THE CHILD HEALTH SERVICES

Report of a Study Group appointed by the Minister for Health

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REPORT OF A STUDY GROUP APPOINTED BY THE MINISTER FOR HEALTH TO INQUIRE INTO THE CHILD WELFARE CLINIC SERVICE AND THE SCHOOL HEALTH EXAMINATION SERVICE.

DUBLIN :
PUBLISHED BY THE STATIONERY OFFICE.

To be purchased from the
GOVERNMENT PUBLICATIONS SALE OFFICE, G.P.O. ARCADE, DUBLIN 1.
or through any Bookseller.

Price : Six Shillings.

(Prl. 171.)

The cost of preparing this report which was presented to the Minister for Health on 6th November, 1967 is estimated to be £2,000 of which £1,100 is the estimated cost of printing and publication.

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ABBREVIATIONS USED IN THE REPORT

CMO ≡ Chief Medical Officer of a health authority.

ACMO ≡ Assistant Chief Medical Officer of a health authority.

DPH ≡ Diploma in Public Health.

DCH ≡ Diploma in Child Health.

ENT ≡ Ear, Nose and Throat.

TERMS OF REFERENCE

STUDY GROUP ON HEALTH AUTHORITY CHILD WELFARE CLINIC SERVICE AND SCHOOL HEALTH EXAMINATION SERVICE

The Study Group shall examine and report on:—

1. The present Child Welfare Clinic Service and the School Health Examination Service.
2. The manner and respects in which the existing services may require to be improved and/or augmented, stating fully the justification for any recommendations made.
3. Such arrangements, in respect of other health services (for example, the public health nursing service, the dispensary service, institutional and specialist services), as may be considered necessary or desirable to ensure that children will get the utmost benefit from the Child Welfare Clinic and School Health Examination Services.
4. The most effective way of co-ordinating any changes recommended in the School Health Examination Service with the school educational services and with local arrangements in the schools.
5. The numbers and types of additional staff which would be required, and the cost of any alterations which may be recommended in the existing Child Welfare Clinic Service and the School Health Examination Service; and also any consequential cost in other services, for example, in the Institutional and Specialist Services.

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Mr. P. A. White, Administrative Officer, Department of Health, acted as Secretary to the Study Group.

INTRODUCTION

1. In May, 1965, the Minister for Health set up a Study Group to examine and report on the Child Welfare Clinic Service and the School Health Examination Service. The Study Group held its first meeting on 15th June, 1965 and held a total of 25 full meetings. During the period, various sub-committees were formed to examine specific problems.

2. Between September, 1965 and October, 1966, the Study Group was concerned with the organisation and analysis of an extensive survey involving the medical examination of some 52,000 school-children. The survey was feasible only through the co-operation of the Chief Medical Officers of the health authorities and their staffs. Throughout our deliberations we repeatedly sought and obtained information from the Chief Medical Officers. In particular, they completed a detailed questionnaire describing the Child Welfare and School Health Services in their areas together with their observations and suggestions. We were very heartened by the extent to which Chief Medical Officers were aware of the modern challenges to the child health services. In addition, they readily furnished us information which we required during surveys of paediatric clinics, of ear, nose and throat clinics, and of Child Welfare Clinics in certain areas.

3. The Study Group are grateful to many other individuals and bodies for their assistance. Some of these we feel obliged to mention because of our special debt to them:—Central Statistics Office; Department of External Affairs; Department of Education; Schools Division, Office of Public Works; Department of Social Welfare; Ministry of Health, London; Department of Education and Science, London; Scottish Home and Health Department; Voluntary Health Insurance Board; University College, Dublin; Mother Nicholas, O.P. (for information on first referrals to St. Mary's Audiology Clinic, Cabra); Our Lady's Hospital for Sick Children, Crumlin (for information on admissions of children with congenital heart disease); ten orthopaedic departments or units (for information on admissions for congenital dislocation of the hip); International Computers and Tabulators Ltd., (I.C.T.) Dublin; Society of Medical Officers of Health, London; World Health Organisation, Geneva; International Children's Centre, Paris; Dr. Lionel Bacon, Deputy County Medical Officer, Hampshire; Dr. R. C. M. Pearson, Medical Officer of Health, Newcastle-upon-Tyne; the weekly journal *Medical Officer*.

4. From the commencement of his appointment as our Secretary, Mr. White displayed energy, ability and initiative to a degree which was quite remarkable and most praiseworthy. He went to immense trouble in collecting the statistics and information relevant to the Study Group's work and made our task considerably lighter by his skill in sifting and his clarity in presenting this material to us. In the drafting of our Report he was most assiduous; his ability in constructing its framework, and in clothing

it, was a very great help towards the completion of our labours. We have felt very much in his debt and wish to record our warm appreciation of Mr. White's services.

We wish also to express our appreciation of the services of Miss N. Gaynor and Mr. J. V. Hurley of the Department of Health who, throughout our deliberations, gave invaluable assistance to the Secretary, Mr. White, in the preparation of documents for our information. Finally, we wish to thank the ladies of the Typing Section of the Department of Health for dealing courteously and efficiently with our many requests for typescripts, often at very short notice.

CHAPTER 1.—ORIGIN AND DEVELOPMENT OF THE SERVICES

Child Welfare Service

The Beginning

1.1. The beginning of a state Child Welfare Service, as it is now understood, came in 1915 under legislation (Notification of Births (Extension) Act, 1915) which permitted local authorities to make suitable arrangements for looking after the health of expectant mothers, nursing mothers, and *children under 5 years of age*. Subsequent Regulations envisaged the formulation by local authorities and voluntary agencies of Maternity and Child Welfare Schemes incorporating a very wide range of facilities which would include:—

(*a*) The establishment of *health centres* at which medical supervision and advice would be made available for expectant and nursing mothers, and children under five years. Medical treatment would be provided for those needing it;

(*b*) The employment of nurses and health visitors;

(*c*) The provision of food for eligible mothers and children;

(*d*) The provision of créches and day nurseries, and other arrangements for attending to the health of children whose mothers go out to work; and

(*e*) Co-operation between local authorities and voluntary agencies engaged in maternity and child welfare work.

Grants of up to 50% of approved expenditure could be paid from central funds to local authorities and to voluntary agencies in respect of arrangements made by them for attending to the health of expectant or nursing mothers and of children under five years of age.

The plan underlying the Maternity and Child Welfare Schemes was remarkably far-seeing and comprehensive, and the last 50 years has essentially seen successive attempts to translate the schemes into practice. The idea of a *health centre* for the supervision of the health of children and for giving advice on infant and child care to mothers is still the keystone of the Child Welfare Service. The Local Government Board (which was then responsible for public health) saw the chief value of such centres in providing medical and hygienic advice. Mothers were to be urged to bring their children for advice and weighing, "*whether ailing or not*". The Board wished also to see a health visitor and doctor in attendance at the centres, together with voluntary workers who would assist in weighing babies, entertaining mothers and giving instructions in elementary hygiene, cooking and sewing.

Children requiring treatment, other than minor treatment, were to be referred to the family doctor.

Growth of Child Welfare Service

1.2 The Maternity and Child Welfare Schemes were developed by both local authorities and voluntary agencies (mainly nursing associations) on a common model. By 1939, a total of 148 approved schemes were in operation—30 were administered by local authorities, and 118 by voluntary agencies. The local authority schemes were then limited to the county boroughs of Dublin, Cork, Limerick and Waterford, 21 in urban districts, and the county health districts of Dublin, Kildare, Limerick, Monaghan and Wicklow. The voluntary agencies comprised 101 nursing agencies, 11 institutions and 6 boarding-out agencies. The following summary for the year ended 31st December, 1939 gives some idea of the work of the schemes:

TABLE 1.—MATERNITY AND CHILD WELFARE SCHEMES (1939)

	Number of separate cases visited		Total visits paid	Total attendances at clinics		Number of Nurses
	Mothers	Children		Mothers	Children	
1. Local Authorities	44,566	86,308	390,015	56,129	70,112	71
2. District Nursing Associations ..	11,864	24,020	679,684	3,955	4,893	106
3. Lady Dudley Nursing Scheme	3,600	8,265	302,074	—	—	49
TOTALS ..	60,030	118,593	1,371,773	60,084	75,005	226

NOTE: The figures for Local Authorities comprise the work done by nurses employed by these authorities or by associations subsidised by them; figures for District Nursing Associations are for associations recouped directly by the Department of Local Government and Public Health.

The most comprehensive schemes were operated in Dublin, Cork, Limerick and Waterford cities and in Dublin county. These schemes provided advice on maternity and motherhood; medical supervision for the under 5 year olds; hospital treatment for the under fives; food and medicine where necessary, and home visits by nurses. In the rural parts of the country, the service was limited to home nursing, largely by nurses of the District Nursing Associations, apart from the care provided by general practitioners functioning as such. The White Paper on the Health Services which was issued in 1947 noted that the Child Welfare Service "had developed unevenly over the country as a whole and has not grown beyond the health visitor stage, save in the cities and a few urban centres. In the cities the service is for all practical purposes confined to the poorer classes". Regulations made under the Health Act, 1947, continued the existing Child Welfare Schemes.

New Legislation

1.3 This was still the position when the Health Act, 1953 was passed with provisions for a new Child Welfare Service. Health authorities were required to make available a free medical, surgical and nursing service for children *under 6 years*, in accordance with Regulations. Clinics were to be established (under Regulations made in 1954) as soon as practicable in each town with a population of 3,000 persons or over, but they could also be provided in smaller towns. The arrangements were to include the attendance of a doctor at fixed times and the provision of any ancillary nursing services. Dental, ophthalmic and aural treatment and appliances were to be given free of charge in respect of defects discovered at the clinic. Treatment for other defects depended, however, on the normal eligibility of the parent under the Health Acts.

The Child Welfare Clinic Service is still governed by these provisions. The main changes introduced as a result of the Health Act, 1953 were:

(1) Health authorities were *obliged* to set up clinics in towns of 3,000 or more population subject only to the qualification "as soon as is practicable" after August, 1954.

(2) The age-limit for children covered by the Child Welfare Service was raised by one year to include children under 6 years of age.

(3) A separate service for expectant mothers in the lower and middle income groups and for their infants up to six weeks of age was inaugurated.

Aim of the Present Service

1.4. The objectives and detailed guidelines for the new Child Welfare Service were set out by the Department of Health in a circular issued in March, 1955 to health authorities. The key features of the Service are as follows:—

(1) *The Aim:* To provide advice, and to discover and secure, as far as possible, treatment for defects at an early stage, and in general to raise the standard of health of children under 6 years of age.

(2) *Periodic Medical Examinations:* Children attending the clinics should have at least 9 *examinations*—at the age of 6 weeks or on the first visit to the clinic, at the age of 3 months, 6 months, 9 months, 1 year, and at the end of the 2nd, 3rd, 4th and 5th years. The examination is to be as complete as possible and is designed to determine deviations from the normal.

(3) *Advice:* The attendance of parents at clinics is urged; they should be advised of any defects discovered. The opportunity of parents' attendances should also be availed of for the giving of advice on dietary problems and the encouragement of immunisations and vaccinations.

(4) *Reference to General Practitioners:* Treatment at general practitioner level is not provided at clinics, and children should be referred to their family doctor where appropriate. The clinic doctor is expected to co-operate with the family doctor.

The guidelines envisaged that the doctor in the clinic would be of ACMO grade. He should possess the Diploma in Child Health (DCH) or have had equivalent experience. He would work in other branches of the Health Services in addition to Child Welfare. The *examination* at the clinic is free in all cases but only treatment of a first-aid nature, e.g. for cuts, can be provided at the clinic.

Child Welfare Clinics To-day

1.5 There are now over 100 Child Welfare Clinics, operating in 72 cities and towns. Some 11 towns with populations greater than 3,000 have no clinics while clinics are held in 28 towns with a population below 3,000 (see Appendix 1). Clinics are usually held in a County Clinic or in suitable dispensary premises. A full clinical examination of the baby is carried out at the first visit; the comprehensiveness of the examination on subsequent visits of the child is a matter for the doctor's discretion. A nurse is usually in attendance to weigh the baby, to advise the mother on its feeding and management and to assist in completing clinical cards.

Nutrients are given to mothers in the lower income group at Dublin clinics; in Cork city, the Cork Child Welfare League, a voluntary organisation, sell nutrients at reduced costs to mothers. In some clinics, children are immunised.

National statistics on Child Welfare Clinics are shown in Appendix 2. Almost half of the attendances relate to the Dublin area.

School Health Service

Legislative Basis

1.6 The School Health Service in Britain commenced with the Education (Administrative Provisions) Act, 1907. This pioneering legislation gave local education authorities the duty to provide for the medical examination of children in public elementary schools.

It was not until 1919, when the Public Health (Medical Treatment of Children) (Ireland) Act was passed that the legislative basis was laid for a School Health Service in Ireland. The Local authorities were to be responsible for the services and were eligible for a Government grant of up to 50% of the cost. Comprehensive guidance for the establishment of the School Health Service was issued the following year in the Public Health (Medical Treatment of Children) (Ireland) Order, 1920, which required local authorities to submit schemes for the School Health Service. Each scheme was to cover

(1) the appointment of wholetime School Medical Officers, dentists and nurses (or the making of arrangements with voluntary nursing associations for nursing services);

(2) the provision of medical, surgical, dental, ophthalmic and nursing instruments, necessary for the inspection and treatment of the children;

(3) the provision of properly equipped, heated and lighted premises as would be required; and

(4) arrangements for admission and treatment of children in hospitals, institutions and dispensaries.

The actual amount of grant payable (maximum 50%) was to be determined in the light of the reports of Inspectors of the Local Government Board. The Inspectors' reports would deal with arrangements made by the local authorities for medical inspections, follow-up of defects found, and subsequent treatment. The system of medical examination laid down comprised:

(*a*) general and rapid inspection of all children but confined to hands, head, eyes and mouth;

(*b*) particular inspection of any child obviously in need of special and detailed examination *or* who was referred by the parent, teacher or school nurse;

(*c*) particular inspection of any child who entered school within the last 6 months or since the previous inspection;

(*d*) particular inspection of children whose last examination was 3 *years or more* previously or who would have left school before the next inspection; and

(*e*) re-examination of any child found with a defect at the previous inspection.

Parents were to be encouraged to attend; the inspection was to take place in a special room or in a section of the classroom which was screened off. There was no obligation on a parent to submit a child to medical inspection or treatment.

Inauguration of Service

1.7 Some years were to pass, however, before the inauguration of the School Health Service. In 1924, Cork city and Clonmel started the first such Service; Dublin city commenced in 1928 by appointing two School Medical Officers, and Counties Cork, Kildare, Louth and Offaly also started a service in the same year. In the other county areas, the development of the School Health Service occurred later and generally went hand in hand with the appointments to the newly created posts of County Medical Officer. The decade 1930–1940 was one of outstanding growth in the coverage of the School Health Service, as the following Table shows:—

TABLE 2.—MEDICAL EXAMINATIONS (INSPECTIONS) UNDER THE SCHOOL HEALTH SERVICE

Year	Number on Rolls in national schools	Number who had school medical inspections	Inspections as percentage of those on rolls
1930	511,549	48,565	9·5%
1931	509,396	85,513	16·8%
1933	513,349	107,954	21·0%
1935	495,829	93,638	12·9%
1937	481,599	124,256	25·8%
1939	469,972	135,404	28·8%
1940	471,233	126,341	26·8%
1950	463,703	145,625	31·4%
1960	506,208	157,040	31·0%
1961	503,218	147,139	29·2%
1962	500,794	153,246	30·6%
1963	502,059	145,364	29·0%
1964	476,164*	144,999	30·5%
1965	473,357	118,171†	25·0%
1966	476,400	146,188	30·7%

*The Department of Education changed the basis on which the national school population was compiled.

†The substantial decline in numbers inspected in 1965 was due to concentration by School Medical Officers on the oral polio campaign.

1.8 The School Health Service concentrated on defects of teeth, eyes, nose and throat, minor ailments, malnutrition and conditions of uncleanliness; free treatment was related to the means of the parents but the School Medical Officer had a large measure of discretion in the assessment of eligibility. In affording correction and treatment, existing facilities—hospitals and organisations—were availed of as far as possible. Spectacles were supplied to children who needed them. The annual Reports of the Department of Health clearly indicated that the treatment facilities provided under the School Health Service were not satisfactory in all areas. The schemes in the Dublin area were generally more advanced than in the rest of the country.

The Modern Service

1.9 The modern Service is governed by the Health Act, 1953 which requires health authorities to make available a health examination and treatment service. This Service is intended to include:—

(1) three health examinations of each pupil as near as possible to the following stages—school entry, the age of 10 years and the expected date of school leaving;

(2) institutional and specialist services, and dental, ophthalmic and aural treatment and appliances, free of charge, in respect of defects discovered at a school health examination.

The periodic attendance of doctors and dentists, and any necessary nursing or ancillary services are to be arranged under the Service. All national schools are included. The examination service (but not the associated treatment service) can be extended to private elementary schools by order of the health authority, if the authority is satisfied that an adequate health examination service is not available to the pupils.

Conclusion

1.10 By 1920, the basic plans for Child Welfare and School Health Services in this country were incorporated in legislation enacted in England. The political disturbances in the subsequent period and the limited hospital and specialist facilities available had a seriously inhibiting effect on the evolution of the Services, particularly the School Health Service. In fact, the essential features of the Services have changed little. The Health Act, 1953 placed them on a more regular basis, particularly in relation to treatment. The main structural change was the initiation in 1954 of a Maternity and Infant Welfare Service (for the lower and middle income groups) involving private general practitioners with responsibility for the infant to the age of 6 weeks. However, the Child Welfare Service is still founded on clinics in cities and towns backed by available district nurses; the School Health Service is still based on medical examinations by public health doctors (ACMOs) in the national schools.

CHAPTER 2.—EVALUATION OF THE PRESENT SERVICES

Child Welfare Service

Clinics

2.1 Health authorities are required to make Child Welfare Clinic Services available in any town with a population of 3,000 or more persons. The present position can be seen from the Table:—

TABLE 3.—NUMBER OF CHILD WELFARE CLINICS (1967)

Size of city or town	Total number of towns this size	Number of towns with Child Welfare Clinics	Number of Child Welfare Clinics (est.)
3,000 or more persons ..	55	44	82
1,500—3,000 persons ..	47	18	18
Under 1,500 persons ..	—	10	10
TOTALS ..		72	110

NOTE (1) Dublin and Dún Laoghaire Boroughs are regarded as a single unit.
(2) In the major cities, clinics are held in more than one centre.
(3) Population sizes based on 1966 census.

Eleven towns with a population of 3,000 persons or over lack Child Welfare Clinics:—Athlone (11,000), Mullingar (8,000), An Uaimh (6,000), Portlaoise (6,000), Castlebar (5,500), Dungarvan (5,000), New Ross (4,500), Letterkenny (4,500), Greystones-Delgany (4,000), Tramore (3,000) and Loughrea (3,000). A clinic was started in Castlebar but ceased through lack of public support and of district nursing personnel; clinics also ceased to operate in Portlaoise and Letterkenny. On the other hand some 28 towns which are below the minimum statutory population size of 3,000 have established clinics. A few counties have not any Child Welfare Clinics within their area: Leitrim, Roscommon (neither county has a town of size 3,000 persons), Laois, Meath and Westmeath.

The map opposite shows the present distribution of Child Welfare Clinics; the clinic towns are widely dispersed and in western areas are few and far between. Child Welfare is normally concerned with pre-school children and these, in the main, are

LEGEND

- TOWNS OF 5000 OR MORE WITH CHILD WELFARE CLINICS
- TOWNS OF 3000 - 5000 WITH CHILD WELFARE CLINICS
- TOWNS OF LESS THAN 3000 WITH CHILD " "
- TOWNS OF 3000 OR MORE WITHOUT " " "

CARNDONAGH
MOVILLE
BUNCRANA
NEWTOWNCUNNINGHAM
LETTERKENNY
SLIGO
MONAGHAN
BALLINA
CLONES
BALLYBAY
CASTLE-BLANEY
CAVAN
DUNDALK
CASTLEBAR
BAILIEBOROUGH
ARDEE
GRANARD
DROGHEDA
LONGFORD
NAVAN
BALBRIGGAN
MULLINGAR
SKERRIES
TUAM
SWORDS
ATHLONE
BALLINASLOE
LUCAN
DUBLIN & DUN LAOGHAIRE
GALWAY
NAAS
CLONDALKIN
TULLAMORE
RATHCOOLE
BRAY
LOUGHREA
BIRR
DROICHEAD NUA
GREYSTONES-DELGANY
ATHY
RATHNEW
PORTLAOISE
WICKLOW
ENNIS
ROSCREA
NENAGH
CARLOW
ARKLOW
SHANNON-AIRPORT
TEMPLEMORE
KILKENNY
KILRUSH
THURLES
LIMERICK
ENNISCORTHY
CASHEL
THOMAS-TOWN
LISTOWEL
TIPPERARY
CARRICK-ON-SUIR
NEW ROSS
CLONMEL
TRALEE
WEXFORD
KANTURK
MITCHELS-TOWN
WATERFORD
MALLOW
FERMOY
DUNGARVAN
TRAMORE
KILLARNEY
MACROOM
CORK
MIDLETON
YOUGHAL
COBH
DUNMANWAY
BANDON
BANTRY
CLONAKILTY
KINSALE
SKIBBEREEN

children under the age of 5. The total number of children under 5 years of age in Ireland was 300,000 in 1961; about 145,000 of these, or 48% of the total lived in a "clinic town" or its suburbs. Thus, 52% or just over half of the children under 5 years of age were not convenient to a clinic town, and for all practical purposes were deprived of the benefits of this organised service.

Attendances

2.2 Annual returns for the Child Welfare Clinic Service are sent to the Department of Health by health authorities. The returns supply the following information:—Centre (town); number of clinics held; number of children examined; and the state of health, under broad categories of defect, of the children examined. The salient information given by these returns in the most recent period of six years is summarised in Appendix 2.

2.3 The trend in attendances at Child Welfare Clinics is shown by Table 4.

TABLE 4.—ATTENDANCES AT CHILD WELFARE CLINICS

Year ended December	Number of Centres	Clinics held in year	Children examined at clinics
1960	103	4,198	59,306
1961	98	3,846	75,248
1962	91	4,365	79,695
1963	91	4,163	73,939
1964	98	4,286	78,470
1965	112	3,893	71,779
1966	109	3,980	80,560

Considerable fluctuations are evident in the returns, particularly as regards the numbers of children examined. It appears, however, that these figures may refer in the main to attendances at clinics, rather than the total number of children examined. Since some children would attend on more than one occasion in the year, the inclusion of all attendances would exaggerate the number of children examined. Thus in 1966, Dublin city and Dun Laoghaire accounted for 35,446 of the 80,560 shown in Table 4; however, the Dublin figure related to the total examinations undertaken at clinics, as the number of children examined was not readily available from the records. In view of these qualifications, it is not possible to calculate the proportion of eligible children who at present attend a Child Welfare Clinic in the course of any year.

Furthermore, the returns for defects do not distinguish between defects discovered and those already known, nor is the nature and extent of the follow-up from the clinic indicated.

2.4 The Study Group felt that additional information was required to permit an objective assessment of the Child Welfare Clinic Service. Two extra sources of information were used:—

(*a*) a detailed questionnaire was sent to all CMOs in 1965 to obtain their observations; and

(*b*) a survey (December, 1965—January, 1966) of Child Welfare Clinics in Dublin, Cork, Kildare and Louth was carried out, primarily to ascertain the reasons why mothers brought infants to Child Welfare Clinics.

The following analysis draws heavily on the information yielded by the questionnaire and the survey.

Usage of Service

2.5 The Child Welfare sessions are held mainly in dispensaries or County Clinics, and the facilities in these premises are, on the whole, considered adequate by CMOs. The peak age for attendances is under one year, and they rapidly decline from that age onwards. Very few children aged 4—5 years attend. The demand for the Service is considered by CMOs to be good in nine areas, and these areas include the cities of Dublin, Cork, Waterford and Galway. In the remaining areas the CMOs considered the demand for Child Welfare unsatisfactory, for a variety of reasons:—mothers are not conscious of the need for Child Welfare and see no immediate benefit from it; mothers of large families cannot easily leave home to visit a clinic; mothers with older children feel they do not need advice at a clinic about the care and management of their latest baby; the clinics are purely advisory and a child with a defect or illness has to be brought for treatment to the family doctor or to a specialist; clinics in country areas are held relatively infrequently (once or twice a month); home visiting by nurses is inadequate. As to mothers' reasons for bringing their children to the clinic, a variety of motives were advanced:—to have the baby immunised; to obtain nutrients or tonics free or at reduced cost (Dublin and Cork cities); for advice on infant welfare and management, and minor ailments; the district nurses, particularly in Dublin and Cork cities, have asked them to attend; the baby has some ailment about which the mother does not wish to trouble the family doctor; to avail of free facilities for dental, ophthalmic or aural treatment. Nine areas stated specifically that mothers attending the clinics were mainly from the lower income group, while another six said that both lower and middle income groups comprised the attendances. Mothers do not generally travel to a clinic from outside a radius of more than 3—5 miles, and in a substantial number of areas, attendances were confined to mothers from the clinic town itself.

2.6 There is, therefore, an interplay of *negative* factors, which inhibit or tend to discourage mothers from using the clinic, and of *positive* factors, which tend to induce them to do so. The Study Group regard the insufficiency of home visiting by district nurses to encourage mothers to come to clinics, and the lack of a clear appreciation

by mothers of the value of Child Welfare facilities, as key deficiencies in the present service. (Note: For convenience, the term "district nurse" will be used in the Report to denote a "public health nurse or Jubilee nurse on district duties").

2.7 The survey of Child Welfare Clinics carried out in Dublin, Kildare, Cork and Louth also elicited a variety of motives for attending clinics. During the period December 1965 to January 1966 special questionnaires (see Appendix 3) were completed in respect of children brought to Child Welfare Clinics in these areas. The purpose of the survey was to obtain evidence of the extent to which children were brought to clinics primarily for a routine medical check on the development of the baby, rather than for other reasons, e.g. to have a minor ailment treated; for free dental, ophthalmic or aural treatment; to secure immunisations or hospital or specialist treatment, or to obtain nutrients. In the view of the Study Group, the most important purpose of Child Welfare is to assess the development of the "well" child and the survey was designed to give some indication of the extent to which mothers appreciated this fundamental aspect. The overall results are shown in Table 5 beneath.

TABLE 5.—PRIMARY REASONS FOR ATTENDING CHILD WELFARE CLINICS

AREA	Total number of completed question-naires	% of children brought to the clinic who came primarily for—						
		(1) "Well-baby" check	(2) Acute Minor Ailment	(3) Dental, Ophthal-mic or Aural Defect	(4) Other ailment for which re-ferral was desired	(5) Other reasons, e.g. im-munisa-tions, nutrients	Combina-tion of reasons 1—5	Total %
Dublin City	1,506	26·9%	14·3%	3·8%	5·8%	39·6%	9·6%	100%
Dun-Laoghaire Borough	127	63·0%	17·3%	3·1%	2·4%	12·6%	1·6%	100%
Dublin County	164	30·5%	5·5%	3·6%	6·1%	22·6%	31·7%	100%
Cork City	752	4·5%	12·0%	1·9%	1·2%	77·9%	2·5%	100%
Cork County	118	48·4%	5·9%	16·9%	7·6%	3·4%	17·8%	100%
Kildare	60	—	—	—	—	100·0%	—	100%
Louth	86	33·7%	12·8%	17·4%	25·6%	5·8%	4·7%	100%
Totals	2,813	23·3%	12·6%	4·1%	5·0%	46·4%	8·6%	100%

Thus 2,813 children were seen by doctors during the survey. Two particularly striking features emerge:—

(*a*) a minor proportion (23·3%) come for a "well-baby" check;

(*b*) the proportion coming for other reasons, mainly nutrients or immunisations, is the biggest single category, comprising almost 50% of all attendances.

All of the Kildare children attended for immunisations. The numbers attending the clinics in Dun Laoghaire for "well-baby" checks are markedly higher than elsewhere.

As the "well-baby" category is of particular interest, it is analysed further in Table 6 below.

TABLE 6.—ANALYSIS OF "WELL-BABY" CATEGORY

	Children brought for "well-baby" check		Children in "well-baby" category whose parent had been requested by a nurse to come to the clinic	
	Number	Percentage of all children in area brought to the clinic during survey	Number	Percentage of total in "well-baby" category
Dublin City ..	405	26·9%	211	52·1%
Dun Laoghaire Borough ..	80	63·0%	8	10·0%
Dublin County ..	50	30·5%	31	62·0%
Cork City ..	34	4·5%	16	47·1%
Cork County ..	57	48·4%	42	73·7%
Louth	29	33·7%	26	89·7%
Kildare	—	—	—	—
TOTALS ..	655	23·3%	334	51·0%

In cases where the mother brought the child for a "well-baby" check, the proportion asked to do so by a nurse is high (51%) and underlines the vital importance of home visiting by the nurse.

The number of attendances by each child was also analysed, and found to be as follows:—

TABLE 7.—ATTENDANCES AT CHILD WELFARE CLINICS

Children with 1 attendance	.. ..	744 being 27·6%	of all children attending
,, ,, 2 attendances	.. ..	384 ,, 14·2%	,, ,, ,, ,,
,, ,, 3 ,,	.. ..	452 ,, 16·7%	,, ,, ,, ,,
,, ,, 4 ,,	.. ..	246 ,, 9·1%	,, ,, ,, ,,
,, ,, 5 to 9 ,,	.. ..	665 ,, 24·8%	,, ,, ,, ,,
,, ,, 10 or more attendances	..	204 ,, 7·6%	,, ,, ,, ,,
TOTAL	..	2,695 ,, 100%	,, ,, ,, ,,

NOTE: The total 2,695 is somewhat less than the total of 2,813 in the survey as a whole, as the relevant portion of the questionnaire was not completed in some instances. The children with one attendance are those who visited a Child Welfare Clinic for the first time during the survey.

A significant feature of Table 7 is that about one third of the children had five or more attendances; in fact some 200 children had 10 attendances or more. When it is remembered that these children would be almost entirely less than 2 years old, and the majority under one year, the *frequency* of attendance is extremely high and, as we have seen, the overwhelming motivation is not related to a preventive or "well-baby" check. Attendances do not occur at specified intervals, and the aim of periodic medical examinations at 3 months, 6 months, 9 months, 1 year and at the end of the 2nd, 3rd, 4th and 5th years is not being achieved at present.

2.8 The areas included in the survey account for about three quarters of all attendances at Child Welfare Clinics in recent years. The weather conditions during the period of the survey may have resulted in lower "well-baby" attendances than would be the case at other times of the year. The Study Group are satisfied, however, from their own knowledge of the Child Welfare Clinic Service that the results give a reasonable indication of the main trends in attendances at Child Welfare Clinics.

The Work of the Clinics

2.9 The Child Welfare Clinic is usually staffed by an ACMO and by a public health nurse—in a few areas general practitioners operate the clinic for the health authority. The infant receives a full clinical examination on its first visit. The nurse generally weighs the infant and may discuss feeding and management with the mother; the nurse is also available to give the doctor background information. The doctor usually obtains some family and obstetric history from the mother; he discusses with her the progress of the infant and advises and re-assures her where necessary. Specific advice given would cover such matters as diet, skin ailments, feeding and the general care of the baby. The general aim of the clinical examination is to detect any disabilities, including congenital defects, and to see if the child is making normal progress. Details

of the examination are entered on a special Child Welfare Record Card for each child. An infant requiring treatment is generally referred back to the family doctor. For dental, ophthalmic and aural defects, referral is direct to the dental surgeon, ophthalmic surgeon or ENT specialist, as the case requires. (Treatment and appliances for these defects are provided,free of charge, if the defects have been discovered at a Child Welfare Clinic.) In the case of other defects, some clinics refer children whose parents are eligible for such services, direct to the appropriate specialist, e.g., a paediatrician or orthopaedic surgeon. In Cork city, a Coeliac clinic and Rheumatic Heart disease clinic are associated with the Child Welfare Service. The process of direct referral in these instances has developed on an *ad hoc* basis, as a result of pressure from parents. Clinics in a few areas undertake immunisations; in others, audiometric testing or urine testing is carried out. Thus, there is considerable variation in the activities of the clinics and little uniformity of procedures. This is no more than a reflection of the historical evolution of the Services in different cities and towns and the endeavours made by the CMOs and their staffs over the years to improve the service given and to tailor it to local circumstances.

2.10 CMOs feel that, generally speaking, mothers act on the advice given in the clinics. Effective follow-up of infants referred for treatment is limited in many areas by the shortage of district nurses but where the nursing strength is nearer to the *desideratum* (particularly in Dublin and Cork cities) they undertake this work. Follow-up is also achieved in other ways—at the mother's next visit to the clinic she will be asked whether she had brought the child for treatment; if the clinic has arranged direct referral (e.g. for ophthalmic examinations) the health authority can follow up; parents whose children have defects may be asked specifically to attend regularly at the clinics.

2.11 Since the majority of children are probably referred to the family doctors, with whom the clinics have not good liaison at present, really effective follow-up is lacking, particularly if there are not enough nurses to carry out the home visiting which is highly desirable. In fact, the existence of sufficient nurses for field work in Child Welfare seems, to the Study Group, a necessary precondition for inducing mothers to attend clinics regularly, and for ensuring a satisfactory follow-up afterwards.

Relationships with other Medical Agencies

2.12 The Child Welfare Clinic, being primarily an agency of preventive medicine, is part of a network involving the parents, the family doctor, specialists, hospitals and the School Health Service. Its basic purpose is screening and ascertainment, and referral for treatment. If it undertakes direct referral to specialists or hospitals, the family doctor may feel aggrieved. If it merely refers the child back to the family doctor, the mother often feels that her trip to the clinic has been of little value. The doctor in the clinic who finds a defect will be anxious to see it treated and will naturally feel frustrated if he suspects that the mother will not bring the child to a general practitioner. Another problem is that mothers may have no family doctor as such. Liaison with the School

Health Service is not fully achieved because the Child Welfare Records are inadequately associated with the School Health Service Records. These are very real problems and their solution is necessary if the clinic is to do its work properly and if the mother and the clinic doctor alike are to feel satisfied with its results.

Role of the Clinic

2.13 Among mothers of young children there is no real appreciation of the proper function and the value of a Child Welfare Clinic. This is evidenced by the small proportion of infants brought for "well-baby" checks, and by the small attendances at many clinics. The majority are brought to obtain immunisations, for treatment of acute minor ailments, or for referral for treatment of defects already known. The clinic doctors sometimes find themselves under pressure to provide treatment or arrange for it; they are aware that the basic aim of Child Welfare is preventive but the translation of this ideal into practice is not easy. Clinics do, however, make a positive contribution to child welfare. The very fact that there are at least seventy to eighty thousand attendances annually means that thousands of infants come under medical notice at an early stage. Defects are found and treated; young mothers receive advice and assurance in the difficult process of rearing children. The nurses have a high status with the mothers and have ready access to their homes. The doctors often achieve a close and satisfying relationship with the mothers. Child Welfare in the cities has been established for many years and is a trusted source of advice to the mothers in these areas.

2.14 The service provided in the clinic should be the central element in a Child Welfare Service. The value of a clinic depends on

(*a*) the quality of the clinical examination,

(*b*) the knowledge of developmental paediatrics which the doctor possesses,

(*c*) the opportunity which he and the nurse have for discussion with the mother, and

(*d*) the facilities and equipment available.

The Study Group believe that in these aspects, the Child Welfare Clinics at present are short of modern requirements.

Late Age of Ascertainment

2.15 We had the impression from our experience in the field that children were not being referred for specialist attention at a sufficiently early age. To test the validity of this impression we decided to investigate closely the age/referral pattern of three defects of considerable importance for children viz. congenital dislocation of the hip, hearing loss, and congenital heart disease. The results of enquiries into the ages of first referrals for these defects could, we felt, be taken as important *indicators* of the effectiveness or otherwise of present arrangements for the early health screening of children.

The three defects we chose were ideally suited to the investigation we had in mind since there is an optimum time for ascertainment and treatment of each of them. Thus, congenital dislocation of the hip may be ascertained through a test (Ortolani's) carried out in the neo-natal period. The results of treatment commenced in the first few weeks

(or months) of life are very good. However, treatment begun at a later stage (and particularly after the age of 6 months) is generally more prolonged and the results of the treatment are not as satisfactory. In fact, late referral for treatment may permanently impair the child's capacity to walk properly.

In the case of hearing loss, a preliminary test can be carried out at the age of 6—9 months. The development of speech is closely associated with good hearing. Speech habits tend to become fixed in the pre-school years and for this reason the early referral for specialist attention of children with suspected or actual hearing loss is desirable.

As regards congenital heart disease, there is a high probability of diagnosis through routine examination between the ages of about 6 weeks and 6 months. Detection at these ages can reduce the number of avoidable deaths from the condition.

The results of our enquiries are as follows:

Congenital Dislocation of the Hip

2.16 Statistics of the ages of first referral of children for the investigation or treatment of congenital dislocation of the hip were obtained from ten orthopaedic departments or units for the years 1961 to 1965 inclusive (Appendix 4). Of a total of 291 children, only 34 (12%) were referred in the first six months of life while 141 (48%) were *aged 2 years or over* when first referred. Since ascertainment of the defect shortly after birth is possible, the high proportion of children commencing treatment after the age of 6 months is very unsatisfactory.

Hearing Loss

2.17 In the eighteen months between August, 1964 and February, 1966, one hundred and thirty-four children were referred for the first time for hearing assessment to St. Mary's Audiology Clinic, Cabra. Only four were referred in the first twelve months of life. (Details in Appendix 5.) An important finding was that sixty-nine of the children could have been regarded as "at risk" by reference to the mother's obstetric history but only three of these were referred in the first twelve months. A very high number (51) of the "at risk" group were found to have a hearing loss of some kind. Since hearing tests can be carried out at the age of 6—9 months, it is apparent that the present ages of referral are much later than the optimum.

Congenital Heart Disease

2.18 In the six years 1961–1966 (inclusive), some 626 children were admitted to Our Lady's Hospital for Sick Children, Crumlin with congenital heart disease (see Appendix 6). Exactly half the children (313) were aged one year or more when admitted to the hospital and almost one third (199) were 5 years of age or more at the time of admission. It is possible to detect congenital heart disease by medical examination during the first year of life but only half of the children included in the survey had been referred to the hospital within this period. These figures are of serious significance since mortality from congenital heart disease is highest in the first year of life.

The findings of these three enquiries could reasonably be regarded as showing that arrangements for the early health screening of children are not yet sufficiently effective. They confirm the need for greater emphasis on the needs of the pre-school child.

Conclusions on Child Welfare Service

2.19 In the light of the preceding analysis, we would summarise our conclusions as to the deficiencies in the present Service as follows:—

(1) the real function of the Child Welfare Clinic Service needs to be more precisely defined and understood by all those engaged in the Service;

(2) the demand for the Child Welfare Clinic Service in the centres where it operates is not generally satisfactory; many infants are never brought to the clinic, those who attend do so irregularly, attendance is exceptional after the first year of age and rare in later years. The aim of periodic medical examinations at specified intervals is not being achieved;

(3) only a minority of mothers bring their infants primarily for a preventive health check (i.e. "well-baby" check). The need for regular medical checks on the development of the apparently healthy infant is not generally understood by mothers;

(4) there are not enough nurses to permit of systematic home visiting;

(5) the clinics are not sufficiently orientated towards comprehensive clinical examinations with the emphasis on developmental progress, and their facilities and equipment need improvement;

(6) many children are not being screened for major defects at a sufficiently early age;

(7) the liaison between the Child Welfare Clinic Service, general practitioners, the Maternity and Infant Welfare Service (which cares for infants in the lower and middle income groups up to 6 weeks of age) and the School Health Service is not at all as satisfactory as it ought to be;

(8) the Child Welfare Clinic Service does not extend to children living in rural areas, who comprise over half the eligible child population;

(9) the present statistical data concerning the Service are inadequate.

School Health Service

Statistics of Examinations

2.20 In recent years the School Health Service has examined on average 150,000 pupils annually in about 2,300 schools. This coverage represents about 30% of the pupils on rolls, and half of the national schools in the country. There is, however, considerable variation in the proportion examined as between counties.

Each year, the health authorities send to the Department of Health returns of the defects noted at school medical examinations and treatment provided during the year. A national summary for the last six years is shown in Appendix 7. The Study Group examined the statistics for recent years in an endeavour to assess the significance of the defects found in school children. The incidence of defect was calculated per 1,000 children examined over a period of four consecutive years. The Central Statistics Office, which we consulted on the interpretation of these statistics, confirmed our view that valid deductions could not be drawn from them because of the apparent lack of uniformity in the way they were compiled for similar defects in different areas.

An element of "observer decision" is almost inevitable where statistics are based on the diagnoses of different doctors. The variation due to subjective decision was aggravated in the case of school health statistics by the very broad classifications of defect employed up to the present, and the fact that some areas include in their returns to the Department, defects which are noted for observation only, while others exclude them. Defects noted for observation are very numerous and their omission or exclusion affects fundamentally the comparability of the figures.

2.21 In order to assess the value of the School Health Service, the following information is essential:

(1) The significance of the defect which is *discovered* by the Service. The available data did not distinguish, however, defects which were newly discovered by the School Health Service from those which were either already under treatment, discovered by a family doctor or known to the parents.

(2) The significance of discovered defect *at each of the three examinations* which children should receive i.e., the examination soon after school entry (Entrance), the examination around the age of 10 years (Intermediate) and the final examination near the end of the pupil's national school career (Leavers). Thus, for example, in the case of some defects discovered at the Entrance examination, detection in the *pre-school* period might have been possible; similarly, defects first noticed at either the Intermediate or Leavers examination might reasonably have been detected at a previous examination. Certain defects can develop between school medical examinations and some idea of the volume and significance of these defects is also desirable.

In fact, no information on the ages of children examined or on the examinations at different stages was available.

School Health Survey

2.22 The Study Group, therefore, decided to undertake a special survey of the School Health Examination Service. Our aim in this was to inform ourselves as to the extent, character and seriousness of defect present in national school children, and as to the effectiveness of the existing School Health Examination Service in dealing with it. Finally, we wished to clear our minds as to whether the Service should be retained at all, or should be retained in a form which would give improved results.

2.23 A special School Health Survey form was designed in conjunction with the Central Statistics Office, who gave us most valuable advice and guidance throughout the operation. The Survey form (Appendix 8) incorporated over 100 defect classifications based largely on the International Classification of Diseases. We hoped that a more detailed defect classification than that used in the annual returns would reduce the element of subjective decision in assigning a defect to a particular heading.

Dental defects were excluded, because a detailed nationwide survey of the incidence of dental caries had already been carried out under the Health (Fluoridation of Water Supplies) Act, 1960. If a defect was noted during the Survey, the examining doctor was required to indicate which one of six categories it fell into *viz.*, defect referred for specialist in-patient or out-patient treatment or investigation; defect

referred for general practitioner treatment; defect noted for observation only; defect already under treatment otherwise than through the School Health Service; serious defect not amenable to treatment; defect discovered at a previous school health examination and receiving treatment. The Survey form also provided for the recording of details of the child's age, the presence or absence of a parent at the examination, and whether the child had had a previous school health examination. The Survey aimed at a sample of 10% (about 50,000) of national school children in each health authority area, with approximately the same proportion of the aggregate of County Boroughs, of urban areas (towns of 1,500 population and over) and of rural areas. In September, 1965 the Survey forms were issued to all CMOs, with guidance on their compilation and the samples required were finally achieved in May, 1966. The results of the Survey, following analysis by computer, were available in October, 1966. County Roscommon was unable to participate in the Survey due to a shortage of staff at the time.

Children in the Survey

2.24. The Table beneath classifies the children included in the Survey, according to age, area and whether they had a previous school medical examination or not.

TABLE 8.—CLASSIFICATION BY AGE, AREA, EXAMINATION EXPERIENCE

	NO PREVIOUS EXAMINATION Entrance Group					WITH PREVIOUS EXAMINATION				
						Intermediate Group			Leavers Group	
	5 years and under	6 years	7 years	8 years and over	Total No previous examination	6 years and under	7–10 years	Total up to 10 yrs. with previous examination	11 years and over with previous examination	Grand Totals
County Boroughs	3,428	1,330	757	2,714	8,229	395	3,777	4,172	3,043	15,444
Urban Areas	2,093	790	553	1,257	4,693	195	2,363	2,558	1,699	8,950
Rural Areas	3,787	2,708	2,025	4,053	12,573	459	7,509	7,968	6,845	27,386
National Totals	9,308	4,828	3,335	8,024	25,495	1,049	13,649	14,698	11,587	51,780

NOTE. The various examination groups have been defined for the purpose of our analysis as follows :
ENTRANCE GROUP : All children who had no previous school medical examination.
INTERMEDIATE GROUP : Children aged 10 years or under who had at least one previous examination.
LEAVERS GROUP : Children aged 11 years or over who had at least one previous examination.

Almost one third (8,024) of the children who had no previous examination were aged 8 years and over, indicating that a high proportion of children have to wait for a few years after school entry before receiving their initial medical examination.

Children without any Defect

2.25. In the case of almost 60% of those seen during the Survey, the examining doctor recorded them as having no defect. We would have expected much more children at the Intermediate and Leavers examinations to have had no defect; surprisingly, however, the proportion without defect varies little at any stage. Table 9 illustrates the point:—

TABLE 9.—CHILDREN WITH NO DEFECT

	Numbers with no defect	Total children examined	Percentage of total examined with no defect
			%
Entrance examination	14,741	25,495	57·82
Intermediate examination ..	8,227	14,698	55·97
Leavers examination	6,567	11,587	56·68
All examinations	29,535	51,780	57·04

Thus 29,535 children out of the total of 51,780 were recorded as having no defect. These figures suggest that out of 150,000 children examined annually under the School Health Service, some 85,500 (i.e., 57%) would be recorded as without defect.

Overall Incidence of Defect

2.26. During the School Health Survey, 22,245 children were recorded with defect. The nature of the defects noted varied considerably, e.g., some were noted for observation only, while others were referred to a specialist for investigation. The overall incidence of defects per 1,000 children examined is shown as follows:

TABLE 10.—DEFECTS IN DIFFERENT CATEGORIES PER 1,000 CHILDREN EXAMINED

Category of Defect	Examination Stages			
	Entrance	Intermediate	Leavers	All stages
Referred for specialist investigation or treatment (Category 1)	236·7	223·5	195·6	223·7
Observed for first time at school medical but being treated outside of School Health Service (Category 4)	37·9	17·4	16·0	27·2
Discovered at previous school health examination and receiving treatment (Category 6)	—	90·4	130·5	58·5
Miscellaneous: Noted for observation only (Category 3), referred back for general practitioner treatment (Category 2) or serious defect not amenable to treatment (Category 5)	303·5*	259·4	237·5	272·5
Total incidence	578·1	590·7	579·6	581·9

*Includes 7·4 entered during Survey in error in Category 6.

In each 1,000 children examined in the course of the Survey, the doctors noted 582 defects of all kinds, of which about

(*a*) 496 needed action of some kind (224 were referred to specialists and 272 were noted for observation, referred to a general practitioner, or were not amenable to treatment. The last category was of negligible size)

(*b*) only 86 defects were already under treatment (27 were being treated outside the School Health Service while 59 were being treated under the Service).

The Survey indicates that a high volume of defect is referred for specialist attention (average of 224 defects per 1,000 children), and that the volume of defect being treated outside of the School Health Service (27 per 1,000 children in Category 4) is relatively small. It is important to bear in mind that since some children had *more than one* defect, the actual incidence of children with defect would be less than the statistics for defects.

Significance of the Defects

2.27 The significance of the defects found at school medical examinations can be assessed by reference to the complete list of individual defects which were included in the Survey (Appendix 9). Certain defects e.g., visual, skin, can be competently ascertained by a nurse; others require a doctor's assessment. Table 11 overleaf distinguishes between these two kinds of defect; the top 50 defects (as measured by their overall incidence) which require medical competence, are shown first; defects appropriate to the nurse (visual, skin etc.) are shown separately.

It will be seen that the most common defects requiring a doctor's attention were tonsils and adenoids, most of which were noted for observation only; next in order were strabismus, flat foot, speech defects and defective posture.

Role of the Nurse

2.28 A very high proportion of the defects noted at all stages—Entrance, Intermediate and Leavers examinations—were appropriate to the nurse. Thus, the total incidence of referral to specialists (Category 1) was 223.7, of which, defects within the nurse's competence accounted for 96·9. Visual defects were the most important group, and the significance of referrals of them for specialist attention can be seen from the following breakdown:—

TABLE 12.—VISUAL DEFECTS : INCIDENCE OF REFERRALS FOR SPECIALIST ATTENTION DURING THE SCHOOL HEALTH SURVEY

Grade of vision	Incidence per 1,000 children examined (Category 1)
Grade I (6/12, 6/18, in either eye)	69·3
Grade II (6/24, 6/36 in either eye)	18·5
Grade III (6/60 or less in either eye) ..	3·9
Total	91·7

Feasibility of Earlier Ascertainment

2.29 We considered firstly the extent to which defects discovered at the Entrance school medical examination could have been discovered by a pre-school service, and secondly, the extent to which defects discovered at the Intermediate and Leavers examinations should have been discovered at the Entrance examination. These defects would, in the main, be congenital in origin or appear early in childhood e.g., strabismus, some visual defects, mental handicap, large moles, defects of bones and organs of movement, hernia, ichthyosis, torticollis, congenital heart disease, impaired hearing, congenital

(Continued on page 40)

TABLE 11.—INDIVIDUAL DEFECTS IN CERTAIN CATEGORIES PER 1,000 CHILDREN EXAMINED DURING SCHOOL HEALTH SURVEY

NOTE: CATEGORY 1: Defect referred for Specialist investigation or treatment.
CATEGORY 4: Defect now observed for first time at School Health Examination and already under treatment otherwise than through School Health Service.
CATEGORY 6: Defect discovered at a previous School Health Examination and receiving treatment.

{CATEGORY 2: Defect referred back for general practitioner treatment.
{CATEGORY 3: Defect noted for observation only.
{CATEGORY 5: Serious defect not amenable to treatment.

Rank in overall incidence	Defect Heading (Code No. from Survey Form)	Entrance Exam.: Incidence per 1,000 children				Intermediate Exam.: Incidence per 1,000 children				Leavers Exam.: Incidence per 1,000 children				Total all Exams.: Incidence per 1,000 children				Total all categories: Incidence per 1,000 children	Rank in overall incidence
		Children: 25,495				Children: 14,698				Children: 11,587				Children: 51,780					
		Cat. 1	Cat. 4	Cat. 6	Cat. 2 3, 5	Cat. 1	Cat. 4	Cat. 6	Cat. 2 3, 5	Cat. 1	Cat. 4	Cat. 6	Cat. 2 3, 5	Cat. 1	Cat. 4	Cat. 6	Cat. 2 3, 5		
1.	Tonsils and Adenoids (061-064)	44·4	—	—	116·8	33·5	—	—	97·4	28·6	—	—	74·1	37·8	—	—	101·7	139·5	1
2.	Strabismus (046)	27·3	6·1	1·3	1·6	15·3	1·2	18·3	1·2	8·7	0·8	16·8	0·7	19·7	3·5	9·6	1·3	34·1	2
3.	Flat Foot (113)	7·6	1·3	—	18·3	9·5	0·2	2·5	21·4	7·4	0·3	2·6	22·4	8·1	0·3	1·3	20·1	29·8	3
4.	Speech Defect (140) ..	10·4	0·9	0·2	10·3	7·9	0·4	3·3	3·8	6·1	0·3	3·0	3·7	9·1	0·6	1·7	7·0	18·4	4
5.	Defective Posture (110) ..	1·2	—	0·1	9·7	1·1	0·1	0·5	12·4	2·1	—	0·4	19·6	1·4	0·0	0·3	12·7	14·4	5
6.	Other Deformities (117) ..	4·4	0·9	0·0	8·4	3·6	0·3	1·7	6·6	4·1	0·9	1·2	4·6	4·0	0·7	0·8	7·0	12·5	6
7.	Other Psychological Disorders (156)	0·4	0·2	0·0	8·7	0·7	0·2	0·1	10·0	0·7	0·1	0·1	9·1	0·5	0·2	0·1	9·2	10·0	7
8.	Iron Deficiency Anaemia (072)	0·9	0.3	0·1	8·5	1·3	0·3	0·5	8·2	0·7	0·1	0·8	6·3	1·0	0·3	0·3	7·9	9·5	8
9.	Bronchitis and Asthmatic Bronchitis (082)	3·8	0·9	0·1	7·3	2·4	0·5	0·8	3·7	1·9	0·7	1·2	2·7	3·0	0·7	0·5	5·2	9·4	9
10.	Ribs and Sternum (116) (acquired)	1·1	0·2	0·0	7·7	1·8	0·1	0·5	6·6	1·9	0·1	0·9	6·3	1·5	0·2	0·4	7·1	9·2	10
11.	Other Miscellaneous Defects (188)	2·0	0·7	0·1	6·4	1·8	0·2	0·4	5·6	2·2	0·5	0·7	3·9	2·0	0·6	0·3	5·6	8·5	11
12.	Blepharitis (042)	1·4	0·1	0·1	5·6	3·1	0·1	0·5	5·4	2·4	0·3	0·9	7·1	2·1	0·1	0·4	5·9	8·5	12
13.	Other Nose and Throat defects (067)	2·2	0·4	0·1	6·4	2·9	0·2	0·5	5·2	2·2	0·1	0·1	2·9	2·4	0·3	0·2	5·3	8·2	13
14.	Mild Mental Handicap (160)	5·1	0·3	0·0	1·2	5·2	0·5	0·9	1·5	6·0	0·5	0·7	2·0	5·3	0·4	0·4	1·5	7·6	14
15.	Defective Hearing (050)	5·6	0·3	0·1	0·5	4·8	0·4	1·3	0·2	5·4	0·4	1·5	0·1	5·3	0·4	0·8	0·3	6·8	15
16.	Congenital Heart Disease (071)	3·1	0·9	0·3	1·5	2·0	0·3	2·7	1·5	2·2	0·1	1·7	1·0	2·6	0·6	1·3	1·4	5·9	16
17.	Enuresis (154)	2·6	0·4	0·1	2·7	2·0	0·2	0·5	2·2	0·7	0·2	0·7	0·9	2·0	0·3	0·3	2·2	4·8	17
18.	Undescended Testicle (182)	1·9	0·1	—	3·3	1·6	0·1	0·4	2·4	1·9	—	0·6	0·8	1·8	0·1	0·3	2·5	4·7	18
19.	Otitis Media (052) ..	3·1	0·8	0·1	0·9	2·6	0·2	0·5	1·0	2·7	0·1	0·6	0·6	2·9	0·5	0·3	0·8	4·5	19
20.	Asthma (080)	1·1	2·3	0·1	1·0	0·6	0·9	0·7	1·0	0·8	0·4	1·4	1·1	0·9	1·5	0·6	1·0	3·9	20
21.	Other Eye Defects (046) ..	1·2	0·2	0·0	1·3	2·2	0·2	0·8	2·0	1·5	0·1	0·4	1·8	1·6	0·2	0·3	1·6	3·7	21
22.	Other Endocrine System, Nutritional, Metabolic (106)	0·4	0·1	—	2·3	0·7	0·2	0·1	2·1	0·2	0·1	0·1	2·7	0·4	0·2	0·1	2·3	3·0	22
23.	Acute Respiratory Infections (including Tonsillitis) (170)	0·0	0·1	—	3·6	0·1	0·1	—	1·9	—	0·1	—	2·1	0·0	0·1	—	2·8	2·9	23
24.	Other Defects of Bones and	0·9	0·4	0·1	1·6	0·7	0·2	0·5	1·1	0·8	0·1	0·3	1·6	0·8	0·3	0·3	1·4	2·8	24

24.	Other Defects of Bones and Organs of Movement (Congenital) (126)	0·9	0·4	0·1	1·6	0·7	0·2	0·5	1·1	0·8	0·1	0·3	1·6	0·8	0·3	0·3	1·4	2·8	24
25.	Disorders of Digestive Tract (090)	0·4	0·5	—	1·6	0·5	0·1	—	1·6	0·3	0·1	0·1	3·1	0·4	0·3	0·0	1·9	2·7	25
26.	Hernia (180)	1·4	0·4	—	1·6	0·7	0·2	0·2	1·2	0·4	—	0·2	0·9	1·0	0·3	0·1	1·3	2·7	26
27.	Obesity (105)	0·2	—	—	1·3	0·5	0·1	0·2	2·3	0·7	0·1	0·2	1·9	0·4	0·0	0·1	1·7	2·2	27
28.	Hallux Valgus and Varus (114)	0·5	0·1	0·0	0·8	0·5	—	—	0·7	1·1	0·1	0·4	2·2	0·6	0·1	0·1	1·1	1·9	28
29.	Other Ear Defects (053)	0·7	0·1	—	1·2	0·8	0·1	0·1	1·0	1·0	—	0·1	0·8	0·7	0·1	0·1	1·0	1·9	29
30.	Heart Disease of Rheumatic Origin (070)	0·9	0·5	—	0·4	0·8	0·5	0·3	0·3	0·7	0·3	0·5	0·4	0·8	0·5	0·2	0·4	1·9	30
31.	Other Lung Defects (Non-Tubercular) (083)	0·6	0·2	—	0·5	0·9	0·3	—	0·5	0·3	0·4	0·2	0·3	0·6	0·3	0·0	0·5	1·4	31
32.	Otitis Externa (051) ..	0·8	0·2	—	0·2	0·6	—	0·1	0·3	0·7	—	—	0·3	0·7	0·1	0·0	0·3	1·1	32
33.	Conjunctivitis (045) ..	0·5	—	—	0·8	0·4	—	0·1	0·3	0·4	—	0·1	0·1	0·4	—	0·0	0·5	1·0	33
34.	Other Psychomotor Disorders (152)	0·1	0·0	—	1·1	—	0·1	—	0·5	—	—	0·1	1·2	0·0	0·0	0·0	0·9	1·0	34
35.	Other Defect of the Male Genitalia (184)	0·6	0·0	—	0·9	0·1	—	0·3	0·5	0·1	—	0·1	0·1	0·3	0·0	0·1	0·6	1·0	35
36.	Deflected Nasal Septum (065)	0·4	0·0	0·0	0·2	0·6	—	0·1	0·1	0·4	—	0·2	0·3	0·4	0·5	0·1	0·2	0·8	36
37.	Migraine (134)	0·3	0·1	—	0·1	0·2	0·2	—	0·6	0·3	0·1	0·2	0·8	0·3	0·1	0·0	0·4	0·8	37
38.	Behaviour Disorders of Childhood (150)	0·5	0·1	—	0·2	0·3	0·2	—	0·1	0·3	0·1	0·3	0·3	0·4	0·1	0·1	0·2	0·8	38
39.	Coeliac Disease (104) ..	0·1	0·6	—	0·0	—	0·3	0·3	—	—	0·4	0·2	0·2	0·0	0·5	0·1	0·1	0·7	39
40.	Curvature of Spine (acquired) (112) ..	0·2	0·0	0·0	0·4	0·2	0·1	0·1	0·4	0·1	0·1	0·2	0·3	0·2	0·1	0·1	0·3	0·7	40
41.	Defects of Rib and Sternum (Congenital) (122)	—	0·0	—	0·5	0·1	—	—	0·7	—	0·1	—	1·0	0·0	0·0	—	0·7	0·7	41
42.	Epilepsy Petit Mal (130) ..	0·1	0·4	0·1	0·1	0·2	0·3	0·2	0·1	0·2	0·2	0·3	—	0·1	0·3	0·2	0·1	0·7	42
43.	Epilepsy Grand Mal (131)	0·0	0·4	—	—	0·1	0·5	0·5	—	0·1	0·2	0·2	0·1	0·1	0·4	0·2	0·0	0·7	43
44.	Cleft Palate (186) ..	0·0	0·7	—	0·0	0·1	0·1	—	0·1	0·1	0·3	0·3	0·3	0·1	0·4	0·1	0·1	0·7	44
45.	Cleft Lip (185)	—	0·5	—	—	—	0·1	0·1	0·1	0·1	0·3	0·3	0·2	0·0	0·3	0·1	0·1	0·6	45
46.	Late Effects of Poliomyelitis (173)	—	0·2	0·0	0·2	—	0·3	0·1	0·3	—	0·4	0·2	0·4	—	0·3	0·1	0·3	0·7	46
47.	Pulmonary Tuberculosis (171)	0·0	0·4	—	0·3	—	0·1	0·1	0·2	0·1	0·2	0·2	0·1	0·0	0·3	0·1	0·2	0·6	47
48.	Torticollis (125)	0·4	0·2	—	0·0	0·2	—	0·2	0·1	0·1	0·1	0·5	—	0·3	0·1	0·2	0·0	0·6	48
49.	Goitre (100)	0·1	0·0	—	0·2	0·1	—	0·1	0·5	0·3	0·1	0·1	0·6	0·2	0·0	0·0	0·4	0·4	49
50.	Nystagmus (043)	0·4	0·1	0·0	—	0·5	—	0·1	0·1	—	—	0·7	—	0·3	0·1	0·2	0·0	0·6	50
I.	Total Incidence of Defects Ranked 1–50	141·9	23·1	3·3	247·9	115·7	10·7	41·5	216·7	98·9	10·4	42·8	194·2	124·9	16·7	23·0	227·0	391·6	
II.	Defects appropriate to the Nurse viz. vision, infestation, scabies, eczema, psoriasis, ichthyosis, large moles and haemangiomata, ringworm, impetigo, nail defects	92·6	11·7	4·0	45·5	105·8	6·0	48·0	39·7	95·0	4·6	86·1	41·3	96·9	8·5	34·9	42·9	183·2	
III.	Other defects included in Survey i.e. defects on Survey Form less those included at I & II above	2·1	3·1	0·2	2·6	2·0	0·7	1·0	3·0	1·6	0·9	1·6	2·1	2·0	1·9	0·7	2·6	7·2	
IV.	Grand Total all Defects ..	236·7	37·9	7·5	296·0	223·5	17·4	90·4	259·4	195·6	16·0	130·5	237·5	223·7	27·2	58·5	272·5	581·9	

spinal curvature. It is clear from the Survey results that many of these defects which are referred for specialist attention at each of the present three medical examinations could have been discovered and referred for treatment at an earlier stage.

Psychological Defect

2.30 The incidence of psychological disorder noted during the survey was small, and occurred mainly in the County Boroughs. The total incidence per 1,000 children examined, for all examinations and all categories is shown in Table 13:

TABLE 13.—INCIDENCE PER 1,000 CHILDREN EXAMINED OF SPECIFIED PSYCHOLOGICAL DISORDERS, IN ALL CATEGORIES

Defect Heading	County Boroughs	Urban Areas	Rural Areas	All Areas
Behaviour disorders of childhood (truancy, jealousy, tantrums, etc.)	1·2	0·7	0·6	0·8
Tics	0·6	0·2	0·2	0·3
Other Psychomotor disorders ..	2·9	0·1	0·3	1·0
Disorders of sleep	0·5	0·2	0·1	0·3
Enuresis	5·9	5·1	4·2	4·9
Encopresis	0·2	0·2	0·1	0·1
Other psychological disorders ..	32·8	1·3	1·2	10·0
Totals	44·1	7·8	6·7	17·4

The total incidence for psychological disorders of 17·4 per 1,000 children examined is very small in relation to the total incidence of 582 of all defect for all categories. There is, however, a substantially higher recording of psychological disorders in the County Boroughs—most of it is of a relatively minor nature e.g., nail biting. In the smaller urban areas and in rural areas, we consider that psychological defect is under-recorded, thus reflecting the traditional orientation of the School Health Service towards physical defect.

Presence of Parents

2.31 The School Health Survey also set out to ascertain the extent and the value of attendance of parents at school medicals. Our information on attendances is summarised below:—

TABLE 14.—ATTENDANCE OF PARENTS AT SCHOOL HEALTH EXAMINATIONS

Examination Stage	Percentage of children examined with a parent present in			
	County Boroughs	Urban Areas	Rural Areas	All areas
	%	%	%	%
Entrance ..	9·79	24·44	24·22	19·60
Intermediate ..	6·30	20·21	21·80	17·12
Leavers	3·22	12·12	15·75	11·93

The turnout of parents in County Boroughs is substantially lower than in the other areas. The variation in attendance between counties is great (Appendix 10): thus in Donegal the average at all stages was 84%, inWaterford 58%, Monaghan 53%, Leitrim 6%, Meath 1% and in Wicklow less than 1%. We were anxious to ascertain the determining factors governing these trends and sought the views of the CMOs in these six areas. The main factors suggested for *high attendance rates* were:— a tradition among parents; the educational work of the nurses; the impact of announcements in the churches of forthcoming school medical examinations, and good co-operation between parents, teachers and nurses. The areas with a *low turnout* of parents stressed the following factors as disincentives:—distances to be travelled, the problem of younger children at home, lack of accommodation facilities in the schools, attitude of school authorities. Thus the reasons for variation in the attendance of parents are complex and cannot be attributed to any single factor.

2.32 In the case of 21 defects, where the availability of information from a parent would specifically assist the doctor in ascertainment, a special analysis was made of the discovery rate where parents were present or were absent. The results (Appendix 11) generally show a much higher rate of discovery when parents are present, and stress the need to encourage them to attend.

City/Rural Differences

2.33 We have already referred to some differences between the cities (County Boroughs) on the one hand, and the rural and small urban areas on the other *viz.*, the higher recording of psychological defect and the very low attendance of parents at school medical examinations in the cities. In fact, the Survey, as a whole, showed a higher level of recording of defect in the cities:—

Areas	Percentage of children with defect
	%
County Boroughs ..	49·04
Urban Areas ..	41·27
Rural Areas	40·08
All areas	42·96

Thus in cities, just under 50% of the children examined were recorded as having a defect, while in other areas the proportion was much lower, at about 40%. Further analysis disclosed the following features:

(*a*) The incidence of children being treated *outside* of the School Health Service is twice as high in the cities as in the other areas.

(*b*) The total incidence of defects noted for observation only, defects referred back for general practitioner treatment, and of permanent defects not amenable to treatment is about twice as high in the cities as in the other areas.

We believe that the true incidence of defect is no less in the smaller urban and rural areas, and that the differences disclosed in the Survey can be attributed to a more detailed recording of defect in the cities.

Other Aspects

2.34 In the majority of counties, each school is visited by the School Medical Officer only every two or three years and all the children in the school are medically examined on the occasion of the visit. In the counties along the western seaboard which have a higher proportion of scattered small schools, the interval tends to be longer. The larger schools in the cities (and in a few counties) are visited annually and children in the recommended age groups are examined, i.e., infants, children around the age of 10 years, and those in their last year at school. Other children for whom an examination is requested by the parents are also examined on these occasions, as well as children under observation from a previous examination.

Apart from the large schools and those built in recent years, the physical conditions under which school medicals are conducted are poor. The main deficiencies are in the lack of a separate room for the examination, and in heating, water supply, and lighting.

The number of children examined at a session in schools is generally high and the average time given to each child is in the range of 3 to 6 minutes (according to the information we received from CMOs). Doctors may endeavour to complete the examination in remote schools in a single day: in these circumstances up to 60–70 children would be examined in the day. There is an excessive burden on the School Medical Officers through having to examine large numbers of children in 4,800 schools, many of them small, in remote areas and with inadequate facilities for the

examinations. As a consequence, the School Medical Officer has not the opportunity to spend much time on a particular child or to discuss the children with the mothers, if they attend.

In the case of ear, nose, throat, eye and dental defects, referral for specialist attention is, traditionally, direct from the School Health Service to the specialist concerned, with the consent of the child's parents. Referral for the specialist investigation of other defects is usually undertaken by the School Health Service only if, in addition, the family doctor has no objection. The CMO can usually check if appointments with the specialists have been kept. At the subsequent school medical examination the progress of the child can also be checked.

Conclusions on School Health Service

2.35 Our conclusions, in the light of the School Health Survey and other information considered by us, are as follows:

(1) The volume of defect discovered at school health examinations is sufficient to justify the continued existence of a School Health Service. Thus the total incidence of defect noted during the Survey was 581.9 per 1,000 children examined : 223.7 of these defects were referred for specialist attention while only 27.2 were under treatment outside of the School Health Service.

(2) A substantial proportion of defect could be competently detected by a nurse and would not require initial diagnosis by a doctor.

(3) An appreciable volume of defect should be discovered in the pre-school period, at the Entrance examination rather than the Intermediate and at the Intermediate rather than the Leavers examination.

(4) Psychological disorders are not being adequately discovered—particularly in the rural areas and non-county borough towns.

(5) The examination of large numbers of healthy children occupies an excessive amount of the doctors' time : it results in a tendency to rush examinations in order to complete the school within a certain period. The doctors are, therefore, working under pressure—very often in inadequate accommodation —and they have little opportunity to concentrate on children needing particular care and attention.

(6) The attendance of parents at school medical examinations is clearly associated with a higher rate of ascertainment of certain defects. The attendance rates for parents are low in the city areas and in certain counties.

(7) The most common defects encountered at school medical examinations are tonsils and adenoids, visual, strabismus, flat foot, infestation and speech.

We conclude that the School Health Service should be retained in some form, because it is still the most important agent in discovering defect in national school children. It requires remodelling, however ; the routine examination of large numbers of healthy children should cease. More time and skilled attention should be devoted to those selected for examination, and there is a need for some re-orientation of emphasis towards psychological disorders.

CHAPTER 3.—OUTLINE PROPOSALS FOR CHILD WELFARE AND SCHOOL HEALTH SERVICES

Introduction

3.1 This chapter outlines the Study Group's proposals for the future structure of the Services. The detailed organisation envisaged for the Services is elaborated in subsequent chapters.

Child Welfare Service

Child Welfare Abroad

3.2 We studied the literature on the operation of pre-school health services in Britain, continental Europe, the U.S.S.R. and the Canadian Provinces. Surveys in England and Wales suggest that mothers associate the clinics more with weighings, advice from the nurse, nutrients and immunisations than with developmental progress. Some three-quarters of children under 1 year old attend clinics but the proportion declines shortly after the second year. In Canada, some child welfare clinics are conducted solely by nurses (Saskatchewan, British Columbia); other clinics have a doctor available. In Europe, infant welfare centres generally perform regular examinations of the children and give health education and general advice to parents on nutrition and upbringing and in many instances, immunise against infectious diseases. In the U.S.S.R., which has a highly developed paediatric service, 80% of infants in towns undergo periodic medical examination and children are under constant health supervision until 14 years of age.

Objectives

3.3 The objectives of the Child Welfare Service should, in our view, be :—

(1) To ensure, by regular screening tests, that pre-school children develop both physically and mentally in a healthy and normal manner. This is the aspect of developmental progress ;

(2) To discover and to arrange for the further investigation or treatment of any deviation from normal physical and mental progress. Arrangements for the full assessment of handicapped children would be included. This is the discovery and treatment aspect.

(3) To promote the proper management, feeding and care of infants and pre-school children and of good health practice generally. This is the health education aspect.

Options

3.4 We considered the means by which these objectives could best be achieved in present circumstances. We examined the feasibility of a service based on different options, e.g.:

(1) *Comprehensive Public Health Clinics:* The aim would be to improve the facilities and service at existing clinics and to develop new clinics in the parts of the country not adequately covered at present. We concluded that a child welfare service based entirely on clinics would be impracticable because of the difficulty of operating viable clinics to cover rural areas.

(2) *Service based entirely on nurses:* Under such a service reliance would be placed on home visiting by nurses, and on clinics in major towns as advice centres to mothers and staffed solely by nurses. We rejected this alternative, on the grounds that adequate medical supervision would be lacking.

(3) *Service based entirely on general practitioners:* This would envisage agreements with general practitioners to carry out periodic examinations of pre-school children in all areas. (The lower and middle income groups could be catered for by extending the existing Maternity and Infant Welfare Service from 6 weeks to cover the entire pre-school period.) In examining this proposal we were conscious of the desirability of a much greater involvement of the family doctor in preventive medicine, and with local authority services. The proposal in the recent White Paper on the Health Services to permit general practitioners as a body to provide general medical services for the lower income group is a step in this direction.

The chief concern in any child welfare service must be to ensure that the child receives expert and skilled examination. Child health and developmental paediatrics nowadays require specialised knowledge. Unfortunately many doctors are not sufficiently trained in this field.

The single-handed general practitioner working in the cities and towns would, in many cases, find it difficult to meet the demands of child welfare work superimposed on a busy practice. (Group practice, which offers the prospect of specialisation in the same way as public health clinics, has not developed to any great extent here). We recognise that individual general practitioners have become skilled in child care; but health authority clinics can provide a doctor whose main pre-occupation is with children, who has post-graduate qualifications and experience in this field and who has well-trained nurses immediately available for consultation and follow-up. **Our conclusion, therefore, is that a clinic where viable—from the viewpoint of child population density—offers a better prospect of expert assessment for the child.**

Scheduled Medical Examinations

3.5 **We recommend that all children should have a scheduled medical examination when they reach the ages of 6 months, 1 year and 2 years.**

A child could have extra examinations up to two years of age and in the interval before school entry, if the examining doctor so desired. The examination would be carried out by reference to a detailed schedule and the examining doctor would be required to keep a record for each examination. The Record Card used would require the doctor to make a definite entry for all items in the scheduled examination.

Urban Areas

3.6 **In the larger urban areas, the scheduled examinations would be carried out by doctors on the CMO's staff.**

Existing doctors should, if necessary, acquire special training in the requisite techniques, and the equipment and facilities at the clinics should be of adequate quality. "Clinic towns" should, we feel, have a population of not less than about 5,000, if they are to be viable and attain the status we desire. A town of 5,000 population would have about 325 children 0—2 years and, given maximum response for periodic examinations, would provide about 27 children per month for medical examination. (The latest year for which ages are available is 1961 and for estimation purposes the percentage of the population aged 2 years and under—6·5%—has been used). A stream of this size would be the minimum required to support a clinic on a regular basis. We believe that concentration on developing first-class clinics in towns of 5,000 population and over (there are now 33 such towns) would be better than trying to build up clinics to the required level in, say, towns of 1,500 population and upwards (of which there are 103). However, where an existing clinic is successfully operating at present in a town of less than 5,000 population and the CMO wishes to retain it, we would see no objection.

3.7 While children would be medically examined at the regular intervals specified, mothers could at other times visit the clinic for consultation with the nurse concerning feeding, management and child development. The nurse would have a major role in this field and would most usefully help the doctor to develop a wide range of health education activities at the clinic.

Rural Areas

3.8 It would be impracticable to arrange clinics outside the towns and cities or to provide transport for mothers and their young children from rural areas to clinics in the towns. Recognising that these rural mothers and children are equally entitled to services as those living in the towns, **we recommend that outside of the clinic towns, the scheduled medical examinations would be undertaken by general practitioners under agreements with the health authority.** The examination would also be based on a detailed examination schedule, detailed records being likewise kept, and the doctor would be paid a fee, following certification by the CMO. A similar procedure operates at present for the Maternity and Infant Welfare Service (available to mothers in the lower and middle income groups) under which general practitioners provide ante and post-natal care until the infant is 6 weeks old. We envisage that in most instances, the same doctor would also provide the Child Welfare Service proposed.

Home Visiting by District Nurses

3.9 The district nursing service is now in the process of effective expansion. The nurse would have a major role in encouraging mothers to bring their children for periodic medical examination under Child Welfare. In the course of domiciliary visiting she would also be able to advise the mother in the home on the care of the child, have a critical look at the child, and observe his behaviour and development and the general conditions in the home. Over and above these gains from home visiting, the nurse would be able to learn a great deal of information about the child's health, development and so forth which could be passed on to the doctor—the general practitioner or the clinic doctor. The increased availability of district nurses would be, in fact, a precondition of a successful Child Welfare Service.

General

3.10 While recommending that the final periodic examination should take place at the age of 2 years, we are conscious that the ideal would be to continue periodic examinations at the third, fourth and fifth birthdays, etc. until the child entered national school. We recommend the 2-year limit because:

(1) The successful implementation of a service ceasing at 2 years would require a major effort on the part of all concerned. In particular, the involvement of general practitioners in rural areas in the service could only be assessed properly after it had been operating for some time.

(2) The ascertainment of defect would be relatively higher in the first two years of life and the yield in welfare terms from the considerable expenditure involved in operating a Child Welfare Service on the basis which we recommend would be correspondingly higher in those first years than in the second to the fifth years.

If the Service we envisage is implemented and proves successful, the extension of periodic examinations to later ages could be reconsidered.

School Health Service

Introduction

3.11 We have already stated our belief that a School Health Examination Service is still necessary, in view of the volume of defects found in school children, and the need to detect psychological disorders at this stage of life. It is important in the case of the School Health Service (as in the Child Welfare Service) to be clear on the objectives of such a preventive health service for children before proceeding to settle the arrangements to operate it. Thus, the School Health Examination Service is essentially a preventive health service for children between the ages of 5 and 13 years of age and a service to supervise their physical and mental development; the use of schools rather than clinics as examination centres, and of the CMO's staff rather than general

practitioners as examiners, involves a choice of the best way of achieving the preventive aims of such a Service. We mention these, perhaps obvious, considerations to underline the fact that a variety of options are open in choosing a frame-work for a School Health Service.

Objectives

3.12 In our view the following should be the objectives of a School Health Service :—

(1) to ensure that school children develop both physically and mentally in a healthy, normal manner ;

(2) to detect at the earliest possible stage any defect or disorder which would interfere with the child's educational progress and to see that effective remedial measures are taken ;

(3) to concentrate particularly on the ascertainment of handicapped children and to arrange for their further investigation and care.

The School as a Centre

3.13 We are in favour of continuing the use of the school as the basic centre for medical examinations. It provides a "captive audience" since the children are conveniently assembled. It enables close consultation with the teacher—a constant observer of his pupils—on the child's behaviour and progress. We see the School Health Service as being much more concerned than heretofore with behaviour and psychological disorders, educational retardation and mild mental handicap. The teacher's observations derived from classroom knowledge of the child would be an invaluable asset to the doctor. We also envisage a much higher attendance rate of parents at school medical examinations. This would provide an opportunity for greater parent-teacher and parent-doctor consultation concerning particular children.

A disadvantage in the use of many schools for medical examinations is the lack of a suitable separate room (apart from a classroom). The schools in city areas and the majority of new schools now being built normally have such a room (see Paragraph 5.12). The trend towards larger sized schools will also in time lead to a considerable improvement. We feel that the positive advantages of basing the Service on the schools are such that their continued use as examination centres is justified.

Examining Doctors

3.14 We consider that ACMOs should continue to carry out school medical examinations. The majority have the Diploma in Child Health and in the course of their work develop an expertise in detecting health deviations in children and in supervising their development. Generally, they become personally acquainted with the teachers and gain their confidence. Hitherto, there has not been any major problem in recruiting ACMOs and while this position remains, we recommend that these officers should be

responsible for the School Health Examination Service. We note a growing participation of general practitioners in the school health service in England and Wales; this development is occurring, however, in a situation of considerable difficulty in recruiting school doctors and where the turnover of doctors in the service is high. So far, this is not the case here. The employment of ACMOs in the School Health Service need not, of course, exclude a high degree of liaison between the School Health Service and general practitioners. **The question of the participation of general practitioners could be reconsidered if an acute problem in recruiting ACMOs arises in the future.**

Future Trends

3.15 The incidence of many *gross* physical defects formerly encountered among school children has been declining. If a comprehensive pre-school Child Welfare Service is established, the incidence of such physical defect which has not been under medical notice at school entry should be much reduced. The School Health Service in future will require a more refined type of examination in order to ascertain the less obvious forms of physical defect. The School Medical Officer will require a preventive approach and a knowledge of developmental paediatrics. Fields of medical knowledge increasingly relevant will be those on the borderland between health and education (e.g., mental handicap, behaviour disorders) and skill in detecting and dealing with emotional and personality problems of children. The essential sources of information about the child—pre-school medical history, the parent, teacher, family doctor, nurse—will need to be used thoroughly.

Selective Examination

3.16 The present aim of the School Health Service is to give each child three medical examinations over the period spent at national school. The routine examinations could be made much more effective if more comprehensive consultation with parents, teachers and nurses were undertaken; if the School Medical Officer were more orientated towards mental well-being, and if adequate pre-school medical records were available and associated with those of the school medical examinations. Routine examinations annually would, of course, give an even better guarantee of a high rate of ascertainment. If medical manpower were unlimited this situation might be the ideal. We consider, however, that a balance must be struck between, on the one hand, a school health procedure which offers a good prospect of early ascertainment of defect and of adequate supervision of the child's development, and on the other, the optimum use of the medical personnel available. The medical and financial resources available to the Service are crucial factors; they must be employed in the most efficient manner. For this reason, we examined the means whereby the extent of routine examination of large numbers of healthy children could advantageously be cut-back without detriment to the children.

Other Countries

3.17 A selective system of school medical examinations, rather than the routine examination of *all* children in certain age groups, has been adopted or is being tried by

about half of the local education authorities in England and Wales. Generally, a medical examination of all new entrants is carried out, but subsequent examination depends on a child's selection on the basis of some indication from the parents, teacher, nurse, or because previous medical history demonstrates its need. A routine medical examination may be held in the child's last year at school (minimum school leaving age is 15 years) but in the interval from the Entrance examination, reliance is placed on a selective system. Important features of the selective system are more frequent visits (perhaps once a term) by the School Medical Officer to the school; discussions between head teacher, school nurse and doctor; frequent visits by the nurse (who undertakes vision testing) and the use of detailed questionnaires to the parents about the child's health, background and behaviour.

We considered in particular the selective system introduced in 1959 in Hampshire where the school population is over 120,000. All new entrants are medically examined, vision is tested annually by a nurse, the Intermediate examination has been discontinued, and school leavers are medically examined only if it appears necessary in a particular case, following an interview. In place of the examination of *all* children in the intermediate age group, particular children are selected for examination—mainly on the basis of consultation between the doctor, nurse and teacher, and by reference to a questionnaire completed by the parents of 8 and 12 year olds. The system operates very satisfactorily and has resulted in much closer links between the School Health Service staff and the teachers.

In Scotland, the Home and Health Department asked (1962) local authorities to consider modifying the usual system of routine examinations at the ages of 5, 9 and 13 years in favour of routine medical inspections for the 5 and 13 year olds. A selective system based on close medical contact with parents and teachers would, however, supervise the child at other ages.

In British Columbia a revised school health programme was introduced (1962) under which the School Medical Officer examines *only* those children referred to him by the nurse following teacher/nurse conferences. The nurse also carries out routine vision and hearing tests of certain groups.

It will be seen from this brief survey that the main innovation in school health services abroad is the replacement, in varying degrees, of routine examination systems by procedures which *select* children for medical inspection on the basis of some indicator other than age.

We consider that, in this country, a selective system of examination of the school children would bring about a considerable improvement, provided it was well organised and supported by—an improved Child Welfare Service ; better and closer contacts between the School Medical Officers, family doctors, teachers and parents ; improved treatment facilities ; better follow-up ; more accurate recording of defects, and fully-adequate supervision.

Study Group's Proposals

3.18 The Study Group's outline proposals for the future structure of the School Health Service are:

(1) **INITIAL ROUTINE MEDICAL EXAMINATION : A comprehensive medical examination of all national school children would be carried out between the 6th and 7th birthdays, and of children above this age who have not had the initial examination.** Children who started school at 5 years of age would then be in school for up to 2 years before the initial examination. We favour an interval between school entry and the first examination because the child will have settled down in school, his general development can be better assessed, and because an interval after school entry would allow the teacher to know the child better. Another reason for deferment is the tendency for young children in their first few months at school to develop temporary infections and ailments which are of little lasting medical significance.

(2) **ROUTINE SCREENING BY NURSES : We recommend that the district nurse should carry out annual vision testing of all children in a school. She would also inspect for cleanliness and posture. Any child in whom she suspected other defects would be referred for examination by the doctor on his next visit. A nurse trained in audiometry would also undertake audiometric testing of new school entrants and other selected groups.** All new entrants would, therefore, have a vision and hearing test in their first year at school.

(3) **SPECIAL SELECTIVE MEDICAL EXAMINATION OF 9 YEAR OLDS:** The ages 8 to 9 are years during which emotional difficulties and psychological stress are likely to be recognised. **We recommend that all 9 year old children be specially considered by the School Medical Officer in consultation with the nurse and teacher, reference being made to a special questionnaire completed by parents. Having assessed the need for a medical examination in each case the doctor would select children requiring examination.** We estimate that these screening and selection procedures would result in about 30%—40% of all 9 year olds being picked out for examination.

(4) **REFERRALS AND RE-EXAMINATIONS:** The School Medical Officer would, we envisage, visit schools *at least* once a year. On these visits he would examine any child referred by the nurse or teacher, or for whom the parent requested a medical examination. Some children would be under observation from previous examinations and might need to be examined again.

3.19 In small rural schools (say under 30 pupils), it may be more practicable to examine all the children in the school once every two years, rather than to endeavour to select special groups.

3.20. The proposed scheme would involve the participation of parents, teachers, nurses, and School Medical Officers in a team effort. The aim would be to assemble as much relevant information as possible on the child being evaluated by the doctor. The

doctor would visit each school at least once a year, and the district nurse more frequently. We believe that a Service as outlined would permit the detection of defects, both physical and mental, much earlier and more effectively than at present.

We have considered whether the discarding of repeated routine examinations would entail the overlooking of many defects in children not selected for examination and we are satisfied that there is little likelihood of this occurring on a significant scale.

3.21 Some health authorities already have reduced the number of routine examinations.

In Dublin County, the Leavers routine medical inspection has been modified to an inspection of children for vision, tonsils, dental, and orthopaedic defects only. The children are also interviewed.

In Tipperary North Riding, schools are visited annually and the Entrants and Leavers groups are medically examined. In the intermediate age range, medical examination is confined to children who are mentally or educationally retarded, children who are hard of hearing, children with defective speech or poor vision, children under observation from a previous examination or children whose parents request an examination. All children are tested annually for vision.

3.22 We envisage a Service in which—

doctors would be able to concentrate more, and at an earlier stage, on children really needing attention ;

full antecedent support would be forthcoming from a substantially improved Child Welfare Service, effectively integrated with the Service for schools ;

full co-operation would be achieved between the school health personnel, the parent, and the teacher ;

fully-adequate follow-up would be undertaken ;

fully-adequate supporting specialist services would be available ; and

better records and continuing effective supervision of the Service would be maintained.

Maternity and Infant Welfare Service

3.23. General practitioners who have entered into agreements with the health authority provide ante- and post-natal care for mothers in the lower and middle income groups and care for the baby up to 6 weeks of age. The doctor concerned is required to carry out a medical examination of the baby before the end of the 6 weeks period. In order to make the Child Welfare and School Health Examination Services more effective,

we recommend that the doctor be required to undertake a scheduled medical examination of the baby at the age of 4-6 weeks; the items to be included in the examination would be detailed on an appropriate record card. Medical assessment at the 4–6 weeks stage should prove invaluable in the earlydetection o f congenital defects.

Conclusion

3.24 In summary, our proposals for the full range of child health services include a scheduled medical examination at the age of 4-6 weeks (for which infants in the lower and middle income groups would be eligible) ; medical examinations at the ages of 6 months, 1 year and 2 years, for all children; a further medical examination in national school at 6 years of age and a selective examination of 9 year old children with provision for referral for medical examination at any time while attending national school. Annual vision testing and an initial audiometric screening would also be provided. The pre-school Child Welfare Service would be centred on clinics in towns of 5,000 population and over, while in other areas the general practitioner would provide the Service. Co-ordination between the three existing Services catering for children is essential, and could be greatly assisted by effective association of the medical records at succeeding stages. The development of the Services on the lines we envisage would, we are satisfied, make a notable contribution to child health.

CHAPTER 4.—DETAILED ORGANISATION OF PROPOSED CHILD WELFARE SERVICE

Fundamental Features

4.1 We have proposed periodic child welfare examinations at the ages of 6 months, 1 year and 2 years—to be undertaken in clinics in the larger towns by doctors on the CMO's staff, and in other areas by general practitioners. The organisation of the Service will, therefore, vary as between urban and rural areas, but will at least have important common features, viz. a comprehensive clinical examination, with full records kept, and extensive domiciliary visiting by district nurses.

Child Welfare Record Card

4.2 The Record Card would be the basis of the examination. It would provide for entries to be made by the doctor at each examination covering, for example, the general appearance of mother and child, and for the latter, posture and locomotion, vision, hearing, social behaviour, sleeping, appetite and elimination. At each examination, the doctor would check whether specific milestones of development had been reached. A self-explanatory specimen Record Card which we designed is shown at Appendix 12.

Domiciliary Visits by Nurses

4.3 As mentioned already (paragraph 3.9) visits by a nurse to the home of an infant can help in several ways. Domiciliary visiting by nurses must be viewed as an important component of a child welfare service. At present, where it can be carried out in rural areas, it is the only element of Child Welfare Service provided by health authorities; in the cities and towns it is a major factor in inducing mothers to attend clinics. Under the proposed Service, the district nurse operating in clinic-towns could pass on relevant information to the CMO's office for the benefit of the ACMO who will be holding the clinic. If she herself assists at the clinic she can directly advise the clinic doctor about cases from her district. In rural areas where the general practitioner would be providing the service, good liaison between him and the nurse would be desirable.

A Register of Children

4.4 We consider that the maintenance by the CMO of a register of births of all children would be a valuable aid to the efficient running of the Child Welfare Service. It could be used to inform nurses of births in their districts and as a basis for notifying mothers, in advance, of the approaching due date of the child's next periodic examination. Regular advance reminders to mothers would act as a stimulus to them and would reinforce the work of the nurse. In the absence of such a system, an undue burden would be placed on the nurse if she were expected to visit routinely all mothers of young

children shortly in advance of the time for a periodic examination. Even if a full complement of district nurses were available, such a degree of routine visiting might not easily fit into her normal schedule of duties, and would not represent an optimum use of her time.

A register on the lines envisaged can be built up from the notifications of births which are normally supplied to CMOs who use them at present to inform district nurses of births in their area. We envisage the systematic updating of the register to take into account deaths of children, movement out of, and into the area.

Special Periodic Examinations

4.5 Over and above the specified periodic examinations at fixed intervals (6 months, 1 year, 2 years) special medical examinations would be carried out if the examining doctor considered them necessary. Thus, he might wish to recall a child at the age of 3 years. In rural areas, the general practitioner would seek the CMO's agreement to such extra examinations.

Clinics in Towns and Cities

Staffing

4.6 The clinics in urban areas would be staffed by an ACMO with special training in developmental paediatrics and by a nurse to meet mothers who came with their infants for a periodic examination *or* who wish to consult her. An additional nurse to assist the doctor in his examination would be desirable but not essential; a clerk to make initial entries on Record Cards would free the nurse of clerical duties.

Facilities

4.7 The clinic environment should be bright, warm and attractive. The doctor's room should permit the child to be observed while crawling or walking; it should have a table on which to put the child during examination; a rug on the floor could be used to let the child sit or play. Equipment should include an auriscope, and test-material for sight, hearing and developmental progress.

4.8 The nurse should have a room adjacent to the doctor's in which to meet the mothers initially. She should have a weighing-scale available. Comfortable chairs for mothers and a play corner for children would be desirable. The nurse could talk individually or have general discussions, with mothers.

4.9 Separate facilities for lectures or welfare talks to mothers could be provided also. Facilities for a cup of tea would be a decided attraction.

Appointment System

4.10 An appointment system for mothers at clinics would, we consider, be extremely desirable. The elimination of long waiting periods at the clinics would encourage mothers to attend. The appointment system would also raise the status of the periodic examination in the eyes of the mothers, and should ease the work of the clinic staff. The actual form of the appointment could vary, e.g. 4–5 mothers could be allocated to a particular hour *en bloc* or individual appointments could be made for say 10–15 minute intervals. A provisional appointment could be sent with the advance notification to mothers, with a pre-paid card for return to the CMO if the appointment did not suit. Inevitably, some appointments would not be kept due to difficulties such as bad weather, or the lack of anyone to look after the rest of the family. Allowance for failures to turn up could be made by calling an "excess" of mothers, estimated from experience. While we realise the practical difficulties in establishing a workable appointment system for this kind of service, we believe the objective to be so desirable that every effort should be made to attain it.

The Nurse

4.11 The smooth running of the clinic would depend primarily on the nurse. She would control the flow of mothers and children to the doctor for periodic medical examinations. She would also deal with mothers who come on an *ad hoc* basis to consult her; within her competence, she could advise these mothers on any particular problem they had in rearing the infant, and on its development. If the periodic medical examination system is to work (particularly if appointments are made) the flow of cases of minor ailments to the doctor and of children for medical examinations additional to the periodic ones, would have to be strictly controlled. The nurse would be in a key position to control access to the doctor. We believe that the number of mothers seeking the doctor's attention outside of periodic medical examinations would be relatively small, once the function of Child Welfare Clinics in relation to periodic examinations was appreciated. The role of the family doctor in relation to the treatment of acute ailments and their referral for further investigation would then be underlined.

The nurse would organise talks, discussions and mothercraft sessions; the development of these activities would be a matter for each individual clinic.

The Doctor

4.12 At the 6 months periodic examination, the doctor should have available any relevant information arising from the mother's obstetric history and from the "At Risk" Register (paragraph 4.21). In the case of children whose parents are in the lower and middle income group he should have information from the 4–6 weeks examination which we have recommended (paragraph 3.23) to be carried out under the Maternity and Infant Welfare Service. Any information gained by the nurse in the course of domiciliary visits would also be at his disposal. In the course of his own examination, he would have a general discussion with the mother on any aspect of the child's health which worried her. He could advise her on the procedures for obtaining any treatment which he considered necessary; he could also encourage her to come for the next periodic examination.

4.13 If a defect requiring further treatment was ascertained at the clinic, the family doctor would be given the option of making the necessary arrangements. The clinic doctor could inform him that arrangements for specialist investigation of the child would be made by the clinic, in the absence of any indication to the contrary from the family doctor within a certain interval. Where the family doctor chose to refer the child, he could be requested to supply a copy of the specialist's report in due course, so that the clinic doctor would know the up-to-date position when the child came to the clinic for its next examination. In the case of dental, ophthalmic and aural defects the practice of direct referral by the clinic doctor would continue as at present.

Other Aspects of Clinics

4.14 In some areas, immunisations are carried out during Child Welfare sessions, while in others, separate immunisation sessions are held. Where numbers permit, immunisation should be provided in special sessions. In any event, the periodic medical examinations envisaged would not coincide with the recommended intervals for vaccinations and immunisations. If immunisations can be provided in a Child Welfare Clinic without upsetting the basic running of the clinic, we would see no objection.

4.15 The clinics would be intended primarily to serve families in the town and its suburbs. Mothers outside of the accepted urban area would be entitled to make arrangements with general practitioners. However, if such a mother wished to avail of the clinic service, we recommend that she be permitted to do so, after informing the CMO of her choice. An appointment could then be made for her.

Child Welfare Service in Rural Areas and smaller Towns

Agreements

4.16 We have proposed that in rural areas and towns with a population of less than 5,000 persons, general practitioners should provide the Child Welfare Service. At present, the majority of general practitioners have made agreements with health authorities to provide Maternity and Infant Welfare services until the infant has reached 6 weeks. Under the agreement, fees for the performance of specified services are fixed and are paid on certification by the CMO. We envisage that general practitioners participating in the proposed Child Welfare Service would also make agreements with the health authority and that agreed fees would be paid for each periodic examination following certification by the CMO. The Record Card we have designed (Appendix 12) covers both services, i.e. Maternity and Infant Welfare, and Child Welfare. Since a mother would usually retain the same doctor for the post 6 weeks stage as for the preceding stage, a combined Record Card would be widely availed of in the case of children in the lower and middle income groups.

Examinations and Records

4.17 The mother would herself arrange with the general practitioner the date, time and place of periodic examination of her child. The clinical procedure for the examina-

tion would be similar to that in the clinics. The general practitioner would be expected to return the Record Card to the CMO so that

(*a*) the approval for the payment of the fee could be given by the CMO, and

(*b*) the CMO could initiate follow-up action to ascertain if the child had been brought for specialist investigation or treatment as advised by the examining doctor.

4.18 The CMO would be particularly concerned to ensure that children with handicapping conditions (or suspected handicap) were brought for early attention. The generally accepted categories of handicap* are: blind, partially-sighted, deaf, partially-deaf, physically handicapped, educationally subnormal, epileptic, delicate, maladjusted, speech defective. In the case of children in these categories (and, indeed other children referred for specialist attention) the CMO could encourage mothers to bring the child to the specialist. In this co-ordinating and follow-up capacity the, CMO is working towards the same objective as the general practitioner, viz. the welfare of the individual child. We believe that general practitioners would, in fact, accept the role of the CMO in this respect. We would consider it reasonable and desirable that general practitioners should make the results of specialist investigation available to the CMO for his information and vice versa. We recommend that, after the final periodic examination at 2 years, the CMO should retain the Record Card for association in due course with the School Health Service records.

Failure to Attend Periodic Examinations

4.19 Some mothers will not bring their child for a periodic examination. The CMO would become aware of such lapses on the part of mothers registered with general practitioners if the latter undertook to return the Record Cards within a certain interval, say, 2 months, after the due date for a periodic examination. Thus, if he did not receive the Card in a particular case within the agreed interval, the CMO would assume that the child had not been brought to the doctor. He could then arrange for the nurse to visit and advise the mother as appropriate. A procedure on these lines appears to be the only effective one which would permit the CMO to become aware of failure to bring children to the doctor and to organise follow-up action. The utmost co-operation from general practitioners would be required if the Service is to function effectively and if unnecessary visits by nurses to mothers in their homes are to be avoided.

General

Maternity and Infant Welfare Service

4.20 We have already recommended that a special 4–6 weeks scheduled medical examination be incorporated in the present Maternity and Infant Welfare Scheme for persons in the lower and middle income groups. We have included space for record-

*Defined in the Handicapped Pupils and Special Schools Regulations, 1959 and amending Regulations, 1962, HMSO.

ing the results of this examination in our draft Record Card. Where infants in clinic towns are concerned, it would be very desirable for the doctor providing the 6 month periodic examination in the clinic to have the child's medical history available. We therefore recommend that the general practitioners who provide Maternity and Infant Welfare Services in these towns should retain a copy of the maternity portion of the Record Card, and transmit the rest to the CMO's office some time before the 6 month clinic examination was due. In rural areas (and towns under 5,000 population) a similar procedure may be followed—not because the CMO would need the information for the 6 month examination, but to enable him to initiate any follow-up action required after the 4–6 weeks examination. In addition, payment to the general practitioner would be expedited. (See Paragraph 4.17.)

" At Risk " Register

4.21 Health authorities are at present establishing registers of children, who because of an unfavourable family history or an adverse pre- or post-natal influence, are likely to suffer from predictable defects, and are, therefore, considered to need special supervision. Arrangements for the examination of children on this "at risk" register could be made within the framework of the Child Welfare Service envisaged for towns and rural areas. These children would probably require more than the three examinations included in the proposed Child Welfare Scheme. We would hope to see the "at risk" register closely associated with the list of other children who require special attention following the periodic medical examinations.

Office of the Chief Medical Officer

4.22 The CMO and his office would have a major responsibility in administering the Child Welfare Service described. He would require adequate clerical staff to handle the communications with general practitioners, clinics and district nurses. In particular he would be responsible for

(*a*) organising and supervising the functioning of the clinics held in the clinic towns and the functioning of Child Welfare work in the smaller towns and rural areas;

(*b*) communicating with the district nurses as to newborn infants, and children not brought either for periodic examinations *or* for specialist investigation;

(*c*) notifying mothers that a periodic examination was due shortly for particular children;

(*d*) supplying Record Cards, and certifying them on return from general practitioners for payment purposes;

(*e*) arranging for specialist examinations and for the further assessment of certain handicapped children;

(*f*) ensuring that children on the "at risk" register were kept under review;

(*g*) statistics relating to the Service, and work emerging from them;

(*h*) general promotional and health education activities in connection with the Child Welfare Service.

CHAPTER 5.—DETAILED ORGANISATION OF THE SCHOOL HEALTH SERVICE

Introduction

5.1 The School Health Service which we envisage, comprises a comprehensive entrance examination for all children aged 6–7 years; a special selective examination of 9 year olds; the examination of any child at any other time where requested by parent, teacher, or nurse; finally, annual vision testing and, for certain groups, audiometric testing—both these tests to be done by a nurse.

School Health Team

5.2 Everyone directly concerned should work together for the health of the school child. Thus the School Medical Officer, the nurse, the teacher and the parent all contribute to the health of the child in school. They comprise what can be termed the *School Health Team.* Other specialised personnel must also be co-opted from time to time on to the team, e.g. educational psychologist, speech therapist, dental surgeon. One of the basic objectives is to ensure that the maximum information about each child from all sources—home, teacher, nurse, doctor— is available and effectively used.

Parents' Consent

5.3 The consent of the parents is necessary before any health examination of the child can be carried out. During a child's national school career, he would, under our proposals, have an annual vision test, an audiometric test once, and at least one medical examination, with a possibility of others. We recommend that the initial consent sought from the parents should cover all examinations by doctors and nurses under the School Health Service, with, of course, a provision that parents could opt out of the arrangement at any time. Such a blanket consent would obviate the necessity for distributing consent forms to parents in advance of each examination.

Visual and Audiometric

5.4 Vision tests (with and without glasses) would be undertaken annually, by the district nurse where available. On the same occasion she would also inspect the children for cleanliness and for postural defects. She would take note of any child in whom she suspected a physical or other defect, or who had been mentioned to her by the teacher, and she would bring these children to the attention of the School Medical Officer. We would hope that the nurse would develop a close acquaintance with the schools in her district and that she would visit them on a number of occasions each year.

5.5 Testing for hearing loss would be carried out by a nurse specially trained in audiometry who is usually attached to the CMO's office. The Department of Health have recommended that the following groups should be tested by audiometer:

(*a*) school entrants;

(*b*) children thought to be specially "at risk" in regard to defects of hearing;

(*c*) children of any age referred by doctors, teachers or parents as suspected cases of impaired hearing.

The practice among health authorities as to the groups tested shows much variation at present and we feel that closer adherence to the groups recommended for testing would be desirable.

Doctor's Visits

5.6 We recommend that the School Medical Officer should visit national schools at least once a year. (In very small schools—e.g. of less than 30 pupils—biennial visiting would suffice.) Ideally, given a selective examination system, the School Medical Officer should visit each school on a few occasions each year in order to examine selected children at the earliest possible stage and to maintain continuous medical supervision over the pupils. Frequent visiting also leads to closer relationships with the teachers and a better knowledge of the pupils. In existing circumstances where less than half the national schools are visited annually we feel that the recommendation of at least one visit each year is reasonable as an initial objective.

5.7 In the course of a medical inspection, the School Medical Officer would examine the following groups:—

(*a*) all children aged 6 years (i.e. those having the initial scheduled examination) and older children who have not had a previous examination;

(*b*) 9 year old children selected for examination following screening of all the children in this age group;

(*c*) any child of any age (e.g. 5 years, 10 years, 12 years) selected by the doctor as a result of a request by the parent, teacher or nurse;

(*d*) children who at a previous examination were noted for re-examination because of an actual or suspected defect.

Parents

5.8 The aim would be to have a special questionnaire completed by the parents for each child being examined. Such a questionnaire would seek information on the child's health condition as perceived by the parents, e.g. tendency to contract colds, sore throats, speech difficulties. We have designed a specimen questionnaire for this purpose

(Appendix 13). Questionnaires would be completed for *all* 9 year olds to aid the doctor in his selection of those needing examination; in the case of this age group and children who had a previous school medical examination, the information sought on the questionnaire would relate to a limited preceding period, e.g. one year. The extent to which parents will complete the questionnaires satisfactorily cannot be predicted. Experience where they are used at present suggests that parents do co-operate well. In city areas, where parent response may be less, extra efforts to stress the importance of the questionnaires may be necessary. The district nurse would encourage parents and visit the homes where questionnaires were not returned or were sent back incomplete.

5.9 A parallel aim would be to secure the maximum attendance of parents at School Health Examinations. Consultation between doctor and parent could elaborate on the replies to the questionnaire, or bring new information to light. In most areas the attendance of parents is very poor at present, and a firm effort to encourage higher attendances must be made.

5.10 The doctor would be accompanied by a public health nurse attached to the CMO's office. The appropriate district nurse should attend the school during his visit. Prior to any examination session, the doctor would consult with the teacher and the local nurse. The teacher would comment on any significant aspect of a child's behaviour, e.g. school attendance, class performance, relationship with other children, extreme attitudes. The district nurse would indicate any relevant information about the child's home background and any observations based on her visits to the school. The doctor would generally have available to him a completed questionnaire and previous medical records (from Child Welfare or School Health). With all this data he would have valuable information on children due for examination (e.g. children having the initial routine examination) and would select a proportion of the 9 year olds for examination.

The Examination

5.11 The School Medical Officer uses a School Health Record Card in the course of his examination. We have designed a specimen Card (Appendix 14) which would be suitable: it includes a more detailed classification of defects than is generally used at present, and provides space for recording the relevant comments of the parent, teacher and nurse. We consider 10 minutes a reasonable length of time for the examination. This would permit a more careful assessment and would allow for some discussion with the parent, if present. The time spent will of course vary from child to child. At present, the average duration is 5 minutes or less; it is insufficient and reflects the pressure on doctors. We have mentioned (Paragraph 5.10) the communication of information about pupils' behaviour, etc. by the teacher to the doctor. The flow of information should not, however, be one-way only: if the School Medical Officer finds a condition in a child which adversely affects the child's educational capacity he should inform the teacher so that allowance could be made for the child in the classroom. Thus, in the case of children with impaired hearing or visual defects, the teacher who was aware of the conditions could let the children sit at the front of the class where they would be better positioned to see the blackboard and hear the lessons.

School Facilities

5.12 The report on "Investment in Education" contains valuable information on facilities in national schools. The following table brings together the items most relevant to school medical examinations:—

TABLE 15.—FACILITIES IN NATIONAL SCHOOLS

Facilities	Percentage of all schools which have the facility specified in Col. 1	Percentage of schools *with 4 teachers or more* which have the facility specified in Col. 1
	%	%
Drinking water (in the school or on the school site)	47	95
Heating other than open fires ..	37	82
Electric Current	63	93
Principal's room	9	47
Staff Room	14	44

The facilities desirable for school medical examinations are lacking in many schools but particularly in the smaller schools—the main deficiency is the absence of a suitable room for examining the children. **We recommend that the needs of school medical examinations should be taken into account in the design of new schools.** We understand that new national schools will generally be of the 3–4 teacher size and upwards and that they will include a general purposes room. We have examined some typical plans for these schools and we are satisfied that ample accommodation (apart altogether from classrooms) would be available for school medical inspections. In addition, good sanitary and washing facilities, and central heating would be included in these schools.

The Teacher

5.13 In the School Health Service outlined, the teacher would play an important role. We believe that teachers are becoming more aware of the interdependence of health and education. As first hand observers of the child for a substantial portion of his active hours, they rank next to the parents as a source of information on matters relevant to his medical assessment. **We, therefore, recommend that a series of lectures by doctors and administrators on appropriate aspects of child health, on the School Health Service and on the teacher's role in the Service should be provided in Training Colleges for student teachers.** In particular, the type of defects where the teacher's comments are significant could be described. **We further recommend that serving teachers should also be made familiar with developments in the School Health Service and of their place in it.** We understand that the Department of Education would be prepared to co-operate fully in implementing these recommendations.

Schools Psychological Service

5.14 A schools psychological service staffed by educational psychologists would assist School Medical Officers in the ascertainment and initial assessment of educationally-retarded and mentally-handicapped children. Educational psychologists are at present employed by the Department of Education, but we understand that while the intention is to develop a psychological service for all schools, this is unlikely to become effective for some years. Accordingly, the School Medical Officer will continue to have the basic responsibility for the ascertainment and preliminary assessment of educational retardation and mental handicap in school children. His training should be such as to equip him for this. We note also that the Commission on Mental Handicap envisaged a basic school team comprising a School Medical Officer, a school psychologist and a social worker, for screening children with mental handicap. A committee has been established by the Minister for Education to investigate educational retardation in school children and to report on measures for their education. The findings of this Committee will be of considerable interest to the School Health Service.

Administrative Procedures

5.15 The selective examination system described assumes the operation of effective administrative procedures at the level of the school and in the CMO's office. We do not intend to specify in detail the procedures to be followed as considerable flexibility will be required, depending on local circumstances. We will consider the main requirements and possible ways of dealing with them.

5.16 Questionnaires to parents (and consent forms where appropriate) need to be distributed in advance of the doctor's visit, *viz.* for 6 year olds, 9 year olds, and for children due for re-examination or referred by the teacher, nurse or parent. At present the preparatory distribution of consent forms is variously carried out by the teacher, the nurse, or a clerical officer from the health authority. There is considerable advantage in the district nurse doing this work as she can assist the teacher in selecting children for examination and can obtain from the CMO's office details of children due for re-examination. If the teacher selects children on his or her own judgment, discretion will be needed to avoid any feeling of discrimination.

5.17 The School Medical Officer could endeavour to select and examine children during one visit to a school, which could, in large schools, occupy a few successive days or longer. Alternatively the initial visit to select children would precede the examinations by a fortnight or so. The latter procedure would allow advance notice to be given to the parents of the 9 year old children selected for examination and would allow the relevant medical records of the selected children to be extracted in the CMO's office.

The association of the Child Welfare Records with the appropriate school children will be a practical problem. The use of a code number at the Child Welfare stage based on the child's date of birth would help in this.

Dental Examinations

5.18 We have not considered the problems of the health authority dental service for children in detail because they have been intensively analysed in recent years by the Department of Health and the dental profession. At present, the dental condition of children in national schools is generally noted by the doctor in the course of School Medical Examinations, as health authorities have not enough dental surgeons to carry out the preliminary screening examinations. Our proposal to replace the Intermediate and Leavers school medical examinations by selective procedures would mean that children would only be assured of a routine dental examination at the entrance stage. However, since practically all children have dental defects, special routine screening examinations of the school population by School Medical Officers at regular intervals would not appear to be necessary or to justify the use of the doctors' time for this purpose.

An alternative would be to call the children direct for attention by a dental surgeon on an automatic basis, at regular intervals. The district nurse could assist in the follow-up of children failing to attend the dental surgeon.

Follow-Up of Children with Serious Disabilities

5.19 As soon as the School Medical Officer becomes aware that a child with a serious disability has left school, he should encourage the parents to have the child referred to a centre for assessment and treatment and, if appropriate, for training. Otherwise there is a danger that the child's further welfare may be neglected once he has left the educational system. (The CMO himself would, where necessary, make the arrangements for the referral of the child.)

Since detailed medical information on the child would be available to the CMO (from the School Health Service), it would be a pity if it were not used to advantage in the critical period when the handicapped child is trying to adapt to the adult world.

Conclusion

5.20 A selective procedure incorporating extensive consultation between different persons implies interdependence and full co-operation, if it is to succeed. The rewards of success in terms of child health would be substantial. The ability of the School Health Service in the past to win the confidence of school managers, teachers and parents augurs well for the future of such a service as we have described.

CHAPTER 6.—STAFFS AND SKILLS FOR THE CHILD WELFARE AND SCHOOL HEALTH SERVICES

Introduction

6.1 The doctor who deals with children needs a knowledge of developmental paediatrics which includes the physical, mental, emotional and social development of the normal child. He needs skill in the systematic undertaking of developmental tests and medical examinations, and practice in perceiving the child with deviations from the normal.

Assistant Chief Medical Officers

6.2 At present, 76 doctors (excluding CMOs) employed by health authorities undertake work in the Child Welfare Clinic and School Health Examination Services. Of these 69 are of ACMO rank, the remaining 7 being of special grades unique to the Dublin area. (Appendix 15—Table 2.) The majority of the doctors have a wide range of public health duties in addition to Child Welfare and School Health, e.g. infectious diseases, disability allowances, sanitation, food hygiene regulations. In Dublin and Cork cities, 10 and 2 doctors respectively are assigned wholetime to Child Welfare or School Health.

The qualifying conditions for entry to the ACMO grade are as follows: a recognised diploma in Public Health, Sanitary Science or State Medicine; a degree or diploma in Child Health, Paediatrics or diseases of children *or* at least six months satisfactory experience as house surgeon, house physician, resident medical officer, or analogous post in a children's hospital or department *or* other adequate experience or training in diseases of infants and children *or* adequate experience in a child welfare service; certain experience of T.B. treatment. In practice, all ACMOs possess the DPH while available information indicates that over half of them have the DCH.

During the last 3 years, 20 permanent posts were filled through the Local Appointments Commission. Seven of these posts were filled by women, of whom there are now 19 in the ACMO grade. As far as can be ascertained, only one ACMO resigned from the health authority service within the last 3 years. Other vacancies which arose were caused by retirements, or transfers to other areas. No general problem of recruitment to the ACMO grade is yet manifest.

The Future Needs

6.3 We have related the number of ACMOs available in each health authority area to:—the estimated numbers of children who would be eligible for the Child Welfare and School Health Services, the numbers of schools and the size of the area to be covered. The results (Appendix 15—Tables 3, 4, 5) indicate great variations as between health

authorities and a far from uniform capacity to provide the Services. Differences in the proportion of time which doctors spend on general public health activities also affect the manpower available for the child health services.

6.4 The task facing ACMOs can be summarised by stating that they would be responsible, *firstly*, under the Child Welfare Service for some 80,000 children up to 2 years of age (in at least 33 towns with a population of 5,000 each and over) and, *secondly* for providing the School Health Services for about 475,000 children in 4,800 national schools. At present about 150,000 children (say one-third of the total) are examined annually by the School Health Examination Service and about 2,300 schools (about one-half of the total) are visited during the year.

We estimate that up to 80,000 individual medical examinations under Child Welfare (assuming maximum response) and at least 100,000 in the schools might need to be carried out by ACMOs employed by health authorities under the revised Services we envisage. The requirement of at least an annual visit to about 4,200 schools of more than 25–30 pupils, and visits biennially to about 600 smaller schools underlines the challenge presented, when one remembers that no more than 2,300 of the 4,800 national schools are visited in a year under the present system. Even if schools with less than 50 pupils are visited only every 2 years, a total of 3,900 schools would still have to be covered in a particular year.

6.5 We assessed the total number of doctors required. We feel that an examination in the pre-school stage would occupy 15 minutes, and at school 10 minutes (re-examinations would take less time) and we assumed that about *two-thirds* of the ACMO's working time would be devoted to the two Services. It would be reasonable to expect an ACMO to complete the necessary procedures in a school of 75 pupils during a single day as only a minority would be medically examined at each visit. Taking these factors into account, we estimate that on the basis of the present school population the number of ACMOs required would be in the range of 70–90. Given the fact that the present distribution between health authorities is somewhat uneven, the number needed would most probably be close to 90, on the important assumption that two-thirds of the doctor's time would be available for the Child Welfare and School Health Services. This estimate is given with some reserve because only informed guesses can be made about the time which the selective procedures would occupy.

Experience abroad suggests that the system is initially very time-consuming but as experience is acquired in operating it, the time declines. An increase in the school population would require an increase *pro tanto* in the staff of ACMOs.

Availability of ACMOs

6.6 If the DPH is to remain an essential qualification for an ACMO some idea of the future availability of entrants could be obtained from the numbers taking it. Figures furnished by University College, Dublin indicate the trend in recent years:—

TABLE 16.—NUMBERS TAKING THE DPH

Academic Session	Obtained DPH	Likely to work in Ireland
1963–64	12	3
1964–65	8	3
1965–66	5	2
1966–67	6	3

The DPH is unusual as a post-graduate medical qualification in that it requires whole-time attendance for about 9 months, during which the candidate has to maintain himself and pay fees with, at the best, only nominal opportunity of practising his profession. These requirements are not conducive to attracting candidates for the Diploma and must be substantially responsible for the small numbers taking the course and likely to work in Ireland.

ACMO Qualifications

6.7 The DPH has, of course, been a useful aid to doctors entering the public health field, although little training in medical administration has been included in the syllabus. The DCH is more relevant to child welfare and school health. The latter has, however, tended to have a clinical bias and from the point of view of the ACMO the syllabus is somewhat lacking in social and developmental paediatrics. We recognise that the DCH is orientated also towards the needs of doctors in private practice and that modifications in the syllabus to accommodate public health needs might not be practicable. In considering the qualifications of the ACMO we were conscious of the fact that CMOs are normally recruited from among ACMOs and that candidates for CMO are expected to have a knowledge of public health matters such as are included in the present DPH.

6.8 In view of the decline in numbers taking the DPH and the need for greater concentration on child development **we recommend that**

(*a*) **The Diploma in Child Health be substituted for the Diploma in Public Health as an essential qualification for ACMOs.**

(*b*) **A special in-service course be provided (for new entrants to ACMO posts) which would comprise social and developmental paediatrics, and certain public health material covered by the present DPH.**

In making these recommendations we are conscious that as matters stand, a doctor, entering the public service would be ineligible to compete for a CMO post, unless he possessed a diploma or degree in Public Health, Sanitary Science or State medicine.

Courses for Existing ACMOs

6.9 If our proposals for revised Child Welfare and School Health Services are accepted, we recommend that existing ACMOs be given refresher courses. The courses should be organised in conjunction with the Universities and the Children's Hospitals. Courses of about 4–6 weeks duration covering the following are visualised:—

(1) Clinical paediatrics, especially for doctors without the DCH, or who have held the DCH for five years and over;

(2) Developmental paediatrics;

(3) Mental handicap and its assessment;

(4) Statistics, morbidity and services relating to child health.

The sections of the course would be taken at intervals to avoid disturbance of the Services. Courses on these lines are being organised increasingly in Britain.

6.10 We also recommend that women doctors with a DCH who are married, should be permitted to provide services on the basis of a temporary appointment. Where such qualified doctors are available, their employment would be a valuable addition to the Child Welfare and School Health Services.

6.11 The Study Group believe that revised child health services as proposed, based on clear objectives, using medical and nursing time efficiently and involving close consultation with those intimately concerned with the welfare of the child would increase considerably the satisfaction derived by the doctor from his work, aside from the primary result of better service for the children. The reduction in the routine examinations of healthy school children would contribute particularly to this.

The proportion of the ACMO's time available for these services should be about two-thirds of his effective working time and should not be regarded as reducible at will when other responsibilities arise. It is, unhappily, too often the case that child welfare and school health work are the first to suffer when pressure on staff arises. The achievement of proper staffing standards is, therefore, a necessary precondition of satisfactory services for children.

A joint ACMO appointment by two health authorities may be advisable where neither authority has an area which would justify a whole-time appointment.

6.12 Much of an ACMO's time outside city areas is spent on travelling to schools. We recommend that there should be more flexibility in setting the hours of duty of an ACMO. Thus, if he wished to arrive at a school at 9.30 a.m.–10 a.m. and if the journey

took one hour by car, 9.00 a.m. or earlier would be more appropriate than 9.30 a.m. as his hour of commencing duty. The school day is relatively short, and flexibility in the ACMO's hours of duty would allow him to make full use of it.

General Practitioners

6.13 It would be highly desirable that general practitioners participating in the Child Welfare Service should be fully acquainted with the techniques necessary for the periodic examinations. Short refresher courses, seminars and lectures would be useful for this purpose. We recommend that the co-operation of the medical profession be sought in order to increase awareness of developmental paediatrics among general practitioners participating in the proposed Child Welfare Service outside of clinic towns.

Nurses

6.14 The availability of public health nurses and nurses employed by voluntary nursing agencies varies enormously as between health authorities. A major scheme which aims to double the number of district nurses was commenced in 1966. We understand that the special six month training courses provided by An Bórd Altranais since October, 1966 are being well supported by health authorities who have readily sent candidates forward. By March, 1968 the courses will have been operating for 17 months and some 140 nurses will have completed them. The target of doubling the nurses on public health and district duties is likely to be achieved within the next few years.

6.15 We recommend that one public health nurse in the CMO's office be assigned to each ACMO to assist him in his visits to national schools.

CHAPTER 7.—TREATMENT: FACILITIES AND ELIGIBILITY

Treatment Facilities

Introduction

7.1 This chapter examines the adequacy of the facilities available for the specialist treatment of children referred from the Child Welfare or School Health Services, and the eligibility of children in national school for free treatment.

An improved Child Welfare Service with national coverage, and a more effective School Health Service should result in greater numbers of children being referred for specialist investigation. We find it difficult to make reliable estimates of the out-patient facilities required in different areas to match this expected demand. The approach we have adopted is to assess

(*a*) the capacity of out-patient clinics to deal with current demand, and

(*b*) the possibility of expanding clinic facilities to meet growing needs.

Paediatric Out-Patient Facilities

7.2 Eight paediatricians hold specialist out-patient clinics in areas outside Dublin under arrangements with the health authorities. Four of these reside in the provinces (Cork, Limerick, Galway, Drogheda) and the remaining four, who live in Dublin, operate as visiting paediatricians to the areas to which they are attached. In the Dublin area some 22 paediatricians hold clinics. Two health authorities have no arrangements for paediatric clinics within their areas. In April, 1966 we sought information from all health authorities on the frequency of clinic sessions, sources of referral and waiting lists. The results of this survey are at Appendix 16.

Results of Paediatric Survey

7.3. Referral to the clinic had, in most cases, been from the general practitioner. Some of these patients would have previously been referred by the Child Welfare or School Health Service to the general practitioner for further attention. The waiting list position was generally good, and in the majority of areas those on it would be seen within a month. In a few western areas, the position was not satisfactory, e.g. average waiting periods of 2 years, 4–5 months, 3 months.

7.4 One index of the adequacy of paediatric "cover" in any area is the child population aged 0–14 years divided by the number of paediatric clinics held per month. Using

this index we found great variation in the paediatric facilities, e.g. Carlow has 5,500 children, Clare has 10,700, Mayo, 19,000 and Kerry 34,000 children per monthly clinic. These variations are only to some extent reflected in waiting lists, since they are indicators of the potential rather than actual demands on the clinics. The demands made on paediatric facilities are likely to grow, particularly in areas whose ratio of child population to clinics is relatively high at present.

7.5 The number of paediatric clinics should be increased so that all children should be seen within a month or so. We recommend that additional clinics should be provided in order to achieve one monthly clinic for each 7,000 children aged 0-14 years.

7.6. The development of paediatric clinics has led to a better assessment of disorders in children. The clinics are widely appreciated by doctors in private practice and in the public health service. Improved Child Welfare and School Health Services would undoubtedly increase the flow of children to clinics. It is, therefore, imperative that the systematic development of paediatric clinic facilities to the level recommended should be initiated at an early stage.

We considered the residential location of specialists to provide paediatric clinics but we could not reach unanimity in the matter.

Two opinions were advanced: one, that they should be confined to the existing hospital centres, Dublin, Cork, Limerick, Galway and Drogheda and attend in other areas from these centres; the other, that subsidiary paediatric hospital centres be established in Sligo and Waterford.

Ear, Nose and Throat (ENT)

7.7 Health Authorities engage ENT surgeons to hold out-patient clinics for adults and children. Children are referred for assessment of tonsils and adenoids, hearing defects, certain infective conditions etc. We obtained detailed information from health authorities about these clinics (Appendix 17).

7.8 The ENT clinic situation is at present very unsatisfactory. In seven areas, no consultant is available and children are referred to Dublin hospitals; the service provided in eight other areas appears unsatisfactory, mainly because of long waiting lists, while in the remaining areas the service seems satisfactory. Examples of the time to clear waiting lists in some centres which have a service are as follows: 1½—2 years in one county; 4—5 months in five counties. Two areas (Mayo, Cavan) have not succeeded in obtaining an ENT consultant to provide clinics while in some areas the existing consultant is unable to increase the number of clinics because of his commitments.

7.9 Two basic causes of the present position are the scarcity of ENT consultants and the high rate of referrals. Many of the children and adults attending the clinics could appropriately be dealt with by a general practitioner.

7.10 Children ascertained by audiometric testing as having a suspected hearing loss should be seen by the CMO before referral to the ENT clinic.

7.11 We consider that the ENT clinic service is unsatisfactory, that clinics are urgently needed in areas which have none at present, and that the provision of extra clinics in areas with long waiting lists is required.

Tonsillectomy

7.12 The School Health Survey showed the proportion of children examined who were referred direct to hospital for tonsillectomy or who were referred to the ENT specialist for his opinion. (Appendix 18). There is little uniformity in the practice of health authorities. For instance in one county, all children with tonsils and adenoids were referred direct to hospital for tonsillectomy while in two counties, all children with tonsils and adenoids were referred to the specialist for his opinion.

7.13. We feel that more uniformity in the practice of referring children for the investigation or removal of tonsils or adenoids would be desirable. **We recommend that School Medical Officers should not refer children direct to hospital for tonsillectomy, except where the reasons are compelling.** Cases appropriate to the general practitioner should be referred to him rather than the ENT clinic.

Our views on tonsillectomy are supported by medical opinion in other countries which is now tending to question the advisability of tonsillectomy in many cases. For example, the following statement appeared in a recent issue of the Journal of the American Medical Association:—*

> The indications for tonsillectomy have become fewer and fewer in recent years as physicians have developed increasing agreement with a British view that "tonsillectomy is usually done for no particular reason and with no particular result".

Ophthalmic Facilities

7.14 Ophthalmic surgeons are employed on a part-time basis by most health authorities and provide a service (which includes the prescribing of spectacles when necessary) for children referred from Child Welfare Clinics or School Health Examinations. In Dublin and Cork, the ophthalmic clinics at the out-patient departments of the voluntary hospitals provide a similar service.

**JAMA*, June 19th, 1967—Vol. 200, No. 12, page 1138.

7.15 A detailed review of the ophthalmic services was recently completed by the Ophthalmic Medical Officer of the Department of Health. Long waiting lists had arisen in a few counties but we understand that the Department has advised the health authorities concerned to arrange for extra clinics to reduce the waiting period to a few weeks. Recommendations made by the Ophthalmic Medical Officer included:— an adequately equipped central clinic in each county; the introduction of an appointments system at clinics; changing from the present contract system of supplying spectacles to one based more on personal service; extension of the orthoptic service for the treatment of squint; more routine ophthalmic surgery at regional level; minor ophthalmic surgery at local level and greater utilisation of ophthalmic beds at Limerick Regional Hospital, and Ardkeen Hospital, Waterford.

7.16 We fully support these recommendations for the improvement of the ophthalmic service, which affects so many children. The improvement of the clinic facilities and of the method of supplying spectacles are priorities.

7.17 The Ophthalmic Medical Officer was not in favour of the capitation rate system of payment for ophthalmologists as in some counties excessive numbers of children are seen at a clinic. A three hour clinic should, in his view, deal with 15—18 children and when this limit is exceeded (as is often the case at present) essential tests may not be carried out. The capitation system has a built-in incentive for the ophthalmologist to deal with large numbers of children at a clinic and to recall children somewhat too frequently. Its main advantage is that the large numbers of children referred to the clinics are seen at a much earlier date than would occur under a sessional basis of payment. If the clinic has a dispensing optician present to measure children for spectacle frames and a nurse to marshal them, the ophthalmologist will be able to concentrate on examining the children who come before him. If a nurse is trained to record the visual acuity of children on arrival at the clinic, the ophthalmologist can devote more of his time to specialist examination.

7.18 One alternative to the capitation rate is a fixed remuneration for each clinic session, (*i.e.*, sessional method). The sessional method of payment guarantees a certain remuneration irrespective of the numbers seen during the session. It enables the ophthalmologist to give all the attention needed to a particular child and is more conducive to high standards of examination. Nevertheless, given the volume of referrals to clinics, long waiting lists would probably occur if all the existing clinics were operated on a sessional basis since the numbers dealt with would fall. Other arguments against the sessional system are—

(*a*) Much less than the optimum number of children may be seen at a session.

(*b*) Some of the children called to the clinic fail to keep the appointment.

(*c*) The sessional payment may be inadequate to compensate for the time which the ophthalmologist has spent in travelling to the clinic.

There are thus merits in both systems and two views were expressed during the Study Group's deliberations: one, that only under the sessional method will children receive a proper ophthalmic examination; the other, that the capitation system taken in conjunction with good organisation at the clinic could deal with large numbers at a satisfactory level of examination.

7.19 **In general we feel that the payment of a fixed remuneration for each session offers a better chance of comprehensive ophthalmic examination for the child.** We recognise that there would be practical difficulties in adopting this method universally, *viz.*, long waiting lists would occur because of the lesser numbers seen at clinics, especially as ophthalmologists might be reluctant to increase the number of clinics; ophthalmologists at present operating clinics under the capitation system would be likely to oppose a changeover to a sessional system. We recommend, however, that the capitation system should not be extended to areas where the sessional arrangements now operate and that where an ophthalmologist ceases to provide a clinic, the sessional basis of payment should be retained or introduced in any new arrangements.

Speech Therapy

7.20 The potential demand for speech therapy is high. The School Health Survey indicates that the total incidence of speech defect per 1,000 children examined during the Survey was 18·5, of which 9·1 were referred for specialist investigation or treatment. Speech therapy facilities are available in a few of the Children's Hospitals in Dublin; elsewhere a number of clinics are held by speech therapists who travel from Dublin. The present service is extremely limited, because of the lack of qualified speech therapists in Ireland. Health authorities have decided to establish 8 posts of regional speech therapists. The posts were advertised recently, at a salary scale similar to the British one, but no qualified candidate applied. **The limited speech therapy facilities available are a grave lack in the present range of treatment facilities for children. We recommend that their development should be pursued vigorously.** If qualified candidates cannot be attracted, a scholarship scheme to send suitable Irish girls to speech therapy colleges in Britain for training should be inaugurated.

Mental Illness

7.21 The facilities available for psychiatric treatment for children, and child guidance will be of vital importance, if the Child Welfare and School Health Services become effective in ascertaining psychological disorder. The recent report of the Commission on Mental Illness will presumably have a major influence on the development of child psychiatric services.

7.22 The Commission envisage that a child would be referred from the Child Welfare or School Health Service to a district child psychiatric clinic staffed by a psychologist, a psychiatrist with a minimum experience of one year in child psychiatry, and a social

worker. Complex cases would need to be referred to a regional child psychiatric clinic staffed by a fully qualified child psychiatrist, a psychologist, and a social worker. The regional clinic would consult where necessary with other specialists (e.g., paediatricians) and a wide range of ancillary staff (e.g., speech therapists).

7.23 Since the Child Welfare and School Health Services would be referring children (with the consent of the family doctor) to the district child psychiatric clinic, close links between these Services and the clinics would be desirable. We feel that the district nurse would be an important link between the home, the district clinic and the public health services. Her knowledge of home and school backgrounds would be a valuable source of information to the psychiatrist in the clinic.

7.24 We welcome the report of the Commission on Mental Illness; the practical development of district and regional child psychiatric services will be of the utmost benefit to the work of the Child Welfare and School Health Services. The greatest scope for better ascertainment by these two Services is, in fact, in the field of psychological disorder.

Mental Handicap

7.25 The recent report of the Commission on Mental Handicap recommended that each health authority make available a diagnostic, assessment and advisory service to cater for the mentally handicapped at the earliest possible stage. It envisaged that *school teams* comprising the School Medical Officer, a school psychologist and a social worker would deal with mental handicap, as manifested within the school. The school team would refer some children direct to special day schools and classes. Cases of doubt or difficulty, cases in need of residential care, and cases where the parents wanted a second opinion would be referred to general teams appointed by voluntary bodies and consisting of a psychiatrist, a psychologist and a social worker.

7.26 We agree in principle with these recommendations. It is likely, however, that it will be some considerable time before educational psychologists and social workers become available in sufficient numbers to enable school teams to screen the national school population for mental handicap. At present the School Medical Officer is the only member of the projected team widely available, and he will be supported to an increasing extent by district nurses.

7.27 If the proposals of the Commissions on Mental Handicap and Mental Illness are implemented, we see some danger of duplication and lack of liaison, if psychologists and social workers are to be members of the separate teams recommended by each of these Commissions. We recommend that the role of the nurse on district duties, as the link between the homes in her district and the health services, should be specifically

recognised. The plan, now well under way, to double the number of district nurses within the next few years would permit the individual nurse to make a real contribution to the mental illness and mental handicap services.

General

7.28 Good out-patient specialist services are needed if the Child Welfare and School Health Services are to function effectively. One of the main aims of the latter Services is to ensure that treatment is provided as early as possible for defects discovered in children. In many cases this will involve reference to a specialist for advice, active treatment, and continuing supervision. If the appropriate care at specialist level is not forthcoming, or is not available for perhaps a long time, the child's health may deteriorate, the possibility of his condition being remedied may be seriously jeopardised, and the burden of the parents' worry about the child will be increased. Moreover, the doctor and the nurse who see the child initially will become discouraged, and the repute of the Services as a whole will suffer. Two factors will tend to increase the demand for specialist facilities:

1. A higher volume of referrals for specialist attention from the comprehensive pre-school health service, and the more effective School Health Service which we have proposed. In particular, referrals of children for psychological or behaviour disorders would be expected to increase considerably.
2. Population projections suggest that the child population (aged 0—14 years) will continue to increase. Currently accepted estimates indicate an increase of 12% in the period 1966–76; the group under 5 years of age would, on this estimate, increase by about 20% while those aged 5 to 14 years would rise by 8%. Increases of this magnitude would create a greater demand within the next ten years for health services, particularly for the pre-school group.

We strongly recommend, therefore, that all necessary steps be taken promptly to improve the out-patient specialist facilities where they are deficient, and that these services should be maintained in a high state of efficiency. The dividends from doing this would be out of all proportion to the effort and cost involved.

7.29 We found it difficult to foresee the influence which our recommendations would have on the future demand for hospital in-patient facilities for children. The expected increase in the child population together with the likely regional population distribution, should be considered in hospital planning.

Eligibility For Treatment

Present Eligibility

7.30 Treatment can legally be provided, free of charge, under the Child Welfare Clinic and School Health Examination Services only if the defect was *discovered at an*

examination conducted by these Services. Eligibility for free treatment for defects discovered under both Services may be summarised as follows:

(*a*) *Institutional and specialist services:* These services are provided free of charge in respect of defects discovered at school health examinations only.

(*b*) *Dental, Ophthalmic and Aural treatment and appliances:* Out-patient treatment and appliances are given free of charge under both the Child Welfare and the School Health Services for defects discovered at examinations under the Services.

Eligibility for free institutional treatment for dental, ophthalmic and aural defects under the Child Welfare Service is not however specifically defined in the legislation and the practice in deciding eligibility varies among health authorities.

The major difference between the Child Welfare and School Health Services is the lack of free institutional and specialist services for the general range of defects which are discovered at the child welfare examinations. Children availing of either Service are not however entitled to medicines and appliances (apart from dental, ophthalmic and aural appliances) as part of the out-patient specialist services provided.

7.31 As regards the School Health Service, the legal requirements to have a defect "discovered" have been modified by well-established practice so that free treatment is provided if the School Medical Officer has "noticed" it at a school medical examination. This surmounts the difficulty of establishing the "discoverer" e.g., the parents of a mildly mentally-handicapped child would in all likelihood be aware of the handicap, but the strict application of the law could exclude the child from free treatment, since the School Medical Officer would not have "discovered" the handicap in such a case. Traditionally, defects of the teeth, eyes, ears and nose have been a major concern of both the Child Welfare and the School Health Services. There is a long-standing practice of free treatment for those defects in some areas, where the health authorities regard any pre-school child or child attending national school as automatically eligible for free dental, ophthalmic or aural treatment and do not require discovery or notice at an examination under the Services as a condition of entitlement.

Anomalies

7.32 Two major disadvantages are inherent in the present provisions.

Firstly, the existence of a more comprehensive range of legal entitlements to free treatment at the school stage rather than in the, at least equally-important, preceding pre-school period is in conflict with the accepted ideal of discovery and treatment of defects as early as possible. Thus, the lack of free institutional and specialist treatment in the pre-school period may result in treatment being deferred until the child goes to national school, at which stage he enters into eligibility for treatment without charge.

We consider that there are no logical grounds for this disparity between the eligibility provisions of the two Services, and that by militating against early discovery and treatment, these provisions are, in effect, a barrier to good health practice.

Secondly, the legal restriction of eligibility under the School Health Service to defects *discovered or noted at examinations* means that urgent treatment of defects which first come to notice *between school health examinations* or during school holidays has to be paid for by the parents. As the intervals between school medicals are generally 2—3 years long, cases of this nature arise frequently, and parents feel aggrieved when the School Health Service will not accept responsibility for treatment. If, on the other hand School Medical Officers were able to visit schools every year, the chances of a defect coming to the timely attention of the school doctor would be higher.

7.33 The purpose of the School Health Examination Service as embodied in legislation is to discover health defects in school children and to provide free treatment for these defects. The Service was not originally intended to serve as a *comprehensive* treatment service for *all* ailments in school-going children. However, the problems arising from the restriction of treatment to defects discovered or noted at a school medical examination, and the growing public demand for comprehensive free treatment for school children, has resulted in much criticism of the present arrangements under the School Health Examination Service.

Desirable Features

7.34 We consider that arrangements for the treatment of defects in pre-school and national school children should incorporate the following features :

(1) The present provisions for free treatment under the pre-school health service should be extended so as to offer at least as much inducement to parents to have a child treated, as a School Health Service would offer. Equal eligibility for both pre-school and school children would remove any temptation to defer treatment. Treatment at the earliest possible age is so desirable that a case could, in fact, be argued for providing more attractive treatment facilities under the Child Welfare Service than under the service for school-children.

(2) The apparent anomalies created by making free treatment conditional on discovery or notice at a particular examination, should be reduced as far as possible.

(3) The principles underlying the Child Welfare and School Health Services should harmonise with those applying to the entire public health services. Entitlement for hospital and specialist services is normally related to a person's income group but departures from this principle are specifically made for certain purposes, e.g., the promotion of community health through vaccination.

Proposals

7.35 Universally free specialist and hospital treatment for all children up to 14 years of age, irrespective of the parent's income and covering all defects at all times, would undoubtedly overcome many of the difficulties inherent in the present scheme. A universal scheme would, however, encroach unduly on the existing field of private medical practice with possible detrimental effects on the standard of medicine (particularly paediatric care), and could not be easily justified in view of the general principle of "ability to pay" which underlines the health services. We would stress that the purely *preventive* aspect of the proposed Child Welfare and School Health Services (*i.e.*, medical examinations in clinics, surgeries and schools) would be free of charge to all income groups.

7.36 We now outline our proposals concerning the eligibility of pre-school and national school children for medical treatment. Eligibility for the free services proposed, apart from the scheme for specified long-term defects, would depend on the parents opting for the Child Welfare and School Health Examination Services, and the child participating satisfactorily in the Services. This qualification is discussed in Paragraph 7.37.

It should be borne in mind that children whose parents are in the lower income group (holders of medical cards) are already entitled to completely free treatment.

(1) IN-PATIENT HOSPITAL CARE : The daily hospital charge of up to 10/- in a public ward would be waived for both pre-school children and pupils of national schools in the middle income group, irrespective of where the defect was discovered. The higher income group would be responsible for making their own arrangements for the hospital care of children in these categories.

COMMENT: Waiver of the 10/- daily hospital charge would permit eligible children of the *middle income group* to obtain completely free institutional care for defects whether discovered under the Child Welfare and School Health Services or not. The distinction between discovery at a particular examination and elsewhere would be eliminated. Any element of hardship at present involved in the payment of public ward charges in respect of hospital treatment for children would be removed.

Except in respect of institutional care for certain long-term defects, we recommend that higher income group parents should be responsible for hospital treatment for defects in their children which are discovered at school health examinations, or elsewhere. As noted already, such parents have never been eligible for free hospital treatment for their children's defects as a result of discovery under the Child Welfare Service.

This recommendation should not involve any appreciable hardship since we understand that the vast majority of higher income group persons would be covered by

Voluntary Health Insurance, and since additional cover for any uninsured children should not impose an undue burden.

The premiums for Voluntary Health Insurance cover hospital in-patient treatment for a period of 30 weeks. We understand that, apart from certain long-term conditions, very few children have to remain in hospital longer than 30 weeks.

(2) LONG-TERM DEFECTS.

Out-patient specialist services and institutional treatment for long-term defects specified by the Minister for Health would be automatically free of charge for all children. Examples of the defects which might be specified are : mental handicap, cystic fibrosis, haemophilia, diabetes, phenylketonuria and other inborn errors of metabolism. Other long-term (or recurring) defects could from time to time be added by the Minister to the specified list.

COMMENT: All children whether they participated in the Child Welfare or School Health Services or not, would be eligible. The out-patient specialist service and in-patient hospital treatment would be free to children of all income groups irrespective of where the defect was discovered. The specified defects would be of a kind normally excluded from Voluntary Health Insurance.

It is difficult to make provision in our recommendations for all possible cases of hardship. For example, there may be some persons in the higher income group who, for one reason or another, may not be covered by Voluntary Health Insurance; a particular child may have a defect which is excluded from cover by the Voluntary Health Insurance Board and which is not on the specified list recommended above. We consider that such cases may be covered by a sympathetic interpretation by health authorities of the "hardship" clause under Section 15 of the Health Act, 1953.

Drugs and medicines for out-patients with the specified defects could be satisfactorily covered as follows:

Middle income group: The White Paper on the Health Services (1966) envisages a scheme whereby middle income group persons could obtain assistance from the health authority, if their expenditure on drugs and medicines exceeded a certain specified level in a fixed period. The person being assisted would pay part of the cost of the items.

Higher income group: Persons in this income group can be assisted by the health authority if the burden of the cost of drugs and medicines imposes hardship.

(3) OUT-PATIENT SPECIALIST SERVICES.

Apart from the specified long-term defects, specialist out-patient treatment would be provided free of charge for both pre-school children and pupils of national schools in the higher income group, if referred to the specialist through the School Health Service (as at present) or through the Child Welfare Service, in respect of defects noted at examinations under these Services.

COMMENT: Specialist out-patient charges for middle income group persons and their children will be abolished in any event under the Government's proposals in the recent White Paper on the Health Services. Our proposals would retain the present eligibility for specialist out-patient services of higher income group *national school* children and *extend* it to cover, for the first time, children of this income group when using the Child Welfare Service. This would equate the pre-school and school facilities so far as concerns eligibility for free out-patient specialist services. The examining doctor would then be able to make arrangements for specialist investigation since the child would be eligible for free specialist services.

Furthermore, outside the cities, specialist facilities (other than health authority clinics) are often not available within a convenient distance. If higher income group children were not eligible to attend health authority clinics following the discovery or noting of a defect at a child welfare or school health examination, the parents might be very reluctant to bring the child, (under a private arrangement) to a specialist who was a good distance away. The more frequent medical examinations envisaged under the proposed Services would overcome, to some extent, the difficulties which might arise under our proposals where referral would depend on the defect being noted at an examination. We examined two alternatives to our proposal:

(*a*) *Abolition of the right of higher income group children* to a free out-patient specialist service if a defect is discovered or noted at a school medical examination *i.e.*, abolition of present entitlement, or

(*b*) *entitlement to free out-patient specialist services in all circumstances* for pre-school and national school children in the higher income group.

We did not consider either of these alternatives to be acceptable.

(4) DENTAL, OPHTHALMIC AND AURAL SERVICES.

Pre-school and national school children of all income groups would, irrespective of the place or time of discovery, be entitled to free dental, ophthalmic and aural treatment and appliances. Aural treatment would refer to hearing defects only.

COMMENT: The proposal is to remove the restriction on the need to have the defect discovered at a particular examination. We recommend putting these three services in particular on a comprehensive basis for children of all income groups because of the high frequency of visual, dental and hearing defects and their critical importance in the educational development of national school children. At present, the vast majority of children needing ophthalmic examination, glasses or hearing aids obtain them through the Child Welfare or School Health Services.

In-patient hospital treatment for tonsils and adenoids would depend on the child's general eligibility for in-patient hospital care as proposed at (1) above.

The improved examination services which we have already recommended would probably detect nearly all dental, ophthalmic, and hearing defects, so that terminating the need to have these defects noted at a particular examination would probably mean little actual difference. Our proposal would, however, cover any case of these three defects which came to the notice of a child or parent between examinations, particularly in the interval between the last scheduled child welfare examination at 2 years and the initial school medical examination. We realise that the public dental service is unable to cope with the present demands on it. Our proposal to extend eligibility represents, for this service, a long-term aim. The proposed extension might result in a loss of some private practice by ophthalmic surgeons, opticians and dentists. We would expect these professions, however, to gain a *quid pro quo* following the extension of the dental, ophthalmic and aural services to the middle income group, as contemplated in the recent White Paper on the Health Services.

Opting for the Services

7.37 The ascertainment of defect must precede treatment. Preventive medical examinations are so important that some inducement to seek them should be built into the Child Welfare and School Health Examination Services. Our proposals would liberalise eligibility for the treatment of dental, ophthalmic and hearing defects, for the treatment of certain long-term defects for all children and for hospital care for middle income group children, since the defects would not have to be noted at examinations under the Services in question. This may reduce the incentive to have a child examined under the Child Welfare or School Health Services since treatment would be free in any event. We feel that if parents are to benefit from extended eligibility for free treatment, they should in return be expected to co-operate with the child health services. **Consequently we recommend that eligibility for the free treatment should depend on the parents opting for the Child Welfare Service and, later, for the School Health Service, and availing of the examinations offered under these Services.** In some instances, a parent might be unable to bring a child for a particular periodic medical examination; the CMO would have discretion in such a case to allow the child to remain within the scheme for free treatment.

7.38 In Norway, a somewhat similar procedure operates in relation to the dental service provided by local authorities. Parents are required to opt for the service and must agree to have the child attend regularly at the clinic for dental examinations, if they wish to obtain free dental treatment. If they opt for the scheme, and if the child fails to attend the clinic when required, the child will not be permitted to re-join the dental scheme unless it is made dentally fit.

7.39 Out-patient specialist and hospital treatment for specified long term defects would be free for all children and would not depend on the parents opting to participate in the Child Welfare and School Health Examination Services. We propose automatic eligibility for these defects because treatment of them can impose a heavy burden on any income group.

7.40 The need to opt which we propose does not, we feel, conflict with any parental rights, as parents would still be free to make a choice, and would not be compelled to submit the child for medical examinations.

Review of Proposals

7.41 The set of eligibility provisions we have proposed are designed to reconcile in a reasonable manner three potentially conflicting factors *viz.*,

(1) the demand by parents for more generous facilities;

(2) the interests of the medical profession, and

(3) the form which the existing structure of the public health services has taken.

We were guided towards our conclusions by the fact that we were endeavouring to adapt the existing schemes of free treatment to modern requirements in reasonable fashion, rather than to construct with a free hand a completely new scheme. We feel that our proposals represent a reasonable balance of these considerations.

(In Paragraphs 7.42 and 7.43 it is assumed that the children participate satisfactorily in the medical examinations offered under the Child Welfare and School Health Services).

7.42 The children in the *middle income group* would gain free hospital treatment in the pre-school period irrespective of where or by whom a defect is discovered; their present eligibility for hospital facilities under the School Health Service would be widened to include defects coming to notice outside of school health examinations. Their present entitlement to treatment for dental, ophthalmic and hearing defects would also be widened—so that they will be eligible for treatment at all times in the pre-school and national school stages. (The White Paper on the Health Services also envisages the abolition of all out-patient specialist charges). For specified long term defects, institutional treatment would be automatically free of charge irrespective of whether the parents had opted to have the child participate in the Child Welfare or School Health Services.

7.43 Children in the *higher income group* would gain free out-patient specialist treatment in respect of defects noted at child welfare examinations. They would also be entitled to free treatment for dental, ophthalmic and hearing defects at all times in the pre-school and national school stages, irrespective of where or by whom the defect was noted. For specified long-term defects (e.g., mental handicap) they would automatically be entitled to free out-patient specialist and institutional care: at present such eligibility would depend on discovery at a school health examination, and is not available under the pre-school service. (The "hardship" clause is at present used in some cases to meet institutional expenses of higher income group children).

ELIGIBILITY FOR TREATMENT FACILITIES : COMPARISON OF EXISTING AND PROPOSED PROVISIONS

Item	Income Group	Present Provisions	Proposed Provisions	Comments
1. Long term defects (In-patient hospital care and Out-patient specialist services).	Middle	Out-patientand specialist hospital treatment free if defect noted at a school medical examination. If treatment not provided under School Health Service, liable for 10/- daily charge in a public ward. Expenses can be reduced if the daily charge imposes hardship.	For certain scheduled long-term defects, (e.g. mental handicap) out-patient specialist and in-patient hospital care would be *automatically* free of charge irrespective of where the defect is discovered.	Eligibility would not depend on participation in the examination procedures under the Child Welfare and School Health Services.
	Higher	Out-patient specialist and hospital treatment free only if defect noted at a school medical examination. The charges can be reduced if financial hardship is involved.		The major defects not covered by Voluntary Health Insurance would be included in the specified list. Eligibility would not depend on participation in the examination procedures under the Child Welfare or School Health Services. The "hardship" clause under Section 15 of the Health Act, 1953 would also enable health authorities to deal with any cases of hardship where a child required treatment for a defect which is not on the specified list.
2. In-patient hospital care (apart from specified long-term defects).	Middle	Treatment free if defect noted at school medical examination. Otherwise, liable to 10/- per day hospital charge in a public ward.	Waiver of 10/- daily hospital charge (public ward) for both pre-school children and pupils of national schools in the middle income group irrespective of where or by whom the defect was discovered. Eligibility for waiver would depend on participation in the examination procedures under the Child Welfare or School Health Services.	Pre-school children will now be entitled to free hospital treatment; the present difficulty arising from the need to have the defect noted at a school medical examination would be eliminated.
	Higher	Treatment free if defect noted at a school medical examination. Otherwise they are responsible for arranging hospital treatment privately.	Present entitlement to free treatment in respect of defects noted at school medical examinations (apart from specified long-term defects) would be removed.	We understand that the vast majority of this group are in the Voluntary Health Insurance and can be adequately covered for hospital care up to 30 weeks duration in any one year.
3. Out-patient specialist services (apart from specified long-term defects).	Middle	Treatment is free if referred through School Health Service. Otherwise 2s. 6d. per consultation or 7s. 6d. per X-ray.	Out-patient specialist charges are to be abolished under the proposals contained in White Paper on the Health Services.	Out-patient charges will be completely free for the middle income group.
	Higher	Treatment is free if the child is referred through the School Health Service. Otherwise, the parents make their own arrangements privately with the specialist concerned.	Treatment would be free if the child is referred from the Child Welfare Service or School Health Service, in respect of defects noted at examinations under these Services. Eligibility would depend on participation in examination procedures.	The higher income group would retain their existing entitlement under School Health, and the extension for the first time to Child Welfare would bring both Services into line.
4. Dental, Ophthalmic and Hearing Defects.	Middle and Higher	At present both income groups are entitled to dental, ophthalmic and aural treatment and appliances free of charge in respect of defects noted at child welfare and school health examinations. Some areas regard any child who has not yet left national school as entitled to these services, irrespective of where the defect was discovered. Some health authorities also include the removal of tonsils and adenoids as part of the aural treatment facilities under Child Welfare.	Treatment of dental, ophthalmic and hearing defects would be provided free for both pre-school children and pupils of national schools of any income group irrespective of where or by whom the defect was noted. Eligibility would depend on participation in the examination procedures of the Child Welfare and School Health Services.	Eligibility for in-patient hospital care for (*a*) defects of the ear other than defects of hearing and (*b*) tonsils and adenoids would depend on the child's general eligibility for hospital care. (See 2 above.)

This income group would lose entitlement to free hospital treatment for defects (apart from the specified long-term defects) noted at school health examinations. Such treatment would be adequately covered at moderate cost by Voluntary Health Insurance.

Referral Procedures

7.44 Referral from a clinic or school would be initially to an out-patient department for specialist investigation or treatment. Since specialist treatment would in such cases be free to all income groups, the doctor who refers the child would not need to identify the parents' income group. The in-patient hospital care (other than for the specified long term defects) of higher income group children would be the parents' responsibility: the hospital concerned could ascertain the parents' status while the child is in hospital, in the same way as is done for adults at present.

Children in Non-Aided Primary Schools

7.45 In 1963/64 there were 21,000 children receiving primary education in 192 schools which do not receive any financial aid from the State (Report "Investment in Education"). At present these non-aided primary schools are not covered by the School Health Service. A health authority can make an order under Section 19 of the Health Act, 1953, extending school health examinations to a non-aided primary school, if the health authority are not satisfied that an adequate school health examination service is available for pupils. The pupils would not, however, be automatically eligible for any treatment services, free of charge, under the Health Acts by virtue of the defect being discovered at such an examination. An order of this nature has apparently been made in only one instance to date.

All children would be eligible for the periodic medical examinations at the ages of 6 months, 1 year and 2 years which we have recommended as part of the Child Welfare Service. Thus children who eventually attend non-aided primary schools could have benefited from the periodic examinations. Children in these schools would also be eligible for the free out-patient specialist and hospital treatment proposed for long term defects.

7.46 We would expect that pupils of non-aided primary schools would generally come from families where adequate private arrangements would be made for medical and dental services and we do not recommend the extension of the School Health Examination and Treatment Services to such schools. However we consider that the existing provision should continue whereby a health authority may, if necessary, arrange for the medical inspection of any such school.

Summary

7.47 We summarise the existing provisions and our proposals in the chart overleaf. The lower income group are not specifically dealt with in the chart, since they are entitled to free health services in any event.

CHAPTER 8.—FURTHER ASPECTS OF THE CHILD HEALTH SERVICES

Health Education

8.1 The Cohen Committee (1964) which examined health education in Britain specified four contributions it should make to health:

(1) advice about specific preventive measures e.g., vaccination and immunisation, which require individual co-operation on only a limited number of occasions;

(2) education with a view to inculcating habits and attitudes which will promote health and prevent disease e.g., taking exercise, refraining from smoking;

(3) education to understand and support the need for community health measures e.g., full and responsible use of available health services; and

(4) education to seek advice from the doctor at an early stage for certain conditions.

8.2 Thus health education is a very broad concept. Its scope extends more widely than to the Child Welfare or School Health Services alone. Nevertheless the day-to-day working procedures practised in these two Services would inevitably make an incidental but useful contribution to health education. The doctor in the Child Welfare Service will advise the mother on health matters; so will the nurse on district duties in course of domiciliary visiting; the close liaison which we envisage in the School Health Service between the parent, teacher, nurse and doctor will give parents a better understanding of the health and the health needs of their children. The child can also profit from meeting the doctor and the nurse in the school.

8.3 Formal health education has, nowadays, become a specialist field. We recognise the needs for more health eduction—both formal and informal—and we feel that it is a problem which deserves a special *ad hoc* study.

8.4 To inculcate in parents a realisation of the need for bringing children for periodic medical examinations, and of the need for a routine screening of the apparently healthy child, involves an exercise in public relations. If parents have not grasped the purpose of child welfare examinations and the value to be derived from them, they will probably be disinclined to bring the children for examination; likewise, they may delay in availing of specialist facilities unless the advantage of early investigation is understood. **We recommend that positive steps be taken towards "selling" to parents the benefits for their children of the Child Welfare and School Health Services.**

Nutrition

8.5 Schemes aimed at improving the nutrition of children are relevant to child health. Free milk is provided for children under 5 years in the lower income group by nearly all health authorities; welfare foods and nutrients are supplied to a limited extent.

Local authorities in urban areas can make arrangements for providing school meals in national schools; rural areas cannot participate in the scheme except in the Gaeltacht. The School Meals Service has a limited coverage, e.g., in 1965 some 14% of national schools and 15% of the pupils were included. The meals generally consist of one or more of the following items: milk, cocoa, bread, buns, butter, jam. The Department of Social Welfare administers the School Meals Service.

The total cost to the State funds of the free milk scheme, welfare foods and School Meals Service is now over £350,000 per year.

8.6 We consider that the various schemes aimed at improving the nutritional standards of mothers or children should be viewed in an integrated manner and that the need for them should be assessed in the context of current circumstances. Specifically we recommend the re-appraisal of the School Meals Service.

Co-ordination of Services

8.7 Three distinct public health services are directly concerned with the development of the child, *viz.*, the Maternity and Infant Welfare service up to 6 weeks of age; the Child Welfare Service which deals primarily with the pre-school child, and the School Health Examination Service which is concerned with the child in national school. These Services relate to successive phases of the child's life; they should be regarded as forming a continuous whole, tracking the developmental progress and supervising the health of the child. The availability of medical records from preceding Services is an obvious requirement for effective co-ordination at a working level.

We recommend that the three Services should be renamed the Child Health Services as a first step towards stressing their interdependence.

8.8 **Every endeavour should be made to push back the screening processes to the earlier stages and to make them comprehensive,** so that the contribution which the Child Health Services can make towards good health and sound development in later years may be of real value.

We recommend that more effort should be devoted to effective health screening at birth and in the neo-natal period. The whole logic of discovery and treatment argues for the most comprehensive and effective screening at this initial stage of life. Thus, for example, the routine testing of new-born infants for congenital dislocation of the

hip (as urged recently by the CMO of the Department of Health in a circular letter to CMOs) can avoid prolonged, expensive treatment and perhaps serious handicap later in life.

Role of Department of Health

8.9 The Department of Health is in a unique position to supervise, co-ordinate and evaluate the development of the Child Health Services. It alone has access to relevant information from the 27 health authorities. We recommend that the Department should administer these Services in an active manner—for example, by setting targets for the development of the examination services; by regular checking on developments and deficiencies in different areas, and by preventing bottlenecks in the associated treatment services to which the children are referred.

8.10 Closer relations between the Department on the one hand, and the CMOs and doctors and nurses actually providing the Services, on the other, would promote a better mutual appreciation of the practical problems. By helping to improve communications and relations between the different personnel, the Department could help to foster a beneficial *esprit de corps* in the Services. Some ways of achieving this might be: the issue of a brief annual survey and statistics of the Services, outlining the main developments, problems and innovations; seminars or discussions involving ACMOs and CMOs from a particular region or from the whole country; visits by the Medical Officers of the Department of Health to different areas to discuss the Services.

Statistics

8.11 In order to evaluate and administer a service, reliable and up-to-date statistics are necessary. In the course of our examination of the existing Services we found the statistics deficient. **We recommend that reliable statistics necessary for effective administration should be collected by the Department of Health.** It is important that the intended purpose of the statistics should be explained to the health authorities, so that they will appreciate the need for collecting them. We also recommend that health authorities should examine their methods of compiling statistics of the Services and in particular the possibility of introducing mechanical methods of computation.

Extension to Post-Primary Groups

Background

8.12 There are about 135,000 day pupils in secondary and vocational schools, and 25,000 pupils in secondary boarding schools. Parliamentary Questions have been addressed to the Minister for Health about the possibility of extending the School Health Examination Service to these pupils (November, December, 1965). The Minister

intimated inreply that he would consider the question of extending the School Health Service to day pupils in secondary and vocational schools in the light of the Study Group's report.

There are two important aspects to be considered; firstly, the need for medical examinations of the post-primary group; and secondly, their eligibility for treatment and appliances free of charge.

Routine Medical Examination

8.13 Assuming the installation of the system of examinations we envisage for pre-school and national school pupils (of whom a sizeable proportion would proceed to secondary or vocational schools at age 12—13), we do not consider that routine medical examination of the post-primary pupils is immediately necessary or really feasible.

Selective Medical Examination

8.14 We feel, however, that there is a case for a selective examination of post-primary day pupils before the age of 16 years and that a stronger case can be made for specially following-up those pupils who leave national schools with significant defects needing further observation. A selective examination of post-primary day pupils would, we envisage, take place at the ages 14—15 years and would be based on a questionnaire to parents, discussion with the teachers, and available medical records. Under the selective procedure a proportion of pupils would be selected for examination.

Deferred Implementation

8.15 We recommend that any extension of the School Health Examination Service to post-primary schools should not be introduced until the services for pre-school and national school children have been overhauled on a more rational, selective and scientific basis, and until the new-type service has attained a smooth working rhythm. The services for the younger children are so important—from the aspect of early detection and treatment of defects which could seriously impede the child's health, his general development and his capacity to absorb education—that they have first claim on the resources of the health authorities. These resources will have to be augmented, and will inevitably have to be stretched to a degree, if the transition to the new type services which we have recommended for the younger and national school children is to become really effective as soon as would be desirable. In at least one area in Britain which switched over to a similar new type of service for the school children, the initial growing pains and organisational difficulties persisted for some years. This will also occur here—but on a national scale—and the initial problems would be aggravated if the task of launching an entirely new service for a substantial new category of young people had to be assumed at the same time. Any extension of services to secondary pupils should be confined to day-pupils since secondary boarding schools generally have private arrangements with doctors. It would, in our view be unnecessary and inappropriate to provide a service for pupils attending evening classes in vocational schools.

Eligibility for Treatment

8.16 Spectacles and dental treatment are the most common requirements at the post-primary ages. **We consider that the extension of the dental and ophthalmic services to the middle income group proposed in the White Paper on the Health Services (January 1966) would cater adequately for this group.** The range of free treatment services envisaged for national schools need not, we feel, be extended to post-primary schools, as the main bulk of defect should by then have come under notice and have been treated. The range of free services would already have accomplished its basic purpose, *viz.*, to encourage parents to have defects in children treated at an early stage during the critical phase of health development. It should be noted that a young person becomes eligible under the law for institutional and specialist health services in his own right on reaching the age of 16 years.

Youths in Employment

8.17 We also considered the position of those who leave national school at 14 years of age, e.g. to take up employment. The majority would, we believe, be in the lower income group and entitled as such to the full range of free health services. If possible, the remainder could be granted any facilities made available to their contemporaries in post-primary schools. We see, however, considerable practical difficulty in arranging for any kind of medical examination for working adolescents because of the fact that they are not nearly so readily accessible as school pupils.

Cost of the Study Group's Proposals

Present Cost of the Services

8.18 The estimated cost of the Child Welfare Clinic and School Health Examination Services in the year ending 31st March, 1967 based on the returns made by health authorities is as follows:

Child Welfare Clinic Service ..	£172,300
School Health Service	£375,700
	£548,000

These figures include an apportionment of the salaries of doctors and nurses, specialists' fees (e.g., paediatricians), travelling expenses. The items included vary, however, as between counties. The cost of hospital treatment arising out of the School Health Services is not included, and separate figures for such treatment are not available.

Similarly, the cost of Dental, Ophthalmic and Aural Services obtained by children referred from the Child Welfare or School Health Services is not known. The total estimated cost of the Dental, Ophthalmic and Aural Services for *children and adults* in the financial year 1967/68 is £375,000, and probably half to threequarters of this sum relates to children.

Thus the total cost of the Child Welfare and School Health Examination Services and of treatment arising from them would be considerably more than the figure of £548,000 given above.

Difficulties in Estimation

8.19 A major problem in estimating the cost of our recommendations is to distinguish between costs which will be incurred in any event through current plans to improve the health services, and these extra costs which would arise largely from our recommendations. We have excluded the following items from our calculations for the reasons stated below:

1. *Mental Illness and Mental Handicap:* Improved out-patient facilities have already been recommended by the Commissions which reported to the Minister.
2. *Speech Therapy:* Health authorities have previously decided to appoint 8 regional speech therapists.
3. *Dental and Aural Services:* Improvements in the services were announced in the White Paper on the Health Services and their Further Development (1966).

It is extremely difficult to estimate the impact on the out-patient specialist services of our recommendations. Some clinics may be able to accommodate extra patients, while additional clinics may be necessary in some specialities or areas. Special emphasis is, in fact, being given by the Department of Health to the development of out-patient consultant services. Provision has, however, been made in our estimates for paediatric, ENT and orthopaedic clinics, and the ophthalmic services, since improved child health services would make particularly heavy demands on them.

Estimates of Cost

8.20 We have provided for extra clerical assistance for CMOs as the satisfactory operation of improved child health services would demand efficient administration.

Under our recommendations, general practitioners who had made agreements with health authorities would undertake medical examinations of infants aged 4—6 weeks (as part of the Maternity and Infant Welfare Service) and of pre-school children outside of towns of 5,000 population and over at the ages of 6 months, 1 year and 2 years (as part of the Child Welfare Service). The maximum annual number of examinations to be carried out by general practitioners, assuming a full response from eligible children, would be as follows:

	Medical Examinations
4—6 weeks examination	43,000
Periodic examinations at ages of 6 months, 1 year and 2 years	103,000
	146,000

The annual cost of 146,000 medical examinations would depend on the fee per examination to be paid to the doctors involved; this fee, in turn, would be determined following negotiations between the profession and the Department of Health. Once the fee has been negotiated an estimate of the total cost can readily be made. At this stage, however, we have no valid basis for knowing what the negotiated fee would be, and consequently we feel that no useful purpose would be served by estimating the total annual cost of the examinations.

Estimates of other costs resulting from our recommendations are shown opposite:

ESTIMATE OF COST OF STUDY GROUP'S RECOMMENDATIONS

(Apart from cost of certain medical examinations to be carried out by General Practitioners).

	Initial Costs of capital nature	Annual Recurring Costs
	£	£
I. CHILD WELFARE CLINIC SERVICE		
Improved facilities at clinics (assumes expenditure of £1,000 on 71 premises in 33 towns of 5,000 population or more)	71,000	
II. ITEMS COMMON TO BOTH CHILD WELFARE AND SCHOOL HEALTH SERVICES		
1. *Medical Personnel:*		
(*a*) 14 ACMOs at mean of salary, plus travelling expenses		33,000
(*b*) Special in-service courses for 14 new ACMOs (Salaries, travelling, subsistence, admin. expenses)	3,000	
(*c*) Refresher courses of 4–6 weeks for existing ACMOs (travelling, subsistence, admin. expenses)	9,000	2,000
(*d*) Refresher courses, seminars for GPs in the Child Welfare Service in rural areas		2,000
2. *Hospital and Specialist Treatment*		
(*a*) Waiver of 10/– per day hospital charge for middle income group children		40,000
(*b*) *Specified Long-term defects:* Out-patient specialist and in-patient hospital care		66,000
(*c*) Out-patient specialist services — paediatric, ENT, and orthopaedic		7,000
3. *Ophthalmic Services:* Allowing 25% increase over present levels		12,500
4. *Administration:*		
Extra clerical staff in CMOs' offices—say 40 Clerk-Typists at mean of scale		23,000
TOTALS	83,000	185,500

CHAPTER 9.—EPILOGUE

General Review

9.1 In round figures, there are 300,000 pre-school and 500,000 national school children, i.e. a total of about 800,000 which is over one quarter of the total population of the country. The sheer bulk of the numbers involved and the fact that the field health services for these children must survey virtually all aspects of the children's health, highlight both the size of the problem of providing good health services for this important section of the community, and the need to secure that, within our resources, everything necessary should be done to ensure that the services are fully adequate both in concept and execution. The potential contribution which these services can make to the national welfare has not generally been realised; equally the extent of avoidable suffering and damage to scores of thousands of our children through failure to develop and use the child health services fully has, we fear, not been widely appreciated.

Now that many other health problems considered to be more immediately pressing—the building of hospitals, grappling with infectious diseases, improving the status and building-up the numbers of hospital and public health personnel, the overhaul of services for the mentally ill and mentally handicapped—have been put in hands, the broad task of upgrading the field health services for children should be faced. Essentially this is one of working out what must be done so as to ensure that the needs of those children who really require examination, treatment and follow-up will be attended to; that unnecessary work will be cut out; that the requisite specialist and other facilities to back the work of the first-line medical and nursing personnel will be available; that the functioning of the service will be kept under continuous review, and that the appropriate education of all concerned—as to what the service is all about, its importance and its value—will be undertaken. We are satisfied that the resources in personnel and expertise exist to make the services which we envisage quite feasible, and we believe that, considering the numbers of children involved and the dividends which will result, the extra cost will be money well spent.

Summary of Recommendations

9.2 Our chief recommendations are summarised below:

1. **All children should have a scheduled medical examination when they reach the ages of 6 months, 1 year and 2 years. (Par. 3.5).**

2. **In urban areas with a population of 5,000 or more persons, the scheduled medical examinations for pre-school children should be carried out in clinics by doctors on the CMO's staff; in smaller towns where Child Welfare Clinics are now operating, the clinics could be retained if the CMO desires it. (Par. 3.6).**

3. In rural areas and towns without clinics, the scheduled medical examinations for pre-school children should be undertaken by general practitioners who have made agreements with the health authority. (Par. 3.8).

4. The school should continue to be used as the basic centre for school health examinations. (Par. 3.13).

5. ACMOs should continue to carry out school medical examinations. The question of allowing general practitioners to participate in this work could be reconsidered if an acute problem in recruiting ACMOs arises in the future (Par. 3.14).

6. The aim of three routine medical examinations during a child's national school career should be replaced by the following system:—a comprehensive medical inspection of all children between the 6th and 7th birthdays; routine annual screening by the district nurse for vision, posture, cleanliness; audiometric testing of special groups; a selective medical examination of 9 year old children (a proportion would be selected for examination); the examination in any year of a child referred by the parent, teacher, or district nurse; some children would also be due for re-examinations (Par. 3.18).

7. The School Medical Officer would visit schools at least once a year (Par. 3.18).

8. In small schools (e.g. under 30 pupils) it may be more practicable to examine all the children in the school every two years (Par. 3.19).

9. Doctors providing services under the Maternity and Infant Welfare Service (which extends to 6 weeks after birth) should be required to undertake a scheduled medical examination of the infant at the age of 4-6 weeks, using an appropriate record card (Par. 3.23).

10. The maintenance by the CMO of a register of all pre-school children would be a valuable aid to the efficient running of a child welfare service (Par.4.4).

11. An appointment system for mothers due to bring their infants to clinics for a scheduled medical examination would be extremely desirable (Par. 4.10).

12. The nurse should control access to the doctor in a Child Welfare Clinic, deal with mothers who came specially to consult her and organise associated health education activities. (Par. 4.11).

13. Where the Child Welfare Service is provided by the general practitioner, the child's Record Card should be retained by the CMO after the final periodic examination at the age of 2 years and should subsequently be associated with the School Health Service (Par. 4.18).

14. In clinic towns, the general practitioners providing the Maternity and Infant Welfare Service (up to 6 weeks of age) should make available to the CMO certain medical records in time for the 6 months examination of the infant in the clinic (Par. 4.20).

15. Everyone directly concerned with the health of the school child—parent, teacher, doctor, nurse—should work together as a school health team (Par. 5.2).

16. The initial consent sought from parents before an examination of their child under the School Health Service should cover all examinations by doctors and nurses in the school during subsequent years. The parents could withdraw the consent at any time (Par. 5.3).

17. A special questionnaire should be completed by the parent of each child being examined under the School Health Service (Par. 5.8); a parallel aim would be to secure the maximum attendance of parents at the examinations (Par. 5.9.)

18. If the School Medical Officer finds a condition in a child which adversely affects the child's educational capacity, he should inform the teacher so that allowance would be made for the child in the classroom (Par. 5.11).

19. The needs of school medical examinations should be taken into account in the design of new national schools (Par. 5.12).

20. Information on the teacher's role in the School Health Service should be systematically given in Teachers' Training Colleges and to serving teachers (Par. 5.13).

21. We estimate that about 90 doctors would need to be employed by health authorities for the Child Welfare and School Health Services, on the assumption that two-thirds of their working time was devoted to these Services (Par. 6.5). At present 76 doctors are engaged in the Child Health Services but there are great variations in the proportion of time which they can devote to the Services.

22. The DCH should be substituted for the DPH as an essential qualification for post of the ACMO. A special in-service course for new entrants to the ACMO grade should be organised and would comprise social and developmental paediatrics and certain public health material covered by the present DPH (Par. 6.8).

23. Existing ACMOs should be given refresher courses of 4-6 weeks duration, covering clinical paediatrics, developmental paediatrics, mental handicap and its assessment, and child health services (Par. 6.9).

24. Women doctors with the DCH who are married should be permitted to provide Child Welfare and School Health Services on the basis of a temporary appointment (Par. 6.10).

25. The proportion of the ACMO's effective working time which is available for the Child Welfare and School Health Services' should be about two-thirds and should not be reducible at will as soon as other pressures arise (Par. 6.11).

26. There should be more flexibility in setting the official working hours for ACMOs so that they can make the best use of the relatively short school day. (Par. 6.12).

27. The co-operation of the medical profession should be sought in order to increase awareness of developmental paediatrics among general practitioners participating in the proposed Child Welfare Service. (Par. 6.13).

28. One public health nurse in the CMO's office should be assigned to each ACMO to assist him in his visits to national schools. (Par. 6.15).

29. Additional paediatric clinics should be provided up to the level where there is one monthly clinic to every 7,000 children aged 0-14 years. Children should be seen within a month or so of referral. (Par. 7.5).

30. ENT clinics are urgently required in areas lacking a clinic service at present, or which have excessive waiting lists. (Par. 7.11).

31. School Medical Officers should not refer children direct to hospital for tonsillectomy except where the reasons are compelling. Cases appropriate to the general practitioner should be referred to him rather than to the ENT clinic (Par. 7.12).

32. The capitation system of payment to ophthalmic surgeons who hold clinics for health authorities should not be extended to areas where sessional arrangements (i.e. fixed remuneration per session) now operate. Whenever a particular ophthalmic surgeon ceases to hold a clinic, the sessional method of payment should be retained or introduced in any new arrangements (Par. 7.19).

33. The development of speech therapy facilities should be vigorously pursued (Par. 7.20).

34. The role of the district nurse, as the link between the homes in her district and the health services, should be specifically recognised in the mental illness and mental handicap services (Par. 7.27).

35. All necessary steps should be taken promptly to improve the out-patient specialist services where they are deficient and they should be maintained in a high state of efficiency (Par. 7.28).

36. In general, entitlement to free treatment under the Child Welfare and School Health Services should depend on the parents opting for the Services and the child participating satisfactorily in the various examinations offered. Subject to option and participation, the present entitlements for free treatment under the Child Welfare and School Health Services should be modified as follows: the 10/- daily hospital charge (public ward) for both pre-school and national school children in the middle income group should be waived irrespective of when, where or by whom the defect was discovered; certain long-term defects should be scheduled and children of any income group automatically entitled to free out-patient and institutional treatment for them irrespective of whether they had opted for the Child Health Services; higher income group children should, for the first time, be entitled to free specialist out-patient treatment for any defect noted at a child welfare examination, and should retain their entitlement to free out-patient specialist services under the School Health

(This has been done in 1970/71)

Service; the present eligibility of higher income group children in national school to free short-term hospital treatment should be removed and reliance placed on Voluntary Health Insurance; children of all income groups should be entitled to free treatment and appliances for dental, ophthalmic and hearing defects irrespective of where or by whom the defect was discovered. The White Paper on the Health Services envisages the abolition of out-patient specialist charges for the middle income group (Par. 7.36).

37. Entitlement to free treatment (apart from treatment for specified long-term defects) under the Child Welfare and School Health Services should depend on the parents opting for participation in these Services, and on the child coming forward to a reasonable extent for the various examinations offered (Par. 7.37).

38. Health education should be the subject of a special study (Par. 8.3).

39. Positive steps should be taken to persuade mothers of the benefits for their children of the Child Welfare and School Health Services (Par. 8.4).

4p. The various schemes aimed at improving the nutritional standards of mothers or children should be viewed in an integrated manner and the need for them assessed in the context of current circumstances. In particular the School Meals Service should be re-appraised (Par. 8.6).

41. The three Services concerned with children—the Maternity and Infant Welfare Service, the Child Welfare Service and the School Health Service—should be regarded as forming a continuous whole, tracking the developmental progress, and supervising the health of the child. These three Services should be renamed the Child Health Services (Par. 8.7).

42. Every effort should be made to push back the screening processes to earlier stages. In particular, more effort should be devoted to health screening at birth and in the neo-natal period. (Par. 8.8).

43. The Department of Health should administer the Child Health Services in an active manner (Par. 8.9). It should collect reliable statistics as an aid to evaluation and administration of the Services (Par. 8.11).

44. There is a case for a selective examination of post-primary day pupils at the ages 14-15 years; an extended School Health Service could also follow-up, where necessary, pupils under medical observation from national schools (Par. 8.14). The School Health Service should not be extended to post-primary groups until the Service in national schools is working satisfactorily (Par. 8.15).

45. The treatment facilities under the Service envisaged for national schools should not be extended to post-primary schools. The proposal in the White Paper on the Health Services to extend the dental, ophthalmic and aural services to the middle income group would meet the main needs of post-primary pupils (Par. 8.16).

46. If possible, facilities granted to post-primary pupils should be granted also to their contemporaries who have dropped out of the educational system (Par. 8.17).

SIGNATURES TO THE REPORT

K. U. CONNOLLY (*Chairman*)

MARY HAMILL

S. HENSEY

J. C. JOYCE

P. Ó COILEÁIN

B. O'DONNELL

J. O'HAGAN

JOAN STACK

O. C. WARD

C. F. WARDE

P. A. WHITE (*Secretary*)

6th November, 1967.

APPENDIX 1.—DETAILS OF LOCATION AND USAGE OF CHILD WELFARE CLINICS

	City or Town	Population (1966)	Number of Child Welfare Centres	Children examined		Clinics held	
				1965	1966	1965	1966
1.	Dublin and Dún Laoghaire ...	734,967	33	35,247	35,446	1,628	1,835
2.	Cork	125,283	4	13,447	25,834	443	584
3.	Limerick	58,082	4	1,163	1,086	287	278
4.	Waterford	29,842	1	2,734	2,398	101	101
5.	Galway	26,295	1	1,225	1,410	143	146
6.	Dundalk	21,678	1	1,774	1,277	22	24
7.	Drogheda	17,908	1	32	40	9	9
8.	Bray	13,668	1	2,734	2,587	48	49
9.	Sligo	13,424	1	358	464	42	51
10.	Wexford	12,744	1	731	610	56	50
11.	Kilkenny	12,030	1	537	589	101	101
12.	Tralee	11,976	1	184	113	11	10
13.	Clonmel	11,457	1	63	122	11	11
14.	Athlone	10,987			No Clinics		
15.	Carlow	9,765	1	9	8	50	50
16.	Ennis	9,181	1	450	970	22	26
17.	Mullingar	7,943			No Clinics		
18.	Thurles	6,949	1	95	90	24	24
19.	Killarney	6,877	1	176	172	12	11
20.	Tullamore	6,874	1	236	265	48	47
21.	Cobh	6,726	1		Monthly Clinics Held		
22.	Enniscorthy ...	6,279	1	220	229	24	48
23.	Ballina	6,084	1	102	27	20	20
24.	Arklow	6,083	1	419	511	48	51
25.	An Uaimh	5,907			No Clinics		
26.	Portlaoise	5,873			No Clinics		
27.	Mallow	5,845	1		Monthly Clinics Held		
28.	Ballinasloe	5,828	1	43	41	12	10
29.	Castlebar	5,639			No Clinics		
30.	Dungarvan ...	5,380			No Clinics		
31.	Youghal	5,221	1		Monthly Clinics Held		
32.	Droichead Nua ...	5,161	1	473	494	23	21
33.	Clondalkin ...	5,079	1	419	829	22	43
34.	Monaghan	4,895	1	83	60	11	12
35.	Carrick-on-Suir ...	4,874	1	78	197	10	12
36.	Tuam	4,942	1	78	60	10	11
37.	Nenagh	4,609	1	54	40	23	91
38.	New Ross	4,568			No Clinics		
39.	Naas	4,529	1	249	310	20	21

	City or Town	Population (1966)	Number of Child Welfare Centres	Children examined		Clinics held	
				1965	1966	1965	1966
40.	Letterkenny ...	4,527			No Clinics		
41.	Tipperary	4,507	1	39	65	9	10
42.	Cavan	4,205	1		Monthly Clinics Held		
43.	Midleton	4,181	1	248	245	24	24
44.	Longford	4,129	1	625	680	12	12
45.	Athy	4,069	1	334	391	19	22
46.	Greystones-Delgany	3,952			No Clinics		
47.	Birr	3,924	1	173	131	11	9
48.	Bandon	3,825	1		Monthly Clinics Held		
49.	Fermoy	3,721	1		Monthly Clinics Held		
50.	Roscrea	3,511	1	40	31	10	11
51.	Wicklow	3,340	1	692	812	48	51
52.	Tramore	3,271			No Clinics		
53.	Balbriggan ...	3,248	1	340	160	22	19
54.	Buncrana	3,115	1	526	327	22	22
55.	Loughrea	3,001			No Clinics		
56.	Malahide	2,967			No Clinics		
57.	Westport	2,927			No Clinics		
58.	Ardee	2,919	1	50	57	12	11
59.	Edenderry	2,902			No Clinics		
60.	Skerries	2,893	1	293	N.A.	22	N.A.
61.	Gorey	2,858			No Clinics		
62.	Listowel	2,822	1	114	103	12	10
63.	Portarlington ...	2,804			No Clinics		
64.	Passage West ...	2,771			No Clinics		
65.	Kilrush	2,734	1	301	325	12	12
66.	Kildare	2,731			No Clinics		
67.	Roscommon ...	2,729			No Clinics		
68.	Cashel	2,682	1	58	63	10	11
69.	Mitchelstown ...	2,617	1		Monthly Clinics Held		
70.	Mountmellick ...	2,580			No Clinics		
71.	Rush	2,488			No Clinics		
72.	Newcastle West ...	2,483			No Clinics		
73.	Tallaght	2,476			No Clinics		
74.	Clara	2,424			No Clinics		
75.	Clonakilty	2,422	1		Monthly Clinics Held		
76.	Bantry	2,341	1		Monthly Clinics Held		
77.	Macroom	2,323	1		Monthly Clinics Held		
78.	Ceannanus Mór ...	2,274			No Clinics		
79.	Ballyshannon ...	2,233			No Clinics		
80.	Muinebeag ...	2,154			No Clinics		
81.	Lucan-Doddsborough*	2,100	1	—	542	—	22
82.	Carrickmacross ...	2,094			No Clinics		
83.	Castleblayney ...	2,083	1	68	79	10	12
84.	Rathluirc	2,056			No Clinics		

*Clinics commenced December, 1965.

	City or Town	Population (1966)	Number of Child Welfare Centres	Children examined		Clinics held	
				1965	1966	1965	1966
85.	Clones	2,038	1	42	72	11	12
86.	Templemore ...	2,031	1	20	22	10	12
87.	Skibbereen ...	2,028	1		Monthly Clinics Held		
88.	Kanturk	1,938	1		Monthly Clinics Held		
89.	Swords	1,892	1	247	N.A.	19	N.A.
90.	Trim	1,856			No Clinics		
91.	Boyle	1,789			No Clinics		
92.	Blanchardstown ...	1,782			No Clinics		
93.	Tullow	1,775			No Clinics		
94.	Kinsale	1,748	1		Monthly Clinics Held		
95.	Cahir	1,740			No Clinics		
96.	Castleisland ...	1,673			No Clinics		
97.	Shannon Airport ...	1,658	1	258	504	7	12
98.	Cahirciveen ...	1,649			No Clinics		
99.	Carrick-on-Shannon	1,636			No Clinics		
100.	Castlerea	1,613			No Clinics		
101.	Rathkeale	1,542			No Clinics		
102.	Celbridge	1,514			No Clinics		
103.	Donegal	1,507			No Clinics		

TOWNS LESS THAN 1,500 POPULATION WITH CHILD WELFARE CLINICS

1.	Bailieborough ...	1,173	1	288	217	12	11
2.	Dunmanway ...	1,406	1		Monthly Clinics Held		
3.	Thomastown ...	1,193	1	82	97	21	22
4.	Moville	1,059	1		Clinics commenced 1967		
5.	Carndonagh ...	1,058	1	—	13	—	6
6.	Granard	1,045	1	266	384	12	12
7.	Rathnew	924	1	199	139	12	12
8.	Ballybay	754	1	30	41	11	12
9.	Rathcoole	333	1	142	N.A.	24	N.A.
10.	Newtown-cunningham ...	310	1		Clinics commenced 1967		

APPENDIX 2.—SUMMARY OF NATIONAL STATISTICS OF THE CHILD WELFARE CLINIC SERVICE 1961-1966

	1961	1962	1963	1964	1965	1966
Number of centres	98	91	91	98	112	109
Number of clinics held ...	3,846	4,365	4,163	4,286	3,893	3,980
Number of children examined	75,248	79,694	73,939	78,470	71,779	80,560
GENERAL CONDITION*						
Good	19,440	24,582	27,241	34,271	31,587	38,760
Fair	1,652	1,515	2,129	1,146	6,842	10,653
Poor	540	270	410	139	279	174
Infestation	224	233	364	301	225	129
Skin	1,559	1,910	1,838	1,314	1,393	1,419
Nose and throat	1,655	1,541	1,736	2,005	1,546	1,610
EYE AND EAR						
External eye disease	479	326	375	880	573	464
Defective vision	966	919	887	1,289	1,147	1,023
Defective hearing	178	158	225	259	183	309
ORTHOPAEDIC DEFECTS						
Posture	155	174	232	180	164	151
Foot defects	493	421	454	348	382	415
Others	24	99	81	247	239	163
OTHER DEFECTS						
Speech	149	181	201	305	260	292
Heart	127	133	143	189	151	140
Circulation	45	58	33	57	64	46
Lungs	985	1,143	1,170	862	1,018	990
Nervous system	137	73	139	156	131	149
Hernia	425	381	452	391	343	329
Mental condition	106	118	154	174	186	257
others	2,187	2,488	3,817	3,023	1,895	2,409

*Information on General Condition is not available for all the children examined.

APPENDIX 3.—QUESTIONNAIRE USED IN CHILD WELFARE CLINIC SURVEY

PART I

1. Health Authority.....

2. Centre:.....

3. Sex: { Male ☐ / Female ☐

4. Date of Birth:.....

5. Attendances: First attendance { Yes ☐ / No ☐

If *no*, how many previous attendances ?———————

How many other attendances in previous 12 months ?———————

PART II

Place tick √ in relevant box(es) below:

The child was brought to the clinic primarily for the following purpose:—

1. A general medical check on the health and development of the child (i.e., well-baby check). ☐

   If so, had the parent been urged by a nurse visiting the home to bring the child { Yes ☐ / No ☐

or

2. The child had an acute minor ailment of which the parent was aware and for which treatment at the clinic was sought but which was in fact appropriate to a general practitioner. (e.g., coughs, colds, skin defects) ☐

or

3. The child had a dental, ophthalmic or aural defect of which the parent was aware and for which he wished the child to be *referred* for treatment under the Child Welfare Service. ☐

   If so, did the parents know that treatment under Child Welfare was free { Yes ☐ / No ☐

or

Appendix 3—contd.

4. The child had an ailment of which the parent was aware and for which she wished the child to be referred for specialist or hospital treatment ☐

or

5. For other reasons (e.g., immunisations, nutrients etc.), please specify..... ☐
.....

PART III

1. Was any physical or mental defect* discovered? Yes ☐ / No ☐

2. If *yes*, please specify the defect.*.....

**Do not include* in this category any case in which *only advice or information* was given—on such things as, for example, feeding problems or normal developmental progress of the child.

APPENDIX 4.—SURVEY OF CONGENITAL DISLOCATION OF THE HIP

TABLE 1.—CONGENITAL DISLOCATION OF THE HIP (1961-65): AGES AT WHICH CHILDREN WERE FIRST REFERRED FOR INVESTIGATION OR TREATMENT

	1961	1962	1963	1964	1965	Totals
1–3 months	3	2	3	5	3	16
4–6 months	2	3	2	5	6	18
7–9 months	—	2	2	2	3	9
10–12 months	—	1	3	4	1	9
13–15 months	1	2	3	6	6	18
16–18 months	5	4	5	5	8	27
19–21 months	5	4	5	7	7	28
22–24 months	3	5	4	3	10	25
2 years	9	7	15	11	24	66
3 years	12	6	6	7	2	33
4 years	2	3	5	5	2	17
5 years	1	2	—	—	2	5
6 years	—	—	3	1	—	4
7 years	1	1	—	1	3	6
8 years	—	1	1	2	1	5
9 years	—	1	—	—	1	2
10 years	—	—	—	—	1	1
11 years	—	—	—	—	—	—
12 years	—	—	—	—	—	—
13 years	1	—	—	—	—	1
14 years	1	—	—	—	—	1
	46	44	57	64	80	291

TABLE 2.—CONGENITAL DISLOCATION OF THE HIP (1961-1965). DIAGRAM SHOWING NUMBERS OF CHILDREN BY AGE, IN YEARS, REFERRED INITIALLY FOR INVESTIGATION OR TREATMENT

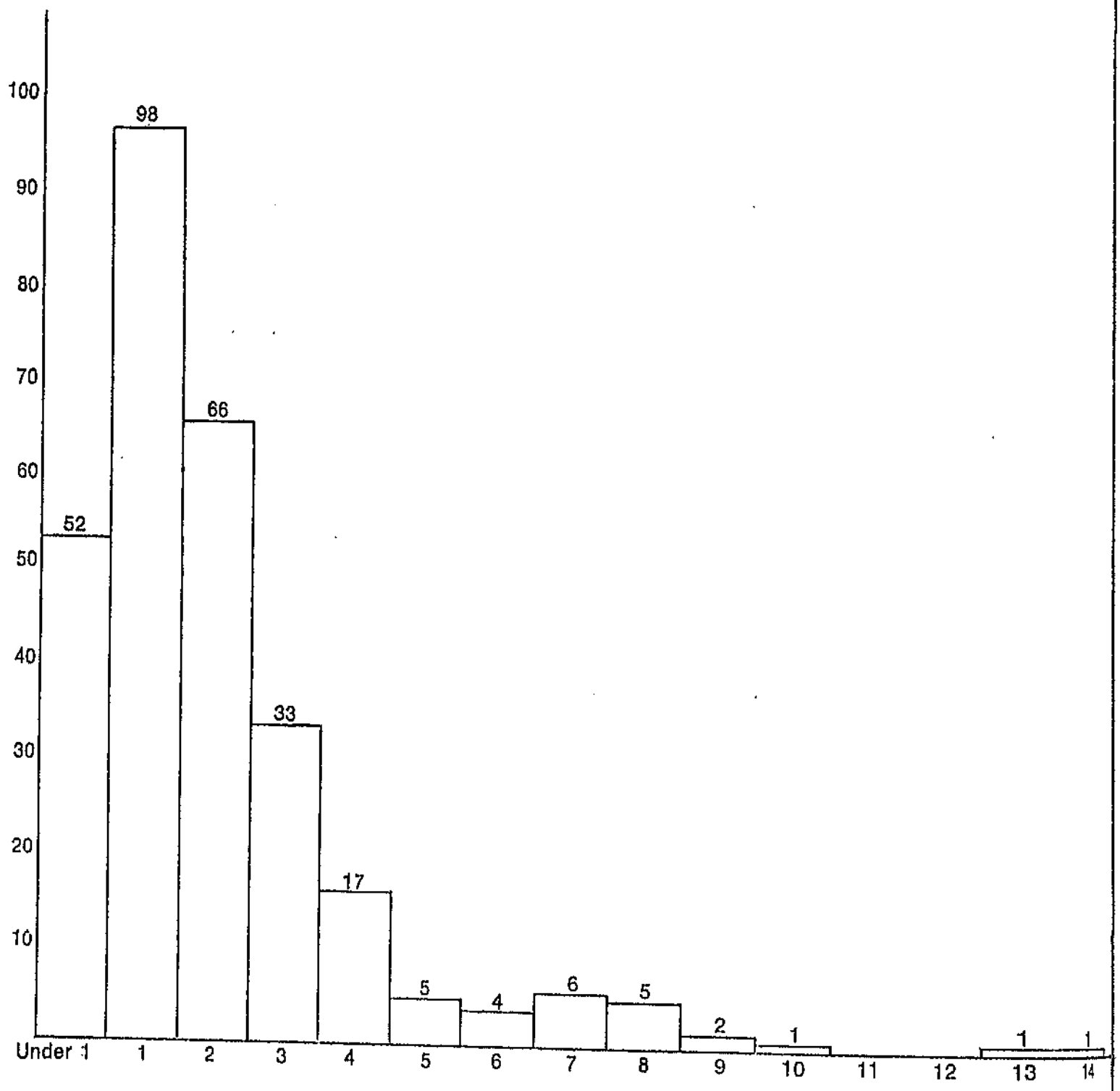
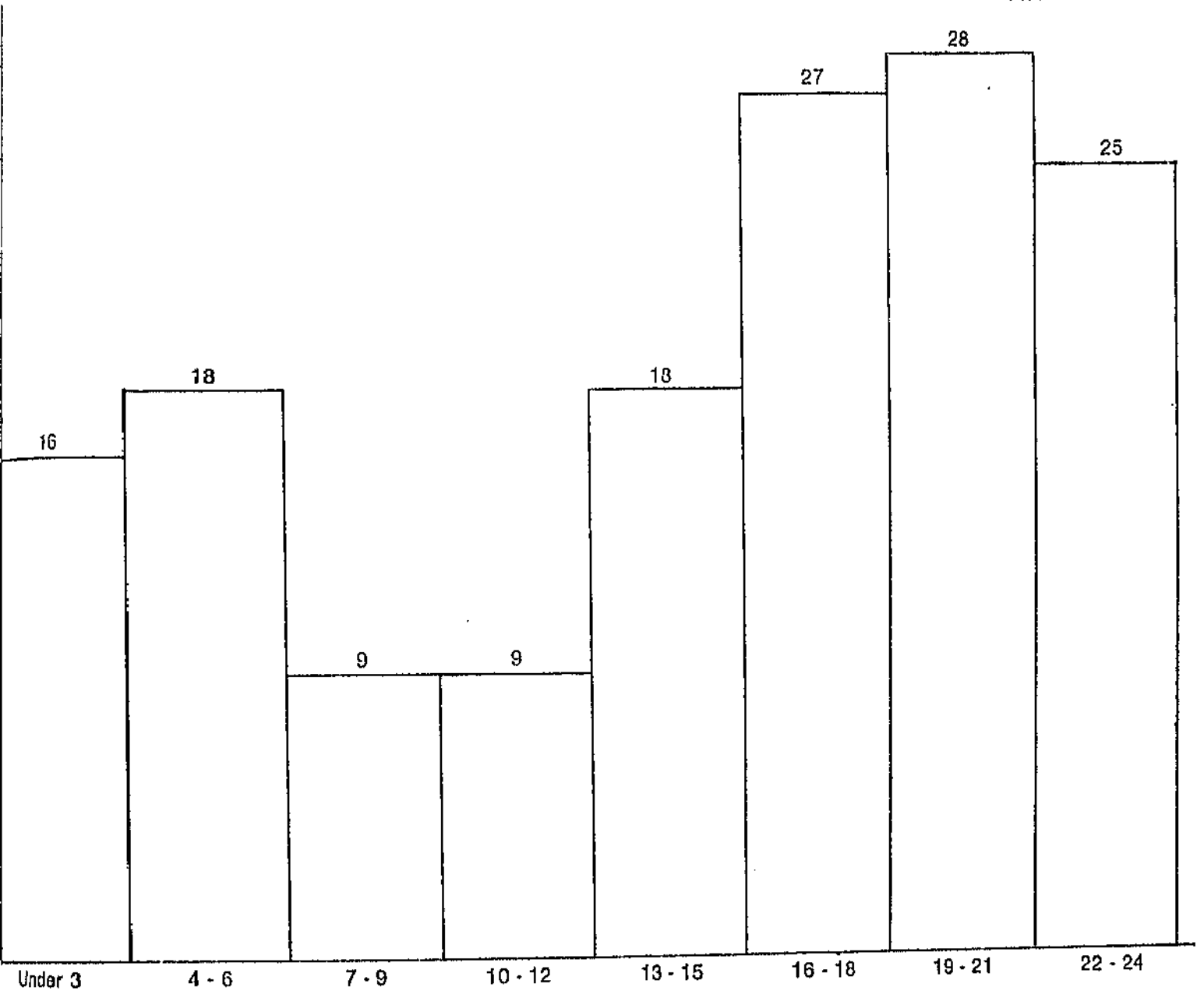


TABLE 3.—CONGENITAL DISLOCATION OF THE HIPS (1961-1965): AGE OF REFERRAL OF CHILDREN UP TO 2 YEARS OF AGE BY 3 MONTHLY INTERVALS



APPENDIX 5.—FIRST REFERRALS FOR HEARING ASSESSMENT TO ST. MARY'S AUDIOLOGY CLINIC, CABRA

I. FIRST REFERRALS TO ST. MARY'S AUDIOLOGY CLINIC IN PERIOD AUGUST 1964 TO FEBRUARY, 1966

Age	Numbers	Percentage of total
		%
6 months–12 months	4	2·9
1 year–3 years	34	25·6
3 years–5 years	36	27·0
5 years–7 years	18	13·4
7 years–9 years	3	2·2
9 years–12 years	19	14·1
12 years–15 years	10	7·4
15 years–17 years	8	6·0
Over 21 years	2	1·4
	134	100·0

II. ANALYSIS BY REASON FOR REFERRAL

Reason for Referral	Number referred	Number found to have some degree of hearing loss
1. "At Risk" group	69	51
2. Late onset of handicap, with suspected cause, e.g., measles, meningitis, scarlet fever.	11	11
3. Failure or delay in babbling and speech	11	9
4. Defective speech or slowness in school	19	12
5. General retardation	8	2
6. Heedlessness	4	2
7. Ear discharge	3	1
8. Discovered at school medical	2	2
9. Loss of speech at 5 years	1	—
	128*	90

*Note: While 134 altogether were referred for the first time to the clinic during the period, information as to cause of referral is available only for 128.

APPENDIX 6.—CASES OF CONGENITAL HEART DISEASE

AGE AT ADMISSION TO OUR LADY'S HOSPITAL FOR SICK CHILDREN, CRUMLIN 1961-1966

	Age at Admission							
Year	0–1 month	1–6 months	6 months –1 year	1–2 years	2–5 years	5–10 years	10–15 years	Totals
1961 ...	9	12	6	8	5	25	4	69
1962 ...	14	22	6	6	9	29	11	97
1963 ...	19	28	16	9	10	19	8	109
1964 ...	28	35	9	12	9	19	14	126
1965 ...	16	26	6	10	19	24	9	110
1966 ...	29	25	6	7	11	33	4	115
Totals	115	148	49	52	63	149	50	626

APPENDIX 7.—SUMMARY OF NATIONAL STATISTICS OF THE SCHOOL HEALTH EXAMINATION SERVICE 1961-1966

	1961	1962	1963	1964	1965	1966
Number of children examined	147,139	153,246	145,364	144,999	118,171	146,188
Number of schools visited ...	2,180	2,394	2,317	2,177	1,601	2,028
Total national schools in country.	(4,880)	(4,867)	(4,864)	(4,848)	(4,847)	(4,797 prov.)
GENERAL CONDITION*						
Good	132,524	141,785	134,964	136,360	111,476	138,086
Fair	11,195	9,433	9,083	7,769	4,353	6,368
Poor	1,549	1,864	1,067	849	716	1,734
Infestation	7,956	7,729	6,857	7,310	5,978	6,946
Skin	2,666	4,488	4,116	4,468	4,046	5,223
Nose and throat	19,666	23,567	22,289	20,573	16,417	20,543
EYE AND EAR						
External eye disease	2,117	2,232	2,384	2,691	2,105	2,452
Defective vision	24,201	23,765	22,913	22,298	20,075	24,873
Defective hearing	815	1,216	1,194	1,475	1,212	1,538
ORTHOPAEDIC DEFECTS						
Posture	4,510	6,442	7,087	5,382	5,796	3,694
Foot defects	4,308	4,505	5,409	4,721	5,168	5,938
Others	1,497	2,546	3,131	2,218	2,795	3,279
OTHER DEFECTS						
Speech	1,574	2,243	2,441	2,790	2,312	3,113
Heart	3,024	} 4,310	4,148	4,297	3,938	4,070
Circulation	502		324	255	432	461
Lungs	1,963	2,051	1,817	2,373	2,160	2,387
Nervous system	472	784	641	551	469	401
Hernia	131	108	109	113	97	299
Mental condition	844	988	1,460	1,320	1,119	1,660
Others	10,402	7,436	6,664	9,094	8,939	8,660
INSTITUTIONAL TREATMENT PROVIDED						
Tonsils and adenoids ...	4,113	3,543	3,369	3,737	3,087	3,188
Respiratory defects	73	165	232	153	109	66
Orthopaedic defects	538	419	436	447	518	448
Other defects (excluding ophthalmic and dental).	1,138	1,010	1,032	1,155	1,015	1,358

*Information on General Condition is not available for all children examined.

APPENDIX 8.—SCHOOL HEALTH SURVEY

For Office use only

1. Health Authority .....

2. School.....
(Name and Address)

3. Child's reference number .....

Day	Month	Year

4. Sex ☐ Male ☐ Female

5. Date of Birth

6. Date of Inspection

7. Previous Inspection ☐ Yes ☐ No.

8. Parent Present ☐ Yes ☐ **No.**

9. Summary

☐ No defect ☐ Visual defect only ☐ Other single defect ☐ Multiple defects

NOTES

(1) Place tick ✓ in appropriate box for items number 4, 7 and 8.

(2) Information is required as to the action taken on defects discovered and each such defect should be recorded on the appropriate line on the back of this card by indicating to which of the following categories it belongs.

Category Number

1. Child referred by the School Medical Officer, or through a general practitioner, for specialist inpatient or outpatient investigation or treatment (this includes child guidance, speech or hearing investigation, etc.).
2. Child referred back for general practitioner treatment.
3. Defect noted for observation only.
4. Defect now observed for first time at School Health Examination and already under treatment, otherwise than through the School Health Service.
5. Serious defect not amenable to treatment.
6. Defect discovered at a previous School Health examination and receiving treatment.

Example—(i) Where conjunctivitis is discovered in a child during the School Health Examination and the child is referred for general practitioner treatment the figure 2 should be put opposite code number 045 in the column headed "Category Number".

(ii) Where hernia is discovered and the child is referred for specialist opinion the figure 1 should be put opposite code number 180 in the column headed "Category Number".

(3) Under heading "Summary" at 9 above place tick ✓ in appropriate square on each card.

DEFECTS

Code No.	Category Number*	
		INFESTATION
010		(Infestation of any degree, including the presence of nits, should be recorded).
		SKIN AND CELLULAR TISSUE
020		Scabies
021		Eczema
022		Psoriasis
023		Ichthyosis
024		Large moles and haemangiomata.
025		Ringworm
026		Impetigo
027		Nail defects
028		Other defects (specify)..... .....
		EYE
		Defective vision:—
030		Grade I (6/12, 6/18 in either eye).
031		Grade II (6/24, 6/36 in either eye).
032		Grade III (6/60 or less in either eye).
040		Strabismus
041		Tarsal cysts
042		Blepharitis
043		Nystagmus
044		Cataract
045		Conjunctivitis
046		Other defects (specify) (e.g. Ptosis)..... .....
		EAR
050		Defective hearing
051		Otitis externa
052		Otitis media
053		Other defects (specify)..... .....

Code No.	Category Number*	
		NOSE AND THROAT
060		Tonsillectonomy already carried out. Hypertrophy of tonsils and adenoids (excluding acute). (This includes Adenoid Vegetations, Adenoids, Chronic tonsillitis, Enlargement of tonsils (and adenoids), diseased or enlarged tonsils (and adenoids).
061		Referred direct to hospital for tonsillectonomy.
062		Referred to specialist for opinion.
063		Referred back to general practitioner for opinion.
064		Noted for observation only
065		Deflected nasal septum
066		Nasal Polyp
067		Other defects (specify)..... .....
		CIRCULATORY AND BLOOD DISEASE
070		Heart disease of rheumatic origin.
071		Congenital heart disease
072		Iron deficiency anaemia
073		Other anaemia
074		Pupura and other haemorrhagic conditions.
		LUNGS (NON-TUBERCULAR)
080		Asthma
081		Bronchiectasis and/or atelectasis.
082		Bronchitis and asthmatic bronchitis.
083		Other defects (specify)..... .....

Code No.	Category Number*	
090		DISORDERS OF DIGESTIVE TRACT (specify)..... .....
		ENDOCRINE SYSTEM, NUTRITIONAL AND METABOLIC
100		Goitre
101		Diabetes mellitus
102		Diseases of other endocrine glands.
103		Vitamin deficiency
104		Coeliac disease
105		Obesity
106		Other defects (specify)..... .....
		BONES AND ORGANS OF MOVEMENT (ACQUIRED DEFECTS)
110		Defective posture
111		Osteomyelitis
112		Curvature of spine
113		Flat foot
114		Hallux Valgus and Varus
115		Club Foot
116		Defects of ribs and sternum (e.g. pidgeon chest, Harrison's sulcus) (specify) ....
117		Other deformities (specify)... .....
		BONES AND ORGANS OF MOVEMENT (CONGENITAL DEFECTS)
120		Spinal Curvature
121		Dislocation of hip
122		Defects of ribs and sternum
123		Talipes
124		Achondroplasia
125		Torticollis
126		Other defects (specify)..... .....

Code No.	Category Number*	
		CENTRAL NERVOUS SYSTEM
130		Epilepsy: Petit Mal
131		Epilepsy: Grand Mal
132		Epilepsy: Other (specify)..... .....
133		Cerebral spastic infantile paralysis.
134		Migraine
135		Motor neurons disease and muscular atrophy.
136		Facial paralysis
137		Chorea
138		Hydrocephalus
139		Spina bifida
13x		Other acquired defects (specify) ....
13y		Other congenital defects (specify) ....
		SPEECH DEFECT
140		Specify (for example, stammer, dyslalia).
		PSYCHOLOGICAL DISORDERS
150		Behaviour disorders of childhood (for example, truancy, jealousy, tantrums, pathological lying, stealing).
151		Tics
152		Other psychomotor disorders (specify) ....
153		Disorders of sleep
154		Enuresis
155		Encopresis
156		Other disorders (specify)..... .....
		MENTAL HANDICAP
160		Mild mental handicap (approx. I.Q. 50 to 70).

Code No.	Category Number*		Code No.	Category Number*	
161		Moderate mental handicap (approx. I.Q. 25 to 50).	178		German measles
			179		Worms
162		Severe mental handicap (approx. I.Q. 0 to 25).	17x		Other diseases (specify)..... .....
		INFECTIVE AND PARASITIC DISEASES			MISCELLANEOUS DEFECTS NOT OTHERWISE CLASSIFIED
170		Acute respiratory infections (including tonsillitis).	180		Hernia
171		Pulmonary tuberculosis	181		Branchial cleft, cyst or fistula
172		Tuberculosis of bones and joints (specify)	182		Undescended testicle
			183		Epispadias Hypospadias
			184		Other defect of the male genitalia.
173		Late effects of poliomyelitis	185		Cleft lip
174		Mumps	186		Cleft palate
175		Chicken pox	187		Albinism
176		Pertussis	188		Other defects (specify)..... .....
177		Measles			

*See note (2) on p. 113.

APPENDIX 9.—INCIDENCE OF EACH DEFECT, FOR EACH CATEGORY, PER 1,000 CHILDREN EXAMINED DURING SURVEY (TOTAL CHILDREN INCLUDED IN SURVEY = 51,780)

KEY TO CATEGORIES

Category Number

1. Child referred by the School Medical Officer, or through a general practitioner, for specialist inpatient or outpatient investigation or treatment (this includes child guidance, speech or hearing investigation etc.).
2. Child referred back for general practitioner treatment.
3. Defect noted for observation only.
4. Defect now observed for first time at School Health Examination and already under treatment, otherwise than through the School Health Service.
5. Serious defect not amenable to treatment.
6. Defect discovered at a previous School Health Examination and receiving treatment.

Figures are shown correct to first place of decimals.

Code Number	Defects	Incidence per 1,000 children examined						
		Category 1	Category 2	Category 3	Category 4	Category 5	Category 6	All Categories
010	Infestation*[1]	0·8	16·1	2·3	0·1	—	0·2	19·4
	SKIN AND CELLULAR TISSUE							
020	Scabies	0·1	0·6	0·0	0·2	0·0	—	0·9
021	Eczema	0·6	0·4	0·5	0·5	—	0·2	2·3
022	Psoriasis	0·3	0·2	0·3	0·2	—	0·2	1·2
023	Ichthyosis	0·3	0·1	0·9	0·1	0·1	0·1	1·5
024	Large Moles	0·5	—	2·5	0·1	0·0	0·1	3·2
025	Ringworm	0·1	0·3	0·0	0·2	—	0·0	0·7
026	Impetigo	0·2	1·2	0·4	0·2	—	0·0	2·0
027	Nail defects	0·1	0·1	0·5	0·0	—	0·0	0·8
028	Other skin defects	2·1	3·6	11·0	0·9	0·0	0·2	17·7
	EYE							
030	Defective vision—Grade I (6/12, 6/18 in either eye).	69·3	0·1	1·4	3·6	0·1	20·1	94·6
031	Defective vision—Grade II (6/24, 6/36 in either eye).	18·5	0·1	0·1	1·6	0·1	10·2	30·6
032	Defective vision—Grade III (6/60 or less in either eye).	3·9	—	0·0	0·8	0·1	3·6	8·3
040	Strabismus	19·7	0·0	1·1	3·5	0·1	9·6	34·1
041	Tarsal Cysts	0·3	0·0	0·0	—	—	0·0	0·3
042	Blepharitis	2·1	3·3	2·5	0·1	—	0·4	8·5
043	Nystagmus	0·3	—	0·0	0·1	—	0·2	0·6
044	Cataract	0·2	—	—	0·1	0·0	0·0	0·3
045	Conjunctivitis	0·4	0·4	0·1	—	—	0·0	1·0
046	Other eye defects	1·6	0·2	1·4	0·2	0·0	0·3	3·7

Code Number	Defects	Incidence per 1,000 children examined						
		Category 1	Category 2	Category 3	Category 4	Category 5	Category 6	All Categories
	EAR							
050	Defective hearing	5·3	0·1	0·2	0·4	0·0	0·8	6·8
051	Otitis externa	0·7	0·1	0·1	0·1	—	0·0	1·1
052	Otitis media	2·9	0·3	0·6	0·5	—	0·3	4·5
053	Other ear defects	0·7	0·4	0·6	0·1	—	0·1	1·9
	NOSE AND THROAT*[2]							
061 062 063 064	Tonsils and adenoids	37·8	0·7	101·0	—	—	—	139·5
065	Deflected nasal septum	0·4	—	0·2	0·0	0·0	0·1	0·8
066	Nasal polyp	0·3	—	0·0	—	0·0	0·0	0·4
067	Other nose and throat defects ...	2·4	0·5	4·6	0·3	0·1	0·2	8·2
	CIRCULATORY AND BLOOD DISEASE							
070	Heart disease of rheumatic origin ...	0·8	0·1	0·3	0·5	—	0·2	1·9
071	Congenital heart disease	2·6	0·1	1·3	0·6	—	1·3	5·9
072	Iron deficiency anaemia	1·0	6·4	1·5	0·3	—	0·3	9·5
073	Other anaemia	0·1	0·2	0·2	—	—	—	0·4
074	Pupura and other haemorrhagic conditions.	0·1	—	0·2	0·1	0·0	0·0	0·4
	LUNGS (NON-TUBERCULAR)							
080	Asthma	0·9	0·5	0·5	1·5	—	0·6	3·9
081	Bronchiectasis and/or atelectasis ...	0·1	0·0	0·0	0·1	—	0·1	0·3
082	Bronchitis and asthmatic bronchitis	3·0	2·7	2·5	0·7	—	0·5	9·5
083	Other lung defects	0·6	0·2	0·3	0·3	—	0·0	1·4
090	Disorders of digestive tract	0·4	0·3	1·6	0·3	0·0	0·0	2·7
	ENDOCRINE SYSTEM, NUTRITIONAL AND METABOLIC							
100	Goitre	0·2	0·1	0·3	0·0	—	0·0	0·6
101	Diabetes mellitus	0·0	0·0	—	0·2	—	0·0	0·3
102	Diseases of other endocrine glands	0·0	—	0·0	0·0	—	—	0·1
103	Vitamin deficiency	—	0·0	0·0	—	—	—	0·0
104	Coeliac disease	0·0	—	0·1	0·5	—	0·1	0·7
105	Obesity	0·4	0·3	1·4	0·0	—	0·1	2·2
106	Other defects of endocrine system, etc.	0·4	0·5	1·9	0·2	—	0·1	3·0

Code Number	Defects	Incidence per 1,000 children examined						
		Category 1	Category 2	Category 3	Category 4	Category 5	Category 6	All Categories
	BONES AND ORGANS OF MOVEMENT (ACQUIRED DEFECTS)							
110	Defective posture	1·4	0·1	12·6	0·0	—	0·3	14·3
111	Osteomyelitis	—	—	0·0	0·1	—	—	0·1
112	Curvature of spine	0·2	—	0·3	0·1	—	0·1	0·7
113	Flat foot	8·1	0·7	19·4	0·3	0·0	1·3	29·8
114	Hallux valgus and varus	0·6	—	1·1	0·1	—	0·1	1·9
115	Club foot	0·1	0·0	0·1	0·2	—	0·1	0·5
116	Defects of ribs and sternum, (e.g., Pidgeon chest, Harrison's sulcus).	1·5	0·2	6·9	0·2	0·1	0·4	9·1
117	Other deformities	4·0	0·2	6·8	0·7	0·0	0·8	12·5
	BONES AND ORGANS OF MOVEMENT (CONGENITAL DEFECTS).							
120	Spinal curvature	0·1	—	0·1	0·0	—	0·0	0·3
121	Dislocation of hip	0·0	—	—	0·2	—	0·0	0·2
122	Defects of ribs and sternum ...	0·0	—	0·7	0·0	—	—	0·7
123	Talipes	0·1	—	—	0·3	0·0	0·1	0·5
124	Achondroplasia	—	—	0·0	—	—	—	0·0
125	Torticollis	0·3	—	0·0	0·1	—	0·2	0·6
126	Other defects (congenital) of bones and organs of movement.	0·8	0·0	1·4	0·3	0·1	0·3	2·8
	CENTRAL NERVOUS SYSTEM							
130	Epilepsy petit mal	0·1	0·0	0·0	0·3	—	0·2	0·7
131	Epilepsy grand mal	0·1	—	0·0	0·4	—	0·2	0·7
132	Other epilepsy	0·1	0·0	0·0	0·0	—	—	0·1
133	Cerebral spastic infantile paralysis ...	0·0	—	0·0	0·1	—	0·0	0·2
134	Migraine	0·3	0·3	0·1	0·1	—	0·0	0·8
135	Motor neurons disease and muscular atrophy.	—	—	0·0	—	0·0	0·0	0·1
136	Facial paralysis	—	—	—	—	—	0·1	0·1
137	Chorea	—	—	—	—	—	—	—
138	Hydrocephalus	—	—	0·1	0·1	—	—	0·1
139	Spina bifida	—	—	—	0·1	—	—	0·1
13x	Other acquired defects	—	—	—	—	—	—	—
13y	Other congenital defects	—	—	—	—	—	—	—
140	Speech defect (e.g. stammer, dyslalia)	9·1	0·0	6·9	0·6	0·0	1·7	18·5
	PSYCHOLOGICAL DISORDERS							
150	Behaviour disorders of childhood (e.g. truancy, jealousy, tantrums, pathological lying, stealing).	0·4	0·0	0·2	0·1	—	0·1	0·8

Code Number	Defects	Incidence per 1,000 children examined						
		Category 1	Category 2	Category 3	Category 4	Category 5	Category 6	All Categories
151	Tics	0·1	—	0·1	0·1	—	—	0·3
152	Other psychomotor disorders ...	0·0	—	0·9	0·0	—	0·0	1·0
153	Disorders of sleep	0·1	0·1	0·0	0·0	—	—	0·3
154	Enuresis	2·0	0·9	1·3	0·3	—	0·3	4·9
155	Encopresis	0·0	0·0	0·0	0·1	—	—	0·1
156	Other psychological disorders ...	0·5	0·0	9·2	0·2	—	0·1	10·0
	MENTAL HANDICAP							
160	Mild mental handicap (approx. I.Q. 50 to 70).	5·3	0·0	1·4	0·4	—	0·4	7·6
161	Moderate mental handicap (approx. I.Q. 25 to 50).	0·2	—	0·0	0·0	—	0·0	0·3
162	Severe mental handicap (approx. I.Q. 0 to 25).	0·0	—	0·0	—	0·0	—	0·1
	INFECTIVE AND PARASITIC DISEASES							
170	Acute respiratory infections (including tonsillitis).	0·0	0·9	1·9	0·1	—	—	2·9
171	Pulmonary tuberculosis	0·0	—	0·2	0·3	—	0·1	0·6
172	Tuberculosis of bones and joints ...	—	—	—	—	—	0·0	0·0
173	Late effects of poliomyelitis ...	—	0·0	0·2	0·3	0·1	0·1	0·6
174	Mumps	—	—	—	—	—	—	—
175	Chicken pox	0·0	0·2	0·2	—	—	—	0·3
176	Pertussis	—	0·0	0·0	—	—	—	0·0
177	Measles	—	—	—	—	—	—	—
178	German measles	—	—	—	—	—	—	—
179	Worms	—	0·2	—	0·0	—	—	0·2
17x	Other diseases	—	—	—	—	—	—	—
	MISCELLANEOUS DEFECTS NOT OTHERWISE CLASSIFIED							
180	Hernia	1·0	0·1	1·3	0·3	—	0·1	2·7
181	Branchial cleft, cyst or fistula ...	0·1	0·1	0·1	0·2	—	—	0·5
182	Undescended testicle*3	1·8	0·2	2·3	0·1	—	0·3	4·6
183	Epispadias hypospadias*3	0·0	—	0·1	—	—	—	0·1
184	Other defect of male genitalia*3 ...	0·3	0·0	0·6	0·0	—	0·1	1·0
185	Cleft lip	0·0	—	0·1	0·4	—	0·1	0·6
186	Cleft palate	0·1	—	0·1	0·4	—	0·1	0·7
187	Albinism	0·0	—	0·0	0·0	0·0	—	0·1
188	Other miscellaneous defects ...	2·0	0·6	4·9	0·6	0·0	0·3	8·5

**Footnotes*

(1) Code No. 010 Infestation: An incidence 16·1 per 1,000 is shown in category 2; this includes 10·1 from Dublin where the follow-up is, however, by the nurse rather than the general practitioner.

(2) The tonsils and adenoids figures have been arrived at as follows:

Code Number	Heading	Incidence per 1,000 children
061	Referred direct to hospital for tonsillectomy ...	8·8
062	Referred to specialist for opinion	29·0
063	Referred back to general practitioner for opinion	0·7
064	Noted for observation only	101·0

Code Nos. 061 and 062 have been added together and regarded as equivalent to Category 1 in the main table; Code No. 063 has been regarded as equivalent to Category 2 and Code No. 064 as equivalent to Category 3.

(3) Code Nos. 182, 183, 184: These three defects—undescended testicle, Epispadias Hypospadias, Other defect of male genitalia—refer only to males.
On the assumption that an equal number of males and females were included in the survey, the true incidence of these defects *per* 1,000 *males* examined would be twice the figures shown in the Table.

APPENDIX 10.—ANALYSIS OF PARENTS PRESENT AT SCHOOL MEDICAL EXAMINATIONS

TABLE 1.—% OF CHILDREN EXAMINED DURING THE SCHOOL HEALTH SURVEY IN EACH COUNTY WHO HAD A PARENT PRESENT AT THE EXAMINATION

County	Entrance	Intermediate	Leavers	All examinations
	%	%	%	%
Carlow	47·56	44·55	31·88	42·83
Cavan	7·06	3·70	1·64	4·30
Clare	18·01	11·70	7·63	15·36
Cork	35·99	35·36	21·58	32·59
Donegal	87·42	85·33	75·61	83·71
Dublin	4·78	4·15	1·88	4·08
Galway	10·57	8·01	3·30	8·13
Kerry	25·74	21·05	16·32	22·42
Kildare	18·90	20·18	16·33	18·72
Kilkenny	21·56	11·04	9·44	15·60
Laois	7·67	5·20	4·07	5·79
Leitrim	5·88	8·74	3·62	5·84
Limerick	4·39	1·12	1·66	2·94
Longford	12·02	7·35	6·60	8·52
Louth	0·61	—	0·52	0·42
Mayo	6·44	5·41	4·33	5·48
Meath	1·50	1·74	0·59	1·35
Monaghan	56·91	52·23	44·17	52·56
Offaly	27·13	5·68	1·46	15·61
Roscommon	Not included in Survey			
Sligo	4·06	3·46	3·10	3·55
Tipperary N.R.	14·26	30·77	3·78	13·13
Tipperary S.R.	15·23	12·63	8·96	13·42
Waterford	73·17	50·00	18·40	57·94
Westmeath	31·67	11·94	8·80	18·82
Wexford	51·75	46·39	31·90	45·48
Wicklow	0·14	0·37	0·72	0·26
Total	19·60	17·12	11·93	17·18

NOTE: ENTRANCE examination comprises children who had no previous school medical examination.

INTERMEDIATE examination comprises children aged 10 years or less who had a previous examination(s).

LEAVERS examination includes children aged 11 years or more who had a previous school medical examination(s).

TABLE 2.—PRESENCE OF PARENTS AT SCHOOL MEDICAL EXAMINATIONS IN COUNTY BOROUGHS, URBAN AREAS AND RURAL AREAS FOR CHILDREN OF DIFFERENT AGES.

	No Previous Inspection					With Previous Inspection			
	5 years and under	6 years	7 years	8 years and over	Total First Exam.	6 years and under	7–10 years	Total Inter-mediate	Leavers 11 years and over
National:									
(1) Children examined	9,308	4,828	3,335	8,024	25,495	1,049	13,649	14,698	11,587
(2) Parents Present	2,320	981	646	1,051	4,998	210	2,307	2,517	1,382
(3) % present	24·92	20·32	19·37	13·10	19·60	20·02	16·90	17·12	11·93
County Boroughs:									
(1) Children examined	3,428	1,330	757	2,714	8,229	395	3,777	4,172	3,043
(2) Parents Present	590	74	43	99	806	23	240	263	98
(3) % present	17·21	5·56	5·68	3·65	9·79	5·82	6·35	6·30	3·22
Urban Areas:									
(1) Children examined	2,093	790	553	1,257	4,693	195	2,363	2,558	1,699
(2) Parents Present	656	200	113	178	1,147	59	458	517	206
(3) % present	31·34	25·32	20·43	14·16	24·44	30·26	19·38	20·21	12·12
Rural Areas:									
(1) Children examined	3,787	2,708	2,025	4,053	12,573	459	7,509	7,968	6,845
(2) Parents Present	1,074	707	490	774	3,045	128	1,609	1,737	1,078
(3) % present	28·36	26·11	24·20	19·10	24·22	27·89	21·43	21·80	15·75

APPENDIX 11.—PARENTS PRESENT AT SCHOOL MEDICAL EXAMINATIONS IN RELATION TO SPECIFIED DEFECTS

Incidence of defects requiring referral for investigation or treatment (Categories 1 and 2) *per* 1,000 *children* with parents present and with parents absent.

No.	Defect Heading (and Code Number)	First Examination		Intermediate Examination		Leavers Examination		All Examinations		
		Incidence of defect in Categories 1 and 2 per 1,000 children whose		Incidence of categories 1 and 2 per 1,000 children whose		Incidence of categories 1 and 2 per 1,000 children whose		Incidence of categories 1 and 2 per 1,000 children whose		
		parents were present	parents were absent	parents were present	parents were absent	parents were present	parents were absent	parents were present	parents were absent	Total incidence parents present and absent
1	Speech Defects (140)	18·0	9·6	13·9	6·6	13·7	5·1	16·1	7·6	9·1
2	Mild Mental Handicap (160)	7·6	4·5	7·9	4·6	13·0	5·1	8·5	4·6	5·3
3	Defective Hearing (050)	6·0	5·6	10·7	3·6	13·7	4·3	8·5	4·7	5·3
4	Enuresis (154)	10·4	2·1	6·8	2·1	4·3	0·6	8·4	1·7	2·8
5	Undescended Testicle (182)	1·2	2·3	1·6	1·8	2·2	2·1	1·4	2·1	2·0
6	Asthma (080)	3·2	1·2	4·0	0·2	5·1	0·9	3·7	0·8	1·3
7	Digestive Tract (090)	1·6	0·4	2·4	0·3	3·6	0·4	2·1	0·3	0·6
8	Migraine (134)	1·4	0·1	1·2	0·4	2·2	0·8	1·4	0·3	0·5
9	Behaviour Disorders (150)	0·8	0·4	0·8	0·2	1·4	0·2	0·8	0·3	0·4
10	Other Defect of Male Genitalia (184)	0·6	0·6	0·4	0·1	—	0·1	0·4	0·3	0·3
11	Other Psychological Disorders (156)	1·4	0·2	1·6	0·6	0·7	0·7	1·3	0·4	0·6
12	Epilepsy Grand Mal (131)	0·2	—	0·4	0·1	—	0·1	0·2	0·0	0·1
13	Epilepsy Petit Mal (130)	0·2	0·1	0·8	0·1	1·4	—	0·5	0·1	0·1
14	Tics (151)	—	—	0·4	0·2	1·4	—	0·3	0·0	0·1
15	Disorders of Sleep (153)	1·0	0·1	—	0·2	—	—	0·5	0·1	0·1
16	Worms (179)	1·2	0·1	0·4	—	—	—	0·7	0·0	0·1
17	Epilepsy other (132)	0·2	0·1	—	—	0·7	—	0·2	0·0	0·1
18	Other Psychomotor Disorders (152)	0·2	0·0	—	—	—	—	0·1	0·0	0·0
19	Coeliac Disease (104)	0·2	0·0	—	—	—	—	0·1	0·0	0·0
20	Diabetes Mellitus (101)	—	—	0·4	0·1	—	—	0·1	0·0	0·0
21	Encopresis (155)	0·2	0·0	—	—	—	—	0·1	0·0	0·0

NOTE: The differences in the incidence rates when parents were present and absent, respectively, were tested for significance by the Chi-square test. Six defects were tested individually (Nos. 1-4, 6, 7) and the rest were grouped as follows :—(Nos. 8 and 9), and (Nos. 11–21 inc.).
Defects No. 5 (Undescended Testicle) and No. 10 (Other Defect of Male Genitalia) were not tested as separate figures for males were not extracted from the Survey. The differences in the incidence rates tested were significant in all cases at the 1 % level.

APPENDIX 12.—CHILD HEALTH SERVICES: PRE-SCHOOL RECORD CARD

[This portion to be retained by the general practitioner].

Confidential MEDICAL CARE FOR MOTHERS AND INFANT WELFARE SERVICES

.....County Council/Health Authority No. .....

NAME.....Age..... PREVIOUS PREGNANCIES : Live Births.....Still Births.....Abortions/Miscarriages.....

ADDRESS ..... Complications .....

....

..... Relevant Illness : Diabetes/Nephritis Cardiac/Rubella (*strike out*)/Other .....Date.....

L.M.P.....E.D.D..... Operations .....

GENERAL EXAMINATION .....

.....

.....

.....

BLOOD-GROUP.....Rh.....Antibodies.....WR/Kahn Pos./Neg. Previous Transfusions.....

ANTE-NATAL

	Dates of Examinations	Weight Sts. Lbs.	B.P.	Hb.	Urine	Size of Uterus	Presentation	F.H.	Complications (Headaches, Vomiting, Oedema, Haemorrhage, Disproportion)	REMARKS
Prior to the expiration of the 28th week										
After 28th week										

CONFINEMENT

ABORTION/MISCARRIAGE : Date.....Admitted to Hospital : Date..... ; Hospital.....
DURATION OF PREGNANCY (In Weeks) : .....REMARKS.....

BIRTH : Date.....Place.....Whether Doctor in attendance : Yes/No. Analgesia.....
Method of Delivery .....Complications (if any) and Treatment.....

.....

.....

Admitted to Hospital : Date..... ; Hospital..... ; Reasons for Admission.....

.....

.....

POST-NATAL

Dates of Examinations	CONDITION AND TREATMENT GIVEN

Maternal Death : Date..... Cause.....
Six-weeks examination : Date.....Bi-Manual/Visualisation of the Cervix/Other.....

INFANT(S)*

(1) Sex : M./F. Wt.....lbs.....ozs. Stillbirth ☐ Asphyxia ☐ Prematurity ☐ Jaundice ☐
(2) Sex : M./F. Wt.....lbs.....ozs. Stillbirth ☐ Asphyxia ☐ Prematurity ☐ Jaundice ☐
Condition at birth (1).....(2).....
Feeding (1).....(2).....
Death : (1) Date.....Cause.....(2) Date.....Cause.....
*(2) Second space to be completed in the case of a multiple birth.

GENERAL REMARKS : .....

.....

.....

SIGNED.....*Medical Practitioner.* Date.....

CHILD HEALTH SERVICES: PRE-SCHOOL RECORD CARD

[This portion to be retained by the Chief Medical Officer of the health authority].

Confidential **MEDICAL CARE FOR MOTHERS AND INFANT WELFARE SERVICES**

.....County Council/Health Authority No. .....

NAME.....Age..... PREVIOUS PREGNANCIES : Live Births.....Still Births.....Abortions/Miscarriages.....

ADDRESS ..... Complications .....

....

..... Relevant Illness : Diabetes/Nephritis Cardiac/Rubella (*strike out*)/Other .....Date.....

L.M.P.....E.D.D..... Operations .....

GENERAL EXAMINATION .....

.....

.....

.....

BLOOD-GROUP.....Rh.....Antibodies.....WR/Kahn Pos./Neg. Previous Transfusions.....

ANTE-NATAL

	Dates of Examinations	Weight Sts. Lbs.	B.P.	Hb.	Urine	Size of Uterus	Presentation	F.H.	Complications (Headaches, Vomiting, Oedema, Haemorrhage, Disproportion)	REMARKS
Prior to the expiration of the 28th week										
After 28th week										

CONFINEMENT

ABORTION/MISCARRIAGE : Date.....Admitted to Hospital: Date..... ; Hospital.....
DURATION OF PREGNANCY (In Weeks): .....REMARKS.....

BIRTH : Date.....Place.....Whether Doctor in attendance: Yes/No. Analgesia.....
Method of Delivery.....Complications (if any) and Treatment.....
.....
Admitted to Hospital : Date..... ; Hospital.....; Reasons for Admission.....
.....
.....

POST-NATAL

Dates of Examinations	CONDITION AND TREATMENT GIVEN

Maternal Death : Date..... Cause.....
Six-weeks examination : Date.....Bi-Manual/Visualisation of the Cervix/Other.....

INFANT(S)*

(1) Sex : M./F. Wt.....lbs.....ozs. Stillbirth ☐ Asphyxia ☐ Prematurity ☐ Jaundice ☐
(2) Sex : M./F. Wt.....lbs.....ozs. Stillbirth ☐ Asphyxia ☐ Prematurity ☐ Jaundice ☐
Condition at birth (1).....(2).....
Feeding (1).....(2).....
Death : (1) Date.....Cause..... (2) Date.....Cause.....
*(2) Second space to be completed in the case of a multiple birth.

GENERAL REMARKS : .....
.....
.....
.....

SIGNED.....*Medical Practitioner.* Date.....

PERIODIC MEDICAL EXAMINATION AT ABOUT 4-6 weeks

1. PRELIMINARY DETAILS

Child's Name	
Address	
Age Now	
Doctor's Name	

2. EXAMINATION	Details
General appearance and demeanour of mother and child (specify)	
Mother's comments	
Feeding	
Sight and manipulation (state test and response)	
Social Behaviour	

3. PHYSICAL EXAMINATION

ITEMS	Comments	Action Taken (RS, O, T)*
Heart and Circulation		
Respiratory		
Deformities (e.g. hips)		
Muscle Tone		
Alimentary system		
Others (specify)		

* RS—Referred for specialist investigation or treatment.
O—For observation only.
T—Treated or being treated.

Doctor's Signature :

Date :

Code No.	

Surname*	Christian Names*	Date of Birth*	ADDRESS	1.
				2.
				3.

Place in Family	Total Children in Family	Father's Occupation	Mother's Occupation

P.K.U. Test	Date	Result

Family History if relevant →		On	Off
	At risk Register		

Significant Home Conditions →	L	
	I	
	A	

PROPHYLAXIS (DATES)

	Primary Course Completed	Booster
Triple Antigen Poliomyelitis		
	Result	Date
Smallpox		
B.C.G.		

CHILD'S ILLNESSES

Illness	Date	Complications
Whooping Cough		
Measles		
Chicken Pox		
German Measles		
Mumps		
Other, including accidents (specify)		

*These details can be omitted if available on Page 2.

Examination	At about Six Months Date : Age :		At about One Year Date : Age :	
Changes in family circumstances				
General appearance of mother and child				
Posture and Locomotion				
Vision (state test)				
Hearing (state test)				
Social Behaviour				
Sleeping				
Appetite				
Elimination				
Milestones Reached (Please tick ✓ box)	Sits upright on floor for a few seconds — Yes / No		Walks, if hand held — Yes / No	
	Lifts head spontaneously when lying on back — Yes / No		Begins to say single words with meaning — Yes / No	
PHYSICAL	Comments	Action taken (RS, O, T)*	Comments	Action taken (RS, O, T)
Teeth				
Skin				
Eyes				
Ears				
Heart and circulation				
Nose and Throat				
Lungs				
Nervous System				
Deformities				
Others (specify)				

Doctor's initials :

*RS ...Referred for specialist investigation or treatment.
O ...For observation only.
T ...Treated or being treated.

At about Two Years Date : Age :	Date	Age	PROGRESS NOTES	M.O.'s Initials

Dry, by night	Yes	No

Runs	Yes	No

Comments	Action taken (RS, O,T.)

DATE	AGE	PROGRESS NOTES (continued)	M.O.'s INITIALS

ADDITIONAL EXAMINATIONS

Examination	First Additional	Second Additional
Changes in family circumstances		
General appearance of mother and child		
Posture and Locomotion		
Vision (state test)		
Hearing (state test)		
Social Behaviour		
Sleeping		
Appetite		
Elimination		

Physical	Comments	Action Taken (RS, O,T)	Comments	Action Taken (RS, O,T)
Teeth				
Skin				
Eyes				
Ears				
Nose and Throat				
Heart and Circulation				
Lungs				
Nervous System				
Deformities				
Others (specify)				

Doctor's initials :

Third Additional		Fourth Additional	
Comments	Action taken (RS, O,T)	Comments	Action taken (RS, O,T)

APPENDIX 13.—QUESTIONNAIRE FOR COMPLETION BY PARENTS

.....Health Authority.

CHILD HEALTH SERVICE.

Dear Parent,

Your child.....will be medically examined under the Child Health Service on.....at about.....a.m./p.m. in the school. It would be very useful to the doctor if you could be there while your child is being examined. You will be more than welcome to come along.

Meanwhile, it would be appreciated if you would answer the queries on this form.

.....Chief Medical Officer.

Please read "he" or "she" where applicable:

(1) Has he been immunised against Diphtheria? Yes/No (Year.....)
(2) Has he had Smallpox Vaccination? Yes/No (Year.....)
(3) Has he had Oral Polio Vaccination? Yes/No (Year.....)
(4) Has he had B.C.G. Vaccination? Yes/No (Year.....)
(5) Does he get frequent colds or sore throats?.....
(6) Does he snore at night or breathe through his mouth?.....
(7) Has he ever had earaches or running ears? .....
(8) Have you any reason to suspect deafness in one or both ears?.....
(9) Do you think there is anything wrong with his vision?.....
(10) If he wears glasses do you consider them satisfactory?.....
(11) Any difficulty with his speech?.....
(12) Does he suffer from asthma or any other chest ailment? If so, how?.....
.....
(13) Has he plenty of energy?.....
(14) Do you consider him backward for his age?.....
(15) Does he suffer from any of the following nervous conditions? If so, underline which one: Nail-biting, Night terrors, Twitching, Undue timidity, Excessive anxiety.
(16) Does he wet the bed?.....
(17) Has he been in Hospital?.....If so, why?.....
(18) Is he at present undergoing treatment for any condition?.....
.....
(19) Are you worried about him in any way?.....If so, give details.....
.....
.....
(20) Who is your family doctor? .....

Signature of Parent:.....
Date: .....

NOTE: The questionnaire completed by the parents of 9 year old children would be used by the School Medical Officer as an aid in selecting children for medical examination. The introduction to the questionnaire would have to be modified in such cases as only a proportion of the children would be selected for examination. If the information sought related to a limited preceding period e.g. 1 year, this would also be stated in the introduction.

APPENDIX 14.—SCHOOL HEALTH CARD

Code No.

Surname	Christian names	Date of Birth

Address 1. .....

2. .....

1. Family Dr.....
Address .....
.....
.....

2. Family Dr.....
Address .....
.....
.....
.....

Number in Family	Place in Family	Father's occupation	Mother's occupation

Significant Home Conditions →

Family Medical History if Relevant →

At Risk Register	On	Off

School

1.

2.

3.

Illnesses, Operations, Accidents	Age	Complications
Whooping Cough		
Measles		
Scarlet Fever		
Mumps		
Chicken Pox		
Diphtheria		
Poliomyelitis		
Other Illnesses, including accidents (specify)		

	Prophylaxis	
	Primary Course Completed	Booster
Triple Antigen		
Poliomyelitis		
	Result	Date
Smallpox		
B.C.G.		

Vision	Date													
Without Glasses	R													
	L													
With Glasses	R													
	L													

Hearing (Audiometric)

Date	Result

Special Tests (date, test, result)

Date	Test	Result

SUMMARY OF FINDINGS.

RS = refer for specialist investigation or treatment
O = for observation only
RGP = refer back for general practitioner treatment
RH = refer to hospital
PD = permanent defect not requiring action

UTO = under treatment otherwise (than through Child Health Service
AT = awaiting treatment from previous school medical examination
UT = under treatment from previous school medical.

		I	II	III	IV
		Date	Date	Date	Date
1	Age				
2	Class or standard				
3	Complete years at school				
4	Type of Examination [E = entrance; SN = selective 9 year old; S = special]				
5	Parent (P = present; A = absent)				
6	Height				
7	Weight				
8	Clothing				
9	Footgear				
10	Hair and scalp (Infestation)				
11	Body				
	EYES:				
12	Strabismus				
13	Blepharitis				
14	Conjunctivitis				
15	Other Eye Defects (specify)				
	EARS:				
16	Defective Hearing				
17	Otitis Externa				
18	Otitis Media				
19	Speech Defect (specify)				
20	Skin Defect (specify)				
	NOSE AND THROAT:				
21	Tonsils				
22	Adenoids				
23	Cervical Glands				
24	Other ENT defects (specify)				
	CIRCULATORY, ETC.				
25	Heart:				
	organic—Rheumatic				
26	Congenital				
27	functional				
28	Anaemia				
29	Other circulatory defects (specify)				
	LUNGS:				
30	Bronchitis				
31	Asthma				
32	Other lung defects (specify)				
33	Digestive tract				
34	Dental condition				
35	Goitre				
36	Diabetes Mellitus				
37	Other Endocrine Glands				
38	Vitamin Deficiency				
39	Coeliac Disease				
40	Obesity				
	BONES AND ORGANS OF MOVEMENT:				
41	Defective posture				
42	Osteomyelitis				
43	Curvature of spine				
44	Flat foot				
45	Hallux Valgus				
46	Defects of ribs and sternum				
47	Dislocation of Hip				
48	Talipes				
49	Other (specify)				
	CENTRAL NERVOUS SYSTEM:				
50	Epilepsy				
51	Cerebral Palsy				
52	Migraine				
53	Motor neurons disease and muscular atrophy				
54	Facial Paralysis				
55	Chorea				
56	Hydrocephalus				
57	Spina Bifida				
	PSYCHOLOGICAL DISORDERS:				
58	Emotional (e.g. fears, seclusiveness, depression) specify				
59	Habit (e.g. tics, enuresis, sleep, appetite, nailbiting) specify				
60	Behaviour (e.g. temper, jealousy, aggressiveness) specify				
61	Psychotic (e.g. autism, etc.) specify				
62	Educational and vocational difficulties (e.g. listlessness, lack of concentration) specify				
	MENTAL CONDITION:				
63	Dull or Backward				
64	Mild Mental Handicap				
65	Moderate Mental Handicap				
	INFECTIVE AND PARASITIC:				
66	Acute Respiratory (inc. tonsillitis)				
67	Pulmonary Tuberculosis				
68	T.B. of Bones and Joints				
69	Late effects of Poliomyelitis				
70	Acute specific fever (specify)				
	MISCELLANEOUS DEFECTS:				
71	Hernia				
72	Undescended Testicle				
73	Cleft Lip				
74	Cleft Palate				
75	Albinism				
76	Torticollis				
77	Other defects not elsewhere specified				
	Summary: Please tick space in columns if the child had:— No defect				
	Observation Defect(s) solely				
	At least one Defect RS				
	Any other Combinations				

[Space for extra comments on back page]

Background Information on Child	Doctor's Advice or Instructions	Initials
Teacher Date		
Nurse Date		
Parent Date		

PROGRESS NOTES ON CHILD

(including results of specialist investigations etc.)

Date	Observations	Doctor's Initials

APPENDIX 15

TABLE 1.—CHILDREN ELIGIBLE FOR PROPOSED CHILD WELFARE AND SCHOOL HEALTH SERVICES; NATIONAL SCHOOLS; AND AREA (SQUARE MILES), IN EACH COUNTY

TABLE 1

Health Authority	Eligible Children			National Schools (June 1965)	Area (Sq. miles)
	Est. 0–2 years in towns 5,000+	National School Children (1 Feb. 1965)	Total Eligible Children		
Carlow	635	6,030	6,665	61	346
Cavan	—	9,149	9,149	190	730
Clare	597	11,649	12,246	176	1,231
Cork	9,300	53,336	62,636	523	2,880
Donegal	—	18,088	18,088	354	1,865
Dublin	48,103	116,019	164,122	418	356
Galway	2,088	26,487	28,575	338	2,293
Kerry	1,225	18,999	20,224	257	1,815
Kildare	330	12,277	12,607	98	654
Kilkenny	782	10,805	11,587	138	796
Laois	382	7,320	7,702	97	664
Leitrim	—	4,890	4,890	125	589
Limerick	3,775	24,722	28,497	208	1,037
Longford ...	—	5,060	5,060	72	403
Louth	2,573	12,126	14,699	86	317
Mayo	761	20,437	21,198	328	2,084
Meath	384	11,298	11,682	125	903
Monaghan ...	—	7,902	7,902	133	498
Offaly	447	9,872	10,319	102	771
Roscommon ...	—	9,744	9,744	160	950
Sligo	872	8,856	9,728	143	693
Tipperary N.R. ...	452				
Tipperary S.R. ...	745	22,096	23,293	248	1,642
Waterford ...	2,289	12,422	14,711	112	710
Westmeath ...	1,230	9,859	11,089	103	681
Wexford ...	1,236	14,379	15,615	142	908
Wicklow ...	1,284	9,535	10,819	110	782
TOTALS ...	79,490	473,357	552,847	4,847	26,598

NOTE: (1) Children 0–2 years of age were estimated by applying the national % in this age group (6·5% in 1961 Census) to the population of towns 5,000+ in each county as given in the 1966 Census.

(2) Details of national school children in each county were obtained from the Department of Education.

TABLE 2—ACMOs EMPLOYED BY HEALTH AUTHORITIES, AVAILABLE EITHER WHOLETIME OR PART-TIME TO THE SCHOOL HEALTH AND CHILD WELFARE SERVICES (FIGURES IN BRACKETS SHOW EACH COUNTY IN THE ORDER OF DESCENDING MAGNITUDE)

Health Authority	Number of Posts*	1. Eligible children per doctor*	2. National schools per doctor	3. Square Miles per doctor
Carlow	1	6,700 (11)	61 (16)	346 (18)
Cavan	1	9,100 (5)	190 (1)	730 (3)
Clare	2	6,100 (15)	88 (8)	616 (5)
Cork	10	6,300 (13)	52 (19)	288 (23)
Donegal	4	4,500 (24)	89 (7)	466 (10)
Dublin	15	10,900 (2)	28 (26)	24 (26)
Galway	3	9,500 (3)	113 (5)	764 (2)
Kerry	3	6,700 (12)	86 (9)	605 (6)
Kildare	2	6,300 (14)	49 (22)	327 (22)
Kilkenny ...	3	3,900 (25)	46 (24)	265 (24)
Laois	2	3,900 (26)	49 (23)	332 (21)
Leitrim	1	4,900 (21)	125 (3)	589 (7)
Limerick ...	3	9,500 (4)	69 (14)	346 (19)
Longford ...	1	5,100 (20)	72 (11)	403 (13)
Louth	2	7,300 (9)	43 (25)	159 (25)
Mayo	3	7,100 (10)	109 (6)	695 (4)
Meath	1	11,700 (1)	125 (4)	903 (1)
Monaghan ...	1	7,900 (6)	133 (2)	498 (8)
Offaly	2	5,200 (19)	51 (21)	386 (15)
Roscommon ...	2	4,900 (22)	80 (10)	476 (9)
Sligo	2	4,900 (23)	72 (12)	347 (17)
Tipperary N.R.	2	5,800 (16)	62 (15)	411 (12)
Tipperary S.R. ...	2			
Waterford ...	2	7,400 (8)	56 (17)	355 (16)
Westmeath ...	2	5,500 (17)	52 (20)	341 (20)
Wexford ...	2	7,800 (7)	71 (13)	454 (11)
Wicklow ...	2	5,400 (18)	55 (18)	391 (14)
	76	7,300	64	350

*Notes (1) Of the 15 doctors in Dublin, 8 are ACMOs, 4 are temporary medical officers, 2 are junior medical officers, and 1 is an assistant medical officer. Ten of the fifteen are engaged wholetime on Child Welfare or School Health Services. For the purpose of these tables, the 15 Dublin doctors are classified as ACMOs

(2) Eligible children includes the estimated number of children 0-2 years of age in towns of 5,000 population or more, and national school children (See Table 1). Children per doctor shown to the nearest 100.

TABLE 3—ESTIMATED NUMBER OF CHILDREN ELIGIBLE FOR PROPOSED CHILD WELFARE AND SCHOOL HEALTH SERVICES PER ACMO AVAILABLE TO THE SERVICES IN EACH AREA

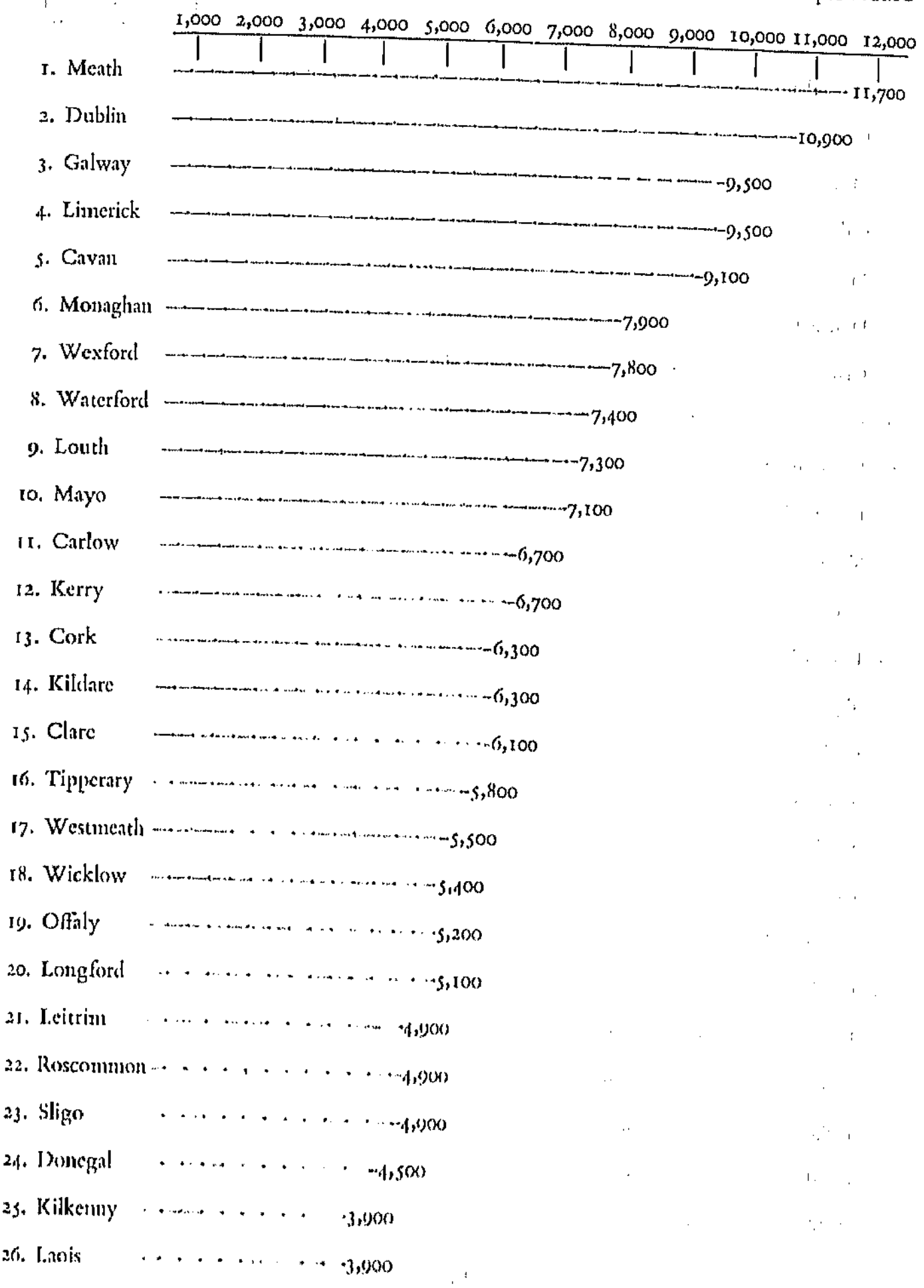


TABLE 4—NUMBER OF NATIONAL SCHOOLS (JUNE, 1965) PER ACMO AVAILABLE TO THE CHILD WELFARE AND SCHOOL HEALTH SERVICES IN EACH AREA

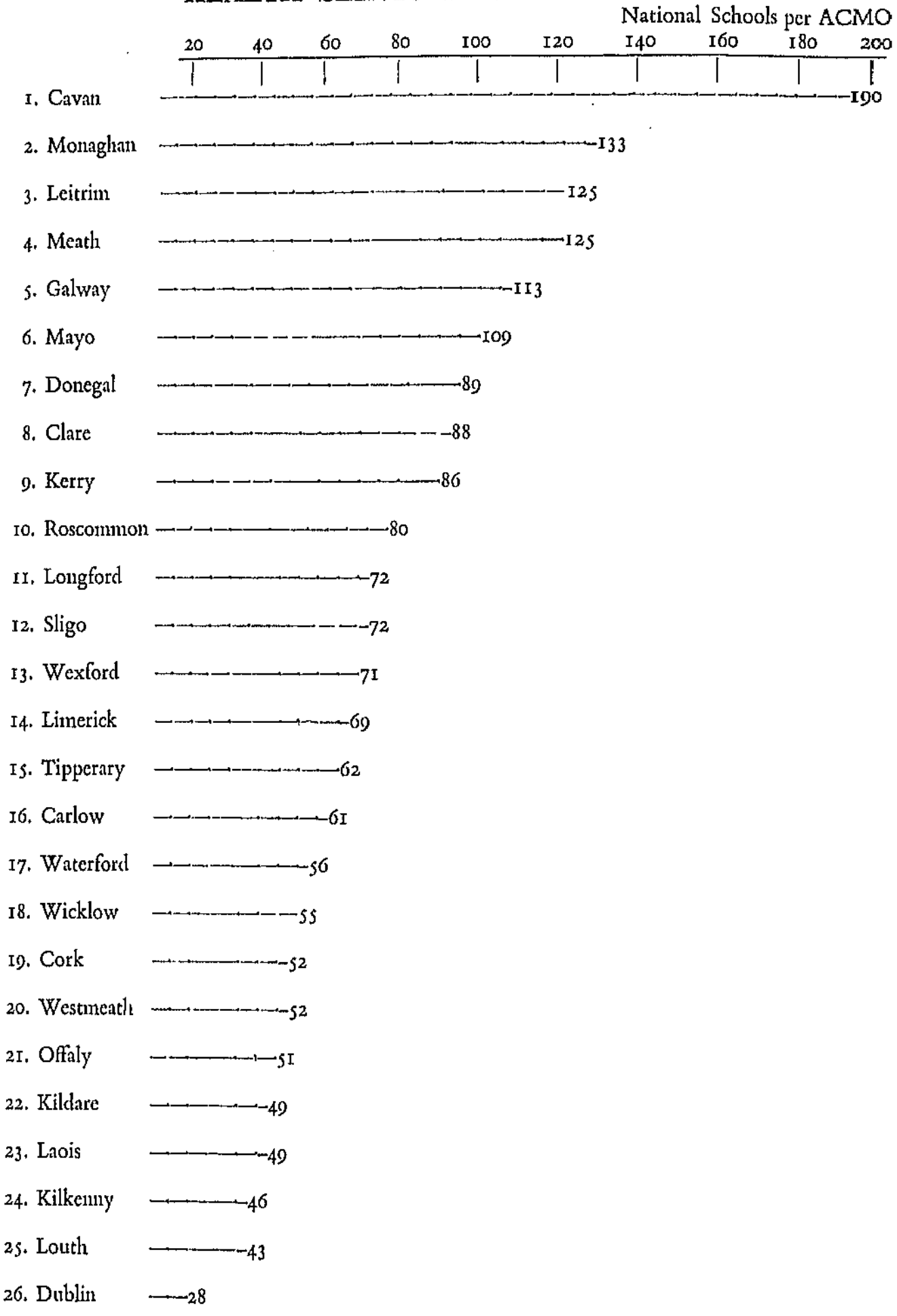
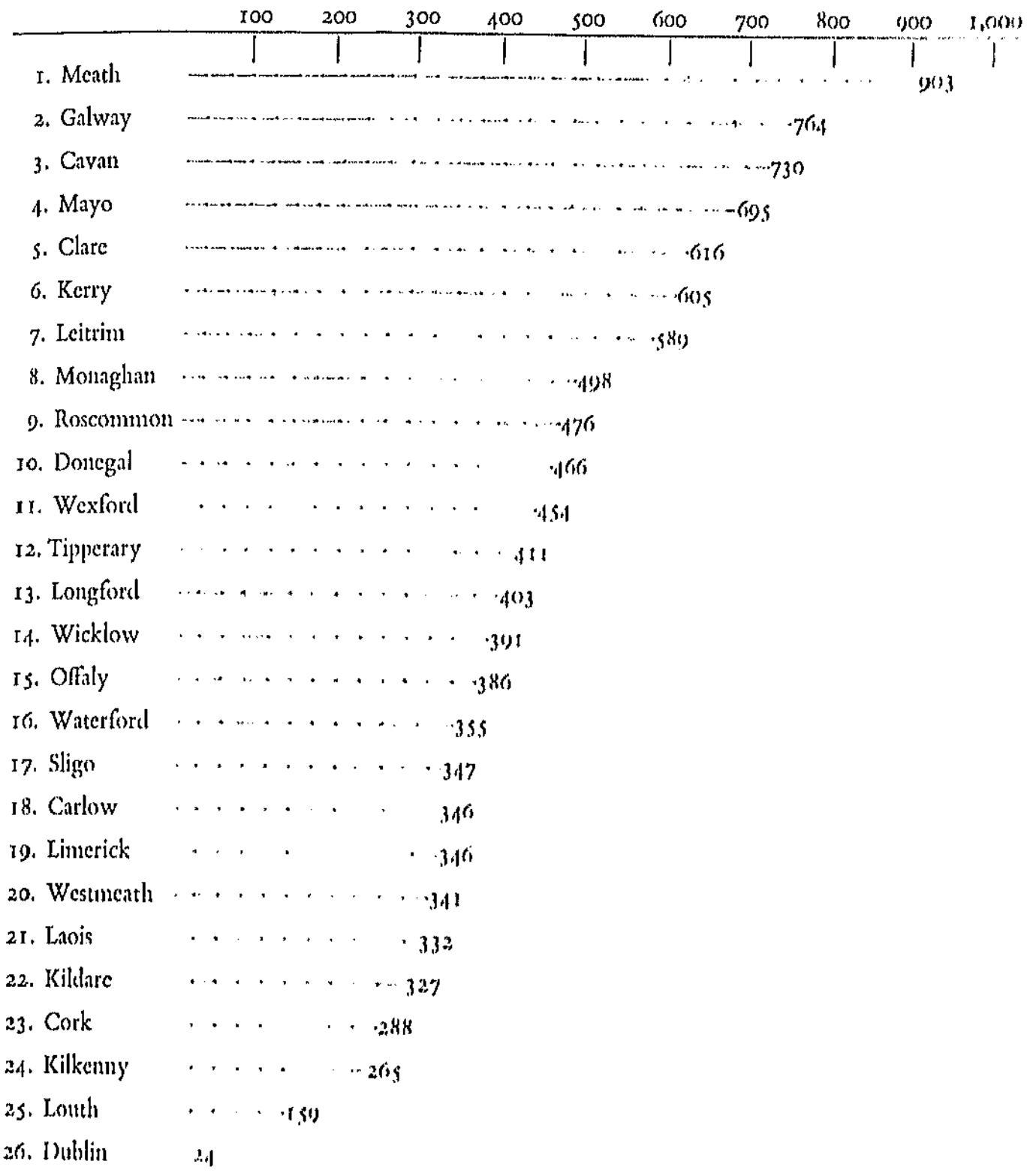


TABLE 5.—NUMBER OF SQUARE MILES PER ACMO AVAILABLE TO CHILD WELFARE AND SCHOOL HEALTH SERVICES IN EACH AREA

Sq. Miles per ACMO



APPENDIX 16.—PAEDIATRIC CLINIC SURVEY

Region and Counties	Number of clinic centres in county	Number of clinics per month	Percentage of referrals in 1965 to clinic from					Waiting list for first referral (May '66)		Attendances (1965)			Child Population 0–14 years (1961)	Child population per monthly clinic (to nearest 100)
			S.H.S.	G.P.	C.W.	Specialist	Miscellaneous	Number of such first referrals	Time necessary to clear	Total	First Attendance	First Attendances as % of total		
REGION 1 :														
Sligo ..	1	1	11·9%	81·9%	3·1%	3·1%	—	—	Nil	160	95	60·0%	15,778	15,800
Leitrim ...	1	1	23·8%	75·0%	—	1·2%	—	—	Nil	84	43	51·0%	9,177	9,200
Kilkenny ...	1	2	39·0%	46·4%	14·6%	—	—	6	Nil	First clinic October, 1965			19,688	9,800
Waterford ...	1	2	—	—	—	—	—	—	—	First clinic February, 1967			21,697	10,800
REGION 2† :														
Mayo ...	1	2	9·9%	87·1%	—	3·0%	—	32	3 months	171	109	64·0%	38,099	19,000
Galway ...	1	4*	8·7%	70·0%	—	21·3%	—	12	2–3 weeks	643	243	38·0%	47,481	11,900
Roscommon	1	2	43·6%	56·4%	—	—	—	—	Nil	110	77	70·0%	17,090	8,500
REGION 3† :														
Clare ...	1	2	12·0%	78·0%	8·0%	2·0%	—	40	4–5 months	182	50	27·5%	21,451	10,700
Limerick ...	2	12*	8·0%	84·0%	1·0%	7·0%	—	—	Nil	3,000	900(est)	30·0%	43,633	3,600
Kerry ...	1	1	13·3%	72·5%	—	14·2%	—	125	2 years	215	69	32·0%	34,488	34,500
Tipperary N.R. ...	1	2	38·0%	50·0%	5·0%	7·0%	—	18	2 months	290	100	34·5%	16,614	8,300
REGION 4†:														
Cork ...	3	5*	5·0%	82·5%	4·9%	5·9%	1·7%	41	1–1½ months	600	303	50·0%	97,931	19,600
REGION 5 :														
Laoighis ...	2	3	31·4%	68·6%	—	—	—	21	1–3 months	719	161	22·5%	13,992	4,700
Offaly ...	1	3	60·2%	35·2%	4·6%	—	—	22	1–1½ months	687	189	27·4%	16,976	5,700
Kildare ...	4	4*	18·7%	76·1%	4·8%	0·4%	—	—	Nil	789	209	26·5%	22,387	5,600
Carlow ...	1	2	46·0%	51·0%	3·0%	—	—	6	Nil	589	156	26·0%	11,066	5,500
Wexford ...	1	1	18·0%	65·6%	11·5%	4·9%	—	1	Nil	191	61	31·8%	26,512	26,500
REGION 6 :														
Monaghan ...	1	2	21·3%	76·4%	1·5%	0·8%	—	—	Nil	267	204	76·5%	13,913	7,000
Cavan ...	1	2	39·2%	45·0%	—	—	15·8%	10	Nil	456	329	72·0%	16,878	8,400
Longford ...	1	1	—	80·0%	—	—	20·0%	7	Nil	N.A.	N.A.	N.A.	9,549	9,500
Meath ...	1	2	27·2%	70·7%	—	2·1%	—	9	1 month	389	123	31·6%	21,687	10,800
Westmeath...	1	2	15·2%	72·5%	—	0·7%	11·6%	15	Nil	290	114	39·5%	17,185	8,600
REGION 7† :														
Louth ...	1	4*	—	90·0%	—	—	10·0%	—	Nil	950	229	24·0%	21,554	5,400
REGION 8														
Donegal ...	4	3	21·6%	75·2%	3·2%	—	—	—	Nil	255	100	39·2%	34,226	11,400
REGION 9† :														
Dublin ...	9	144*	—	—	—	—	—	N.A.	N.A.	29,031	8,562	29·4%	226,761	1,600
OTHERS :														
Tipperary S.R. ...	No clinic service												22,793	
Wicklow ...	" " "												18,653	

*The number of monthly clinics was obtained by multiplying the weekly clinics by 4.
†Paediatrician(s) resident within region. In other regions, visiting Paediatricians provide the service.

APPENDIX 17.—ENT CLINIC SURVEY

Region and County	Centres where ENT clinics are held	Total sessions per month	Position of waiting list (as at 1st quarter 1967)	Child Population 0–14 years	Child Population per monthly session (to nearest 100)
REGION 1 :					
Galway	Regional Hospital	4 } 6	5 months	47,481	7,900
	Merlin Park	2 }			
Roscommon ...	County Clinic, Roscommon	2	1½ to 2 years	17,090	8,500
REGION 2 :					
Kildare	Naas (occasionally Athy or elsewhere)	3	Several months—children waiting not regarded as urgent	22,387	7,500
Leitrim	Manorhamilton Hospital }	1	Nil	9,177	9,200
	Mohill Dispensary }				
Longford	Longford County Clinic	2	1 month	9,549	4,800
Sligo	Charles St. Clinic, Sligo	2	2–3 months	15,778	7,900
Westmeath ...	County Clinic, Mullingar	2	1 month	17,185	8,600
Offaly	County Clinic, Tullamore	1	Service commenced, 28th July, 1967	16,976	17,000
REGION 3 :					
Kilkenny	Health Dept., Kilkenny	2	5 months	19,688	9,800
Tipperary S.R. ...	County Clinic, Clonmel	2	5 months	22,793	11,400
Waterford ...	Ardkeen Hospital	4	2 weeks	21,697	5,400
Wexford	Wexford, Enniscorthy }	2	2 weeks	26,512	13,300
	Gorey, New Ross }				
REGION 4 :					
Clare	Regional Hospital, Limerick	2	4 months	21,451	10,700
Limerick	Regional, St. John's and }	16	3–4 weeks at Barrington's only	43,633	2,700
	Barrington's, Limerick }				
REGION 5 :					
Donegal	Letterkenny, Donegal }	3	3–7 months	34,226	11,400
	Buncrana }				
REGION 6 :					
Kerry	County Clinic, Tralee	4	Indefinite—at 31st Dec., 1966, 120 children on list	34,488	8,600
REGION 7 :					
Louth	..Drogheda, Dundalk	6	Nil	21,554	3,600
REGION 8 :					
Cork	Cork City (5), Mallow	65	Maximum is 2 weeks to 1 month at Mallow	97,931	1,500
REGION 9 :					
Dublin	21 centres	217	Majority have little or no waiting period. A few booked 1–2 months ahead.	226,761	1,000
REGION 10 :					
Tipperary N.R. ...	County Hospital, Nenagh	2	1 month	16,614	8,300
COUNTIES WITHOUT ENT CLINICS					
Carlow	No specialist since September, 1960			11,066	
Cavan				16,878	
Laoighis	Have failed to obtain ENT specialist for sessions			13,992	
Mayo				38,099	
Meath				21,687	
Monaghan ...				13,913	
Wicklow				18,653	

NOTE (1) All clinics are for *both* children and adults except in Waterford (2 clinics for adults and 2 for children), Wexford (children only).
(2) In the following areas *two* E.N.T. specialists hold clinics :—Limerick, Louth.

APPENDIX 18.—TONSILS AND ADENOIDS—STATISTICS FROM SCHOOL HEALTH SURVEY

	Tonsils already removed		Referred direct to Hospital for tonsils and adenoids		Referred to Specialist for opinion on tonsils and adenoids		Referred back to G.P. for opinion		Noted for observation only	
	Number	* %	Number	* %	Number	* %	Number	* %	Number	* %
Carlow	46	7·85	23	3·92	1	0·17	—	—	134	22·87
Cavan ...	18	1·36	7	0·53	5	0·38	1	0·08	118	8·91
Clare	102	8·16	3	0·24	56	4·48	1	0·08	266	21·28
Cork	220	3·96	37	0·67	167	3·00	2	0·04	628	11·29
Donegal ...	32	1·60	19	0·95	50	2·50	5	0·25	70	3·50
Dublin ...	801	6·70	51	0·43	504	4·22	11	0·09	1,355	11·34
Galway ...	87	3·06	4	0·14	27	0·95	—	—	359	12·63
Kerry	66	2·71	96	3·94	42	1·73	3	0·12	714	29·33
Kildare ...	57	3·69	3	0·19	57	3·69	1	0·06	65	4·21
Kilkenny ...	13	1·43	16	1·76	2	0·22	1	0·11	22	2·42
Laois	7	0·76	—	—	34	3·70	—	—	36	3·92
Leitrim ...	6	1·13	16	3·02	—	—	1	0·19	23	4·34
Limerick ...	24	0·86	4	0·14	129	4·64	—	—	113	4·06
Longford ...	5	0·72	—	—	13	1·88	—	—	41	5·92
Louth	37	3·90	3	0·32	90	9·49	—	—	106	11·18
Mayo	21	0·73	7	0·24	22	0·77	—	—	156	5·45
Meath ...	18	1·16	6	0·39	110	7·10	1	0·06	132	8·52
Monaghan ...	66	6·51	4	0·39	—	—	—	—	15	1·48
Offaly ...	8	0·76	6	0·57	39	3·71	2	0·19	142	13·52
Roscommon ...	Not included in Survey									
Sligo	7	0·58	4	0·33	7	0·58	—	—	64	5·30
Tipperary N.R.	8	0·70	2	0·17	31	2·70	—	—	17	1·48
Tipperary S.R.	3	0·24	1	0·08	16	1·29	1	0·08	38	3·05
Waterford ...	27	2·04	6	0·45	29	2·19	2	0·5	229	17·32
Westmeath ...	52	3·74	69	4·96	4	0·29	1	0·07	178	12·79
Wexford ...	45	2·86	—	—	65	4·13	5	0·32	179	11·37
Wicklow ...	34	3·07	69	6·05	1	0·09	—	—	30	2·63
TOTALS	1,811	3·50	456	0·88	1,501	2·90	38	0·07	5,230	10·10

*Percentage of all children examined in the area during the School Health Survey.

NOTE (1) All clinics are for *both* children and adults except in Waterford (2 clinics for adults and 2 for children), Wexford (children only).
(2) In the following areas *two* E.N.T. specialists hold clinics :—Limerick, Louth.

APPENDIX 19.—FURTHER READING

1. World Health Organisation Publications :

Expert Committee on School Health Services—technical Report Ser. 1951, 30.
European Conference on School Health Services, Grenoble, France, 1954—WHO, Regional Office for Europe, Geneva.
European Seminar on Child Health and the School, Noordwijk-aan-Zee, 1963—WHO, Regional Office for Europe, Copenhagen.
Symposium on Maternal and Child Health Problems in Europe, Bern, June-July, 1961—WHO, Regional Office for Europe, Copenhagen.
Maternal and Child Health in the U.S.S.R. (1962) Public Health Papers No. 11—WHO, Geneva.
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Administration of Maternal and Child Health Services—technical Report Ser. 1957, 115.
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From a School doctor's notebook. P. Rochat. World Health. October, 1964.

2. Legislation :

Public Health (Medical Treatment of Children) (Ireland) Act, 1919—9 & 10 Geo. V, c. 16
Public Health (Medical Treatment of Children) (Ireland) Order 1920—No. 61,034/1919 Miscellaneous.
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3. Ireland :

Annual Reports of the Department of Local Government and Public Health.
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Annual Reports of Chief Medical Officers of Health Authorities.
The School Medical Service in a Rural County, J. C. Joyce. Journal of the Irish Medical Association. May, 1956.
Child Development Services : H. Dolan. Journal of the Irish Medical Association. January, 1966.

4. United States, Canada, Europe (Exc. Britain) :

The Paediatric Clinics of North America—School Health Problems Ed. H. Medovy, (1965) London : W. B. Saunders Company.
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A new approach to the School Health Programme (British Columbia) Benson and Beattie ; Medical Officer, 6th August, 1965.
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5. Child Welfare Services :

The Doctor and the Child Welfare Centre (1967)—Society of Medical Officers of Health, London.
Towns and Village Clinics—Some Differences Revealed : I. D. McIntosh. Medical Officer, 16th October, 1964.
Psychiatric Problems in a Child Welfare Clinic : I. Berg. Medical Officer, 10th December, 1965.
Child Welfare Clinics to-day under local authorities. E. G. Saint. Maternal and Child Care, July, 1967.
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6. School Health Services in Britain :

The School Health Services. S. Leff and V. Leff (1959) London : H. K. Lewis & Co.
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Prevention of Mental Ill-health—The Role of the School Medical Officer: L. J. Bacon. Medical Officer, 31st December, 1965.
The Use of a Questionnaire to Parents at School Medical Examinations. F. Barasi and A. Cartwright. Medical Officer, 1st February, 1957.
The Value of the Routine School Medical Examination—A. Withnell. Medical Officer, 17th January 1958.
The Place of Periodic School Medical Examinations in detecting Physical Abnormalities. J. C. Taylor. Medical Officer, 26th June, 1964.
Selective School Medical Inspection—a pilot scheme in the Isle of Wight. M. Ashley-Miller. Medical Officer, 26th February, 1965.
Evaluation of a questionnaire to parents as a method of screening school-children—J. Leeson. Medical Officer, 11th June, 1965.
The Selective Inspection of nine-year-old school children in Edinburgh. I. F. Craik. Medical Officer, 22nd April, 1966.
Pilot Scheme of Selective Medical Inspection in Birmingham—R. C. F. Todman. Medical Officer, 22nd April, 1966.
Outlook on School Medical Inspection. H. Gordon. Medical Officer, 22nd April, 1966.
The Selection of Children for School Medical Inspection. J. S. Horner. Medical Officer, 21st January, 1966.
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One thousand school children—an evaluation of the Periodic Medical Inspection. P. Asher. Medical Officer, 16th January, 1967.
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School Medical Inspections and the Family Doctor. J. Stuart Horner. Lancet, 21st October, 1967.

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Planning for Health Education in Schools—Longmans/Unesco (1966).
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Medicine in Modern Society : T. McKeown (1965). London : Allen and Unwin.
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