they go to their G.P. they have to pay. So, if someone is suffering from a chronic illness, say something relatively straightforward like hypertension, it would be much cheaper for him to attend the hospital clinic at £25.00 a time to the State and have his blood pressure measured there, than it would be for him to go along to his general practitioner. That is lunacy and it is high time we reformed it. But the way in which we reform it is very important.

The next point I want to make is about the "gatekeeper" function of general practice. We have seen that general practice and the community services in general take only 8% of total health spending. But the point has been made by Tussing and others that general practitioners act as "gatekeepers" to the system, and that even though in themselves they generate very little of total health spending, they do provide access for patients to the much more expensive in-hospital services. Therefore it seems to me that government and all health authorities have an interest in general practice which goes beyond the G.M.S., and I think that we should keep that in mind.

The next point I want to make is about the separation of fees and expenses. I have already referred to a system where doctors who spend on their practices lose by doing so. The problem is what is known as the global fee. The doctor gets paid a fee and it is intended to include everything; his professional services, doctors expenses, just about everything. There must be some separation of the fee element and the expense element, and the expenses element should be paid separately to those doctors (and only to those doctors) who can show that they have incurred the expenses. That way there is an incentive.
POSSIBLE SOLUTIONS

So I would suggest the abolition of the global fee, and certainly I do not think we should be relying exclusively on the single rate fee per item as the way in which to pay doctors, whether they are paid directly by patients or whether the State is paying on their behalf. The problem with the single rate fee per item is that it rewards only personal face to face consultations with patients. So, the more of these consultations that a doctor can fit into any day the more he earns. If he stops doing that for any reason and spends time doing anything else, he is at a loss. So there is no incentive for him to consult with colleagues.

If there is to be a case conference in the community with the community physician, the public health nurse, the social worker, and the G.P. sitting around the table together, the only one actually losing money is the G.P. All the other people are on salaries and are therefore being paid while they are there. So if you want to get effective consultation there must be some change in the system. Those doctors who get involved in consulting with their colleagues should be paid for doing so, and those who don't do it, shouldn't. There is no incentive to delegate to others.

Similarly there is no incentive to long consultation so if you want to really try and sort out a patient's problems, take a very full and detailed history, get involved in taking blood counts and so on, you will do so at considerable cost to yourself as a doctor. The tendency therefore, would be to refer early rather than to sort out who needs to be referred and who doesn't. So prolonged consultations are not rewarded. There is no reward for time spent on practice management. There is no reward for time spent teaching, or training others, and there is no incentive to get involved in retraining yourself. If you are to go away for a day, like today for instance, you do so at cost to yourself. There is particularly no incentive for you to review your own performance, to look at the quality of the work you are doing and see whether it is actually making people better or not.

I would just like to go back to transfer of care. If we want transfer of care obviously there must be fewer referrals, there must be a diagnostic work up before referral so that the patient does not go along to the hospital, have tests done and then have to come for a second visit before anyone actually considers what the problem is. So if that diagnostic work up could be done before they go, so much the better.
There must be much stricter use of accident and emergency departments, but here again the incentive comes in. It should cost the patient more to go to the casualty department than it does to go to their own doctor.

There must be fewer admissions, (We are on the evidence, very much an admission based and admission oriented service), and of course earlier discharge, much wider use of day cases and so on. There must be fewer outpatient returns. There should be a system where consultants come out and actually consult in the community again, do domiciliary visits, and come to surgeries. There must be better use of low cost beds.

In the area of continuing care I think that we can develop the management of patients with long term illness in general practice to quite an extent, and that includes terminal care. But for that we need more sophisticated recall systems. We need to know who the patients are who have the long term illnesses, have them on a list, know how frequently they need to be seen, recall them when they don’t turn up, and follow them up if they still don't turn up. All this requires organisation, it requires staff, it requires much more sophisticated records. It requires investment in general practice.

REQUIREMENTS FOR REFORM

So if those are the things that we want, what are the requirements to enable them to happen? At the moment we have a confrontational situation where wards are closed and patients are made to suffer. The whole thing has become something of a political football. These are, I believe, the sort of things we need if we want to do it in an ordered and reasonable fashion.

First of all the public need to be educated about the different services available in different sorts of hospitals. I mentioned patient incentives; there must also be incentives to improve G.P. facilities. We need more nurses, much more public health nurses and liaison nurses who prepare the way for patients coming out of hospital, to make sure the services are ready to receive them.

There should be more consultants. If they are really to adopt a true consultant role with much smaller teams, we would need much fewer non consultant hospital doctors, because they are the sector who really grew in the ten years from 1975-1985, and they are a very expensive sector. They tend to be the people who see the return patients and keep calling them back, because they have not got the responsibility to discharge them.
They tend to be the people who repeat routine investigations because they feel they must cover themselves from the criticism of their superiors. So they are an expensive sector. We need to establish a combined care committee, by that I mean G.P.s' and consultants' need to sit down together and work out how patients with common conditions should be investigated before admission; what conditions don't need to be admitted at all, what patients could be discharged early, and if they are being discharged early, precisely what checks the consultant wants done and how often, and what system of communication exists between the two sides regularly, so that the consultants can be satisfied on the one hand, that his responsibilities are being fulfilled and secondly that the G.P. knows what is going on.

We need clearly, GP direct access to some of the hospitals facilities. It is absolutely ludicrous to have to send a patient first to a consultant in order to get certain X rays done, lab. tests carried out, day care facilities used, physiotherapy for the patient or psychology assessment. We need to invest in G.P. records. We need to give incentives to doctors to attain responsibility in general practice and not refer. Many or all of those sort of things should form a comprehensive plan.

I think we must now find ourselves in a situation where community services are crying out for reform and an overall plan. Not only that but it should be a plan in the medium term, that allows a gradual voluntary reduction of hospital services extended over a period of time. That means finding an end to ad hoc year to year funding of health services, where nobody knows from one year to the next what is going to happen.

One area that can be developed in general practice is prevention and screening. It is much cheaper and more cost effective and better medicine to develop it in general practice than to set up special clinics in order to do it. Why? Because 70% of the population walk through their G.P.s' surgeries every year, and 95% of them walk through the surgery every five years. So the opportunity is there to catch them as they are going through. We would thus reach sections of the population you would n't otherwise reach.

Not only that, but when they are there they will be better motivated then if you go out and try to catch them on the side of the street. If you screen them and find that they do not have whatever condition you are looking for, that information can be entered in to the G.P. record and that is the most useful place to have it. There is no use in having it stuck in some file in somebody else's office.
The negative information needs to be where it can be used. If it's positive information the way in which it is conveyed to the patient has got to be very sensitive obviously, and should be done by someone who knows the patient. So clearly general practice is the best place to do that. If there is action to be taken, then, the person who does the test should be able to proceed to organise the action and he shouldn't have to refer on to some other person who is going to have to start all over again.

For those who have actually come along looking for screening the most important question is why did this particular person come for screening at this particular time? There may be a whole myriad of reasons. It may have to do with the fact that the brother just dropped dead of a heart attack or that he is under pressure at work or whatever else. But that is the most important question. The best person to answer that question is also the person who knows him best. Lastly the G.P. can deal with those other "by the way" problems which often bring people in.

Finally if I could say something about the "core" team. There is a great deal of talk about the primary care team and the organisation of primary care. But really in the end there has to be something at the centre of it, and at the centre of it, I believe is what I call the "Core team". That consists of the patient, the public health nurse, and the general practitioner, working from the same practice and using the same records, unlike the system we have at the moment where any one public health nurse may find herself having to deal with several G.P.S' and any one G.P. having to deal with several P.H.N.s'. That is not a service, that is a total shambles. It is made worse by the fact that they are based in different premises and they are using different records.

Again if we don't have a core team we have this peculiar situation where integrated personal care of an individual becomes completely fragmented, so you have the G.P., the P.H.N., the family planning clinic, the schools service, the immunisation clinic, the child development clinic, the social work services, now increasingly, hospital out reach with special day centres, cervical screening, now proposed a whole new community psychiatric service and B.P. clinics. Any individual could spend their whole life journeying between these different groups. Not only that but all the information
gathered on each individual will be held by different people. No matter how hard they try they will not communicate with each other sufficiently well to get one comprehensive picture. The hospitals have already made this mistake. They have already super specialised and they have already started talking about the need to revitalise the general surgeon and the general physician and to get away from super specialisation. I don't think we should make the same mistake in the community.

So who is going to gather and collate the information and for what purpose? The only purpose the information is going to be gathered for is the benefit of the patient and I therefore suggest that it should be the general practitioner who acts as the gatherer and collator of information for the purpose of informing the patient's records so that treatment can be better. Where does the buck stop? Some people have called this system the "collusion of anonymity". The patient can't put his finger on any one guy, and say "that is the guy who is actually looking after me", because they are all passing the buck all the time. So the buck has got to stop somewhere. Again I suggest that it should be with the general practitioner or with a "Core Team".

Finally I think it is far more cost effective to do it that way. So we should establish core teams wherever possible. There should be a patient register in every practice and that means change - very substantial change - in general practice. It means that patients who apply perhaps to the V.H.I. or perhaps for hospital cards will be required to nominate their general practitioner so that everyone knows who their G.P. is at any one time and so that the G.P. will know. Public health nurses would have to become practice based. That does not mean we are going to dominate the public health nurses or going to have them as "our handmaids" "at our beck and call", I think we can operate a professional relationship as part of a team. But we would need much more public health nurses and the nurse patient ratio would need to come down closer to 1 to every 2000 people. The following should become core team services, immunisation, child surveillance, family planning and screening. Community care physicians in that system would become largely epidemiologists with responsibility for a total community, consultants to the core team advising them as to what is going on in the community, suggesting new initiatives and so on. The superintendent public health nurses would also have to change their role, perhaps become more like the community physicians with a more consultative relationship with their public health nurse colleagues.
Table 1. shows the growth of Hospital Medical Manpower between 1975 and 1984. (18, 19, 20)

<table>
<thead>
<tr>
<th>Year</th>
<th>Consultants</th>
<th>NCHDs</th>
<th>GPs in GMS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1975</td>
<td>839</td>
<td>1210</td>
<td>1270</td>
</tr>
<tr>
<td>1984/5</td>
<td>1150</td>
<td>1825</td>
<td>1418</td>
</tr>
<tr>
<td>% Increase</td>
<td>37%</td>
<td>51%</td>
<td>11%</td>
</tr>
</tbody>
</table>

Table 2. shows the growth in numbers of administrative and other staff in the Health Services between 1974 and 1981. (21)

<table>
<thead>
<tr>
<th></th>
<th>1974</th>
<th>1981</th>
<th>%Increase</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total staff of</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health Board and</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Voluntary Hospitals</td>
<td>39,792</td>
<td>58,030</td>
<td>46%</td>
</tr>
<tr>
<td>Clerical and Admin.</td>
<td>3,428</td>
<td>5,891</td>
<td>72%</td>
</tr>
<tr>
<td>Paramedical Staff</td>
<td></td>
<td></td>
<td>69%</td>
</tr>
<tr>
<td>Medical and Dental</td>
<td></td>
<td></td>
<td>67%</td>
</tr>
<tr>
<td>GPs in GMS (20)</td>
<td>1,144</td>
<td>1,376</td>
<td>20%</td>
</tr>
</tbody>
</table>
Table 3. shows the growth in expenditure on the Acute General Hospital Programme and the Community Health Services Programme between 1978 and 1982. (20,22,23)

<table>
<thead>
<tr>
<th></th>
<th>1978</th>
<th>1982</th>
<th>Increase in Expenditure/yr</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Hospitals</td>
<td>£195m</td>
<td>£508m</td>
<td>£313m</td>
</tr>
<tr>
<td>Community Health</td>
<td>£53m</td>
<td>£143m</td>
<td>£90m</td>
</tr>
<tr>
<td>GP fees and Drug costs</td>
<td>£40m</td>
<td>£81m</td>
<td>£41m</td>
</tr>
<tr>
<td>GP fees only</td>
<td>£13m</td>
<td>£23m</td>
<td>£10m</td>
</tr>
<tr>
<td>'Expenses Element' (30% of fees)</td>
<td>£3.9m</td>
<td>£6.9m</td>
<td>£3.0m</td>
</tr>
</tbody>
</table>

Table 4. Growth of Capital Expenditure on General Hospitals 1977 - 1982 (22,23)

<table>
<thead>
<tr>
<th></th>
<th>1977</th>
<th>1982</th>
<th>Increase in Expenditure/yr</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Hospitals</td>
<td>£9.46m</td>
<td>£35.76m</td>
<td>£26.30m</td>
</tr>
<tr>
<td>GP Premises and Equipment</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
</tr>
</tbody>
</table>

Table 5. Cost per patient treatment in General Medical Service and the General Hospital Programme in 1982. (22,23)

Average Total Cost of a GMS Visit (incl. medicines) = £10.76
Average Total Cost of an OPD Attendance (rarely includes medicines) = £25.01
Average Total Cost of an Admission = £800.00

Note: These calculations assume that the ratio of cost of admissions to cost of OPD attendances is 32 to 1. (24)
Ladies and Gentlemen

It gives me great pleasure to be here today at your conference on the Development of Care in the Community, and to speak to you on "Nursing Services in the Community".

Nursing in the Community is very different from nursing the patient in hospital. The nurse is the guest visiting each patient in his own home and this has a fundamental effect on nurse/patient relationship. The patient is often more confident, more self-assertive in his own home and the nurse must appreciate the concept of total patient care and understand the effects on the patient of his immediate physical and social environment. Community nurses are responsible for the care of patients and family and must be aware of all their needs when planning a care programme. In addition, community nurses when assessing the care and nursing support needed by the patient and the number of visits required, must also assess if other supportive services are required.

In a recent "Survey of the Workload of Public Health Nurses" published by The Institute of Community Health Nursing in January of this year, the nursing time and number of activities were determined under different categories.

The main activities were home nursing, child welfare visits, ineffective calls, clinics, school health inspections, organised health education, care team consultation, supportive care and clerical.
The percentage of total nursing time for the different Health Board areas was surveyed and the picture looked something like this:

The mean percentage time given to Home Nursing was 44\%
The values varied 39\% (Eastern) in one Health Board to 54\% in another (North Eastern)

The survey was undertaken in order to ascertain the nature and extent of the daily activities involved in the work of the Public Health Nurse.
The Public Health Nursing Register was first opened by An Bord Altranais in 1960 and the total number of nurses on the register to date is 1770.

This number includes those who trained both inside and outside the state. Those who trained outside the state were required to have undertaken a course similar in duration and content to our own Public Health Nursing Course and to be registered midwives. Mostly these nurses were Irish nationals obtaining the Health Visitors qualification in the United Kingdom.

The term "community nurse" has evolved over recent years. The term is often applied to indicate to the general public that the service provided is outside the hospital environment. Today, as well as the Public Health Nurse, An Bord Altranais has provided training for Psychiatric Community Nurses as well as for nurses caring for the Mentally Handicapped in the community. The introduction of community psychiatric nursing services in the 1970's was a major innovation in Irish psychiatric nursing. It was all the more remarkable in that it was largely a grassroots development, extending psychiatric nurses' traditional role.

The Public Health Nurses and these Community Nurses complement each other in providing a service for patients.

Public Health Nursing as we know it today developed from three separate branches of community nursing services:

1. midwifery
2. voluntary nursing services like the Jubilee nurses and the religious orders and
3. from the child welfare services the school health service and the Tuberculosis services including their home nursing.
Training of Public Health Nurses, from the start to the present day, prepared the nurse to carrying out the duties outlined in the Department of Health Circular 27/66.
The Public Health Nursing Programme is presently of one year's duration. Fifty per cent is theory and fifty per cent clinical/practical.

The theory includes:
- Principles and Practice of Public Health Nursing
- Legislation and Health Services
- Sociology, Communication, Research, Psychology
- Paediatrics and Child Health
- Handicaps
- Psychiatry
- Geriatrics and Care of the Aged
- Midwifery
- Subjects related to Public Health Nursing such as data recording, professional conduct, ethics, screening etc.

The clinical experience includes:
- Mental health and Psychiatry
- Paediatrics
- Physical Handicap
- Mental Handicap
- Midwifery
- Eye and Ear
- Care of the terminally ill
- Renal dialysis
- Radiotherapy
- Geriatrics

And the practical experience:
- Preventive and Curative aspects of Public Health Nursing
Current issues, such changes in the patterns of health care, developments in medicine and surgery, early hospital discharge, day surgery and five day wards all have implications for community nursing services.

An Bord Altranais is currently examining the suitability of current community nurse education to see how curriculum content teaching methods and organisation will meet future needs.

With the continuing shift from institutional care to community care the skills of the public health nurse are becoming more diverse. Should the concept of the generalist nurse (the current Public Health Nurse) be maintained or alternatively would it be more effective to have specialist nurses for all different kinds of areas?

Then there is the question of the necessity of a full midwifery qualification for Public Health Nurses being called into question. This is referred to in the Report, Health Care for Mothers and Infants, A review of the Maternity and Infant Care Scheme, Department of Health.

The World Health Organisation says that the changing role of nurses in the Health for all Strategy demands a radical change, not only in a sound grasp of nursing know how, but in their relationship with other health personnel, and the community in need of health care.

The Working Party on General Nursing (1980) questioned whether it was desirable to have public health nurses engaged in delivery of care of a routine curative or post operative nature and suggested that general nurses could provide these services.
These then are some of the current issues arising which could be discussed.

Caring for the patient in his own home is a fundamental part of community nursing. Although it is impossible to meet every need, it is vital that nurses look critically and imaginatively at the needs that are apparent so that priorities can be established and the service can be delivered more effectively.

Patient care must benefit if the nurses involved are well motivated and well trained. It is hoped that training courses will serve to broaden the nurses' knowledge, assist in adaptation of skills and modify attitudes so that they can maintain a high standard of patient care and thus fulfil their nursing, teaching and supportive roles in a domiciliary setting.
PUBLIC HEALTH NURSING SERVICE IN THE COMMUNITY

Miss J. Stack,
Superintendent Public Health Nurse,
Mid-Western Health Board

There is a tendency at present to define Community Care as consisting of all medical services apart from Hospital Care, and this definition has a certain validity and is certainly a definite practical convenience.

But I would like to propose to you a more positive definition and a more wide embracing concept. I would like to define Community Care as being concerned with the total wellbeing of the community and of the individual in the community, not only his physical and mental, but also his social environmental and even cultural wellbeing. In other words the Aim of Community Care should be to allow the individual to fulfill his human potential to the utmost.

Today we are witnessing a greater move into the community than we have ever seen before, and I question the reasons. It is not an exhalation of Community Care for all the good reasons but I suggest a way of off loading patients and nurses from an over-crowded hospital service. There is a general assumption that care in the community will be less expensive than institutional care. There are currently 1,176 Public Health Nurses in Ireland. In addition there are 38 Senior Public Health Nurses, and 34 Supt. Public Health Nurses.

Total in Mid-West 103 Public Health Nurses
3 Snr. Public Health Nurses
3 Supt. Public Health Nurses
6 Counselling Public Health Nurses

The proposed ratio for Public Health Nurses is 1 to 7.5 of population. The average in the Mid-West is 1 nurse to 2,992 patients, therefore, we are depleted of 15 Public Health Nurses. That is 6 Limerick, 6 Tipperary/Limerick, 3 Clare.

We already have the skeleton of a well founded Community Care Nursing service but the staff must be increased considerably.

The function of Public Health Nurses falls into three major categories:

1. to provide comprehensive nursing services for individuals, families and groups;
2. to participate in the development and operation of child welfare, school and community health programmes;
3. to promote the further development of public health nursing and education of those who work in this field.
CARE OF THE SICK

With the trend to combine preventative and curative health services, home care of the sick is becoming generally recognised as a desirable public health nursing function. Early discharge from hospital, the increase in chronic illness with the aging of the population and the development of rehabilitation techniques are only a few of the factors behind the increased demand for home care. In any case, it is the responsibility of the Public Health Nurse to help people get the nursing care they need. Because the care she gives is always under direct medical supervision, her work in this field strengthens the relationship between the Public Health Nurse and the family doctor. Liaison with hospitals plays a very important part in patient care. Weekly visits by Public Health Nurses to all hospitals in the Mid-West area are carried out.

HEALTH EDUCATION AND FAMILY HEALTH WORK

Health education is an integral part of every nursing activity, irrespective of the nurses' position and status. The most important factor in the effectiveness of health education is not so much its technique, as the human relationship between the parties concerned in the educational process. It is for this reason that nurses have special opportunities for health education as well as special obligations and responsibilities. Whether working alone or with other health workers, they are in constant and intimate contact with the sick and the healthy in the community, not only with individuals, families and groups, but especially with teachers, community welfare officers, home helps and public representatives. In the course of these contacts the Public Health Nurse fulfills a role as educator, and as interpreter of the health needs of the community. She listens, supports, reflects back, and thus assists people to realize their own health needs and problems and plan to meet them themselves. All this is not only time-consuming but calls, in different situations, for affection, understanding, detachment, resourcefulness and sound technical knowledge and ability. Material resources are essential if health education is to be carried out and definite budgetary provision should be made for a programme in this field.

The social aspects of the Public Health Nurse's work with individuals, families and groups are closely inter-related with her health work. She is concerned with such social aspects as child development, the psychology of family relationships, and the effect of social problems on physical and mental health. She recognizes social problems, uses her skill in interviewing and giving advice to help the individual or the family, or get them to see the need for assistance, and where necessary makes use of other community resources, referring the case to the appropriate social agency.
CHILD HEALTH SERVICE

This is a general service for all pre-school children with no eligibility tests, made available at Child Welfare Clinics, and consists of advice from the Board's medical and nursing staff on infant welfare and mothercraft. Outside the area where no clinics are held, the service is provided by the visits of the Public Health Nurse. All births are notified to the Director of Community Care.

DEVELOPMENTAL PEDIATRIC PROGRAMME

The most significant step forward in the child health service was the Developmental Pediatric Programme. This concept was designed to assess and monitor the child's mental and physical development in order to detect any deviation from the normal, sufficiently early, so as to be able to cope with them before any disease or defect is apparent. It requires special skills and the medical staff engaged in this work must undergo special training. This service is available to children at the ages of seven months, one year and two years. (C.D.H., Hearing Loss, Congenital Heart, Late age of ascertainment.)

IMMUNIZATIONS

This is an ongoing service which must be maintained and one point which must be stressed is the need for a really adequate and uniform record system. Diphtheria - Whooping Cough, Tetanus immunizations are provided at local clinics or by general practitioners with booster campaigns carried out yearly in all schools.

B.C.G. vaccination against tuberculosis is also carried out. Immunization is organised according to epidemiological needs. Thus influenza vaccination for at-risk groups is carried out in early Autumn.

Rubella Vaccination: This is an important advance in immunization. It is designed to confer immunity on women of child-bearing age to prevent the tragedy of malformation of the unborn foetus which is a risk where pregnant women contact Rubella or German Measles. This vaccination is at present being administered to girls in the 12 - 14 age groups in all primary, secondary and vocational schools.

Measles Vaccination: In this campaign the Public Health Nurses played a very important role. (15 months - 5 years age group)
School Medical Service: School medical examination is carried out yearly of:
(a) All school entrants (6th - 7th Birthday)
(b) Selective examination of 9 - 10 year olds (referrals by doctors, nurses, parents and teachers)

This involves a yearly medical examination in all schools. Routine screening by Nurses is carried out annually, vision testing of all children at school, uncleanliness and posture. A nurse trained in Audiometric testing would also undertake Audiometric testing of all new school entrants and other selective groups.

DUTIES OF THE PUBLIC HEALTH NURSE

1. Care of the Expectant Mother
   - Pre-natal home visits
   - Liaison with maternity hospitals
   - Parentcraft and relaxation sessions
   - Domiciliary midwifery services where required

2. Care of the Baby and Young Child
   - Post-natal visits
   - Home visits, giving support and advice to parents
   - Visits, assessments and reports on children on "at risk" register and at pre-school centres
   - Follow-up of children "at risk" due to genetic, clinical, social, environmental or other factors with general practitioner, Director of Community Care and other appropriate members of the health team.
   - Screening tests, e.g. hearing, vision, P.K.U., Cystic Fibrosis, C.D.H. etc.
   - After-care of patients discharged from hospital.
   - Referrals from general practitioner and others.
   - Recommendations for admission to Day Nurseries and Play Centres.
   - Home accident follow-up (selected cases)
   - Developmental Paediatric Clinics and follow-up of defects found at all clinics.
   - Child Health Centres
   - Advice on Immunization programmes.
   - Visits, assessments and reports on children on "handicapped" register.

3. School Health Service
   - Hygiene inspections
   - School Medical inspections
   - Home visits
   - Liaison between teacher and parent
   - Supervision of ancillary staff
   - Health education and parentcraft
   - Follow-up visits and defaulters
4. **Persons suffering from illness - Adults**

Follow-up of hospital and general practitioner referrals.

Domiciliary nursing in co-operation with the appropriate medical practitioner, including nursing of the aged and chronic sick.

Follow-up of patients discharged from psychiatric hospitals in liaison with the general practitioner, psychiatrist and psychiatric community care worker.

Assessment of social conditions and nursing needs of patients, particularly of the aged prior to admission to hospital and again prior to discharge from hospital.

Visits to old people (referred from many sources)

Compilation of geriatric register resident in her area and regular review of same. Advising the aged on health and social welfare benefits or services to which they are entitled and require.

Home accident visits (selected cases)

Advice on obesity

Visits to widows and widowers over the age of 65 years recently bereaved.

Help with diet, budgeting, health and hygiene (all age groups).

5. **Problem Families**

The care of problem and single-parent families in co-operation with the appropriate members of the health team.

6. **Promotion of Health**

Health education of all age groups.

Talks, discussions at clubs for mothers and talks to voluntary organisations.

Advice on family planning.

7. **Prevention of spread of Infectious Diseases**

Notification of visits, contact tracing, including:

- Clinic work and hospital liaison.
- Visits paid when required.
- Emergency visits in food poisoning or similar outbreaks.
- Supervision of treatment.

8. **Training Students of many disciplines**

Field work instruction of student public health nurses.

9. **Surveys** and collection of data for research.
10. **Liaison with general practitioners**
   
   Attendance at -  
   Baby clinics  
   Cytology clinics - in conjunction with the Cancer Society  
   Blood Pressure clinic  
   Case conferences

11. **Liaison with hospitals** for all types and in some cases full secondment of a Public Health Nurse to hospitals.

12. **Record keeping** and filing of her own work

13. **Attendance at Case Conferences** and liaison with Social Workers and workers in other disciplines.

14. To put into effect agreed plans for the Public Health Nursing Services.

Finally - What is needed in the future?

1. **More Public Health Nurses**
2. We should be building more Day Centres in local communities as the elderly like to live in their own environment.
3. Develop a Twilight Nursing Service to care for the terminally ill at night.
4. Caring relatives providing a 24 hour service 365 days of the year need the odd break - holiday exchange scheme with long-stay institutions should be developed.
5. **More equipment required for the community**  
i.e. Orthopaedic beds, nebulisers, bed tables etc.