SELECT COMMITTEE ON THE HEALTH SERVICES

Memoranda from the Department of Health on submissions made on the Domiciliary Maternity and Infant Care Service, Child Welfare Clinic Service and School Health Examination and Treatment Service
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SELECT COMMITTEE ON THE HEALTH SERVICES

Memoranda from the Department of Health on Submissions made on the Domiciliary Maternity and Infant Care Service, Child Welfare Clinic Service and School Health Examination and Treatment Service

I. DOMICILIARY MATERNITY AND INFANT CARE SERVICE

(Note—This memorandum deals mainly with the domiciliary aspects of the Maternity and Infant Care service referred to in the submissions: the hospital and institutional aspects of this service are dealt with in a separate memorandum on the General Institutional and Specialist Services)

1. The maternity and infant care service is described in some detail on pages 31 to 39 of the General Memorandum on the Health Services prepared by the Department of Health and already circulated to the Select Committee.

In brief, the service provides:

(I) General practitioner and domiciliary midwifery care, with choice of doctor and midwife for eligible mothers and their infants (up to the age of 6 weeks) and, where necessary, hospital and specialist services.

(II) Drugs and medicines are provided free of charge for the lower income group and for the hardship cases in the middle income group. Obstetrical requisites (the maternity pack) are provided for domiciliary confinements for all eligible persons.

Legal Basis


Eligibility for the Service

3. The eligible classes are the lower income group (that is, broadly speaking, those who are unable to provide the services from their own resources) and the middle income group (that is, again broadly speaking, persons insured under the Social Welfare Acts; persons whose yearly means are less than £800; and farmers, the valuation of whose holdings is £50 or less)—these classes are described in more detail in paragraph 15 of the Department's General Memorandum.
Numbers Using the Service

Of the 60,735 births registered in 1960, 41,742 or 69% received attention under the Maternity and Infant Care Service.

Doctors, Nurses and Midwives Providing the Service

4. Apart from the hospital services, domiciliary services are provided by doctors who, under agreements with the health authorities, subject to certain conditions, provide services for a specified fee or fees. District medical officers are entitled, in the same way as other doctors, to participate and they are paid in respect of services under the scheme irrespective of whether the persons to whom services are rendered are or are not medical card holders eligible for the general medical services. Midwifery services are provided through (a) private midwives on the basis of agreement with health authorities, on the lines of those made with the doctor, (b) midwives employed by health authorities on a part-time basis, and (c) public health nurses employed on a whole-time basis by the health authorities or Jubilee nurses employed by voluntary agencies on a similar basis and supplying services on behalf of the health authority.

Cost of the Domiciliary Maternity and Infant Care Service

5. The fees paid to practitioners under the scheme in 1960, totalled £205,000. £34,000 in fees and £90,000 in salaries were paid to midwives and the cost of medicines supplied through chemists' shops under the scheme was £27,000. There are, of course, other additional costs under the scheme which it is not possible to assess accurately, for example, cost of medicines and drugs supplied by district medical officers from dispensary stocks to eligible patients under the scheme and the proportion of the salaries of public health nurses which should be apportioned to the Maternity and Infant Care Service.

6. Submissions on the service, or on particular aspects of it have been made by the following:

Dún Laoghaire Corporation
Cork Health Authority
Irish Medical Association
Dr. E. O'Dwyer
Nurse M. Queally
Dr. E. W. L. Thompson
Catholic Women's Federation of Secondary School Unions
The Irish Nurses' Organisation
L'Èire Notre-Dame de l'Éducation des Jeunes Femmes

Comments on the Submissions in Reference to the Scope of the Service

7. There is no general demand in the submissions for an extension of the classes eligible for this service.
8. The Cork Health Authority (pages 6-13 of the submissions) do not comment specifically on the service itself but merely make suggestions regarding the determination of eligibility for the services. One of the suggestions made (page 11, paragraph 8) is that a person aggrieved by the refusal of the health authority to grant maternity and child health services on the grounds that her income exceeds the statutory limit should have a right of appeal. This question of appeal is referred to at pages 14/15 of the Department of Health memorandum on submissions made on the General Medical Services, at page 10 of the memorandum on submissions made on the General Institutional and Specialist Services and, at page 11 of the memorandum on submissions made on the Financing and Administration of the Health Services. The Health Authority also recommend (page 11) that the income limit for eligibility should be revised as suggested by the Health Authority for Institutional Services. This matter is dealt with at page 9 of the memorandum on submissions made on the General Institutional and Specialist Services.

9. Dr. Thompson defines (pages 156/7) the three income groups by reference to means e.g. lower income group up to £600 per annum in the case of families with 3 or more children, middle income group up to £900 per annum or up to £50 land valuation and the higher income group as above that level. Insured persons in the lower income group and all persons in the middle income group would pay a contribution on the Social Welfare Insurance basis. All persons in the higher income group would be obliged to make a standard yearly contribution towards the cost of the health services. Full maternity and infant services would be made available free to persons in the lower income group (page 159). Women in the middle and higher income groups would be entitled to a subvention towards the cost of maternity service which would represent the basic cost of maintenance in the public wards of a hospital. In addition these women would be entitled to diagnostic procedures at standard hospital rates (page 159). Medical care and maintenance for sick infants up to 6 weeks of age would be provided in neo-natal units (page 159). This infant care service would be free of charge to the lower income group and at a standard and comprehensive rate of charge to the middle and higher income groups (page 159). Dr. Thompson seems to visualise maternity and infant care as a hospital rather than a domiciliary service. His recommendations make no specific provisions for domiciliary midwifery care beyond stating (page 162) that the increasing tendency to lessen ing in domiciliary midwifery care is a concept which has a very sound clinical backing. By and large, it is not clear that the existing middle income group would be as favourably treated under Dr. Thompson’s recommendations as they are at present.

10. It can be inferred from the submission made by the Catholic Women’s Federation of Secondary School Unions (page 169, paragraph 3) that they recommend that a Maternity Service should be available to all classes on a Social Welfare Insurance basis.
11. *The Irish Nurses’ Organisation* (page 183) state that they consider that the existing service is not sufficiently comprehensive and that experience has shown the necessity for providing free dental care, free appliances, as required, and free medicines. They also recommend that there should be more co-ordination to ensure that medicines ordered for a patient are in fact available without delay in outside dispensaries.

12. Free dental care, free appliances and free medicines are of course available to women in the lower income group. There has been no great demand for the provision of these items as part of the maternity service to women outside the lower income group. To provide free dental care under the scheme would be an advance, but while the Minister is anxious to extend the dental services to classes outside those at present eligible he has been unable to do so in view of the difficulty of obtaining sufficient funds and personnel to provide the present services.

13. Regarding the supply of appliances and medicines, under the existing service, a health authority can provide the medicines, free of charge, to a woman availing of services under the maternity and infant care scheme where the health authority consider that it would be an undue hardship on the person ‘concerned to obtain the medicines from her own resources.

14. If medicines were supplied generally under this scheme to persons outside the lower income group there would, undoubtedly, be pressure for a similar arrangement under the general medical services.

15. The Organisation might be asked to clarify the statement regarding delay in the provision of medicines through dispensaries. It is understood that health authorities generally ensure, as far as possible, that there is no undue delay in the provision of medicines.

Comments in the submissions on the manner in making services available

16. None of the memoranda submitted state clearly that the present maternity and child health services do not meet in a reasonable way and at a reasonable cost the essential needs of the various sections of the population. The Irish Medical Association state (page 188) that, in their opinion, the present maternity and child health services are in the main satisfactory. The Society of Medical Officers of Health state (page 188) that the scheme works well in practice.

**Dún Laoghaire Corporation** (page 4)

17. The Corporation do not refer specifically to the maternity services but the services are included in the general recommendation that the rules governing entitlement to the services should be definite, available to everybody; and clearly understandable. This aspect of the submission has been covered in pages 11-12 of the Department’s
memorandum on the submissions on the General Medical Services. As both the lower and middle income groups are entitled to this Service the public are in general fairly clear as to their entitlement.

Irish Medical Association

18. The Association recommend (page 88, paragraph 1) that the services of a consultant should be provided during pregnancy. Under the present domiciliary scheme a doctor has the right to call a consultant, if he considers this necessary. The consultant is paid a fee for his services. The Association may intend to suggest that a consultant should be provided for every pregnancy. Experience indicates, however, that the vast majority of pregnancies are quite normal and well within the competence of a general practitioner—who may, of course, refer his patient for specialist treatment should the necessity arise. Early ante-natal care, which is encouraged under the present scheme, is designed to ensure that any complications will be detected in advance so that arrangements can be made for specialist and/or institutional treatment if necessary. Referral of every patient participating in the scheme for consultant attention would pose many problems, not the least of which would be the difficulty of finding sufficient consultants to handle all the cases. The existing scheme ensures that those women who, in the opinion of their doctor, need specialist attention, are referred for it.

19. Regarding the reference (page 88, paragraph 1) to consultants being available for patients in nursing homes and district hospitals, presumably the term "district hospital" is intended to mean a small non-health authority cottage hospital as the services of a consultant would be available, if required, for a patient in a health authority hospital. Persons entitled to services under the scheme who enter a private maternity home for their confinement are liable for all charges—including consultant's fees—which may be imposed on them. They can receive a subvention of 1½d. a day from the health authority towards the cost of maintenance. Had they decided to avail of the full services provided through the health authority, instead of making private arrangements, the full service (including a consultant if necessary) would be free of charge. In the circumstances there does not appear to be a case for the health authorities making the services of a consultant available in such cases.

20. The same considerations apply regarding the services of an anaesthetist for patients in private maternity homes (see recommendation in paragraph 1, page 88). There is provision under the present scheme for a practitioner providing domiciliary services to call in an anaesthetist to administer an anaesthetic, if he considers this necessary. It may be mentioned that analgesia, as distinct from anaesthesia, can be provided by a midwife under the direction of a doctor.

No objection is seen to the recommendation (page 88, paragraph 2).
of the Association that clinical-administrative conferences should be held periodically in all areas; that is, that representatives of the doctors participating in the scheme and of the health authority might confer on the working of the system. It may be pointed out, however, that under the present scheme, normal relationships between the Chief Medical Officers of health authorities and doctors providing the services under the scheme have operated so far to ensure the smooth working of the arrangements in all areas.

21. The Association recommends (page 88, paragraph 5) that all doctors participating in the scheme should be encouraged to attend periodical refresher courses and that financial assistance should be given to private practitioners to attend such courses on a basis similar to that for district medical officers.

22. There is no evidence to suggest other than that the quality of medical care provided by general practitioners under the scheme is of an acceptable standard. The ordinary process of competition for cases is an encouragement for participating doctors to keep themselves abreast of current developments. Normally, attendance at refresher courses, at public expense, is restricted to permanent officers of health authorities. District medical officers who attend such courses do so in their capacity as officers of the health authority and not as private general practitioners providing maternity and infant care services under the scheme. The courses which the district medical officers attend on special leave are not specifically directed towards obstetrics, but are directed towards the general practitioner service, provided by the doctors.

23. Health authorities have about 1,100 agreements with doctors, who are not district medical officers, for the provision of services under the scheme. The cost of attendance of all such doctors at a refresher course would be in the order of £35,000. There would not appear to be any compelling reason, nor has the Association produced any, in their recommendations, for a subvention of this nature from public funds.

24. The Association recommends (page 88, paragraph 6) an enquiry system to be instituted to investigate maternal deaths to ascertain if there was an avoidable factor. The present maternity and infant care service was initiated in 1956. The number of maternal deaths has dropped from 81 in 1957 to 27 in 1961. Nevertheless, the maternal death rate could not be said with assurance to have reached the irreducible minimum. It is accepted that each maternal death should be investigated to establish whether avoidable factors were present, and the Department of Health has, in fact, been examining ways and means of having such investigation carried out. There are obstacles in the way, however. One is that the Central Statistics Office and the Registrar General are precluded by statute from disclosing details of maternal deaths to an investigation committee; and there is the difficulty that,
under an enquiry system as recommended, principles of medical secrecy might be in danger of breach. Moreover, investigation of maternal deaths would require the full co-operation of the doctor or doctors concerned; any hint of sanctions in the conduct of the inquiries would be fatal. There is also the difficulty that a bereaved relative might gain a false impression from the fact that inquiries were being made into the cause of a woman's death in childbirth.

25. The Association recommend (page 88, paragraph 7) that a body having lesser powers than those of the Medical Registration Council should be instituted to deal with complaints against doctors, with disputed payments and with alleged irregularities. They further recommend that the body should be a single, national, and statutory one and should consist of registered medical practitioners.

26. The terms and conditions of agreements between a general practitioner and a health authority under the maternity and child health service are detailed in Appendix VII to the General Memorandum on the Health Services prepared by the Department for the information of the Select Committee. A health authority is empowered, after suitable investigation, to take certain specified (paragraph 18 of Agreement) disciplinary action against a doctor who has failed to comply with any of the terms of the agreement; and the doctor, if aggrieved, has the right of appeal to the Minister who may refuse the appeal or give to the health authority such directions as he considers appropriate to the case. This does not mean, of course, that an aggrieved doctor may not appeal to the Courts.

27. This present system seems to deal competently with any complaints arising out of the service and there does not appear to be a need for an institution or special body to arbitrate as suggested by the Association. The fact that about 30,000 cases a year have been attended by general practitioners under the scheme since 1956, and that the Minister has been called upon to exercise his appellate function on merely a dozen or so occasions in all does not suggest discontent of an order requiring arbitration by a third party.

28. Again, on the question of fees, it seems only right that the health authority, which pays the fees to the doctors, and is responsible for the provision and administration of the service, should be the body to investigate the complaints and irregularities in the first instance. Article 13 of the Agreement (see Appendix VII to the General Memorandum) prescribes that the health authority, shall, in consideration of services provided by a medical practitioner under the scheme, make payments to him in accordance with such scale as may be approved of or directed by the Minister from time to time. Apart from some initial confusion as to the interpretation of the scale of fees (see Appendix VIII to the General Memorandum), disputes about fees between health authorities and participating doctors have been rare. A doctor is not, of course, precluded from referring a fees-dispute to
the Minister: and a few doctors have done so. During the past twelve months only two such disputes have been referred to the Minister by aggrieved doctors, and in only one instance since the inception of the scheme did a doctor see fit to seek a ruling in Court without prior recourse to the Department.

29. A further point to be considered is that it is objectionable in principle that a body (other than the Courts), not answerable to the Oireachtas or to local authorities, and comprised exclusively of medical practitioners should be empowered to control the disbursement of public moneys drawn from central or local taxation.

30. The Association consider (page 88, paragraph 8) that the present scale of fees under the Maternity and Child Health Scheme is inadequate and recommend an upward revision of the scale.

31. This does not appear to be a matter coming within the terms of reference of the Committee as the scale of fees is a matter for the health authorities in consultation with the Minister. The question of the fees payable to doctors and midwives under the Scheme will be considered in conjunction with any general revision of fees payable to doctors and ancillary staff providing services for health authorities on a fee or sessional basis.

Submission by Dr. Eamon O’Dwyer (page 90)

32. Doctor O’Dwyer suggests (paragraph 3) that the present arrangements which provide that the confinement element of the fee (two guineas) is not payable if this part of the service is not given by the doctor (see Appendix VIII, to the Department’s General Memorandum) tends to discourage doctors from hospitalising patients where this is indicated.

33. It may be pointed out that normally the deduction is made from the fee when the patient is confined, at her own request, in a hospital to which a doctor has not access; or if the doctor, in the course of his ante-natal care, foresees a complication and arranges in advance to send his patient to hospital for her confinement. An important provision of the scale of fees in this connection is that where a patient for whom a domiciliary confinement was intended develops complications late in pregnancy and is removed as an emergency case to hospital, the fees paid to the doctor are the same as if the patient had been confined at home.

34. As regards Dr. O’Dwyer’s suggestion, experience of the working of the scheme does not suggest by any means that fee considerations would induce the doctor to risk the well-being of the lives of a mother and her infant. Indeed, the steady trend from domiciliary to institutional confinements suggests that doctors are, if anything, disinclined to encourage patients to have their babies at home. Of the
confinements which obtained services under the Maternity and Infant care scheme in 1960, 34% were domiciliary, whilst 66% were institutional.

 Submission by Nurse Mary Quealy (page 92)

35. Nurse Quealy suggests that persons who are in the lower income group should obtain the maternity pack and medicines irrespective of whether the confinement takes place at home or in an institution.

36. Under the scheme, drugs and medicines are provided free of charge for persons in the lower income group and for hardship cases in the middle income group. Obstetrical requisites (the maternity pack) are provided free of charge for all mothers availing of the service who elect to have their babies at home.

37. A patient who goes into the public ward of an approved hospital is entitled, of course, to free medicines etc. while in the hospital; it is only where a patient enters a private ward of a hospital or a private maternity home and decides to opt out of the full service provided by the health authority that she has to pay for any drugs, medicines etc. required. The maternity cash grant of £4 is paid to all mothers in the lower income group irrespective of whether the confinement takes place at home or in an institution.

38. A modern maternity unit has been provided at Ardkeen (Waterford County Hospital), and is attended by an obstetrician-gynaecologist. A case for special arrangements for Dungarvan maternity patients can hardly be sustained by the consideration that during a 7-10 day stay at Ardkeen (some 30 miles away, with good public transport) such patients would be deprived of visits from their families.

 Submission of the Irish Nurses' Organisation (pages 183/185)

39. The Irish Nurses' Organisation refer (page 183, paragraph 5) to home nursing care, particularly in the case of women confined at home, and they suggest, in particular, that the service be reviewed—

(i) so that the maximum help and advice will be available to the family; and

(ii) so that the after-care of patients discharged from all hospitals will be adequately dealt with.

40. District nursing services are provided throughout the country by some 145 public health nurses, employed by health authorities, and by some 148 "Jubilee" nurses who are employed by district nursing associations (affiliated to the Queen's Institute of District Nursing) which are subsidised by health authorities in respect of services rendered. There are, therefore, up to 300 nurses who would be available if required to render help in particular cases on the lines recommended by the Organisation.
41. The fundamental object of the service is to provide skilled home nursing, including maternity nursing in cooperation with the doctor. In furtherance of this objective, a special training course in public health and district nursing was conducted by An Bord Altranais in 1959. Sixteen nurses completed this course. The syllabus for a second such course is now being planned by An Bord in consultation with the Department. In the meantime, a series of refresher courses for serving public health nurses and "Jubilee" nurses has been conducted by An Bord Altranais. Eight of these courses, each attended by about twenty nurses, have been held to date and more are planned. The syllabus for all these courses includes instruction on topics ranging from household management (budgets, dietary, safety in the home) to the special needs of the aged.

42. It is proposed to appoint a senior public health nurse in the service of each health authority (excluding Dublin and Cork where superintendents are employed already) in whose areas 10 or more public health or "Jubilee" nurses are already serving. The main function of the new appointees will be to supervise and coordinate the work of district nursing. A special course of training will be arranged for the senior public health nurses, when appointed.

43. It is felt, therefore, that district nursing care—which is a new and developing service—is proceeding on acceptable lines.

44. The Organisation recommend (page 182, paragraphs 10 and 11) that private midwives be allowed to attend refresher courses on the same basis as midwives employed by health authorities on a part-time basis—that is subsistence and travelling expenses being paid by the health authorities.

45. The position regarding the attendance of officers not employed by health authorities at refresher courses has been explained in page 10 of this memorandum in connection with the recommendation by the Irish Medical Association that facilities be extended to doctors participating in the Maternity and Child Health Services to attend refresher courses.

46. The Organisation also recommend that the scale of fees for midwives under the scheme be revised. It has been mentioned on page 12 of this memorandum that the question of the fees payable to midwives under the scheme will be considered in conjunction with any general revision of the fees payable to doctors and ancillary staff providing services for health authorities on a fee or sessional basis.

Jubilee Nurses

47. The Organisation recommend (page 185, paragraph 12) that wherever possible "Jubilee" nurses should be absorbed into the health authority service. The Queen's Institute have been successful in
attracting nurses of exceptionally dedicated character and in providing a high standard of training for them. For many years these girls have supplied a high-quality service; there is no evidence before the Department to suggest that they themselves would welcome absorption into the health authority service. It has been the policy of successive Ministers for Health to encourage voluntary effort in district nursing and not to take any action in framing policy on the nursing services which would be to the detriment of the Organisations responsible for this voluntary nursing service.

Submission of the Society of Medical Officers of Health (pages 186-188)

48. In paragraph 22 (page 188) the Society of Medical Officers of Health state that it should not be free to any doctor to sign an agreement with a health authority for the provision of maternity services.

49. As regards this recommendation it might be noted that before a medical student trained in Ireland can be awarded a primary degree as a doctor he must pass a searching examination in obstetrics. The standard of this examination is designed to ensure that a successful candidate is equipped with sufficient knowledge and skill to enable him to provide normal maternity medical care for his patients.

50. It is unlikely that a doctor who for any reason lacked confidence in his own obstetrical skill, at general practitioner level, would enter into a formal agreement with a health authority for the provision of maternity medical services under the Health Acts.

51. A doctor who encounters special difficulty at a domiciliary confinement is entitled on his own authority to summon another doctor to assist him; he may also refer his patient for institutional and specialist treatment, or he may avail of the Obstetric Emergency (“Flying Squad”) Service.

52. It is not considered, therefore, that participation in the scheme should be limited to those doctors who have acquired higher qualifications in obstetrics.

53. The Society recommend (paragraph 23) that all doctors participating in the maternity service should be actively encouraged to attend periodic refresher courses in maternity and infant welfare.

54. It can be generally agreed that attendance at such refresher courses would be of advantage to the doctors participating in the service and that they should be encouraged to do so. As indicated, however, in connection with paragraph 5 of the Submission of the Irish...
Medical Association, the extent to which attendance at such courses should be subsidised from public funds, particularly in the case of private medical practitioners, is a matter which would require some consideration.

55. In paragraph 16 (page 187) the Society suggest that the services of the district public health nurse should be available free of charge to the middle-income group for general nursing as well as for the purposes of the Maternity and Infant Welfare Schemes. It will be noted that some members of the Society dissent from this suggestion.

56. District nursing services are made available free of charge and without limitation to the lower income group. Maternity nursing services are made available free of charge to the middle income group. District nursing care under the Infectious Diseases, Child Welfare and School Health codes of the health services is provided free of charge for all income groups of the population.

57. Health authorities have been advised by Circular from the Department that (through the agency of their public health nurses) they may provide, and charge for, general nursing and domiciliary midwifery services for those classes of persons who are not entitled to such services free of charge, i.e.:

(a) general home nursing of persons in the middle and upper income groups, and
(b) domiciliary midwifery care for women in the higher income group.

Such services are provided sporadically by health authorities, usually at a fee of 2/6d. per visit for general home nursing and at a fee of £4 4s. (the normal fee payable by a health authority to a midwife for attendance at the domiciliary confinement of a woman in the lower or middle income groups) for domiciliary midwifery services for women in the higher income group.

58. Health authorities have been counselled by the Department that the guiding principle for the provision of home nursing services on a fee basis should be that, if services are already provided in the area concerned by private nurses and midwives or by nurses of voluntary bodies, such services should not be provided without good reason by a public health nurse. At the present stage of the development of the outdoor nursing services it is not considered that this principle should be departed from.

59. The Society also recommend (paragraph 17) that a "Home Help" service should be available for women having domiciliary confinements, as if such a service were available fewer women would seek to have their babies in hospital for purely domestic reasons.
60. As indicated at page 20 of the memorandum from the Department on submissions made on the General Medical Services, such need as exists for a home help service appears to be greatest in urban areas—the domestic problems of the rural community being more easily solved by ordinary good-neighbourly relationships. In general, it is the view of the Department that the question of home help appears to be a field of activity more appropriate to voluntary effort than to organisation by health authorities. Such a service would not be regarded as a health service in the usual meaning of the term.
II. CHILD WELFARE CLINIC SERVICE

61. The Child Welfare Clinic Service is described in pages 40-42, inclusive, of the General Memorandum on the Health Services prepared by the Department of Health and already circulated to the Select Committee. The main purpose of the Service is to provide, for the pre-school child, a health examination service more or less on the same lines as that provided for children attending national schools. The service comprises an advisory and examination service for children under six years of age. Treatment, other than treatment of a "first-aid" nature (for example, for cuts, which no doctor examining a child would fail to give) is not provided at child welfare clinics, nor are drugs, medicines, etc. provided as part of the service (children in the lower income group may be supplied with these through the dispensary service). Children examined at child welfare clinics are entitled to dental, ophthalmic and aural treatment and appliances in respect of defects discovered at child welfare clinic examinations. These services are not normally provided at the child welfare clinics but at other clinics arranged by the health authority.

62. If a child is found to require institutional or specialist treatment as a result of the child welfare clinic examination, the parent is advised to this effect, but the eligibility of the child for such treatment under the health authority service depends upon the eligibility of the parents under Section 15 of the Health Act, 1953. (The classes of persons eligible for these services are set out on page 8 of the Department’s General Memorandum on the Health Services for the Select Committee).

Legal Basis

63. Sections 18 and 20 of the Health Act, 1953, and Articles 27, 28 and 33 of the Maternity and Child Health Services Regulations, 1954.

Eligibility for the Service

64. Children under six years of age, irrespective of their parents’ means, may attend child welfare clinics for medical examinations and advice.

Manner in which the Service is provided

65. An obligation is imposed on each health authority to provide child welfare clinics in each town in its area in which there is a population of 3,000 or more. Health authorities are authorised to make similar services available in other centres but they are not bound to do so. Child welfare clinics are at present held in about 88 centres throughout the country and are conducted by medical officers employed by the
health authorities. These officers are normally Assistant County Medical Officers, working under the general direction of the County Medical Officer.

66. It has been recommended to health authorities by the Department that children attending clinics should, where possible, have at least nine examinations in all—at the age of 6 weeks or on the first visit to the clinic, at the age of three months, six months, nine months and one year and thereafter at the end of second, third, fourth and fifth years (if in the latter case the child is not already attending school). In addition to these examinations the medical officer will examine any children specially referred to him by a parent or nurse and he will also examine any children who, as a result of previous visits to the clinic, he considers need re-examination.

Submissions

67. No submissions referred specifically to the Child Welfare Clinic Service or indicated in any way that the present service does not meet in a reasonable way and at a reasonable cost the essential needs of the various sections of the population.
III. SCHOOL HEALTH EXAMINATION AND TREATMENT SERVICE

68. This service is described in some detail in pages 43-45, inclusive, of the general memorandum on the Health Services prepared by the Department of Health and already circulated to the Select Committee. It comprises:

(i) A school health examination service.
(ii) Institutional and specialist services in respect of defects discovered at school health examination.
(iii) Dental, ophthalmic and aural services in respect of defects discovered at school health examination.

69. The service does not provide for medical treatment at general practitioner level except attention of a "first-aid" nature—for example, for cuts or other superficial injuries or defects, which no doctor examining a child would fail to treat. Free treatment at general practitioner level for defects discovered at school health examination is, however, available to the lower income group as part of the general medical service. Drugs, medicines and nutrients are not provided as part of the School Health Examination Service although children in the lower income group may be supplied with these through the dispensary service, if considered necessary by their district medical officer.

70. The Dental, Ophthalmic, and Aural Services element is covered in a separate memorandum.

Legal Basis

71. Sections 19, 20 and 15 (7) of the Health Act, 1953, and Articles 29, 30, 31, 32 and 33 of the Maternity and Child Health Services Regulations, 1954.

Eligibility for the Service

72. The School Health Examination and Treatment service is available for pupils attending national schools. There is provision in the Health Act, 1953, that a similar service may be made available for pupils attending other elementary schools if the health authority are satisfied that an adequate health examination service is not already available for such pupils and make an order directing that Section 19 of the Act shall apply to the school concerned. (No such orders have been made).

Number of persons entitled to the services

73. There are approximately 500,000 school children attending national schools in this country who are entitled to the service.
74. In the year 1960 the total number of children examined under the School Health Examination Service was just over 147,000.

Manner in which the service is provided

75. School health examinations are conducted by whole-time medical officers employed by the health authorities. These officers are normally Assistant County Medical Officers. The aim is to have at least three medical examinations during the child’s school life as follows:

(a) as soon as possible after entry into the school;
(b) about midway through the school career;
(c) in the last year of attendance at national school.

76. Nurses are available to assist at school health examinations and to carry out the follow-up work.

77. Institutional-and-specialist services in respect of defects discovered in the course of the examination services are provided free of charge (Section 15(7) of the Health Act, 1953). They are arranged for by the family doctor (who may be the dispensary doctor) or by the County Medical Officer, if the parents so wish.

Submissions

78. Submissions on the School Health Examination Service or on particular aspects of it were made by the following:

- Dublin Health Authority.
- Irish Housewives Association.
- Irish Medical Association—this merely refers to the advantages of a properly organised school medical service in ascertaining mental handicap in children.
- Irish Vocational Education Association.
- Catholic Women’s Federation of Secondary School Unions.
- Dublin County Council of Trade Unions.
- The Society of Medical Officers of Health.

79. There is no real criticism of the School Health Examination Service as such in the submissions or no statement that the service does not meet in a reasonable way the needs of the community but there are recommendations as to the extension of the scope of the service.

Recommendations in the submissions that the scope of the service should be extended

80. Three submissions recommend that the scope of the School Health Examination Service should be extended. The Irish Housewives Association (page 22 of the submission) recommend that provision should be made for a health service for young persons in employment in the interval between leaving school and becoming insurable under the Social Welfare Acts. The Irish Vocational Education Association—
recommend that the school health examination and treatment service be extended to pupils attending whole-time day classes in Vocational Schools. The Catholic Women's Federation of Secondary School Unions (page 168) recommend that Health Services should be extended to children who through physical or mental handicap are not eligible for benefits at present as they are not attending a national school or are attending a private school.

Comment on the suggested extension of the scope of the services

81. The recommendation by the Irish Housewives Association that provision should be made for Health Services for young persons in employment from the time they leave school until they become insurable under the Social Welfare Scheme, while meritorious, would be very difficult to operate. For example, it would be difficult to confine the services to past pupils of national schools without extending it to all school children. Moreover these children are entitled to the health services provided for the lower or middle income groups depending on the group to which their parents belong. Probably the services with which the Association are mainly concerned are dental, ophthalmic and aural services, which are available only to children in the lower income group once they have left school. The Minister is anxious to extend these services to the middle income group as soon as possible but until funds and personnel become available he will not be in a position to do so.

82. While there is merit in the recommendation of the Catholic Women's Federation of Secondary School Unions that the school health services should be extended to children who through physical or mental handicap are not attending national schools, there would be difficulties in operating the suggestion. For example, where would these children be seen? Would all such children, irrespective of their parents' income, be eligible? Such children are, of course, at present entitled to a range of health services depending on the category to which their parents belong—lower or middle income group. The Federation refer to children attending private schools not being eligible for the services but, as explained earlier in this memorandum, while health authorities have the necessary power to make orders extending the school health services to elementary schools other than national schools this has not been done. There does not appear to be a compelling case for doing so as the parents of children who can afford to send them to such private schools normally are in a position to pay for any necessary medical services. If the children require hospital or specialist services and their parents are not in the higher income group, they would be entitled to avail of such services free, or at reduced charges.

83. Regarding the suggestion by the Irish Vocational Education Association that the School Health Examination and Treatment Service should be extended to students attending whole-time day courses in Vocational Schools, the position is that there are two categories of whole-time day courses in Vocational Schools; one described as continu-
tion education which is a two years' course at present; the other
described as technical education which, in the case of the bulk of the
students, would exceed two years as these courses are for Architecture,
Art, Dietetics, Engineering, Science, etc. The bulk of the students
attending the continuation education course are under sixteen years—
for example, in 1957/58, 19,631 were under 16 years and 3,660 16 years
and over. In the same year only 100 students doing the technical
education courses were under 16 years, 1,241 being 16 years and over.
The students attending continuation education courses are spread
throughout the country more or less on a population basis whilst the
smaller numbers following technical education courses are concentrated
in the county boroughs.

84. Most of the children attending the continuation education
courses previously attended national schools and, as such, had received
the benefit of the school health service. Most of them will become
insured workers at 16 or 17 years of age, and can avail of the dental
and optical benefits under the Department of Social Welfare Scheme.
They would also become entitled to Institutional and Specialist Services
in their own right as insured persons. The gap in the services occurs
however at a critical age and many of the benefits resulting from
medical examination in National Schools could be lost by reason of that
gap. There is not the same case for an extension of the school medical
service to pupils of secondary schools; the parents of such children are
more likely to be in a position to provide necessary services from their
own resources, and to have defects noticed by the family doctor. It is
significant that in none of the submissions has a recommendation been
made for the extension of the School Health Service to Secondary
Schools.

85. To sum up, there appears to be a good case for the extension of
the school health services to children attending wholetime Continuation
Education courses at vocational schools up to the time they reach 16
years. There are roughly 20,000 children in this category and the
addition will impose a strain on the school health service and will
probably involve additional appointments of public health nurses and
medical officers. Amending legislation would also be required for this
purpose.

Recommendations as to the manner in which services are provided

86. The Dublin Health Authority (page 3) and the Dublin Council
of Trade Unions (page 171) who submitted identical memoranda
recommend—

(i) that school children, absent when the school medical exami-
nation is held, should have the option of examination by the
district medical officer as part of the school medical service;

(ii) that in all cases where adequate school medical services and
inspections are not provided by a health authority, a certifi-
cate from a district medical officer or other qualified medical
specialist should be issued free of charge.
practitioner would qualify a child for treatment under the conditions of the school health treatment service; and

(iii) that sufficient medical staff should be employed to ensure that "every school child whose parents require it should have a medical examination at least every two years".

While the procedure recommended would assist the aims of the School Health Examination Service—that is, the discovery and treatment of defects in national school children as soon as possible—the methods suggested present difficulties. For example, would the district medical officers and private general practitioners be paid by the health authority for the examination of the children? If so, it would be very difficult to differentiate between this service and the extension of a general practitioners' service to children outside the lower income group. There is also the question of who would decide whether the school health service was adequate.

... The recommendations, if adopted, might also encourage parents to hold back their children from the routine school health examination service so as to have them examined privately later. This would greatly disrupt the service and in any case it appears to be more desirable to have all the children examined by the staff employed by the health authorities for this purpose, who are suitably qualified and have experience of the work.

... Many health authorities, particularly in the larger urban areas, arrange that particular age groups are examined at each school health examination—this is to ensure that each child gets the three examinations recommended during his school life. However, a child who missed an examination which included his particular age group need not necessarily wait for the next scheduled examination for his age group. His parents can request to have him examined at the next school health examination at the child's school. This would to a degree meet the case of a child who was absent from school during a school health examination session in which he would normally be included.

... Regarding the third recommendation, that every school child whose parents require it should have a medical examination at least every two years, the Regulations governing these services, as explained earlier in this memorandum, provide for three examinations normally during the child's school going years which normally extend over nine years, that is, an examination approximately every three years. If the parents of any child wish to have their child examined at more frequent intervals, they can ask the health authority to arrange this, as explained in the preceding paragraph.

... Normally three examinations during the national school career are accepted as adequate by the medical authorities for the purpose of the School Health Examination Service. It was never intended that this
service would relieve parents of their obligation to have ordinary childhood complaints looked after by the family doctor, i.e., the district medical officer in the case of the lower income group and the private practitioner in the case of children in the other income groups. The School Health Examination Service is mainly intended to bring under notice defects overlooked, or capable of being overlooked, by parents. To bring the district medical officer and the private practitioner into this service would require its organisation on a different basis from that which obtains at present under which these medical examinations are carried out by whole-time salaried medical officers, i.e., Assistant County and City Medical Officers, as a public health medical service. To meet these recommendations within the scope of the present organisation of the School Health Examination Service, it could perhaps be made more widely known that any parent who wished to have his child examined in any of the circumstances mentioned in the recommendations could present him for examination at the next school health examination taking place at the national school attended by the child.

91. The Irish Housewives Association recommend (pages 22, 23) that children be examined by the school medical officer at least once a year and that there should be more frequent eye examinations during the school career. To do this would require a very big increase in the staff at present employed on the School Health Examination Service. As indicated previously, it is generally accepted on medical advice that three examinations during the national school career are adequate.

92. The Society of Medical Officers of Health recommend (page 188) that the school health service should remain in the hands of the Public Health Medical Officers. This view carries weight as it is the view of the Society which represents the medical officers most intimately concerned with the service and, therefore, best qualified to speak about it. Their recommendation is in contrast to that of the Dublin Health Authority and the Dublin Council of Trade Unions (referred to above) which would bring district medical officers and general practitioners into the service.

93. The Society also recommend that the present periodic inspection of all national school children should be replaced by a system whereby attention could be concentrated on the "lame ducks". While this suggestion has some merit, its acceptance could defeat to a certain extent the aims of the school health service. As previously indicated, three examinations during the national school career of a child are regarded as adequate. A lesser number of examinations might result in some not too obvious defects being overlooked for too long. Under present arrangements attention can be concentrated on the "lame ducks" in the treatment service following the school health examination. The questions of the number of examinations and their nature, and of the application of modern advances to school health work, are under review by the Department.
94. A further recommendation by the Society is that each health authority should be allowed to formulate its own scheme of School Health Examination Service, which might or might not depart from the traditional arrangements. The existing arrangements for the service have been evolved after careful consideration of the aims of the service and the best ways of achieving them. It appears best to have the service provided by all health authorities on fairly well defined lines in accordance with the Regulations dealing with the Service and the advice issued from time to time by the Department in regard to them. However, there is at present room for a measure of flexibility in the arrangements made locally for the service which would enable health authorities to incorporate, to a certain extent, their own ideas into the service. The Minister for Health would welcome suggestions from health authorities for any worthwhile modifications within the scope of the Act and the Regulations. It should also be noted in this connection that apart from the fact that the Minister for Health defrays 50 per cent. of the cost of the school health service, he also carries final responsibility to Dáil Éireann for the health services and so long as this constitutional relationship obtains health authorities cannot be completely autonomous in the formulation of their own health schemes.

An Roinn Sláinte
Meáir Éamháir, 1962.