

May Kelly

# COMMUNITY MEDICINE & PUBLIC HEALTH

## THE FUTURE

*Report of a Working Party*

*appointed by the  
Minister for Health*

April 1990

Dr. Rory O'Hanlon,  
Minister for Health,

Dear Minister,

In approaching the task set out in our Terms of Reference the Working Party noted that community medicine is concerned with the public health in its widest context and hence the title of our Report - "Community Medicine and Public Health - The Future".

The Working Party decided to recommend initially that in future the specialty of community medicine should be known as public health medicine.

In defining the future role of public health medicine the Working Party was conscious of the need to identify and elaborate on the key functions which the public interest requires to be fulfilled as we approach the end of the twentieth century. We consider that these are:-

- \* Surveillance of the health of the population including control of environmental hazards to health and of communicable diseases
- \* The prevention of illness and health promotion through the encouragement of healthy lifestyles and health oriented public policies
- \* Assessment of health service needs, determination of priorities and measurement of outcomes i.e. the planning and evaluation of health services in the light of available resources, including alternative forms of service.

An underlying requirement for the successful performance of these functions is the development of an appropriate range of health information systems.

The specialist in public health medicine as a result of his training is especially well qualified to make a major contribution to the performance of these functions, in particular through the application of epidemiological skills and techniques.

The nineteenth century ideal was of a public health service with all powers and functions vested in local authorities reporting to a single central department of state. The role of the public health

doctor was equally clearcut, especially his ability to influence matters affecting the public health.

Today public health is no longer a single service but an objective that is or should be shared by a number of central departments of state and authorities at regional or local level in the health and other sectors, and by a number of different professions. During the course of our work we became convinced of the potential benefits of giving the modern day specialist in public health medicine an influential role in a new public health function.

In putting forward our recommendations for the establishment of a new public health function which we feel will make a significant contribution to the fulfillment of the three key functions referred to above, the Working Party has assumed that the future role and responsibilities of the Minister and of the health boards will have a new emphasis beyond the provision of traditional services to deal with illness, in line with the consultative statement on health policy "Health - The Wider Dimensions" published by the Department of Health.

We hope that our recommendations, which can be implemented at reasonable cost, will be acceptable and that they will help to provide the organizational framework necessary to improve the public health in the future.

Yours sincerely,

**K.J. Hickey**

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**Chairman**

**30th April, 1990**

## TABLE OF CONTENTS

<b>Chapter 1</b>	Introduction	Page	2
<b>Chapter 2</b>	Summary and Main Recommendations	Page	6
<b>Chapter 3</b>	The Development of Public Health Medicine in Ireland	Page	22
<b>Chapter 4</b>	The Definition and Scope of Community Medicine	Page	46
<b>Chapter 5</b>	Epidemiology and Health Information	Page	50
<b>Chapter 6</b>	The Surveillance and Control of Communicable Diseases	Page	56
<b>Chapter 7</b>	The Environment and Public Health	Page	64
<b>Chapter 8</b>	Health Promotion and Preventive Medicine	Page	70
<b>Chapter 9</b>	Public Health Medicine and Health Service Management	Page	78
<b>Chapter 10</b>	A New Structure for Public Health Medicine	Page	84
<b>Chapter 11</b>	Community Medicine in the Future - a Final Word	Page	100
<b>Appendix A</b>	Bibliographic References	Page	104
<b>Appendix B</b>	Submissions Received by Working Party	Page	108
<b>Appendix C</b>	Consultative Groups Received by Working Party	Page	112
<b>Appendix D</b>	Organisational Chart proposed by McKinsey and Co. for the Community Care Programme	Page	114
<b>Appendix E</b>	Job Description proposed by McKinsey and Co. for the Post of Director, Community Care Services	Page	116
<b>Appendix F</b>	Survey of Tasks carried out by Area Medical Officers	Page	122
<b>Appendix G</b>	Questionnaire forms used in manpower surveys	Page	124
<b>Appendix H</b>	Infectious Diseases Notifiable under Health Act, 1947	Page	128
<b>Appendix I</b>	Health for All by the Year 2000 - Health Authority targets	Page	130

# **COMMUNITY MEDICINE AND PUBLIC HEALTH - THE FUTURE**

## **CHAPTER 1**

### **INTRODUCTION**

- 1.1 The Minister for Health, Dr. Rory O'Hanlon T.D., established a Working Party in April, 1988 with the following terms of reference:

To define the role of community medicine in the health services in the medium to long term.

- 1.2 The following persons were appointed to the Working Party:

**Mr. Kieran Hickey**, Chief Executive Officer, Eastern Health Board, (Chairman)

**Dr. Hugh Dolan**, Director of Community Care/Medical Officer of Health  
North Eastern Health Board

**Mr. Derry O'Dwyer**, Programme Manager Community Care, Midland Health Board

**Dr. Brian O'Herlihy**, Director of Community Care/Medical Officer of Health  
Eastern Health Board

**Dr. Joseph Solan**, Director of Community Care/Medical Officer of Health  
Western Health Board

**Mr. Tadhg Tansley**, Principal Officer, Department of Health

**Dr. James Walsh**, Deputy Chief Medical Officer Department of Health

The Secretary to the Working Party was **Ms. Pauline Moreau**, Higher Executive Officer,  
Department of Health.

- 1.3 The Working Party met for the first time on 2nd May 1988 and met on twenty-one subsequent occasions including two two-day meetings. The Working Party also spent seven days on fact-finding visits.

## ACKNOWLEDGEMENTS

- 1.4 We are grateful to the many individuals and organisations who responded to our invitation to make written submissions to the Working Party. Their work was fully examined and much appreciated. A full list of those who made submissions is contained in appendix B.
- 1.5 We invited a number of persons and organisations to meet with us to discuss particular aspects of our brief. Many travelled long distances to facilitate us and we are very grateful to them for giving so generously of their time and expertise.
- 1.6 During the course of our deliberations we made two fact-finding visits, first to London and then to Northern Ireland and Scotland. We would like to place on record our gratitude to the Department of Health, London; the North-East Thames Regional Health Authority; Lewisham and North Southwark District Health Authority; Newham District Health Authority; The Centre for the Surveillance of Communicable Diseases, Colindale; Eastern Health and Social Services Board, Belfast; Department of Health, Belfast; Health Promotion Unit for Northern Ireland; Greater Glasgow Health Board; The Communicable Diseases (Scotland) Unit and Ayrshire and Arran Health Board all of whom extended a warm welcome to us and gave us many insights into our work.
- 1.7 As part of our research, we carried out two surveys into manpower in community medicine. We would like to thank the staffs of the health board personnel departments and doctors in community medicine who completed our questionnaires. We also wish to thank Mrs. Anita Delaney, Department of Health who ably assisted our Secretary in administering the survey. We sought the assistance of Dr. Mary Hurley and Dr. Mary Hynes of the Eastern Health Board to research the history of public health and the relevant literature. They both gave freely of their valuable time and made a significant contribution to the final report. We thank them for their generous assistance.
- 1.8 The facilities of St. Mary's Hospital, Phoenix Park, Dublin were made available to us for many of our meetings. Our thanks are due to the members of the staff of the Hospital who assisted us and to the Eastern Health Board Secretariat who also assisted us in various ways.
- 1.9 The preparation of a Report such as this requires a huge commitment from the secretarial support staff. We would like to thank Ms. Mary O'Brien and Ms. Mary Harty who typed the drafts of the Report and Mrs. Anita Delaney and Ms. Sheila McBride who checked the typescript.

1.10 We were fortunate to have as our Secretary, Ms. Pauline Moreau. We are indebted to her for her efficiency and painstaking attention at all times in servicing our meetings and in arranging our contacts with those who assisted us both at home and abroad. We also wish to express our appreciation of her work in researching and drafting our Report, including the two manpower surveys and their subsequent analysis. These were substantial tasks which she carried through with the same efficiency and for which she is deserving of the fullest commendation.

#### NOTE

Throughout the report the personal pronoun 'he' is used for convenience and connotes feminine gender.

## **CHAPTER 2**

### **SUMMARY AND MAIN RECOMMENDATIONS**

- 2.1 The Minister for Health, Dr. Rory O'Hanlon, T.D., established a Working Party in April 1988 to define the role of community medicine in the health services in the medium to long term.
- 2.2 Following the establishment of the health boards in 1971, the Minister for Health decided that each Community Care team would be led by a Director of Community Care and Medical Officer of Health (DCC/MOH) who combines a management role with a public health medical function. Those qualified to fill the latter requirements of the post found that the competing general management versus public health medical aspects of the posts prevented full development of either aspect. The existing posts of DCC/MOH are seen to be an unsatisfactory mix of service management, medical and public health responsibilities which do not offer sufficient scope for the development of the potential contribution of public health medicine to the future health status of the population, to the identification of health needs and to the planning and evaluation of future health services.

### **SURVEY OF MANPOWER**

- 2.3 The Working Party considered it necessary to establish the present position with regard to the number of medical posts which exist in community care and the number of those posts which have not been filled by permanent appointments. Each health board was asked for the position on the 1st May, 1989. It was found that there are 195 medical posts in community care in the health boards at present. However a total of 58 of these posts were unfilled on a permanent basis on the survey day. Full discussion of the survey findings can be found in paragraphs 3.33 and 3.34.
- 2.4 The Working Party also considered it desirable to obtain a profile of those doctors who are currently practising in this field of medicine. Each doctor was asked to complete a postal questionnaire and the response is estimated at 89.6%. A full discussion of the findings of this survey is contained in paragraphs 3.36 to 3.47. Among the salient features are the continued increase in the number of female doctors in the field, the differing age structure of the male and female doctors, the necessity to fill 38 senior posts within five years if existing numbers are to be maintained and the significant number of Area Medical Officers who do not have a post-graduate qualification in public health.



## DEFINITION AND SCOPE OF COMMUNITY MEDICINE

- 25 The Working Party have found evidence of confusion about the title of the specialty in Ireland where "community medicine" is frequently, if erroneously, seen as being synonymous with "community care". Neither should "community medicine" be confused with the management of "community care services". *The Working Party recommends that the term Public Health Medicine should replace that of Community Medicine and that in the future the specialty should be known as Public Health Medicine.* The Working Party believes that the term Public Health Medicine is better understood internationally. This title will also help to emphasise the importance of communicable disease and environmental health control.
- 26 The Working Party is aware that there is some confusion and misunderstanding about the role, function and key responsibilities of the specialty of community medicine and sees the principal concerns of the specialty as
- Epidemiology including applied epidemiology;
  - The development of Health Information Systems;
  - Surveillance and Control of Communicable Diseases;
  - Environmental Health;
  - Preventive Medicine;
  - Health Promotion and the encouragement of healthy lifestyles and health orientated public policies;
  - The monitoring and evaluation of outcomes of health services;
  - Health Planning and Health Services Research.
- 27 The Working Party wishes to avoid a return to the relatively narrow interpretation of public health which may have applied heretofore. The Working Party sees the specialty as encompassing the whole spectrum of the health services, including hospital services and indeed the health field in its widest context, being aware that the activities of other agencies and influences can have a bearing on the health status of the population.

## EPIDEMIOLOGY AND HEALTH INFORMATION

- 28 Epidemiology has been described as the core discipline of the specialty of public health medicine. Epidemiologists are trained to analyse and interpret trends in mortality and morbidity data, to gather and assess evidence in relation to factors which are associated with

disease and describe the natural history of disease; to study the benefits of different diagnostic or treatment methods, to develop, maintain and report on routine health information systems; to make recommendations on the optimum conditions for the maintenance of health and for disease prevention and to evaluate the full range of health services. *The Working Party recommends that the epidemiological skills acquired by graduates of the Higher Training programme in Community Medicine be fully exploited in the planning and evaluation of the health services on the basis of population need.*

- 2.9 *The Working Party recognises the weakness of existing health information systems in Ireland and recommends that resources be made available to develop these systems.*
- 2.10 *The Working Party is aware that there is a vast amount of information on illnesses and causes of disability available from the records of the Department of Social Welfare. The Working Party recommends that the Department of Health and the Department of Social Welfare should collaborate in making these sources of information available for epidemiological purposes.*
- 2.11 *General practitioners, all of whom are in the front line in the treatment of illness can contribute much to the development of a detailed health information system. The Working Party recommends that the general practitioners be encouraged to develop an interest in an epidemiological profile of the patients attending their practices and to contribute information on the health status of their patients to a local health information system.*
- 2.12 *The Hospital In-Patient Enquiry, which gathers information on the basis of general hospital admissions, attempts to draw together general morbidity statistics on a broad basis. Evidence has been made available to the Working Party which expresses concern about the lack of quality control of existing data. The Working Party recognises that the Hospital In-Patient Enquiry has short-comings and recommends that resources be made available to develop the HIPE to ensure full coverage in all acute hospitals. The Working Party recommends that a specialist in public health medicine should be given responsibility for collaboration with the hospital clinicians at local level to achieve the highest level of coverage and quality control.*

- 2.13 The Working Party favours the use of a small area as the basis for data collection because it enables differences in the health profiles of seemingly similar populations to be easily identified and it helps the epidemiologist and the specialist in public health medicine to assess influences on the health status of the small area. *The Working Party recommends that the Department of Health and the health boards collaborate to design standardised health information systems which will facilitate the collection of material on a "small area basis" (such as on a District Electoral Division basis) but which will also contribute to the establishment of an overall picture of the health of the population of Ireland.*
- 2.14 Prior to the establishment of the health boards in 1971, the County and City Medical Officers were required to prepare an annual report on the health of the population of their area. This requirement was not incorporated into the job description for the new posts of DCC/MOH and the practice of preparing an annual report lapsed in most areas. *The Working Party recommends that the preparation of an annual report on the health of the population should be resumed and that this should be the responsibility of the proposed Director of Public Health (see paragraph 10.8). The Working Party recommends that the annual report should contain standard data to facilitate inter-regional comparison but the report should also address issues of local concern.*
- 2.15 The annual report will represent the objective professional assessment of the Director of Public Health in relation to the health status of the population of the health board area. The Working Party recommends that the Director of Public Health should be in a position to comment in the annual report on issues he deems to be important and relevant to the health of the population.

#### **THE SURVEILLANCE AND CONTROL OF COMMUNICABLE DISEASE**

- 2.16 The control of disease within the population is an essential task of the public health medical function. The three main objectives of surveillance are: detection of changes in disease patterns to enable early preventive action to be taken when appropriate; evaluation of disease control measures; and the provision of data for health service planning.
- 2.17 The Working Party recommends that a Disease Surveillance Unit be established in Ireland as a priority. The Working Party recommends that the Disease Surveillance Unit should not be administered directly either by the Department of Health or the health boards, although the management board of the Disease Surveillance Unit

- 2.18 The Working Party recommends that close collaboration be fostered between the specialists in public health medicine and the relevant specialists in the various hospitals, public health and other laboratories.
- 2.19 The Working Party recommends the formal establishment of a National Virus Reference Laboratory which would act as the central collector of data on viruses. The Working Party recommends the formal recognition of other reference laboratories throughout the country to concentrate on specific organisms such as salmonella. The Working Party is aware that the Irish laboratories still rely on their overseas counterparts to carry out phage typing of salmonella and other organisms and recommends that one of the reference laboratories develop a capacity to carry out phage typing in order to fulfil the national requirements.
- 2.20 The Working Party believes there is a need for greater surveillance of the incidence of non-communicable diseases in the Irish population. The Working Party recommends that the specialists in public health medicine play a leading role in the establishment of registers of diseases and conditions such as cancers and congenital abnormalities.
- 2.21 The Working Party recommends that in each health board area at least one specialist in public health medicine should be given responsibility for the surveillance and control of communicable disease. The responsibilities of the post would include prevention through, for example, the organisation and management of immunisation programmes, management of outbreaks and contact tracing. There is a central responsibility for a specialist in public health medicine to set, monitor and ensure the achievement of immunisation targets. Where vaccination and immunisation targets have not been reached, the Working Party recommends that the specialist in public health medicine should put in place whatever special arrangements are necessary to ensure the delivery and uptake of these services to meet those targets.
- 2.22 The Working Party has noted that there is considerable under-reporting of communicable diseases in Ireland. If a full and comprehensive picture of the health of the population is to emerge, it is essential that the incidence of communicable diseases be properly measured. Medical practitioners, including those in hospitals are remiss in some instances in not reporting outbreaks or single occurrences of communicable diseases.
- 2.23 In the case of general practitioners it is necessary to build up and maintain the closest possible collaboration at medical colleague level in the interests of ensuring that the epidemiological significance of individual practitioner/patient contacts is continuously

appreciated in the broader population medicine context, particularly in instances involving cases of communicable disease. *The Working Party is of the view that the necessary close collaboration with general practitioners can best be achieved by a specialist in public health medicine and recommends that this should be a responsibility of the proposed District Public Health Director (see paragraph 10.12).*

- 2.24 *The Working Party believes there should be a close working relationship between the specialist in public health medicine and the hospital clinicians in relation to infection control. The Working Party recommends that there should be close collaboration between the local hospitals and the specialists in public health medicine in relation to infection control.*
- 2.25 *The Working Party recommends that each health board develop a plan of action to deal with outbreaks of communicable disease. The Working Party recommends that the Director of Public Health take the initiative and responsibility for the development of such a plan.*
- 2.26 *The Working Party recommends that the plan include the establishment of a small Action Committee in Communicable Disease to include representatives of the general practitioners, hospitals, microbiologists and veterinary officers who should be convened in regular meeting by the District Public Health Director and who should come together regularly to design and review plans to cope with an outbreak of communicable disease. The Working Party also recommends that this group in its regular meetings review measures to prevent possible outbreaks of communicable disease.*
- 2.27 *The Working Party recommends that the public be given a balanced report where an outbreak of food borne or other communicable disease occurs. This report should explain the possible cause of the outbreak, what is being done to contain it, information about those persons most at risk and the steps to be taken by them to avoid or cope with infection. The Working Party recommends that the presentation of reports on outbreaks of communicable disease to the media should be undertaken by the District Public Health Director or if the circumstances so warrant, by the Director of Public Health.*

## THE ENVIRONMENT AND PUBLIC HEALTH

- 2.28 While the major developments in the sanitary services and the recognition of the links between poor hygiene and disease contributed to the decline in the levels of infectious diseases and to an improvement in morbidity and mortality rates during the latter part of the nineteenth and the early part of the twentieth century, these problems have been replaced by a further series of environmental features, the result of modern lifestyles, which impinge upon the health of the population.
- 2.29 Although responsibility for the environment in Ireland rests largely with the local authorities, the monitoring of the environment is generally carried out by the Environmental Health Officers who are employed by the health boards, reporting directly to the DCC/MOH and who provide these services on an agency basis for the local authorities. The DCC/MOH (or City Medical Officer) in turn continues to provide by means of an agency arrangement, public health medical advice to the local authorities.
- 2.30 *The Working Party recommends that there is a particular need to review and strengthen the consultative and advisory process between the local authorities and the health boards on issues which relate to or impinge upon the health of the population.*
- 2.31 *The Working Party recommends that maximum co-operation should exist between the local authorities and the health boards on matters which relate to public health.*
- 2.32 *The Working Party recommends that the District Public Health Director act as adviser to a local authority on matters relating to environmental influences on the health of the population.* The Working Party believes that, as each health board spans a number of counties, one specialist in public health medicine could, if necessary, advise more than one local authority.
- 2.33 The Working Party notes the proposed establishment of a new Environmental Protection Agency as announced by the Government. The Working Party considers that the discharge of the responsibilities of the Director of Public Health and the District Director of Public Health in relation to environmental impacts on health would be strengthened by the support of centrally located activities. *The Working Party recommends that full monitoring of environmental influences on health be carried out regularly in Ireland and recommends that mechanisms be put in place to ensure that adverse effects of the environment on the health of the population are under continual scrutiny.*

2.34 The protection of food from contamination has traditionally been an important public health issue. The development of convenience foods, changing distribution and delivery systems, centralisation of food processing and the widespread use of new technologies and processes have all contributed to an increased potential for food borne disease. *The Working Party recommends that the protection of the food chain be strengthened through greater formal co-operation and collaboration between the various interests in order to ensure that food and food products are uncontaminated when they reach the consumer.*

2.35 *The Working Party recommends that at local level the District Public Health Director should take the initiative to establish a regular group meeting process involving representatives of the producers, the veterinary profession, the environmental health officers, the public analysts, the microbiologists, retailers and consumers to review and monitor the public health aspects of the production, preparation, delivery and sale of food and food products within his district.*

## HEALTH PROMOTION

2.36 Health education has a major role in making the public aware of the outcomes of unhealthy behaviour and the benefits of a healthy lifestyle. The design of health education programmes presupposes a knowledge of the underlying problems in the health of the target community. It is therefore essential that base-line epidemiological data are available to identify these problems and to provide the base against which the effectiveness of a particular programme can be measured. In this and in the design of the health education programme there is a role for the specialist in public health medicine who has developed a health profile of the population as part of the health information system and who can analyse that information to disclose weaknesses in the health behaviour of the population which might be targetted for an educational programme.

2.37 Health is also influenced by factors external to the individual. A recognition of these broader influences on health has brought a new approach to health and to the need for a multi-faceted approach to the promotion of the health of the population in the future. Health promotion has been defined as the process of enabling people to increase control over, and to improve, their health.

2.38 *The Working Party recommends that there should be an integrated approach to the preparation of health promotion and education programmes on the basis of a good*

*working relationship between the Health Promotion Unit at the centre and those who have closer contact with local problems and issues. In this regard the locally based specialist in public health medicine can make a valuable contribution through his knowledge of the health profile of the population.*

- 2.39 *Apart from centrally organised initiatives towards the promotion of health, there is ample scope for local initiatives which can be tailored to meet local problems and local needs. In developing local initiatives towards the promotion of health and a multi-sectoral approach to its attainment, the Working Party recommends that there is a key role for the Director of Public Health and his colleagues who can identify local problems using epidemiological studies and local knowledge and can suggest and implement health educational and promotional projects to tackle those problems in an innovative way. This role should reflect policies and programmes at national level.*

## **PREVENTIVE MEDICINE**

- 2.40 *There has been discussion in recent times about the need to maintain the child health services in their present form, particularly when children have greater access to the general practitioner and other health services, thanks to the better awareness of health and health issues among their parents. The Working Party recognises that in the long term it seems appropriate to increase the involvement of general practitioners with suitable qualifications in providing child health services. However in the short to medium term the service should continue as part of the community care service and should be provided by the area medical officers. The Working Party recommends that a specialist in public health medicine should set targets for and monitor the child health services and should evaluate the resultant epidemiological data on a regular basis. The Working Party recommends the standardisation on a national basis of the examinations and data collected to ensure the emergence of a national picture of the health of children and to permit the identification of regional patterns and trends.*
- 2.41 *Much has been written for and against screening programmes which aim to make early detection of diseases and disorders such as breast cancer and high blood pressure. The specialist in public health medicine is in a position to keep up to date with current scientific thinking on such issues and to combine this knowledge with the needs of the population in order to maximise the benefits of such screening programmes and to make an ongoing evaluation of programmes which are implemented. The Working Party recommends that the Director of Public Health should promote preventive screening programmes which have been shown to benefit the health of the population.*



## **PUBLIC HEALTH MEDICINE AND HEALTH SERVICE MANAGEMENT**

- 2.42 Any consideration of the future role of public health medicine must take full account of the current challenge to the whole character of health care systems and in particular to the role of the acute hospital and the balance between hospitals and primary health care. It has become necessary to plan for health in the wider context rather than the narrower concentration on the treatment of disease. In many countries health services are under scrutiny and evaluation. It is now clear that the trend in future health care will be to deliver services, particularly hospital services, according to the needs of defined populations in the most effective and efficient manner.
- 2.43 An appropriate structural arrangement is necessary to ensure that health boards, hospital authorities, local authorities, other sectors, individuals and the population at large are given consistent and comprehensive medical advice on matters pertaining to public health.
- 2.44 The Working Party is of the view that a district health system should be developed and that this can be readily identified within existing health board areas. It is also of the view that specialists in public health medicine can play an important role including a co-ordinating role in this development.
- 2.45 One of the key requirements for the achievement of this task will be the development of integrated information systems at district level, linking hospital and other services. These information systems will need to be capable of facilitating the qualitative as well as the quantitative requirements of the management process. Health services research of this nature, aimed at assessing the effectiveness of different services for different service delivery settings have been growing internationally. The Working Party is of the view that specialists in public health medicine can make a significant contribution to Irish health services research.
- 2.46 The Working Party believes there is a need to expand the information gathering and evaluation function to facilitate a systematic approach to planning and evaluation as part of the management process. *The Working Party recommends that a planning and evaluation function should be developed in each health board as part of a new public health function.*

## **A NEW STRUCTURE FOR PUBLIC HEALTH MEDICINE**

- 2.47 The Working Party is fully convinced, on the basis of submissions received and following its own review of the situation, that the present structure of community medicine is inadequate to meet the needs of a modern public health service. The Working Party is also convinced that, given a proper structure and status, the specialty of Public Health Medicine as it is now evolving can make a significant contribution to the health of our population into the twenty-first century.
- 2.48 The range and scope of the future role of the specialist in public health medicine cannot be limited to the community care services. The Working Party is satisfied that this limitation has held back the development of the specialty and its potential contribution to public health. The Working Party believes that those who have undergone the higher professional training of the Faculty of Community Medicine have developed the necessary skills, including those of medical epidemiologist, to make a significant contribution across the wide range of activities proposed in this report.
- 2.49 The Working Party considered a number of possible structures for the incorporation of a strong public health function into the health services at health board level and discussed whether future posts would be merely advisory or whether they would carry discernible management responsibility and accountability. The Working Party, whilst acknowledging that there is an advisory element involved, is convinced that there must be a clearly defined management responsibility and accountability attaching to the posts. The Working Party is satisfied that future specialists in public health medicine at health board level should operate as members of a functional team, similar to that of the Personnel and other functions.
- 2.50 *The Working Party recommends the establishment of a Public Health function in each health board to incorporate the planning and evaluation function. The Working Party further recommends the appointment of a Director of Public Health in each health board area as head of the Public Health function who would be a member of the management team. The Director of Public Health would participate in policy planning and decision making at management team level and would work closely with the other team members in such matters as the development of the planning and evaluation element of the function. The Working Party has drawn up a job description for the post of Director of Public Health which is given in Paragraph 10.9.*

- 2.51 The Working Party believes that the Department of Public Health Medicine in each health board should be staffed by a number of specialists in public health medicine who, under the leadership of the Director of Public Health, would discharge the responsibilities of the Public Health medical function in the particular area. In addition to the Director of Public Health, the Working Party envisages that there would be two or more District Public Health Directors making up the new Department of Public Health Medicine in each health board. In the larger health boards the Department could also include one or more specialists without district responsibility who could be assigned by the Director of Public Health to a particular field of specialist interest and responsibility for a whole health board area.
- 2.52 *The Working Party recommends that a specialist in public health medicine be designated as District Public Health Director for an area the population which would be of the order of 100,000 to 200,000 persons and which would as far as possible be co-terminous with a general hospital catchment area, a community care area and one or more local authorities.* The Working Party has drawn up a job description for the post of District Public Health Director which is given in Paragraph 10.17.
- 2.53 This District Public Health Director would report managerially to the Director of Public Health and would be accountable for all aspects of the Public Health medical function in his area.
- 2.54 In the United Kingdom, the specialist to population ratios for the specialty of community medicine range from 1:62,500 up to 1:90,000 and reflect the circumstances in the different parts of the United Kingdom. Given the Irish circumstances, the Working Party believes that initially a ratio of between 1:80,000 and 1:90,000 is appropriate, giving a requirement of between 39 and 43 posts of specialist in public health medicine. The Working Party envisages that the staffing of the Disease Surveillance Unit would in the first instance include two specialists in public health medicine who have developed a special expertise in the field of activity of the Unit. The Working Party believes that the future manpower requirement of the specialty, including the eight posts of Director of Public Health, the posts of District Public Health Director, the additional posts of specialist in public health medicine in the larger health boards and the posts in the Disease Surveillance Unit will correspond closely with the number of posts which would be created by the application of the ratios recommended above.
- 2.55 *The Working Party recommends that the existing posts of Director of Community Care and Medical Officer of Health should be abolished as soon as the new*

*Department of Public Health Medicine recommended in this report has been established in any health board area. The Working Party further recommends that, in order to facilitate the establishment of the Departments of Public Health Medicine, existing permanent holders of posts of DCC/MOH will be offered posts in the new Department of Public Health Medicine.*

- 2.56 Continuing arrangements will be necessary for the general management of the community care services and it will be a matter for separate decision as to what future arrangements will be made for the general management of these services and the leadership of the multi-disciplinary community care team. The Working Party would expect that following the abolition of the post of DCC/MOH, the heads of all the professional groupings in community care would report to the person who becomes responsible for the general management of those services and for leadership of the multi-disciplinary community care team.
- 2.57 However because of the nature of the community medical and environmental health services and the particular roles they play in relation to the health promotion, preventive, inter-sectoral and service co-ordination aspects of the public health function, it is essential that a special collaborative relationship exist between the District Public Health Director and the Senior Area Medical Officer and the Supervising Environmental Officer. *The Working Party recommends that the heads of the community medical and environmental health services should report managerially to the person responsible for the future general management of the community care services. They should however be required to maintain a close functional working relationship with the District Public Health Director in order to achieve the maximum level of co-operation and teamwork.*
- 2.58 In terms of influence within the medical profession, and with the general public, the standing of the specialty of community medicine has been relatively low in a health service dominated by clinical specialties. A number of submissions to the Working Party emphasised the view that the proposed posts in a Department of Public Health should be accorded consultant status. The Working Party has noted that the title 'consultant' has a particular connotation in hospital medicine and that the requirements of clinical consultant posts and posts in public health medicine are different. The Working Party uses the term 'specialist in public health medicine' throughout this report as it feels that this is a more appropriate generic title. *The Working Party recommends that those who complete the Higher Specialist Training of the Faculty of Community Medicine of the Royal College of Physicians of Ireland (or equivalent bodies) and who are appointed to recognised posts in a Department of Public Health Medicine of a health board or equivalent post should be designated generally as "specialists in public health medicine".*

- 2.59 *The Working Party recommends that Fellowship or Membership of the Faculty of Community Medicine of one of the Royal Colleges of Physicians or equivalent should be the recognised qualification for appointment to posts of specialist in public health medicine.*
- 2.60 *The Master's degree in Public Health or Membership of the Faculty of Community Medicine fulfil the public health training requirement for the posts of SAMO within the community care team since the posts were introduced. The Working Party recommends that, in the short-term, the minimum qualification required of all applicants for the post of SAMO should be either the Master's degree in Public Health or Part I examination of the Faculty of Community Medicine. The Membership of the Faculty of Community Medicine should become a requirement for the posts of SAMO as soon as is practicable.*
- 2.61 *The Manpower Survey carried out by the Working Party revealed that a significant percentage of the existing cadre of Area Medical Officers had no post-graduate training in public health. The Working Party believes that each SAMO and each AMO should have such training. The Working Party recommends that SAMOs and AMOs be given the opportunity to follow courses of study leading to the Master's degree in Public Health and to the Higher Training Programme of the Faculty of Community Medicine.*
- 2.62 *The Working Party believes that it is desirable to create higher specialist training posts in public health medicine throughout the country. It recommends that the specialists in public health medicine act as recognised trainers for the Faculty and that Registrar posts be created in the proposed Departments of Public Health Medicine. It recommends that the Faculty of Community Medicine and the health boards work closely together to achieve the establishment of training posts in all health board areas.*
- 2.63 *Communicable diseases remain a major challenge to the medical profession. The Working Party is aware that the Faculty of Community Medicine is concerned about the level of training in relation to environmental health and communicable diseases. The Working Party notes that steps are being taken to strengthen training in these areas but is of the opinion that we cannot afford to be complacent in Ireland. The Working Party recommends that greater emphasis be placed on environmental health and communicable disease*

during higher specialist training in community medicine and that the level of knowledge relating to microbiology should also be increased. When a Disease Surveillance Unit is established in Ireland, the Working Party believes it will play an important role in training doctors and others in relation to communicable disease, environmental health, and the development of health information systems.

## CHAPTER 3

### THE DEVELOPMENT OF PUBLIC HEALTH MEDICINE IN IRELAND

#### INTRODUCTION

- 3.1 Although both the hospital services and the general practitioner services can trace their origins back to the eighteenth century, it was not until the mid-nineteenth century that a separate discipline of public health and public health medicine evolved. At about the time of the Great Famine, which had decimated the population, there was a move to contain infectious diseases, particularly cholera and typhus and the Poor Law Commissioners were granted powers to act to alleviate these diseases. However, with the exception of the programme of vaccination against smallpox, introduced in 1858, there was no systematic approach to the problem (1), although the opening in 1862 of the workhouses to those who were not destitute granted access to the associated fever hospital to a wider population.
- 3.2 **1878 - 1925**
- At about this time an increasing awareness developed of the links between poor hygiene and poor sanitation and the prevalence of enteric diseases. All previous statutory measures to alleviate the problems were incorporated into and expanded upon in the Public Health (Ireland) Act, 1878. This wide-ranging Act encompassed environmental matters such as sanitation, drains, sewers and water supplies. It also introduced hygiene measures such as meat inspection and controls over slaughter-houses and the fitness of food for human consumption. Provision was also made for the first time for the control of infectious disease.
- 3.3 The sanitary authorities, established in accordance with the provisions of the Act, had separate staffing arrangements depending on whether they had urban or rural status. In urban areas, Medical Superintendent Officers of Health were appointed while in rural areas, the Dispensary Medical Officers were called upon to act as local Medical Officers of Health. The sanitary authorities developed the water and sewerage systems to varying degrees until 1898 when their role was incorporated into the remit of the new urban district councils and rural district councils established under the Local Government (Ireland) Act of that year.

- 3.4 In 1900, secondary legislation made under the Local Government (Ireland) Act, 1898 laid down the duties of the Medical Officers of Health and Medical Superintendent Officers of Health. Their duties were not dissimilar and each was called upon to familiarise himself with the influences upon public health in his district, the causes, origins and distribution of diseases in the district and to inspect and report upon conditions injurious to health. He was called upon to advise on measures and legislation which would improve public health.
- 3.5 When an outbreak of infectious disease occurred, the Medical Officer of Health was required to visit the place, inquire into the cause and advise where necessary on the steps to be taken to prevent an extension of the outbreak. He was required to inspect animals, carcasses and food intended for sale and to determine whether it was fit for human consumption. The Medical Superintendent Officer of Health in an urban area was also called upon to advise the sanitary authorities and to make an annual report to the authority on action taken to prevent the spread of disease, on the sanitary state of his district generally and on conditions injurious to health.
- 3.6 Although there was little change in mortality rates attributable to all causes of death during the period 1869-1900, deaths as a result of infectious disease declined (2). Improvements in sanitary services, in particular through the provision of clean drinking water and the underground piping of sewage outflows, brought about a very significant decline in enteric fevers. However the true incidence of infectious disease was not known due to the permissive (i.e. non-mandatory) nature of the Infectious Diseases (Notification) Act, 1889. Tuberculosis was the most common cause of death among the Irish population and did not show the downward trend experienced in other countries (3). There was considerable ignorance in Ireland about the infectious nature of tuberculosis and much apathy on the part of the sanitary authorities towards their responsibility to provide sanatoria, while the lack of compulsory notification of the presence of the disease made it difficult to stem its spread.
- 3.7 The Tuberculosis Prevention (Ireland) Act of 1908 laid down new, but no more successful, provisions for the notification of the disease while it also permitted county councils to establish hospitals for persons suffering from tuberculosis. The Act permitted the sanitary authorities to provide health education on subjects relating to tuberculosis and to provide any drugs or appliances which would prevent or check the spread of the disease. The National Insurance Act, 1911 further advanced the treatment of tuberculosis by providing insurance benefit for insured persons suffering from the disease thereby removing the financial hindrance to patients seeking treatment. During the period from 1910 to 1920 there was a very significant increase in the complement of beds provided to treat



- 3.8 During the early decades of the twentieth century, there were moves to develop health services for mothers and children (4). The Notification of Births Act, 1907 enabled the urban sanitary authorities to put in place a service of health visiting for post-natal mothers but, again due to the permissive nature of the Act, the service was only established in Dublin and Belfast (5). During this time, maternal deaths, frequently caused by puerperal septicaemia, gave cause for concern and in 1917, the Midwives (Ireland) Act required that midwives be registered and that standards and training be established for the practice of midwifery (6).
- 3.9 An amendment to the Notification of Births Act, passed in 1915, permitted the local authorities to put in place suitable arrangements for looking after the health of expectant mothers, nursing mothers and children under five years of age and as a result maternity and child welfare schemes were developed by both local authorities and voluntary agencies (7).
- 3.10 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. The local authorities were responsible for the provision of the service and could recoup half the cost of the service from central funds (8). The scheme provided for the appointment of whole time school medical officers, dentists and nurses who carried out medical screening of all children and particular inspections of school entrants and others who were seen to need examination (9). However in many instances these services were not put in place until the 1940s.
- 3.11 **1925 - 1947**  
The Local Government Act, 1925 replaced the Medical and Superintendent Officers of Health with a new grade to be known as the County or City Medical Officers of Health (CMOsH) who would be responsible for the effective administration of the sanitary laws and of the powers and duties of the boards of health and the local authorities in relation to safeguarding the health of the people, the provision of adequate and sanitary housing accommodation and for advising the boards of health and the local authorities in any instance where expert advice was required on matters affecting the health of the area. The CMOsH were wholetime officers and besides the implementation of the sanitary legislation, they also were responsible for the operation of the maternity and child welfare service, the school health service, the inspection of the midwifery service, the tuberculosis service and the welfare of the blind.

- 3.12 It has been pointed out (10) that many counties were slow to appoint CMOsH but in counties where they were appointed, they quickly made their presence felt. A major hindrance to the development of public health services at this period arose because of the permissive nature of the legislation and the slowness of the local authorities to accept change.
- 3.13 Under the 1925 Act, the rural district councils were abolished and their functions as sanitary authorities were transferred to the newly titled Boards of Health and Public Assistance. The CMOH continued to discharge the functions detailed in 3.11 above and reported to and advised the board of health and public assistance. There was a significant change in local authority management in 1942 with the implementation of the County Management Act, 1940 and the Local Government Act, 1941. The work of the former boards of health and public assistance was transferred to the county councils. A wide range of executive functions and responsibility for policy formulation at local level was vested in the county or city manager to whom the CMOH now reported. However the CMOH retained a number of statutory powers.
- 3.14 **1947 - 1970**  
A major change in the organisation of central government led to sweeping changes in 1947 following the Ministers and Secretaries (Amendment) Act, 1946 which divided the old Department of Local Government and Public Health, resulting in the creation of three Departments, Local Government, Health and Social Welfare. The functions of the Department of Health were set out in the 1947 White Paper on the Health Services and included the prevention and cure of disease and the control of the sale of foodstuffs. Responsibility for sanitary services, including sewage disposal and water supplies, rested with the Department of Local Government although medical advice on the provision of these services would be given to that Department by the Department of Health.
- 3.15 The Health Act, 1947 put in place a number of public health measures. The permissive nature of previous legislation on the notification of infectious diseases has already been referred to and led to widescale under-reporting. The 1947 Act permitted the Minister for Health to make regulations in relation to infectious diseases and the Infectious Diseases Regulations, 1948 were wide-ranging in scope and included an obligation on a medical practitioner to advise the CMOH as soon as he became aware of or suspected that one of his patients was suffering from one of the prescribed infectious diseases.

- 3.16 Extensive Food Hygiene Regulations were made under the provisions of the Health Act, 1947 to register food premises and to prohibit and prevent the sale of diseased or contaminated food and to prescribe hygienic precautions for the manufacture, sale and serving of food. Enforcing officers (Health Inspectors or Veterinary Inspectors) were given wide powers of inspection and those in charge of food or food businesses were required to facilitate them. The enforcing officers could seize, remove and detain food, animals or food material which was suspected to be diseased, contaminated or otherwise unfit for human consumption.
- 3.17 The Health Act, 1953 extended eligibility for hospital services to a much broader proportion of the population, including those persons with social insurance, employees whose income did not exceed a specified limit, farmers whose holding did not exceed a specified valuation and other persons who could demonstrate "undue hardship". This Act also required the health authorities to provide child welfare clinics, previous legislation having been permissive in this regard.
- 3.18 The next twenty-five years saw the decline of tuberculosis as a major cause of death and saw the development of widespread immunisation against and the eradication of diphtheria and poliomyelitis. Other immunisation programmes were developed against tuberculosis, pertussis, (whooping cough), tetanus and rubella (in girls aged 12-14 years). Public health medical officers both in the Department of Health and the local authorities were primarily instrumental in bringing about these achievements.

#### **REORGANISATION OF THE HEALTH SERVICES 1970**

- 3.19 The Health Act, 1970 made sweeping changes in the organisation of the health services, not least in public health medicine. Responsibility for the provision of the health services was transferred from the twenty-seven health authorities to the eight newly formed area health boards. The services of McKinsey and Co., management consultants were retained to advise on the appropriate management structures for the new health boards. They recommended a programme based management structure with separate programmes for hospital care and for community care, each headed by a programme manager. In the larger health board areas, two hospital care programmes were created, one for general hospitals and the other for special hospitals i.e. psychiatric and mental handicap services.

3.20 Within the community care programme, McKinsey and Co. recommended three levels of management with executive responsibility, viz. the programme manager, directors of community care service and senior or superintendent professional staff (for organisational chart see Appendix D). The directors of community care service were seen as the key to the community care organisation structure and it was recommended that

*"the health board's area should be divided into a number of communities, each to be managed by a director of community care service, who should be responsible for the provision of all community care services within his community. Thus, each director should have direct management responsibility for the professional and other staff who provide community care - i.e. medical officers, dentists, public health nurses, health inspectors, assistance officers, social workers and others. All professional staff involved in providing or managing health care services should work specifically in a community under a director of community care service.*

*"The director should also be concerned with relationships with, and any necessary development of, voluntary bodies, with the organization of general practice, and with co-ordinating the work of the services under his direct control." (11).*

McKinsey and Co. put forward a lengthy and detailed job description for the post of director of community care services which is reproduced in Appendix E.

### **INTRODUCTION OF POSTS OF DIRECTORS OF COMMUNITY CARE AND MEDICAL OFFICERS OF HEALTH**

3.21 Following the acceptance by the Minister for Health of the health board management structure proposed by McKinsey and Co., the Minister decided that it was essential that the post of Director of Community Care should be filled by an appropriately qualified medical practitioner and it was seen as likely that most of the new posts would be filled by serving County Medical Officers who would serve as Directors of Community Care and would combine with this role the public health medical function of the Medical Officer of Health. It soon emerged that the existing structures for the medical profession within the community care team were inadequate as was the training available to doctors who wished to practise in the public health field, particularly since the one available course leading to the Diploma in

Public Health had been suspended some time previously. It was agreed that it was necessary to resolve these issues before agreement could be reached on the job description for the post of Director of Community Care and Medical Officer of Health (DCC/MOH). To make recommendations, a Working Party representative of the health boards and the Department of Health was established under the chairmanship of Dr. J. H. Walsh, Deputy Chief Medical Officer, Department of Health.

3.22 The Walsh Report (12) concluded that doctors employed by the health boards in the field of public health should discharge functions in relation to:

- infectious diseases (including tuberculosis);
- food hygiene;
- health education;
- epidemiology of non-infectious diseases;
- Maternity and Infant Care Scheme;
- Child Health Services;
- On-going care of the Handicapped;
- General Medical Service;
- Care of the Aged;
- Welfare Services; and
- Environmental Health.

3.23 The Walsh Report recommended that the overall responsibility for the satisfactory discharge of these functions should rest with the DCC/MOH whose team would serve a population in the range 80,000 to 120,000 persons. The Report recommended that the afore-mentioned range of services would best be provided by area medical officers (AMOs) each of whom would serve a population of about 20,000 persons. The Report also recommended that in each community care area, two of the area medical officer posts would have the title of Senior Area Medical Officer (SAMO) and the holders of each such post would have special expertise and special responsibility in relation to designated functions. In the event, only one SAMO was appointed to each community care area.

#### **THE COMMUNITY CARE MEDICAL TEAM**

3.24 The Walsh Report recommended a job description for the post of DCC/MOH which combined the management functions drawn up by McKinsey and Co. for the proposed post of Director.

of Community Care Services with the public health medical functions previously discharged by the CMOH. This was the job description which was adopted for the post. The person holding the office of DCC/MOH has, within pre-determined policy and operational guidelines, charge of all community care services, provided by the health board in the functional area of the community care team and provides advice and guidance to the local authorities in the area on the environmental services in relation to which the health board has agreed to act as agent. The principal responsibilities of the post of DCC/MOH are:-

- to establish medical and social needs in the community and to assess and agree priorities for health care needs and services in the community;
- to develop targets and plans for services in the community;
- to ensure that plans for the community, when agreed, are put into action appropriately;
- to follow up and report on performance of services;
- to establish a high level of efficiency in the services in his community;
- to enhance the effectiveness of the senior members of his Community care team and their staff;
- to perform functions conferred on him under the regulations relating to infectious diseases and infestation; to food and drink; under the Maternity Homes Act, 1934; and under the Midwives Act, 1944;
- to perform such appropriate duties as may be assigned to him by or under or in connection with the administration of the Local Government (Sanitary Services) Acts, 1878 to 1962, the Factories Act, 1955, the Milk and Dairies Acts, 1935 to 1956, the Slaughter of Animals Acts, 1935 to 1956, the Housing Acts, 1966 to 1970 and the Diseases

- to provide specialist advice and guidance to medical practitioners in his functional area.

3.25 Within the present community care structure, the DCC/MOH is assisted in the discharge of his medical functions by a team consisting of an SAMO and a number of AMOs. The principal duties assigned to the SAMO are as follows:-

- To carry out the functions of a Public Health Medical Officer in the sub-area allocated to him/her.
- To plan the provision of Public Health Medical Services for the community care area and ensure that agreed plans are implemented;
- To co-ordinate and manage the work of the other AMOs in the area;
- To supervise and assist in the training and development of Medical Trainees in Community Care;
- To co-ordinate and monitor any public health work carried out by General Practitioners in the area on behalf of the Health Board; and
- To participate with the DCC/MOH and other members of the community care team in developing targets and plans for the area, and to help review progress and performance by the team.

3.26 The AMO has four principal responsibilities:-

- to provide an agreed programme of services within an allocated budget;
- to develop detailed knowledge of community medical services needs of the area;
- to co-operate with and liaise with persons (including personnel in institutions) and organisations providing health and/or social services in

- to assist the DCC/MOH and the SAMO in the evaluation of the community medical services in the area.

He normally reports to the SAMO but is expected to carry out the work programme with minimal direction and to co-operate closely with other persons and organisations providing health and social services in the catchment area.

3.27 As part of its research, the Working Party analysed the work load of the AMOs through a postal questionnaire. Based on the replies to the questionnaire, the duties and activities of the AMOs can be broken down into a number of different components as listed in detail in Appendix F. These components are largely clinical in nature and can be grouped together as follows :-

*(i) Clinical Duties relating to individual cases :*

*Prevention and Screening*

- Developmental paediatrics
- School health examinations
- General immunisations
- BCG vaccination
- T.B. clinics
- Women's health clinics
- Cervical smear testing
- Rubella screening
- STD clinics.

*Assessments for*

- Disabled Persons Maintenance Allowance
- Domiciliary Care Allowance
- Housing Grants
- Mobility Grants
- Non-accidental injury and child sex abuse
- Foster care.



**(ii) Co-ordination and liaison role in relation to**

- Services for the handicapped
- Services for the elderly
- Services for travellers
- Voluntary organisations
- General practitioners
- Other health professionals.

**(iii) Activities related to general population**

- Contact tracing
- Health education
- AIDS education
- Keeping of registers e.g. the handicapped, the elderly, T.B. and other infectious diseases, congenital abnormalities etc.
- Surveys and evaluation exercises
- Preparation of statistics.

The duties and activities most common to all AMOs (in descending order of frequency) are developmental paediatrics/school health examinations, assessments for Disabled Persons Maintenance Allowance, Domiciliary Care Allowance and Housing Grants, contact tracing and general immunisations.

3.28 In addition to his managerial responsibility for the medical officers, the DCC/MOH also has responsibility for leading the multi-disciplinary community care team. The heads of the various services (public health nurses, environmental health officers, community welfare officers, social workers, and other community-based paramedical staff) report to the DCC/MOH. It was also intended that the DCC/MOH would have responsibility for the dental officers but this responsibility has devolved to the principal dental officers in most areas.

3.29 In 1981, INBUCON, a firm of management consultants was commissioned by the Department of Health to review the organisation of community care services. The terms of reference laid down for the study were :

*To assess and report on the effectiveness of the present organisation of community care services under health boards and, in particular, to provide a factual assessment of:*

- (i) *how the organisation is functioning as compared with the structure adopted by health boards following their establishment ;*
- (ii) *how the present arrangements at community level are functioning in relation to :*
  - *the operation of the community care team, including team leadership ;*
  - *maintenance and development of community medicine, personal social services, voluntary organisations and community work ;*
  - *their contribution to policy formulation under health boards ;*
- (iii) *the attitudes of the staffs working in the community care programme to the present arrangements."* (13).

INBUCON carried out its research on the basis of personal interviews with members of the community care teams in nine community care areas.

3.30 In relation to community medicine, the Report concluded that:

*"The adoption of the present organisational structure for a community care team...makes a commitment to deliver a comprehensive service through a multi-disciplinary team. The role of the DCC/MOH was seen as leader of the team, using his skills as epidemiologist to assess community needs and to co-ordinate the team resources in meeting those needs and further developing the services. However, the community medical service was underdeveloped at the beginning of the new arrangements and appropriate training courses were not fully established until 1976. Doctors with post-graduate qualifications and training in community medicine have only recently begun to take up posts in the areas. This has necessarily delayed the development of community care...*

*"The new post of Senior Area Medical Officer is responsible for the planning organisation and review of community medical services. The bulk of the work involves school medical services and developmental clinics. These services are diagnostic and advisory only. Little epidemiological data has been acquired to date in community medicine....*

*"The most critical talent required of the DCC is that he be able to lead a team of diverse disciplines through his skills in training senior staff to plan and action an agreed programme based on a range of objectives for the area as a whole. The importance of these skills and the time that would be needed to achieve this level of team working experience appears to have been significantly under-estimated.*

*"We are of the view that, given the wide range of managerial and administrative abilities required to undertake the DCC role, which demands a more participative and consultative style as compared with the style required by the MOH role, it is only in a few instances that one would expect to find an individual with sufficient flexibility to fulfil both roles and that much on the job training would be required."(14)*

- 3.31 The combination of the top management post at community care area level exclusively with professional medical functions therefore contributed to the difficulties which developed within the community care programme in the following years. Other members of the community care team believed that they too had the capacity to lead the community care team but they were precluded from competing for the post because of the medical officer of health dimension. At the same time those qualified to fulfil the latter requirements of the post found that the competing general management versus public health medical aspects of the post prevented full development of either aspect. The existing posts of DCC/MOH are seen as an unsatisfactory mix of service management, clinical and public health responsibilities which do not offer sufficient scope for the development of the potential contribution of public health medicine to the future health status of the population, to the identification of health needs and to the planning and evaluation of future health services. It is worth noting that in his Medical Officer of Health capacity, the holder of the post is no longer obliged to produce an annual report on the state of health of his population, as was the case with his predecessor, the CMOH.

#### **COMMUNITY CARE MEDICAL TEAM - MANPOWER SURVEY**

- 3.32 The Working Party considered it necessary to establish the present position with regard to the number of medical posts which exist in community care services and the number of those posts which have not been filled by permanent appointments. Each health board was asked for the position on the 1st May 1989. The Working Party also considered it desirable to

obtain a profile of those doctors who are currently working in this field. Each doctor practising in the community medical services in the health boards, and in the Department of Health and related academic and research fields was asked to complete a personal questionnaire with details of age, sex, grade, qualifications, career profile and present duties. The questionnaire forms are reproduced in Appendix G.

### **STAFF COMPLEMENTS AND VACANCIES**

- 3.33 The returns from the health boards show that there are 195 medical posts in community care in the health boards at present. However, a total of 58 of these posts were unfilled on a permanent basis on the Survey day - 1st May 1989. Table 1 below shows the situation to be most acute in the senior grades, with seventeen posts of DCC/MOH and nine posts of SAMO filled only in a temporary capacity.

<p style="text-align: center;"><b><u>TABLE 1</u></b></p> <p style="text-align: center;"><b>COMPLEMENT OF MEDICAL POSTS IN COMMUNITY CARE AND NUMBER UNFILLED BY PERMANENT APPOINTMENTS ON 1 MAY 1989</b></p>			
	<b>COMPLEMENT</b>	<b>POSTS UNFILLED BY PERMANENT APPOINTMENT</b>	<b>% OF POSTS UNFILLED BY PERMANENT APPOINTMENT</b>
<b>DCC/MOH</b>	31	17	54.8
<b>SAMO</b>	32	9	28.1
<b>AMO</b>	132	32	24.2
<b>TOTAL</b>	195	58	29.7

3.34 The situation with regard to unfilled posts varied between the health boards, as can be seen in Table 2 below. The percentage of posts which are unfilled in a permanent capacity was highest in the Eastern Health Board where 41 per cent of posts were filled in a temporary capacity.

There was a similar situation in the North-Western Health Board where 35 per cent of posts are filled in a temporary capacity and in the Western Health Board where 32 per cent of posts were filled only on a temporary basis.

**TABLE 2**

**SURVEY OF MANPOWER IN THE COMMUNITY CARE MEDICAL TEAM- 1 MAY 1989**

**COMPLEMENT OF POSTS BY HEALTH BOARD AND GRADE**

**AND**

**NUMBER AND PERCENTAGE OF PERMANENT POSTS**

**WHICH HAVE NOT BEEN FILLED THROUGH PERMANENT APPOINTMENT**

	DCC		SAMO		AMO		TOTAL		
Health Board	A	B	A	B	A	B	A	B	C
EHB	10	9	10	4	38	11	58	24	41
MHB	2	1	2	0	7	7	11	3	27
MWHB	3	0	3	1	11	2	17	3	18
NEHB	3	2	3	0	11	0	17	2	12
NWHB	2	1	2	0	10	4	14	5	35
SEHB	4	2	4	1	19	3	27	6	22
SHB	4	1	5	3	17	3	26	7	27
WHB	3	1	3	0	19	7	25	8	32
<b>TOTAL</b>	<b>31</b>	<b>17</b>	<b>32</b>	<b>9</b>	<b>132</b>	<b>32</b>	<b>195</b>	<b>58</b>	<b>30</b>

**A Complement**

**B Posts unfilled by permanent Appointment**

**C % of Posts Unfilled by Permanent Appointment**

## PROFILE OF PERSONNEL IN COMMUNITY CARE AND COMMUNITY MEDICINE

- 3.35 A questionnaire was sent to each doctor who is involved in community care in the health boards, to the doctors on the staff of the Department of Health, and in relevant Departments of the Universities and the Health Research Board. The overall response was 186 completed forms, estimated to represent 89.6% of those in the target group. In making the analysis, the established grade of the respondent was considered rather than any temporary appointment to a higher grade.

### GRADE, SEX AND AGE OF RESPONDENTS

- 3.36 An analysis of the survey findings shows that 78 per cent of those currently involved in this field are female. This represents a dramatic change since 1968 when it was reported that 81 per cent of doctors working in public health in Ireland were male. The swing towards a majority of female doctors in this field was first reported by O'Se et al in 1982 (15) when they found that 66 per cent of those in public health were female. That report attributed the change to the increase in the number of female medical graduates. Despite the increase in the number of female doctors in public health and community care the doctors in the senior grades are still predominantly male.

<u>TABLE 3</u>			
GRADE AND SEX OF RESPONDENTS			
GRADE	MALE	FEMALE	PER CENT FEMALE
DOC/MOH	8	5	38.5
SAMO	8	17	68.0
Registrar	3	5	62.5
AMO	15	115	88.5
Dept of Health	4	1	20.0
Academic/Research	3	2	40.0
TOTAL	41	145	78.0

3.37 Although there is only a small number of men in the basic grade of AMO at present, the Working Party has been told of an increased interest in specialisation in public health among male graduates particularly as the introduction of a higher training pathway in Community Medicine has increased expectation that this field of medicine will afford enhanced career opportunities in the future.

3.38 Table 4 below illustrates that the age structure of the male and female doctors differs considerably. More than half the female doctors are aged under 40 years, compared with only 35 per cent of the male doctors. At the other end of the age range, 34 per cent of the male doctors are aged over 60 years, compared with only 8.5 per cent of the female doctors. It can therefore be expected that the female doctors will continue to be in the majority for a number of years to come.

TABLE 4					
AGE GROUP AND SEX OF RESPONDENTS					
	MALE		FEMALE		TOTAL
	No.	Per cent	No.	Per cent	No. Per Cent
Under 40	14	35.1	77	53.1	91 48.9
41 - 50	7	17.1	34	23.4	41 22.0
51 - 60	6	14.7	21	14.5	27 14.5
Over 61	14	34.1	12	8.3	26 14.1
Not stated	0		1	0.7	1 0.5
<b>TOTAL</b>	<b>41</b>	<b>100.0</b>	<b>145</b>	<b>100.0</b>	<b>186 100.0</b>



3.39 Table 5 shows an age and sex profile of each of the principal grades.

TABLE 5								
AGE GROUP, SEX AND GRADE OF RESPONDENTS								
	DCC/MOH		SAMO		AMO		OTHER	
	M	F	M	F	M	F	M	F
UNDER 40	2	2	0	9	9	61	3	5
41 - 50	3	1	1	4	2	28	1	1
51 - 60	0	2	1	1	2	16	3	2
OVER 61	3	0	6	3	2	9	3	0
Not stated	0	0	0	0	0	1	10	0
TOTAL	8	5	8	17	15	115	10	8

#### FUTURE MANPOWER NEEDS BASED ON THE SURVEY FINDINGS

3.40 Table 3 of the survey findings showed that seventeen posts of DCC/MOH and nine posts of SAMO were filled only in a temporary capacity in May 1989. Table 5 shows that a further three DCC/MOH and nine SAMO posts would fall vacant within the following five years as the post holders reach retirement age. Thus on age grounds alone it would be necessary to fill 38 senior posts within five years if existing numbers were to be maintained. In the basic AMO grade, there were 32 permanent posts vacant at the time of the survey and a further eleven vacancies could be anticipated on age grounds alone.

3.41 While it acknowledges that many of the vacant permanent posts have not been filled on a permanent basis in anticipation of its recommendations, the Working Party believes that this situation affords an opportunity to restructure Public Health Medicine.

## **TRAINING IN PUBLIC HEALTH**

- 3.42 The Walsh Report (16) recognised that there was then an absence of training in public health medicine and recommended the re-establishment of post-graduate training. As a result a new, one-year full-time course leading to a Master's degree in Public Health was established in University College Dublin. The Walsh Report had also recommended that "an attractive training programme with a worthwhile career structure must be provided if the health boards are to succeed in recruiting doctors of the required calibre into the community health services" and that the professional training to be established should be equivalent to training undertaken by hospital consultants. It also recommended that training to that level should be a requirement for both the post of DCC/MOH and of SAMO.
- 3.43 A Faculty of Community Medicine was established to function within, and as an integral part of, the Royal College of Physicians of Ireland and the inaugural meeting of the first Board of the Faculty was held on 15 May, 1976. Following its foundation, the Faculty organised orientation courses for newly appointed DsCC/MOsH and instituted a Higher Specialist Training Programme in Community Medicine.

## **QUALIFICATIONS OF THOSE CURRENTLY WORKING IN THE COMMUNITY CARE MEDICAL TEAM AND RELATED FIELDS**

- 3.44 Among the 186 respondents to the survey, 48 combinations of post-graduate qualifications were listed. Only six respondents, all AMOs, hold no post-graduate qualifications. Fifty respondents, all AMOs and mostly female, have no higher training in public health (DPH, MPH or Parts I and II of the MFCM). Table 6 below shows the geographic location of members of this group.

<b>TABLE 6</b>			
<b>LOCATION OF AMOs WITH NO PUBLIC HEALTH QUALIFICATION</b>			
<b>EHB 3</b>	<b>MWHB 7</b>	<b>NWHB 7</b>	<b>SHB 7</b>
<b>MHB 1</b>	<b>NEHB 5</b>	<b>SEHB 14</b>	<b>WHB 6</b>

These data suggest that distance from a centre for post-graduate training may influence the decision of an AMO to seek post-graduate training in public health.

- 3.45 At the time of the Survey (July 1988), 52 respondents were either Fellows or Members of the Faculty of Community Medicine of the Royal College of Physicians of Ireland. Membership of the Faculty is available to doctors who have successfully completed the two-part Membership examination of the Faculty. Foundation Memberships were awarded to practising public health doctors who were deemed through their experience to have attained comparable standards while Members of the Faculty may be awarded Fellowship status after a suitable period of post-graduate experience. Table 7 below shows the grades of respondents who are Members or Fellows of the Faculty of Medicine.

TABLE 7			
GRADES OF RESPONDENTS WHO ARE MEMBERS OR FELLOWS OF THE FACULTY			
NUMBER		NUMBER	
DCC/MOH	9	AMO	14
SAMO	16	DEPT OF HEALTH	4
REGISTRAR	4	ACAD/RESEARCH	5
TOTAL		52	

- 3.46 An age profile of those with Membership or Fellowship of the Faculty of Community Medicine is given in Table 8 and shows that a significant number of those with specialist training and/or experience will leave the service within five years as they reach retirement age. However the Faculty of Community Medicine has advised the Working Party that 28 of the 35 doctors who have been admitted to the Faculty by examination to date are aged under 45 years. Of these, ten are aged under 35 years and can be expected to have a long career ahead of them.

**TABLE 8****AGE PROFILE OF RESPONDENTS WHO ARE FACULTY MEMBERS OR FELLOWS**

AGE GROUP	NUMBER	AGE GROUP	NUMBER
Under 40	13	Over 61	16
41 - 50	8	Not stated	1
51 - 60	14		

3.47 Table 9 shows a profile of the geographical location of doctors who are Members or Fellows of the Faculty of Community Medicine.

**TABLE 9****LOCATION OF RESPONDENTS WHO ARE FACULTY MEMBERS OR FELLOWS**

HEALTH BOARD	NUMBER	HEALTH BOARD	NUMBER
EHB (Inc Dept + Acad)	32	NWHB	3
MHB	4	SEHB	4
MWHB	4	SHB	1
NEHB	2	WHB	2
	TOTAL		52

More than 60 per cent of the respondents with Faculty Membership or Fellowship are based in the Eastern Health Board area, either on the health board staff, in the Department of Health or in the academic and research fields. This may result in some mobility difficulties when senior posts outside of the Eastern Health Board area come to be filled by qualified persons. This, taken with the comments already made in relation to Table 6 in paragraph

3.44, underlines the need for measures to ensure that doctors outside of the Eastern Health Board area wishing to undertake post-graduate study or higher specialist training in public health medicine should be facilitated as far as possible. The Working Party is aware from its discussions with representatives of University College Dublin and the Faculty of Community Medicine respectively that they are very conscious of the need to widen access to post-graduate and higher specialist training.

## CHAPTER 4

### THE DEFINITION AND SCOPE OF COMMUNITY MEDICINE

#### DEFINITION

- 4.1 Community medicine is one of the newer medical specialties which has been granted recognition by the Medical Council in Ireland and by the General Medical Council in the United Kingdom. Membership of the Faculty of Community Medicine of one of the Royal Colleges of Physicians, or equivalent is the recognised qualification of the specialty. The specialty of community medicine is also recognised by the European Community. Many facets of what is encompassed under the title "community medicine" in these islands are practised in other countries under different names: public health, social medicine, population medicine and community and social medicine among others.
- 4.2 Community medicine has its historical roots within the public health movement and the term "community medicine" first came into use with the publication in 1968 of the Report of the Royal Commission on Medical Education (The Todd Report) in the United Kingdom which described community medicine as the specialty practised by epidemiologists and by doctors who are involved in the management of medical services. The specialty developed in the United Kingdom and specialist posts in community medicine were established with the coincident reorganisation of the health services in the United Kingdom in 1974. In the same year a Faculty of Community Medicine was established at the Royal College of Physicians in London.
- 4.3 In Ireland the major restructuring of the health services in 1971 preceded the recognition of community medicine as a specialty and there are no specialist posts as such currently recognised in the Irish health service. In 1976, the Royal College of Physicians of Ireland established a Faculty of Community Medicine and by the early 1980s the higher training programme for the specialty was in place. The training programme has received the support of the health boards who have created a number of registrar posts for the trainees.
- 4.4 Community medicine is concerned broadly with the health and medical needs of populations, environmental and social hazards to health, the causes of disease, the promotion of health, the identification of health needs, the determination of priorities and the planning and provision of effective services designed to meet those needs.

- 4.5 The Faculty of Community Medicine of the Royal College of Physicians of Ireland defines the aims of the Specialty of Community Medicine as being :

- *to identify, define and describe the health needs of the population;*
- *to plan for the provision of preventive and medical care services; and*
- *to evaluate the effectiveness of the services provided." (17).*

- 4.6 Community medicine has been described (18) as that branch of medical practice which is concerned to promote the health of human communities, differing from the clinical specialties whose primary concern is with the health of individuals. Thus, for the most part, clinicians offer advice and treatment to individuals who usually have consulted the doctor about a health problem they have identified themselves. Specialists in community medicine perform a similar function in relation to the health problems experienced by populations but with two important differences. Firstly, guidance and advice is usually given to those agencies who act on behalf of populations in relation to planning and decision making on matters affecting health. Secondly, the health problems of populations are often better dealt with by prevention and planning for contingencies rather than by responding to problems that have already arisen.

#### **TITLE OF THE SPECIALTY**

- 4.7 The Working Party notes that in the recent report "Public Health in England". (The Acheson Report) (19), attention was drawn to the fact that in England the terms "Community Medicine" and "Community Physician" cause considerable confusion not only with the general public but also with organisations and fellow professionals. That report noted that the problem arose from the application of the term "community" which in addition to its use to refer to whole populations is also widely used to refer to care not given in hospitals and institutions.
- 4.8 The Working Party found evidence of similar confusion in Ireland where "community medicine" is frequently, if erroneously seen as being synonymous with "community care". Many of those making submissions to the Working Party referred to this matter. Neither should "community medicine" be confused with the management of community care services.

- 4.9 *The Working Party recommends that the term Public Health Medicine should replace that of Community Medicine and that in the future the specialty should be known as Public Health Medicine. The Working Party believes that the term Public Health Medicine is better understood internationally. This title will also help to emphasise the importance of communicable disease and environmental health control. The Working Party understands that the Faculty of Community Medicine of the Royal College of Physicians of Ireland is prepared to consider a change of title for the specialty.*

#### **SCOPE OF PUBLIC HEALTH MEDICINE**

- 4.10 *The graduates of the Faculty of Community Medicine have told the Working Party that they found, on qualification, that the existing structure within the community care programme did not afford them an opportunity to put into practice the skills they had acquired during their Higher Training period. Their role is confined to the community care programme and they find that they have no opportunity to make a contribution to the totality of the health services. This view has been expressed for some time by a number of existing DsCC/MOSH.*

- 4.11 *The Working Party sees the principal concerns of the specialty as*

- *Epidemiology including applied epidemiology;*
- *The development of Health Information Systems;*
- *Surveillance and Control of Communicable Diseases;*
- *Environmental Health;*
- *Preventive Medicine;*
- *Health Promotion and the encouragement of healthy lifestyles and health orientated public policies;*
- *The monitoring and evaluation of outcomes of health services;*
- *Health Planning and Health Services Research.*



- 4.12 In setting out the scope of public health medicine, the Working Party wishes to avoid a return to the relatively narrow interpretation of public health which may have applied heretofore. *The Working Party sees the specialty as encompassing the whole spectrum of the health services, including hospital services and indeed the health field in its widest context, being aware that the activities of other agencies and influences can have a bearing on the health status of the population.* Thus the future scope of the public health medical function is much wider than its previously accepted role.
- 4.13 In the chapters which follow, the Working Party explores in detail each of these facets which make up the specialty of community medicine.

## CHAPTER 5

### EPIDEMIOLOGY AND HEALTH INFORMATION

#### INTRODUCTION

- 5.1 Epidemiology has been defined (20) as

*"the study of the distribution of disease and disability in human populations and of the factors which influence that distribution".*

It is a discipline which provides a systematic approach to the study of diseases present in the community and the patterns of delivery of medical care. It looks at the distribution and determinants of diseases and injuries in human populations. The translation of findings into plans for action requires an ability to make mature sound judgement on the potential value or otherwise of a particular medical or related action (21).

- 5.2 There has been a long if limited history of the use of epidemiology in the planning of health services. It is more than 200 years since Frank established a health plan for his region on the basis of vital statistics and infectious disease notifications (22). In the earlier part of this century, epidemiologists tended to confine their studies to the causes and distributions of disease.

However, the past twenty years have brought a considerable change with a particular emphasis on health service planning and a recognition of the contribution which the application of epidemiological techniques can make to the planning exercise. It has been pointed out (23) that epidemiological measurements are necessary at every stage in the process of achieving a sound health service. This process embraces the assessment of demand and need, decisions on priorities and the allocation of finite resources, monitoring the effectiveness of methods chosen to meet the needs and the evaluation of outcomes.

- 5.3 Epidemiology has been described as the core discipline of the specialty of public health medicine. Epidemiologists are trained

- to analyse and interpret trends in mortality and morbidity data;

- to gather and assess evidence in relation to factors which are associated with disease and describe the natural history of disease;
- to study the benefits of different diagnostic or treatment methods;
- to develop, maintain and report on routine health information systems;
- to make recommendations on the optimum conditions for the maintenance of health and for disease prevention;

and

- to evaluate the full range of health services (24).

5.4 Those who have undergone the Higher Specialist Training Programme in Community Medicine have acquired these skills but, apart from their course research work, have had limited opportunity to put them into practice in their present positions. *The Working Party recommends that the epidemiological skills acquired by graduates of the Higher Training Programme in Community Medicine be fully exploited in the planning and evaluation of the health services on the basis of population need.*

#### HEALTH INFORMATION SYSTEMS

5.5 It is widely recognised that there is a dearth of systematic and comprehensive information on the health status of the Irish population at present. Apart from vital statistics collected by the Central Statistics Office, a range of statistics based on take-up rates for the health services collected by the health boards and the Department of Health and statistics on psychiatric in-patients, only the Hospital In-Patient Enquiry (HIPE) attempts to draw together general morbidity statistics on a broad basis. Based on hospital admissions, the HIPE has never achieved full coverage in all hospitals. There have been a number of local initiatives to establish health information systems but there has never been any effort to initiate a standardised health information system for the whole country. The World Health Organisation initiative "Health for All by the Year 2000" (25) recommends that

*"Before 1990, Member States should have health information systems capable of supporting their national strategies for health for all." (Target 35)*

*"Such information systems should provide support for the planning, monitoring and evaluation of health development and services, the assessment of national, regional and global progress towards health for all and the dissemination of relevant scientific information; and steps should be taken to make health information easily accessible to the public."*

5.6 It has been recommended (26) that

*"an ideal set of information for health planning and monitoring would reflect health needs, and health services considered as inputs, processes and outcomes. It would include numerical data and commentaries about accuracy, appropriateness and the problems reflected by the statistics. The components of this health information would be*

1. *Data from regular health surveys of the population. These would give: diagnosis, functional assessment, and length of time of condition in individuals, capable of being translated into service needs; a single, composite measure or 'health index' to assess the impact of services; measures of health attitudes and behaviour, to guide preventive programmes.*
2. *Information on effective prevention or treatment for all conditions dealt with by the health services.*
3. *A description of the resources (finance and staff) and facilities available to the health service, and of the efficiency of their use.*
4. *Details of the presenting complaint, diagnosis, severity, treatment, resources used and outcome for each consultation between patient and doctor, to allow medical audit by clinicians.*
5. *Data about the contacts of individuals (using a unique patient identification number) with all parts of the health service, to assess how individuals and groups make use of the various services.*
6. *Follow-up data giving population outcomes for evaluation of the preventive and treatment services."*

- 5.7 The Working Party recognises that there are many possible different sources of health information such as mortality statistics, data on morbidity of those receiving primary, secondary and tertiary hospital care, and registers of those suffering from particular diseases such as cancers and tuberculosis. The notification procedure for infectious diseases has been unsuccessful and further comment will be made on its failings in Chapter 6. However it is essential that accurate data on the prevalence of infectious disease be available at all times as part of the ideal data set of health information and the Working Party believes that steps should be taken to improve the surveillance and collection of data on infectious diseases. Laboratories are a reservoir of information on infectious disease and there should be an onus on the laboratories to establish reporting relationships with the proposed Disease Surveillance Unit and the public health doctors at local level.
- 5.8 *The Working Party recognises the weakness of existing health information systems in Ireland and recommends that resources be made available to develop these systems.*
- 5.9 Many illnesses are treated in the home by a general practitioner and are not recorded in any of the established data collection processes. In respect of patients who are eligible for Disability Benefit, a form giving the cause of disability is completed by the general practitioner and submitted to the Department of Social Welfare making that Department a repository of vast quantities of data on the incidence of short-term illnesses in the population of insured workers. Similar data are kept on longer term illnesses in respect of which Disablement Allowances are paid. *The Working Party recommends that the Department of Health and the Department of Social Welfare should collaborate in making these sources of information available for epidemiological purposes.*
- 5.10 General practitioners, all of whom are in the front-line in the treatment of illness, can contribute much to the development of a detailed health information system. Although only 37 per cent of the population (those covered by the General Medical Service) are registered with a particular general practitioner, there is a long tradition of attendance at a particular general practice for the remainder of the population. *The Working Party recommends that the general practitioners be encouraged to develop an interest in an epidemiological profile of the patients attending their practices and to contribute information on the health status of their patients to a local health information system. The Working Party considers that responsibility for achieving such a development should rest with the holder of the proposed post of Director of Public Health.*

- 5.11 *The Working Party recognises that the Hospital In-Patient Enquiry has shortcomings and recommends that resources be made available to develop the HIPE to ensure full coverage in all acute hospitals.* With regard to data currently collected in the HIPE, evidence has been made available to the Working Party expressing concern about the lack of quality control of existing data. *The Working Party recommends that a specialist in public health medicine should be given responsibility for collaboration with the hospital clinicians at local level to achieve the highest level of coverage and quality control.*
- 5.12 The Working Party favours the use of a "small area" as the basis for data collection because it enables differences in the health profiles of seemingly similar populations to be easily identified. It helps the epidemiologist and the specialist in public health medicine to assess influences upon the health status of the small area. The Eastern Health Board has been developing an Epidemiological Information System based on small area analysis because an analysis on a city or county wide basis could mask local variations in health. The District Electoral Divisions (DEDs) are the smallest administrative units for which population statistics are published and on average they have a population of about 1,000 persons although the figure is significantly higher in the Dublin area at about 3,000 persons per DED.
- 5.13 *The Working Party recommends that the Department of Health and the health boards collaborate to design standardised health information systems which will facilitate the collection of material on a "small area basis" (such as on a District Electoral Division basis) but which will also contribute to the establishment of an overall picture of the health of the population of Ireland.*

#### **THE NEED FOR AN ANNUAL REPORT**

- 5.14 In the period before the implementation of the Health Act, 1970, one of the tasks which the County Medical Officers of Health were required to perform was the preparation of an annual report on the health of the population they served. The obligation to produce such a report ceased in 1971 and in most areas the practice ceased with the change to the new post of DCC/MOH. *The Working Party recommends that the preparation of an annual report on the health of the population should be resumed and that this should be the responsibility of the proposed Director of Public Health. The Working Party recommends that the annual report should contain standard data to facilitate inter-regional comparison but the report should also address issues of local concern.* In devising the standard data to be incorporated into the annual report, there

- 5.15 The report will represent the objective professional assessment of the Director of Public Health in relation to the health status of the population of the health board area. *The Working Party recommends that the Director of Public Health should be in a position to comment in the annual report on issues he deems to be important and relevant to the health of the population.* The Working Party believes that the publication of the Annual Report of the Director of Public Health will promote an awareness of the many facets of public health in the minds of politicians, national policy makers, members of health boards and local authorities, and those in other sectors such as education and industry whose activities impinge upon the health of the population and finally in the minds of the population who can be educated in the matters which influence their health.

## CHAPTER 6

### THE SURVEILLANCE AND CONTROL OF COMMUNICABLE DISEASES

#### DISEASE SURVEILLANCE

- 6.1 The control of disease within the population is an essential task of the public health medical function. Scientific developments over the past one hundred and fifty years led to vaccination and treatment programmes and to preventive measures all of which contributed to a significant decline in the morbidity and mortality of communicable diseases. However the emergence of new diseases such as Legionnaire's disease and AIDS has placed a new emphasis on the surveillance and control of communicable diseases. Other problems such as salmonellosis, brucellosis and Weil's Disease underline the need to develop links with the veterinary inspectorate. Outbreaks commonly occur of other infections such as hepatitis and gastro-enteritis and these, together with other communicable diseases, all highlight the importance of having an efficient surveillance system in place both locally and nationally. The rate of modern international travel involving the movement of large numbers of people out of and into Ireland, to and from different parts of the world also makes it essential for us to participate in international arrangements for the surveillance and control of communicable diseases.
- 6.2 Three main objects of surveillance have been identified (27): first, detection of changes in disease patterns to enable early preventive action to be taken when appropriate; second, evaluation of disease control measures; and, third, provision of data for health service planning. Population surveillance is of two main types: passive surveillance based on the central collection of data generated locally as part of routine health service functions, and active surveillance, based on special surveys set up with the specific objective of obtaining data for surveillance.
- 6.3 During its work period, the members of the Working Party had an opportunity to visit the Communicable Disease Surveillance Centre (CDSC) at Colindale, London which was established in 1977 and the Communicable Diseases (Scotland) Unit at Ruchill, Glasgow which was established in 1969. Each of these units draws together a multi-disciplinary team including medical personnel with epidemiological and microbiological training. The Scottish Unit also has advisers in environmental health and veterinary medicine. Each unit



was established as a direct outcome of a large-scale outbreak of communicable disease which had demonstrated the need for early warning and a prompt response mechanism and improved liaison with medical officers of health, veterinary officers and food producers. Each of the units has the following main functions:

- surveillance of communicable disease;
- surveillance of immunisation and vaccination programmes;
- investigation and control of communicable disease;
- epidemiological research;
- provision of training and teaching in the field of communicable disease epidemiology;
- production of a weekly bulletin on communicable disease;
- and
- liaison with other surveillance organisations internationally.

6.4 Data is collected by the surveillance centres on a routine systematic basis from a number of sources and a weekly bulletin is produced. This is the main information output and is given wide circulation nationally to those involved in the control of communicable diseases. It is also circulated internationally. A national reporting system for England and Wales is operated by CDSC at Colindale and reports of laboratory diagnosed infections form the core of the surveillance system. The Centre also makes use of data from many other sources to obtain a comprehensive picture of communicable diseases in England and Wales. The Scottish Unit operates on a similar basis and collects and analyses microbiological and other epidemiological data from medical, veterinary and environmental sources.

6.5 The surveillance centres provide advice and support to public health specialists in the control of communicable disease. The staffs of the centres take part in epidemiological investigations with local public health specialists, especially when a disease episode is of national importance or is geographically wide-spread and they work closely during such episodes with the public health and hospital laboratories, the regional and district health

## **A DISEASE SURVEILLANCE UNIT FOR IRELAND**

- 6.6 The Working Party is of the view that there is a need for a small unit for the surveillance of disease in Ireland. The Disease Surveillance Unit might confine its activities to communicable diseases in the first instance but as resources permit it might extend its activities to include non-communicable diseases such as cancers and congenital abnormalities. It should establish a regular reporting scheme on communicable diseases, initiate research on particular topics which are considered to warrant special investigations, e.g. the prevalence of HIV infection, advise on plans for outbreaks and, where outbreaks occur, provide advice and assistance on the control of the outbreak. It should also keep the effectiveness and safety of vaccines under surveillance and keep a watch on the immune status of the population to various diseases. *The Working Party recommends that a Disease Surveillance Unit be established in Ireland as a priority.*
- 6.7 *The Working Party recommends that the Disease Surveillance Unit should not be administered directly either by the Department of Health or the health boards, although the management board of the Disease Surveillance Unit should include representatives of these and other relevant interests.* The Unit would develop close working relationships with Department of Health medical staff, the proposed Directors of Public Health, the public health laboratories, the reference laboratories, the veterinary laboratories, hospital microbiology laboratories, selected hospital clinicians and general practitioners. The Working Party considers it important that the Disease Surveillance Unit should be seen as an independent and authoritative source of objective scientific data and the data resulting from its routine surveillance should be freely available and circulated to all those involved in the control of communicable diseases while findings of special investigations may be published.

## **LABORATORY SERVICES**

- 6.8 The Working Party is aware of the important role played by the Public Health and Public Analysts' Laboratories and the Hospital Microbiology Laboratories and Veterinary Laboratories in the identification of communicable diseases. During its discussions with the virologists, microbiologists and public analysts, the Working Party was informed of the close working relationships which already exist between these specialists and the

community care medical team. However, there was a general feeling that this relationship is under-exploited at present and that the relationships could be strengthened to the benefit of the health of the public. ***The Working Party recommends that close collaboration be fostered between the specialists in public health medicine and the relevant specialists in the various hospital and public health and other laboratories.***

- 6.9 At present the Virus Reference Laboratory located at University College Dublin acts as the National Virus Reference Laboratory. The Working Party recognises the merits of the work carried out at the Laboratory but would welcome the reorientation of its work to ensure that, in the future, data recorded and circulated by the Reference Laboratory would include data on a regional basis rather than the national data currently available. ***The Working Party recommends the formal establishment of a National Virus Reference Laboratory which would act as central collector of data on viruses.*** In recommending the formal establishment of the National Virus Reference Laboratory, the Working Party in no way wishes to diminish the contribution made by the other microbiology laboratories but would hope that, in the future, all the laboratories will work closely together, feeding data back and forward to ensure the prompt availability of material to the Directors of Public Health and specialists in public health medicine on occurrences of viral and bacterial infections. ***The Working Party recommends the formal recognition of other reference laboratories throughout the country to concentrate on specific organisms such as salmonella. The Working Party is aware that the Irish laboratories still rely on their overseas counterparts to carry out phage typing of salmonella and other organisms and recommends that one of the reference laboratories develop the capacity to carry out phage typing in order to fulfil the national requirements.***

## **NON-COMMUNICABLE DISEASE**

- 6.10 The Working Party believes there is a need for greater surveillance of the incidence of non-communicable diseases in the Irish population. ***It recommends that the specialists in public health medicine play a leading role in the establishment of registers of diseases and conditions such as cancers and congenital abnormalities.*** The Working Party believes that there should be uniformity of approach to the surveillance of non-communicable disease and recommends close co-operation between specialists from the different health boards to ensure that comparable regional data are achieved.

## COMMUNICABLE DISEASE CONTROL

- 6.11 The World Health Organisation has called for the elimination of a range of infectious diseases in the European region before the year 2000 (28). Ireland has already achieved the WHO targets in relation to poliomyelitis and diphtheria. Among the other diseases listed by the WHO for eradication before the year 2000 are measles, tetanus and rubella. If these and other infectious diseases such as mumps and whooping cough are to be eliminated, it is essential to establish and maintain immunisation programmes. *The Working Party recommends that in each health board area at least one specialist in public health medicine should be given responsibility for the surveillance and control of communicable disease.* The responsibilities of the post would include prevention through, for example, the organisation and management of immunisation programmes, management of outbreaks and contact tracing.
- 6.12 While there is an increasing involvement of the general practitioners in the clinical administration of vaccines, there is still a central responsibility for a specialist in public health medicine to set, monitor and ensure the achievement of vaccination and immunisation targets and, because Irish children are not registered with a particular general practitioner, as happens in some other health systems, there is also a need for the health board to identify the target population to ensure uptake of the various vaccines at the appropriate age. *Where vaccination and immunisation targets have not been reached, the Working Party recommends that the specialist in public health medicine should put in place whatever special arrangements are necessary to ensure the delivery and uptake of these services to meet those targets.*

## NOTIFICATION OF COMMUNICABLE DISEASE

- 6.13 A medical practitioner is required by law to send a written notification to the DCC/MOH as soon as he becomes aware or suspects that a person on whom he is in professional attendance is suffering from or is the carrier of an infectious disease specified in the regulations made by the Minister for Health. In respect of certain diseases he is required to make an immediate preliminary notification. The DCC/MOH is required to make enquiries and to take the necessary steps to investigate the nature and source of the infection and to remove conditions favourable to the infection. A list of the notifiable infectious diseases is given in Appendix H.

- 6.14 The Working Party has already noted that there is considerable under-reporting of communicable diseases in Ireland. If a full and comprehensive picture of the health of the population is to emerge it is essential that the incidence of communicable diseases be properly measured. Medical practitioners, including those in hospitals, are remiss in some instances in not reporting outbreaks or more frequently, single occurrences of communicable diseases.
- 6.15 In the case of general practitioners it is necessary to build up and maintain the closest possible collaboration at medical colleague level in the interests of ensuring that the epidemiological significance of individual practitioner/patient contacts is continuously appreciated in the broader population medicine context, particularly in instances involving cases of communicable disease. *The Working Party is of the view that the necessary close collaboration with general practitioners can best be achieved by a specialist in public health medicine and recommends that this should be a responsibility of the proposed District Public Health Director.*
- 6.16 The Working Party believes that there should also be a close working relationship between the specialist in public health medicine and the hospital clinicians in relation to infection control. The Working Party noted that there is a close working relationship between the Director of Public Health and hospital infection control committees in some of the health authorities which it visited in England. In some cases a specialist in public health medicine served as a full member of the Hospital Infection Control Team. As a result the specialist in public health medicine is in a position to ensure maximum liaison in the event of an outbreak of communicable disease. *The Working Party recommends that there should be close collaboration between the local hospitals and the specialists in public health medicine in relation to infection control.*

#### **ACTION PLANS FOR DISEASE OUTBREAKS**

- 6.17 The Working Party noted from the evidence received that there have been problems in reacting to various outbreaks of communicable disease, whether viral or bacterial, which have occurred in the past. *The Working Party recommends that each health board develop a plan of action to deal with outbreaks of communicable disease. The Working Party recommends that the Director of Public Health take the initiative and responsibility for the development of such a plan. The Working Party recommends that the plan include the establishment of a small Action Committee*

on Communicable Disease, to include representatives of the general practitioners, hospitals, microbiologists and veterinary officers who should be convened in regular meeting by the District Public Health Director and who should come together regularly to design and review plans to cope with an outbreak of communicable disease. The Working Party also recommends that this group in its regular meetings review measures to prevent possible outbreaks of communicable disease.

- 6.18 The Working Party is aware that an outbreak of communicable disease can, through media publicity, give rise to unwarranted public hysteria. On the other hand the interests of public health demand that the members of the public be given factual information and authoritative advice concerning the outbreak. The Working Party recommends that the public be given a balanced report where an outbreak of food borne or other communicable disease occurs. This report should explain the possible cause of the outbreak, what is being done to contain it, information about those persons most at risk and the steps to be taken by them to avoid or cope with infection. The Working Party recommends that the presentation of reports on outbreaks of communicable diseases to the media should be undertaken by the District Public Health Director or if the circumstances so warrant, by the Director of Public Health.



## CHAPTER 7

### THE ENVIRONMENT AND PUBLIC HEALTH

#### ENVIRONMENTAL INFLUENCES ON HEALTH

- 7.1 Environmental problems may be minor, causing only annoyance or unpleasantness, or they may be major, constituting hazards to health or even to life (29). Poor sanitation contributed in no small way to the high incidence of infectious disease among the nineteenth century population of Ireland. Bad and overcrowded housing contributed to the spread of diseases such as tuberculosis. An absence of good food hygiene practices led to widespread outbreaks of gastro-enteritis and salmonellosis and other food-borne diseases. While the major developments in the sanitary services and the recognition of the links between poor hygiene and disease contributed to the decline in the levels of infectious diseases and to an improvement in morbidity and mortality rates during the latter part of the nineteenth and early part of the twentieth century, these problems have been replaced by a further series of environmental features, the result of modern lifestyles, which impinge upon the health of the population.
- 7.2 A wide range of potentially lethal toxic chemicals is used in industry and agriculture while there are frequently inadequate arrangements for the disposal of domestic, agricultural and industrial waste. Water pollution can be caused by poor agricultural practice, a lack of suitable reprocessing facilities and by inadequate sewage treatment plants. Air pollution can be exacerbated by industrial emissions and by smoke emissions from domestic fires, which can cause "smog" outbreaks in major urban areas. Modern fish farming methods can give rise to pollution problems and shell-fish production is also subject to environmental contamination.
- 7.3 The World Health Organisation in its initiative "Health for All by the Year 2000" (30) places particular emphasis upon the importance of a healthy environment. The W.H.O. European Region notes that

*"the environment of the European Region of the World Health Organisation is changing rapidly in terms of demographic structure, human lifestyles, consumer goods, energy sources, modes of industrial and agricultural production, transport, tourism and migration. All these factors can cause, and can interact to produce, major impacts on health".*



More specifically the W.H.O. recommends (31) that

*"by 1990, Member States should have multi-sectoral policies that effectively protect the environment from health hazards, ensure community awareness and involvement, and support international efforts to curb such hazards affecting more than one country".*

The W.H.O. elaborates on the implementation of this target by pointing out that

*"the achievement of this target will require the acceptance by all governments that well co-ordinated multi-sectoral efforts are needed at central, regional and local levels, to ensure that human health considerations are regarded as essential prerequisites for industrial and other forms of socio-economic development, including the introduction of new technologies; the introduction of mechanisms to increase community awareness and involvement in environmental issues with potential implications for human health; and the development of international arrangements for effective control of trans-frontier environmental health hazards".*

- 7.4 The World Health Organisation document has stipulated (32) specific targets for the control of environmental influences on public health such as toxic chemicals, radiation, harmful consumer goods, biological agents, water pollution, air pollution, food contamination and the disposal of hazardous wastes.

#### **THE SUPERVISION OF THE ENVIRONMENT IN IRELAND**

- 7.5 In Ireland, responsibility for the protection of the environment rests largely with the local authorities under the supervision of the Department of the Environment although special responsibility in regard to radiation has been given to the Nuclear Energy Board. Local authorities are concerned with the provision of water supplies, sewerage and drainage, with the collection and disposal of refuse and with street cleaning. They are responsible also for control of pollution e.g. of water pollution and air pollution and engage in a wide range of activities and responsibilities which impact on environmental health.
- 7.6 The establishment of the health boards in 1971 led to the separation of the health services function from the activities of the local authorities. However the local authorities have statutory responsibility for a range of environmental matters which have a bearing on public

health. They also continue to be responsible for licensing of dairies and slaughterhouses - in fact the Abbatoirs Act, 1988 has extended their powers and functions and requires local authorities to employ full-time Veterinary Officers. The Water Pollution Act, 1977 has extended the responsibilities and functions of local authorities and has led to the setting up of a number of independent laboratory testing facilities. *The Working Party recommends that there is a particular need to review and strengthen the consultative and advisory process between the local authorities and the health boards on issues which relate to or impinge upon the health of the population.*

- 7.7 Although responsibility for the environment rests largely with the local authorities, the monitoring of the environment is generally carried out on an agency basis by the Environmental Health Officers who are employed by the health boards, and who report to the Medical Officers of Health, i.e. either the City Medical Officer or the DCC/MOH. The DCC/MOH (or City Medical Officer) continues to provide, by means of an agency arrangement, public health medical advice to the local authorities. Such advice would relate to matters such as water supplies, sanitation, housing, planning, air pollution, noise control, public health nuisances and the licensing of dairies and places of public entertainment. Financial considerations have placed a strain on the agency relationship between the local authorities and the health boards in the recent past in respect of medical and environmental health services and has led to some curtailment of those services. *The Working Party recommends that maximum co-operation should exist between the local authorities and the health boards on matters which relate to public health.* The Working Party met with representatives of the County and City Managers Association who confirmed that they wish to retain an external source of medical advice from a designated public health medical officer of the health board as takes place at present.

- 7.8 *The Working Party recommends that the District Public Health Director act as adviser to a local authority on matters relating to environmental influences on the health of the population. As each health board spans a number of counties, the Working Party believes that one District Public Health Director could, if necessary, advise more than one local authority.*

- 7.9 The Working Party notes the proposed establishment of a new Environmental Protection Agency as announced by the Government. In Scotland a new Unit known as the Environmental Health (Scotland) Unit has recently been established to monitor the environment, factors which impact on the environment and environmental influences on health and the population. The remit of the Scottish Unit is broadly as follows :

- to advise and liaise with health boards, local authorities, the Scottish Office and other relevant bodies on the epidemiological and medical aspects of environmental hazards;
- the investigation and surveillance of environmental hazards to health and to undertake relevant epidemiological research;
- to facilitate education and training of relevant professions;
- to publish reports of environmental health investigations and surveillance programmes;
- to publish notes on environmental health issued in association with the Communicable Diseases (Scotland) Unit;
- to publish an annual report.

The Working Party considers that the discharge of the responsibilities of the Director of Public Health and the District Public Health Director in relation to environmental impacts on health would be strengthened by the support of centrally located activities such as those being undertaken by the Scottish Unit. *The Working Party recommends that full monitoring of environmental influences be carried out regularly in Ireland and recommends that mechanisms be put in place to ensure that adverse effects of the environment on the health of the population are under continual scrutiny.*

## **THE FOOD CHAIN AND PUBLIC HEALTH**

- 7.10 The protection of food from contamination has traditionally been an important public health issue. Microbiological contamination can lead to infections caused by salmonella, listeria monocytogenes and campylobacter, and intoxications caused by the toxins produced by bacteria such as clostridium botulinum and staphylococcus. The development of convenience foods, changing distribution and delivery systems, centralisation of food processing and the widespread use of new technologies and processes have all contributed to an increased potential for food borne disease. Problems of food hygiene are exacerbated

by the importation of contaminated animal foodstuffs and are complicated by the use of unclean and decomposed raw materials or by unhygienic conditions in food manufacture, processing and delivery systems. The use of chemical additives both directly at the manufacturing stage and indirectly during the production of the raw materials can be potential health hazards.

- 7.11 The Working Party met with representatives of the Irish Veterinary Association who stressed the contribution which can be made to public health by veterinary medicine and confirmed that they would welcome a formal relationship between the county veterinary officer and the specialist in public health medicine.
- 7.12 Besides the veterinary profession, the 'food chain' has inputs and linkages from many other professional fields - the farmer, the market gardener, the meat producer, the manufacturer, the packer, the quality controller, the environmental health officer, and, in the event of a problem, the public health doctors and the public health laboratory staff of microbiologists and bacteriologists. *The Working Party recommends that the protection of the food chain be strengthened through greater formal co-operation and collaboration between the various interests involved in order to ensure that food and food products are uncontaminated when they reach the consumer.*
- 7.13 The Working Party welcomes the establishment, jointly by the Minister for Health and the Minister for Agriculture, of a Food Safety Advisory Committee at national level to replace the former Food Advisory Committee and the Committee on Zoonotic Diseases. The Food Safety Advisory Committee draws together representatives of agricultural and veterinary interests, the public health and hospital laboratories, the National Drugs Advisory Board and the Departments of Health and Agriculture. Its remit is to advise on food safety and it has established three sub-committees to review food legislation, to advise on additives and contaminants and to advise on zoonotic diseases. *The Working Party recommends that at local level the District Public Health Director should take the initiative to establish a regular group meeting process involving representatives of the producers, the veterinary profession, the environmental health officers, the public analysts, the microbiologists, retailers and consumers to review and monitor the public health aspects of the production, preparation, delivery and sale of food and food products within his district.*

## CHAPTER 8

### HEALTH PROMOTION AND PREVENTIVE MEDICINE

- 8.1 The adoption of a healthy lifestyle is a personal choice which cannot be imposed on an unwilling individual. However such decisions can be influenced by knowledge. Health education has a major role in making the public aware of the outcomes of unhealthy behaviour and the benefits of a healthy lifestyle.
- 8.2 The design of health education programmes presupposes a knowledge of the underlying problems in the health of the target community. It is therefore essential that base-line epidemiological data are available to identify these problems and to provide the base against which the effectiveness of a particular programme can be measured. In this and in the design of the health education programme there is a role for the specialist in public health medicine who has developed a health profile of the population as part of the health information system and who can analyse that information to disclose weaknesses in the health behaviour of the population which might be targetted for an educational programme.
- 8.3 Health is also influenced by factors external to the individual. In Chapter 3, it was shown that societal changes over time led to improvements in the health of the population. Chapter 7 discussed some of the environmental influences on the health of the population. A recognition of these broader influences on health has brought a new approach to health and to the need for a multi-faceted approach to the promotion of the health of the population in the future.
- 8.4 In 1986, the First International Conference on Health Promotion held in Ottawa drafted a charter (33) which defined health promotion as :

*"the process of enabling people to increase control over, and to improve, their health. To reach a state of complete physical, mental and social well-being, an individual or group must be able to identify and to realize aspirations, to satisfy needs, and to change or cope with the environment. Health is, therefore, seen as a resource for everyday life, not the objective of living. Health is a positive concept emphasizing social and personal resources, as well as physical capacities. Therefore, health*

*promotion is not just the responsibility of the health sector, but goes beyond healthy life-styles to well-being. The fundamental conditions and resources for health are peace, shelter, education, food, income, a stable co-system, sustainable resources, social justice and equity. Improvement in health requires a secure foundation in these basic prerequisites."*

The conference concluded that good health is a major resource for social, economic and personal development and an important dimension of quality of life. Political, economic, social, cultural, environmental and biological factors can all favour health or be harmful to it. Health promotion action aims at making these conditions favourable through advocacy for health.

- 85 The European Regional Office of the World Health Organisation initiated its "Health Promotion" programme in January 1984. Its perspective on health promotion

*"is derived from a conception of 'health' as the extent to which an individual or group is able, on the one hand, to realise aspirations and satisfy needs; and, on the other hand, to change or cope with the environment" (34) .*

- 86 The World Health Organisation argues that health promotion involves the population as a whole in the context of its everyday life, rather than focusing on people at risk for specific diseases. Because it is directed towards the determinants of health, it requires a close co-operation of sectors other than the health services sector, reflecting the diversity of conditions which influence health. As a result, health promotion combines diverse approaches including communication, education, legislation, fiscal measures, organisational change, community development and spontaneous local activities against health hazards (35) .

- 87 The W.H.O. Health Promotion Programme has laid down guidelines for the development of health promotion policy. It recommends that the 'health' aspect be considered at every level of planning in order to integrate health promotion with policy in other sectors such as work, housing, social services and primary health care. It recommends continuous consultation, dialogue and exchange of ideas between individuals and groups, both lay and professional.

- 88 The W.H.O. recommends that when selecting priority areas for policy development a review should be made of:

- indicators of health and their distribution in the population;

- current knowledge, skills and health practices of the population;
- current policies in government and other sectors..

Further, an assessment should be made of:

- the expected impact on health of different policies and programmes;
- the economic constraints and benefits;
- the social and cultural acceptability;
- the political feasibility of different options (36)

8.9 The importance of the multi-sectoral approach to health and health promotion was again endorsed in 1988 at a W.H.O./ Council of Europe/City of Vienna sponsored conference on the theme of "Health in Towns". The Vienna Conference (37) took note of the "Healthy Cities" programme initiated by W.H.O. as a practical application of the principles of Health for All - a project in which attention is focused concurrently on:

- the objectives of health promotion, creating the opportunities and conditions enabling people individually and collectively to lead healthy lives;  
and
- those of environmental improvement creating the healthy place in which people can settle, work and lead their lives.

The conference stressed that health must be put and kept high on the political agenda and made an important element in the implementation of all policies affecting urban development, e.g. housing and open space, traffic management and planning, urban redevelopment and conservation; the relationship between unemployment and health; local policies for social and cultural development and for children and young persons, the opportunities and the implications of which should be considered as a whole within one coordinated local health strategy.

8.10 In Ireland too, in recent times the focus on health has changed as it has been acknowledged that health education programmes are not sufficient in isolation to promote a healthier community. Neither can health policy confine itself to the traditional health services. "Health: The Wider Dimension" points out (38) the all-embracing nature of health promotion, arguing that :

*"A genuine commitment to health promotion will have to be shared across the entire community - it will not be sufficient to simply state that health promotion is now a part of health policy. To illustrate the nature and magnitude of the change involved may be useful to outline some of the key components in health promotion.*

*It involves:*

- *an acceptance by individuals of personal responsibility for their own health;*
- *an acceptance by public authorities, private corporations, individual entrepreneurs and others whose decisions and actions impinge on the health of the community that they have a responsibility not to cause damage to other people's health;*
- *development of a health service which adopts a lead role in the promotion of positive health and provides a mix of health care which is compatible with this new approach;*
- *to the extent necessary and deemed acceptable by the community, intervention by the state to provide the pre-requisites for good health, e.g. in terms of education, income level, employment etc., and by encouraging or enforcing greater health consciousness on the part of key decision makers in the community."*

8.11 New initiatives towards the promotion of health were taken in 1987 with the establishment of the Health Promotion Unit in the Department of Health. The new Unit assumed responsibility for the programmes previously administered by the Health Education Bureau and expanded upon those activities through the adoption of the broader "health promotion" perspective. An Advisory Council on Health Promotion, broadly based and representative of health, health-orientated and consumer interests, was established to advise the Minister for Health on priorities in the field of health promotion. Finally, and perhaps most importantly, a Cabinet Sub-Committee on Health Promotion has been established by the Government as an explicit acknowledgement of their collective responsibility for health promotion. Chaired by the Minister for Health, it also includes the Ministers for Education, Agriculture, Labour, Energy and the Environment. This committee facilitates inter-Departmental co-operation and provides a formal channel at the highest level through which inter-sectoral health issues can be raised and their implications assessed.



- 8.12 As the Charter of the first International Conference on Health Promotion pointed out (39) health promotion goes beyond health care. It puts health on the agenda of policy makers in all sectors and at all levels, directing them to be aware of the health consequences of their decisions and to accept their responsibilities for the health status of the population. Health promotion policy combines diverse but complementary approaches including legislation, fiscal measures, taxation and organisational change. It is co-ordinated action that leads to health; income and social policies that foster greater equity. Joint action contributes to ensuring safer and healthier goods and services, healthier public services, and cleaner, more enjoyable environments. Health promotion policy requires the identification of obstacles to the adoption of healthy public policies in non-health sectors, and ways of removing them. The aim must be to make the healthier choice the easier choice for policy-makers as well.
- 8.13 The W.H.O. Programme "Health for All by the Year 2000" has given health policy-makers a series of targets for the promotion of health in their populations. Target management (Management By Objectives) offers a useful catalyst to action. The programme also specifies target dates for the achievement of the aims of the programme. The Faculty of Community Medicine of the Royal College of Physicians (London) has translated the W.H.O. goals into a series of achievable targets towards which the English and Welsh District Health Authorities are working. For the information of the reader, these targets are quoted in Appendix I.
- 8.14 During their visit to Newham Health Authority, the members of the Working Party were told of the steps being taken locally in order to achieve the "Health for All" goals. In the annual report on the health of the district (40), the District Medical Officer (now Director of Public Health) presented a situational analysis of each of the 38 targets and the problems associated with their attainment. The Working Party was informed that it was the Director's intention that during 1989 the Newham Health Authority, the local authority's Health Liaison Sub-Committee and the Community Health Council would consider ways of working towards the Health for All targets and of encouraging participation by local people, helping them to seek for and achieve better health and better services related to health. In Lewisham and North Southwark Health Authority (41), it was also intended that during 1989 the Department of Public Health would address the targets of the Health for All Programme using the health related targets defined for the health authorities by the Faculty of Community Medicine of the Royal College of Physicians. (42) .

8.15 *The Working Party recommends that there should be an integrated approach to the preparation of health promotion and education programmes on the basis of a good working relationship between the Health Promotion Unit at the centre and those who have closer contact with local problems and issues. In this regard the locally based specialist in public health medicine can make a valuable contribution through his knowledge of the health profile of the population.* The Working Party was impressed with the five-year plan for health promotion which had been drawn up by the newly established Northern Ireland Health Promotion Unit in association with the Northern Ireland health boards and would welcome the adoption of an appropriate long-term strategy by the Health Promotion Unit in consultation with the health boards.

8.16 Apart from centrally organised initiatives towards the promotion of health, there is ample scope for local initiatives which can be tailored to meet local problems and local needs. The Vienna Conference underlined the crucial role of health in public policy at local level. An initiative such as the Healthy Cities movement is important in that it promotes an explicit concern for health and equity in all areas of policy and decision-making; it ensures that health is a collective and an individual responsibility, affected by many influences outside of the medical professions and health services, and it ensures that all sectors are accountable for the health effects of their actions.

8.17 There are already a number of initiatives in Ireland which have shown the emergence of a multi-sectoral approach to the promotion of health and a healthy environment. The City of Dublin has made a successful application for participation in the Healthy Cities project of the World Health Organisation which seeks to stress and integrate three key aspects of health promotion in an urban context:

- the promotion of healthy lifestyles,
- a greater concern for health as a component of all public policy in the different sectors of the local community and economy,
- the creation of a healthier urban environment, and to have the subject of health high on the political agendas of cities and to ensure the development of concrete plans for improvement of health (43).

8.18 The Kilkenny Health Project (44) was established in 1985 with the specific aim of reducing the risk of heart disease among the people of the City and County of Kilkenny. The Project is

working to a five-year programme and began its work by carrying out a baseline epidemiological survey. It has set itself achievable targets and has now put in place health education programmes, self-help programmes and other activities which will create an awareness among the population of Kilkenny of the aspects of their lifestyles which affect their health and will motivate them to change their behaviour patterns where necessary.

- 8.19 *In developing local initiatives towards the promotion of health and a multi-sectoral approach to its attainment, the Working Party recommends that there is a key role for the Director of Public Health and his colleagues who can identify local problems using epidemiological studies and local knowledge and can suggest and implement health educational and promotional projects to tackle those problems in an innovative way.* This role should appropriately reflect policies and programmes at national level. The specialist in public health medicine has training in epidemiology which will facilitate the design and implementation of base-line studies which demonstrate the health status and needs of a population. He will have established through the discharge of his other functions, contacts with others such as the local authorities and the links in the food chain whose actions and decisions can influence the health of the population. He can act as a catalyst for action through the organisation of multi-sectoral meetings to discuss future plans for the promotion of health and to deal with any problems which arise.

## PREVENTIVE MEDICINE

- 8.20 A very important aspect of preventive medicine is the design and implementation of screening programmes. In Ireland, screening takes place at various stages. New-born infants are screened for congenital abnormalities and where a problem is detected there is a follow-up using both the hospital and the community based services. Developmental paediatric assessment examinations are carried out as a matter of routine on infants who live in all but the smallest population centres. These examinations are carried out by the health board area medical officers and the public health nurses. School children are examined routinely as new entrants and again if the need arises.
- 8.21 There has been discussion in recent times about the need to maintain the child health services in their present form, particularly when children have greater access to the general practitioner and other health services, thanks to the better awareness of health and health issues among their parents. The 1976 Working Party on Public Health Medical Services noted (45) that these services are, essentially, preventive and based on epidemiological principles. They aim at the earliest possible recognition of handicapping conditions and should also ensure that nobody needing attention or intervention is

overlooked. The Working Party has already referred to the need for the closest possible collaboration between the specialist in public health medicine and general practitioners. In its submission to the Working Party, the Irish College of General Practitioners expressed the view that *"a close working relationship between community medicine and general practitioners is essential for the improvement of health care levels, both on an individual and on a community basis."* This view was borne out in discussions with representatives of the College who expressed agreement with the aim of putting health promotion and prevention as high as possible on the general practitioners' agenda.

8.22 The Working Party recognises that in the long term it seems appropriate to increase the involvement of general practitioners with suitable qualifications in providing child health services. However in the short to medium term the service should continue as part of the community care service and would be provided by suitably qualified area medical officers. This question might be examined further by the Director of Public Health. *The Working Party recommends that a specialist in public health medicine should set targets for and monitor the child health services and should evaluate the resultant epidemiological data on a regular basis. The Working Party recommends the standardisation on a national basis of the examinations and data collected to ensure the emergence of a national picture of the health of children and to permit the identification of regional patterns and trends.*

8.23 Much has been written for and against screening programmes whose aim is the early detection of diseases and disorders such as breast cancer and high blood pressure. For example, cervical cytology screening programmes have been criticised on the grounds of inefficiency and ineffectiveness. There has also been considerable discussion of the efficiency and the cost benefits of mammography screening programmes. The specialist in public health medicine is in a position to keep up to date with current scientific thinking on such issues and to combine this knowledge with the needs of the population in order to maximise the benefits of such screening programmes and to make an ongoing evaluation of programmes which are implemented. *The Working Party recommends that the Director of Public Health should promote preventive screening programmes which have been shown to benefit the health of the population.*

## CHAPTER 9

### PUBLIC HEALTH MEDICINE AND HEALTH SERVICE MANAGEMENT

#### THE CURRENT BACKGROUND

- 9.1 Any consideration of the future role of public health medicine must take full account of the current challenge to the whole character of health care systems and in particular to the role of the acute hospital and the balance between hospitals and primary health care. This applies not alone in this country but in different health care systems throughout Europe and in the USA, Canada, Australia and New Zealand. People have started to question the effectiveness of national health systems and in particular of hospitals employing sophisticated technology as the only places where care can be delivered.
- 9.2 The proportion of Gross Domestic Product being devoted to health care has levelled off generally in recent years - in this country due to economic circumstance it has fallen. There has been a growing disillusionment at the escalating costs and diminishing returns in the treatment area. This has given rise to a renewed interest in preventive medicine and health promotion. The emergence of health maintenance organisations in the United States and the financial incentive towards "wellness programmes" is an example of this trend in a health market environment. It has become necessary to plan for health in the wider context rather than the narrower concentration on the treatment of disease. The wider determinants of health are related to factors such as the environment, individual lifestyle and social and economic factors as well as the health services.
- 9.3 Reference has already been made in this report to the W.H.O. global strategy of Health for All and the 38 targets agreed by the member states of the European region. The European programme aims at achieving a shift away from the narrow view of health to a wider approach through action in the following areas:

- (i) Self-care;
- (ii) Integration of health activities with other related activities such as education, recreation, environmental improvements and social welfare (so-called intersectoral action);

- (iii) Integrating the promotion of good health with preventive medicine, treatment and rehabilitation;
- (iv) Meeting the needs of under-served groups;
- (v) Community participation.

Successful action requires that people should be given a positive sense of health so that they can make full use of their physical mental and emotional capacities. In order to achieve community participation, the people themselves should be well informed if they are to be motivated. The co-ordinated action of all sectors is required for the promotion of health - it cannot be achieved by the health authorities working alone. The focus of the health system itself should be on meeting the basic needs of the community through services provided as close as possible to where people live and work.

- 9.4 Reference has already been made to the European Healthy Cities Project which is one mechanism for generating action plans aimed at reaching selected targets. Other mechanisms are also needed. One of the most important requirements for success, which in the view of the Working Party could be fulfilled very successfully by a specialist in public health medicine, is that of providing advocacy for health, within an agreed framework, whether this be at national, regional or local district level.
- 9.5 The tradition of public health doctors accepting responsibility for the promotion of the health of whole populations is something which should be valued and developed. If the specialist in public health medicine is to be successful he must be in a sufficiently influential position to exercise his particular skills, not in isolation but within a multi-disciplinary setting. An appropriate structural arrangement is necessary to ensure that health boards, hospital authorities, local authorities, other sectors and individuals and the population at large are given consistent and comprehensive medical advice on matters pertaining to public health. It is important in this context that a medical capability should exist for the interpretation, within a wider population context, of the advice given by individual doctors whose focus may be much narrower.
- 9.6 Whilst policy and planning functions would be primarily located at national and regional levels these should be bottom up as well as top down activities. The success of such plans

will largely depend on what happens at local district level, i.e. on the effectiveness of organisation and on how appropriate that organisation is to the development of intersectoral co-operation and community participation in the promotion of health as well as the achievement of the maximum degree of co-ordination of health activities, accessibility to services and equity in health.

## **A DISTRICT HEALTH SYSTEM**

- 9.7 The following definition of a district health system was adopted by the WHO Global Programme Committee in 1986:

*"A district health system based on Primary Health Care is a more or less self-contained segment of the national health system. It comprises first and foremost a well-defined population living within a clearly delineated administrative and geographical area, whether urban or rural. It includes all institutions and individuals providing health care in the district whether governmental, social security, non-governmental, private or traditional. A district health system, therefore, consists of a large variety of inter-related elements that contribute to health in homes, schools, work places and communities, through the health and other related sectors. It includes self-care and all health care workers and facilities, up to and including the hospital at the first referral level and the appropriate laboratory, other diagnostic, and logistic support services. Its component elements need to be well co-ordinated by an officer assigned to this function in order to draw together all these elements and institutions into a fully comprehensive range of promotive, preventive, curative and rehabilitative health activities" (46).*

- 9.8 It can be argued that the development of primary care supported by secondary care at district level is the key to greater equity, and to successful health promotion and prevention programmes, as well as to the provision of adequate treatment and rehabilitation services to meet the basic health needs of the population. This will require a rational distribution of health resources based on need as well as co-operation between health personnel, individuals, families, community groups and co-ordination at the community level of all activities relevant to health. The provision of information and education on health related matters to personnel working in sectors that have an impact on health, will also be required.

- 9.9 The Working Party is of the view that a district health system of the type envisaged by W.H.O. should be developed and can be readily identified within existing health board areas. It is also of the view that specialists in public health medicine can play an important role, including a co-ordinating role, in such a system. The Working Party will return to this subject when discussing future structures in Chapter 10.

## THE MANAGEMENT PROCESS

- 9.10 In many countries health services are under scrutiny and evaluation. It is now clear that the trend in future health care will be to deliver services, particularly hospital services, according to the needs of defined populations in the most effective and efficient manner. This will require that the long standing managerial gulf between hospitals and primary care should be bridged.
- 9.11 Acute hospitals and their role in health care are being affected by various changes including new medical technology, cost containment policies and changes in the financing of hospital care. This has given rise to a need for new service delivery strategies and new strategies of care where the acute hospital is not the centre of the system but functions as one component of a closely co-ordinated range of services in a total health system. The acute hospital of the future is likely to be highly specialised and closely linked to the rest of a health system based on the principles of primary health care, where treatment will be delivered at the lowest level of complexity. There is also likely to be a growing emphasis on care rather than cure given the continuing trend towards an ageing in the population. It is clear that unless hospitals accept a partnership role and function in an integrated way with other services in the community a fragmented local health system will persist.
- 9.12 One of the key requirements for the achievement of this task will be the development of integrated information systems at district level, linking hospital and other services. These information systems will need to be capable of facilitating the qualitative as well as the quantitative requirements of the management process. For instance formerly it was considered sufficient to demonstrate that the numbers of patients treated had increased in order to justify higher expenditures. Activity was taken as a proxy for achievement. This is no longer the case nor will it be so in the future. There is an increasing pre-occupation with referral rates as these reflect how wide the gate is open between primary care and more expensive hospital care. The analysis of variations in referral rates, the evaluation of



outcomes to assess the impact of hospital referrals and the comparison of such outcomes with alternative forms of treatment are growing areas of managerial interest. Terms such as 'managed care' and 'utilisation review' are associated with this process. The development of protocols for appropriateness of involvement of the medical practitioners concerned, be they general practitioners or hospital consultants, in the process of the drawing up of such protocols is crucial and this process could be assisted by the participation of a specialist in public health medicine.

- 9.13 The measurement of outcomes of forms of treatment, for example community based treatment as against hospital admission for particular categories of illness or dependency, is another area of growing interest. The availability of information on the outcomes and effectiveness of different services and service settings facilitates health planning and the making of choices of methods of service delivery. Health services research of this nature, aimed at assessing the effectiveness of particular services for different service delivery settings has been growing internationally.
- 9.14 An ability to keep abreast of changes in technology and assessment of new technology through national and international links is also of vital importance since so much of the hospital services and hospital resource allocation is technology led and since change in technology is such a dynamic process. International health services research can be drawn upon for use in the Irish context allied as necessary to research which more closely reflects our particular circumstances. Such research is multi-disciplinary in nature, involving medical and other health professionals as well as other disciplines such as those with skills in management and administration, economics, statistics, information technology, operational research and the social and behavioural sciences.
- 9.15 The Working Party is of the view that specialists in public health medicine can make a significant contribution to Irish health services research. It is also of the view that selected research projects can be carried out by a multi-disciplinary team involving specialist staff attached to the health boards, the Health Research Board or relevant departments of medical schools and universities.
- 9.16 The Working Party has already referred to the importance of information in the planning, management and evaluation of health services. This calls for the further development of proper information systems at health board level which could also be fed into a national bank of epidemiological information. The Department of Health's consultative policy document "Health - the Wider Dimensions" acknowledged that the measurement of health

needs on a wide scale "will call for new skills in collecting, analysing and interpreting health data and in devising policy measures to address particular health problems" (47). It has already been demonstrated by trained specialists in community medicine that they possess these skills. However what has been done in this regard to date has been done on a limited ad hoc basis. More formal structural arrangements are required to give full effect to the potential contribution of these specialists to the planning and evaluation process, which, as part of the management process consists of :

- Identification of health needs in relation to local district, regional (health board) and national populations;
- Translation of needs through choice of priorities into health goals and setting clear objectives and standards;
- Planning the best balance of integrated services to meet chosen goals in health promotion, preventive, treatment and rehabilitation services;
- Measurement of achievement against objectives and relating outcomes to resources used.

9.17 As stated, it is of course essential to the success of this process that adequate information systems are developed which can be allied to applied epidemiology. These must include an improvement in our capacity to monitor the patterns of disease which have changed over the past twenty years. Of particular importance is the surveillance and control of communicable diseases. It is only in this way that attempts can be made to forecast the future patterns of disease and to develop appropriate health promotion, preventive or other service strategies.

9.18 The Working Party believes there is a need to expand the information gathering and evaluation function to facilitate a systematic approach to planning and evaluation as part of the management process. The original management structure envisaged by McKinsey and Co. for the health boards included a planning and evaluation function at management team level in the larger health boards. Such a function has remained relatively undeveloped. *The Working Party recommends that a planning and evaluation function should be developed in each health board as part of a new public health function.*

## CHAPTER 10

### A NEW STRUCTURE FOR PUBLIC HEALTH MEDICINE

10.1 The Working Party is fully convinced, on the basis of submissions received and following its own review of the situation that the present structure of community medicine is inadequate to meet the needs of a modern public health service. The Working Party is also convinced that, given a proper structure and status, the specialty of Public Health Medicine as it is now evolving can make a significant contribution to the health of our population into the twenty-first century.

10.2 A number of key elements of the future role of the specialist in public health medicine have emerged from the review and discussion in this report. These activities range from :

- acting as advocate in the promotion of health; acting as medical advisor particularly at health board and local authority level; involvement in co-ordination of various health and other sectoral services; surveillance of patterns of disease with particular reference to the control of communicable disease;

to

- a significant involvement in the planning and evaluation function; involvement in or monitoring of health services research; and monitoring new technology.

Most of these activities require the involvement of the specialist in public health medicine in the development of information systems and the use of applied epidemiology. Many of these activities will be carried out at regional or local level, i.e. at health board level or below, and some of them are appropriate to national level.

10.3 Reference has been made earlier in this report to the growing perception of the existing post of DCC/MOH as being an unsatisfactory mix of service management, medical and public health responsibilities. This does not offer sufficient scope for the development of the potential contribution of the specialty of public health medicine to the maintenance and enhancement of the future health status of the population, to the identification of health needs and to the planning and evaluation of services.

10.4 The range and scope of the future role of the specialist in public health medicine cannot be limited to the community care services. The Working Party is satisfied that this limitation has held back the development of the specialty and its potential contribution to public health. The Working Party believes that those who have undergone the higher professional training of the Faculty of Community Medicine of the Royal College of Physicians have developed the necessary skills, including those of medical epidemiologist to make a significant contribution across the wide range of activities proposed in this report. It is desirable that individual specialists in public health medicine develop a special interest in particular areas of activity such as information systems, the control of communicable disease or environmental influences on public health.

10.5 The Working Party decided to approach the question of new structures under two headings :

- (i) the structure necessary to give effect to the proposed future role and status of public health medicine; and
- (ii) the structure necessary for the continuation of community medical services as an on-going part of the community care services, and also as a support to the public health medical function.

10.6 The Working Party considered a number of possible structures for the incorporation of a strong public health medical function into the health services at health board level. There was considerable discussion on the question of whether future posts would be merely advisory or whether they would carry discernible management responsibility and accountability. The Working Party whilst acknowledging that there is an advisory element involved, is convinced that there must be a clearly defined management responsibility and accountability attaching to the posts. There is full agreement that the future specialist in public health medicine at health board level should not be seen as remote or academic but rather should be fully involved through applied epidemiology and other activities in the mainstream health issues. This however does not imply direct "hands-on" responsibility for management of services.

10.7 The Working Party is satisfied that future specialists in public health medicine at health board level, rather than being in line management, should operate as members of a functional department similar to that of the Personnel and other functions. The head of the

Public Health medical function would report to the Chief Executive Officer in the same manner as the other functional officers. He would be managerially accountable for the overall health status of the population of the health board area. It is required of the head of a function that he should use his functional authority and expertise to influence line management action in two ways :

- (i) through his involvement in key policy planning and decision making at top management level; and
- (ii) through direct involvement of staff of the function with line management through pre-agreed policies, in situations where special expertise and skills are required e.g. an outbreak of communicable disease in the case of the public health medical function.

The specialist in public health medicine could become directly involved in line management where some specific initiative is being piloted. This might for example involve the co-ordination of hospital and primary health care services, health promotion initiatives involving a broad multi-sectoral approach or the establishment of targets for services such as immunisation programmes.

10.8 *The Working Party recommends the establishment of a Public Health function in each health board to incorporate the planning and evaluation function. The Working Party further recommends the appointment of a Director of Public Health in each health board area as head of the Public Health medical function and as a member of the management team. The Director of Public Health would participate in policy planning and decision-making at management team level and would work closely with the other team members in such matters as the development of the planning and evaluation element of the function.*

10.9 The principal responsibilities of the *Director of Public Health* in relation to the health board area would be as follows :

- to act as head and leader of the Public Health medical function in measuring and monitoring the health status of the population of the area, and in identifying needs and requirements for service provision and for the promotion of health;

- to provide medical and epidemiological advice to the Chief Executive Officer and the Health Board on the formulation of strategies and policies for maintaining and improving the health of the population of the area, and on the setting of priorities;
- to participate in the planning of services, the targetting of resources and in the evaluation of services and outcomes;
- to ensure the surveillance and control of communicable disease in the area, and that a plan is in place to deal with an outbreak of infection;
- to develop health promotion programmes including preventive and health education measures reflecting the particular requirements of the population of the area, taking account of national policies, and to monitor and evaluate the effect of such programmes;
- to produce and publish an annual report on the health of the population of the area, drawing attention to any particular features or changes in the health status of the population and the factors underlying them;
- to ensure the development of health information systems necessary for the proper discharge of the responsibilities of his office;
- to act as chief medical adviser to the Health Board and to provide relevant public health and epidemiological advice to the local authorities in the area with particular reference to environmental hazards to health;
- to act as spokesman for the Health Board on public health issues as required.

10.10 The Working Party accepts that the composition of the Department of Public Health Medicine will vary with the size and other characteristics of the particular health board area. The Working Party does not wish to be over-prescriptive but nevertheless believes it should state its views on the manner in which such a department might be constituted. The Working Party believes that the Department of Public Health Medicine in each health board should be staffed by a number of specialists in public health medicine who, under the leadership of the Director of Public Health, would discharge the responsibilities of the Public

- 10.11 The Working Party was advised in a number of submissions that it would be desirable that a team structure should be established for specialists in public health medicine. The Working Party concurs with that approach and agrees that specialists in public health medicine should not work in isolation. However, in the Working Party's view this would not preclude an individual specialist from having responsibility for a particular population within a health board area.
- 10.12 In addition to the Director of Public Health, the Working Party envisages that there would be two or more District Public Health Directors making up the new Department of Public Health Medicine within each health board area. The total number in the Department would depend on the demography and topography of the health board area and in the larger health board areas it could also include one or more specialists in public health medicine without district responsibility who could be assigned by the Director of Public Health to a particular field of special interest and responsibility for a whole health board area. The Working Party envisages that such areas of interest and responsibility could include surveillance and control of communicable disease and environmental health, development of information systems and application of epidemiological techniques to either the planning and evaluation process or to specific areas such as health needs or the linkages between services. The Working Party envisages that in smaller health board areas, the development of special interest responsibilities would be agreed and assigned between the Director of Public Health and the District Public Health Directors.
- 10.13 If the Public Health medical function were to be solely based on community care areas, this would lead to fragmentation and isolation of the function which might continue to be considered as a part of the community care service rather than part of the totality of the health services. Indeed some health board community care areas, particularly in the Southern and Eastern Health Boards are not co-terminous with either the general hospital or the local authority areas and this could create difficulties in developing important aspects of the role of the specialist in public health medicine. The population for which any specialist would have particular responsibility should be not less than a hospital catchment area for secondary care otherwise the integration and co-ordination of primary health care with hospital care, particularly at the first referral level, would not be facilitated.
- 10.14 Indeed there is also a possibility that a total focus on too small a population would make it difficult for the specialist to develop the broad vision necessary for the development of the public health medical function. The Working Party is of the view that an ideal working

arrangement through which specialists in public health medicine, who would be relatively few in number, can make the maximum contribution would be that they would actively participate in a department concerned with issues relating to a health board area and that a number of them also have special responsibility for a population within the health board area.

- 10.15 Another important consideration in choosing a population district for which a specialist in public health medicine might have special responsibility is that it should ideally encompass one or more local authority areas, so as to facilitate continuance and development of the role and influence of the specialist in public health medicine as medical adviser to a local authority. This would facilitate intersectoral collaboration on various matters such as control of environmental hazards to health, monitoring of the food chain, and various health promotion initiatives.
- 10.16 Community care areas in a number of health boards are already largely co-terminous with a general hospital catchment area and with one or more local authority areas. The Working Party is of the view that such a combination is the ideal basis for a district health system based on primary health care, for which a specialist in public health medicine would have particular responsibility. *The Working Party recommends that a specialist in public health medicine be designated as District Public Health Director for an area the population of which would be of the order of 100,000 to 200,000 persons and which would as far as possible be co-terminous with a general hospital catchment area, a community care area, and one or more local authority areas.*
- 10.17 The principal responsibilities of the *District Public Health Director* would be as follows :
- to be responsible for all aspects of the public health function for a designated district within the health board area;
  - to draw up and maintain an epidemiological profile of the health status of the population of his district, to identify particular problems or needs, and to ensure that this information is available to facilitate health board policies and plans;
  - to co-ordinate the surveillance of communicable diseases and infection in his district as an integral part of control measures to be implemented at health board and national level;



- to act as convenor of the district Action Committee on Communicable Disease;
- to develop collaborative working relationships with the local authorities in his district and to provide relevant public health medical advice to the local authorities;
- to act as convenor of the regular group meeting to review and monitor the public health aspects of the production, preparation, delivery and sale of food and food products in his district;
- to ensure collaboration with and involvement of relevant individuals, interest groups and agencies in health promotion in his district;
- to develop collaborative working relationships with health service providers, including general practitioners and hospitals in his district;
- to work with and support the Director of Public Health in the discharge of the responsibilities of the public health medical function for the health board area;
- to undertake, if required, a 'special interest' responsibility for the health board area.

10.18 The District Public Health Director should report managerially to the Director of Public Health and would be accountable for all aspects of the Public Health medical function in his area. This would not preclude collaboration with a colleague with special skills or who has developed a special interest but the District Public Health Director must retain his authority and responsibility and remain accountable to the Director of Public Health for the public health medical function in his district.

10.19 The Working Party realises that a small group of specialists in public health medicine can achieve little without an appropriate level of direct support staff or without active support and co-operation from colleagues in management and service roles. The Director of Public Health, apart from having collaborative working relationships with other members of the multi-disciplinary management team, must also seek to ensure that the Department of

Public Health Medicine will have available to it or within it, an appropriate level of support from other disciplines including those with special skills e.g. in information technology, marketing and communications, statistics and social and behavioural sciences.

- 10.20 The District Public Health Director will be required to establish positive and co-operative working relationships with those responsible for the overall general management of the community and hospital services in his district. This will be of particular importance in the community care services area and the Working Party is of the view that very close and collaborative working relationships will be essential between the District Public Health Director and the Senior Area Medical Officer and the Supervising Environmental Health Officer for the successful operation of the Public Health function. Indeed the Working Party would envisage that this collaboration could extend to the sharing of support staff and facilities with the community medical services.
- 10.21 The Working Party decided not to be over-prescriptive regarding precise numbers of specialists in public health medicine who might be appointed in the different health board areas. This is a matter for decision at local level but the broad guidelines have been set out in the preceding paragraphs. In terms of overall numbers nationally the Working Party noted in the course of its study of the situation in the United Kingdom that there was some variation in the ratios of specialists to population in Northern Ireland (Eastern Health and Social Services Board), England and Wales, and Scotland (Ayrshire & Arran Health Board). These specialist to population ratios range from 1:62,500 up to 1:90,000 and reflect the different circumstances in each part of the United Kingdom.
- 10.22 *Given the Irish circumstances, the Working Party believes that initially a specialist to population ratio of between 1:80,000 and 1:90,000 is appropriate, giving a requirement of between 39 and 43 specialist posts in public health medicine.*
- 10.23 The Working Party envisages that the staffing of the Disease Surveillance Unit should in the first instance include two specialists in public health medicine who have developed a special expertise in the field of activity of the Unit. The Working Party envisages that the initial manpower requirement for the specialty, including the eight posts of Director of Public Health, the posts of District Public Health Director, the additional posts of specialist in public health medicine in the larger health board areas and the posts in the Disease Surveillance Unit will correspond closely with the number of posts which would be created by the application of the ratios recommended above.

10.24 *The Working Party recommends that the existing posts of Director of Community Care and Medical Officer of Health should be abolished as soon as the new Department of Public Health Medicine recommended in this report has been established in any health board area. The Working Party further recommends that, in order to facilitate the establishment of the Departments of Public Health Medicine, existing permanent holders of posts of DCC/MOH be offered posts in the new Departments of Public Health Medicine.*

10.25 The Working Party has considered the position that will arise in any health board area following the establishment of a Department of Public Health Medicine and the abolition of the post of Director of Community Care & Medical Officer of Health in each community care area. Continuing arrangements will be necessary for the general management of the community care services and it will be a matter for separate decision as to what future arrangements will be made for the general management of these services and the leadership of the multi-disciplinary community care team. The Working Party has already commented on the necessity for the District Public Health Director to establish the closest possible collaborative and positive working relationships with those responsible for the general management of community and hospital services, who under the present health board management structure report to separate programme managers at management team level. The replacement of this structure by a system of geographical general management e.g. a general manager for all services at district level, has been mooted in recent years. In any health board area where district general management were to become established, the Working Party would anticipate that the District Public Health Director would become a very strong functional adviser to the general manager in charge of all district services. The need at the next level below the district manager for managers for community and hospital services or for managers of blocks of services for target groups within districts would however continue, and the remarks already made regarding working relationships would continue to apply.

10.26 Reference has already been made in paragraph 10.20 to the vital importance of the working relationship between the District Public Health Director and the heads of the community medical services and the environmental health services. The Working Party has given considerable thought to the position of Senior Area Medical Officers and Area Medical Officers following the abolition of the post of DCC/MOH and the establishment of a Department of Public Health Medicine in a health board area. Consideration was also given to the position of Supervising Environmental Health Officers and Environmental Health Officers under similar changed circumstances.

10.27 In common with other professionals providing community care services these professional groups have been reporting to the DCC/MOH. The Working Party would expect that following the abolition of the post of DCC/MOH, the heads of all the professional groupings in community care would report to the person who becomes responsible for the general management of the community care services and for leadership of the multi-disciplinary community care team.

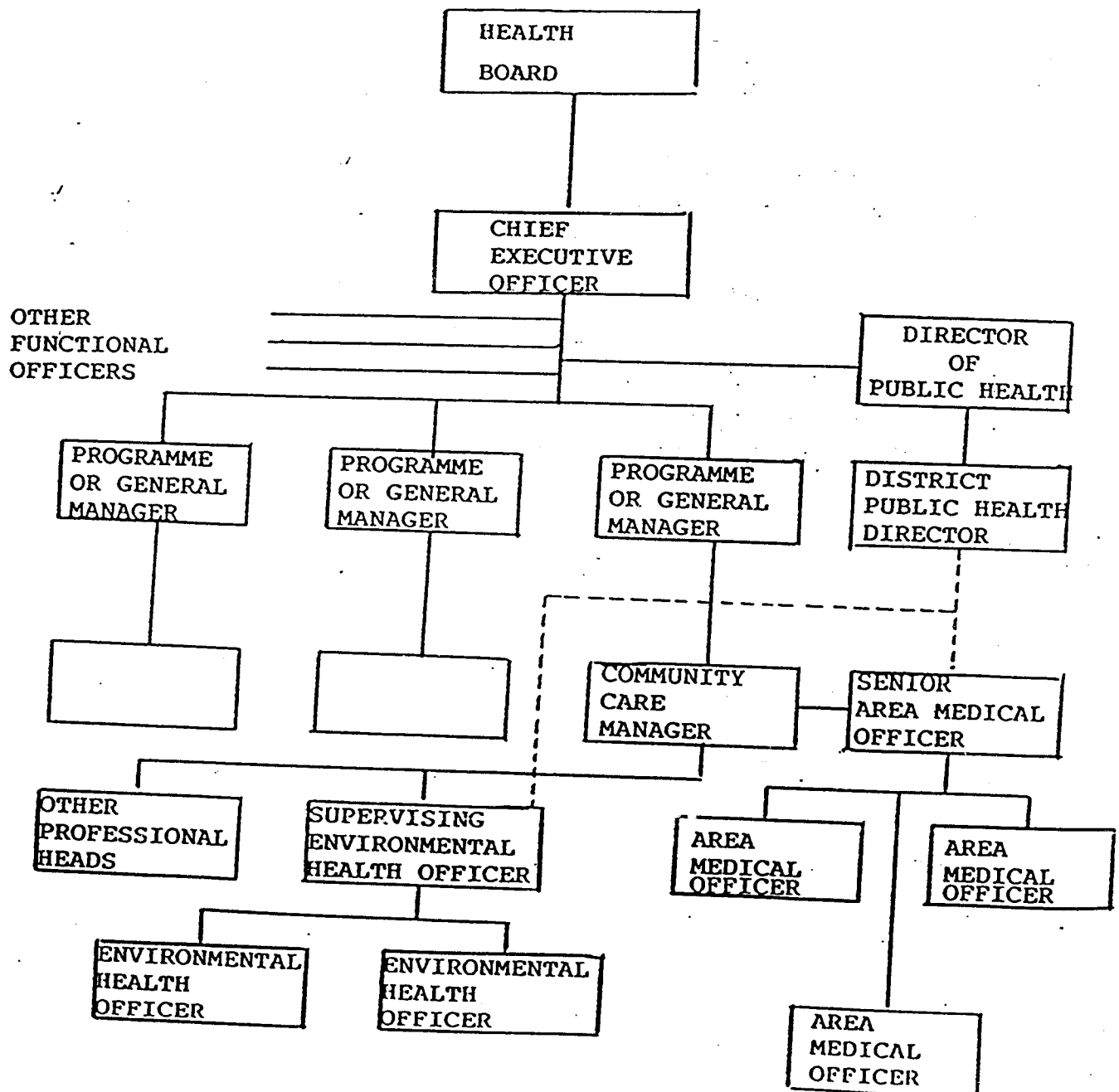
10.28 However because of the nature of the community medical and environmental health services and the particular roles they play in relation to the health promotion, preventive, inter-sectoral and service co-ordination aspects of the Public Health function, it is essential that a special collaborative relationship should exist between the District Public Health Director and the Senior Area Medical Officer and Supervising Environmental Health Officer. The SAMO as leader of the team of AMOs will continue to be responsible for the delivery of the broad range of community medical services which also include clinics, assessments, co-ordination of services for special need groups and liaison with voluntary organisations.

*The Working Party recommends that the heads of the community medical and environmental health services should report managerially to the person responsible for the future general management of the community care services. They should however be required to maintain a close functional working relationship with the District Public Health Director in order to achieve the maximum level of co-operation and teamwork. In order to ensure that the required degree of collaboration and teamwork is maintained the Working Party is of the view that the District Public Health Director should meet the Senior Area Medical Officer and the Supervising Environmental Health Officer on a regular and systematic basis.*

- 10.29 The Working Party believes that this close collaborative relationship with the SAMOs and EHOs is essential if the District Public Health Director is to lead the team in relation to surveillance and control of communicable disease, monitoring of environmental influences on health and particularly in the event of an outbreak of infectious disease or an environmental mishap which requires an immediate and well co-ordinated response. The Working Party is satisfied that this arrangement will also allow for the development of a multi-sectoral team approach to health promotion and for close collaboration and teamwork in relation to various prevention strategies. In the case of the community medical service it will facilitate the establishment, monitoring and evaluation of agreed preventive programmes involving general practitioners or hospital medical staff.
- 10.30 The following chart, Table 10, illustrates the structure and working relationships recommended in the preceding paragraphs for the members of the proposed Department of Public Health Medicine of a health board.

TABLE 10

MODEL ILLUSTRATING THE FUTURE PLACE OF PUBLIC HEALTH MEDICINE  
IN THE HEALTH BOARD STRUCTURE



- 10.31 The Working Party in its consideration of the future role of Public Health Medicine was conscious of the need to ensure that it would be accorded a seniority and status in organisational terms which would enable it to be sufficiently influential in the discharge of its responsibilities. There has been a good deal of debate about the managerial role of the specialty and the need for it to work in a multi-disciplinary environment. The Working Party is satisfied that by according the status of a management function to Public Health Medicine in the health board organisational structure, it has been given an influential role.
- 10.32 In terms of influence within the medical profession, and with the general public, the standing of the specialty of community medicine has been relatively low in a health service dominated by clinical specialties. The Working Party has noted that since the establishment of the Faculty of Community Medicine of the Royal College of Physicians of Ireland, doctors in the specialty of community medicine must complete a programme of Higher Specialist Training in the same manner as those pursuing other specialist qualifications. The Board of the Faculty of Community Medicine, amongst other submissions, emphasised to the Working Party its view that the proposed specialist posts in a Department of Public Health Medicine should be accorded consultant status. The Working Party has also noted that similar posts in Britain and in Northern Ireland have been designated as consultants in Public Health Medicine and advertised as such.
- 10.33 The Working Party notes that the title 'consultant' has a different connotation in hospital medicine and that the requirements of clinical consultant posts and posts in public health medicine are also different. The Working Party has used the term specialist throughout this report as it feels that this is a more appropriate generic title. The Working Party however agrees that a person who has completed the Higher Specialist Training of the Faculty of Community Medicine of the Royal College of Physicians and who is appointed to a designated post in a Department of Public Health Medicine (or equivalent post) should be accorded a status commensurate with such qualification and appointment. *The Working Party recommends that those who complete the Higher Specialist Training of the Faculty of Community Medicine of the Royal College of Physicians of Ireland (or equivalent bodies) and who are appointed to recognised posts in a Department of Public Health Medicine of a health board or equivalent posts should be designated generally as "specialists in public health medicine". The Working Party recommends that Fellowship or Membership of the Faculty of Community Medicine of one of the Royal Colleges of Physicians or equivalent should be the recognised qualification for appointment to posts of specialist in public health medicine.*

- 10.34 Faculty membership has fulfilled the specialist training requirement for the posts of Senior Area Medical Officer within the community care team since the posts were introduced. *The Working Party recommends that, in the short-term, the minimum qualification required of all applicants for the post of SAMO should be either the Master's degree in Public Health or Part I examination of the Faculty of Community Medicine. The Membership of the Faculty of Community Medicine should become a requirement for the posts of SAMO as soon as is practicable.*
- 10.35 The Working Party has already referred in Chapter 3 to the lack of post-graduate training in public health among a significant percentage of existing Area Medical Officers. The Working Party believes that each SAMO and each AMO should have post-graduate training in public health. The Working Party has been informed that many doctors have been experiencing difficulty in gaining access to the university course leading to the Master's degree in Public Health. In some cases this has been caused by the personal disruption necessary to attend a course for a full academic year. In other cases the doctors experienced difficulties in obtaining release from their wholtime duties as Area Medical Officers with the Health Boards. The Working Party discussed the situation with representatives of University College Dublin and is advised that the College is piloting a new modular format for the course leading to the Master's degree in Public Health which will, at least for the trial period, extend over two years. *The Working Party recommends that Senior Area Medical Officers and Area Medical Officers be given the opportunity to follow courses of study leading to the Master's degree in Public Health and to the Higher Training Programme of the Faculty of Community Medicine.*
- 10.36 Higher Specialist Training in Public Health Medicine depends to a considerable extent on practical experience and on health boards employing doctors in training posts for the three year higher training period and on the availability throughout the country of trainers recognised by the Faculty of Community Medicine. The Working Party believes it is desirable to create higher specialist training posts throughout the country. *It recommends that specialists in public health medicine act as recognised trainers for the Faculty and that Registrar posts be created in the proposed Departments of Public Health Medicine. It recommends that the Faculty of Community Medicine and the health boards work closely together to achieve the establishment of training posts in all health boards.*
- 10.37 During the period of higher training, the Faculty of Community Medicine may organise courses in different aspects of public health. Doctors in training also participate in courses in management and in economics and may have a short attachment to particular specialist



Communicable Diseases Surveillance Centre at Colindale for up to three months during their training. The Working Party believe that these activities form an important part of the training process.

10.38 Communicable diseases remain a major challenge to the medical profession and their patterns, both in the hospital and in the community, have changed substantially in the past fifty years. The incidence of tuberculosis is still a problem. Food poisoning outbreaks occur regularly. The goal of measles elimination remains, while the control of HIV virus transmission poses new problems. Thus, knowledge and experience in all aspects of communicable disease control remains an essential element of the training and work of all doctors in public health. From its discussion with the Faculty of Community Medicine in Ireland, the Working Party is aware that the Faculty is concerned about the level of training in relation to environmental health and communicable disease. The Working Party notes that steps are being taken to strengthen training in these areas but is of the opinion that we cannot afford to be complacent about such matters in Ireland. *The Working Party recommends that greater emphasis be placed on environmental health and communicable disease during higher specialist training in community medicine and that the level of knowledge relating to microbiology should also be increased. When a Disease Surveillance Unit is established in Ireland, the Working Party believes it will play an important role in training doctors and others in relation to communicable disease, environmental health and the development of health information systems.*

10.39 University academic departments have an important role at present in relation to the training of doctors in public health medicine. The Working Party hopes this will continue in the future. At present, such departments are not involved in matters relating to service delivery. There may be scope for greater collaboration between academic and service departments of public medicine and in the future some joint appointments might be considered.

## **CHAPTER 11**

### **COMMUNITY MEDICINE IN THE FUTURE - A FINAL WORD**

- 11.1 The Working Party is mindful that it has undertaken its task at a time when there is much discussion on change in the structure of health service administrative structures. The Working Party is of the view that the tasks it outlines for the proposed new Departments of Public Health Medicine are essential to the health services of the future, irrespective of any changes in the administrative structures. It is also of the view that the model it has proposed with a centralised Department of Public Health Medicine and locally orientated specialists can be adapted with ease to suit any administrative structure that may emerge.

SIGNATURES TO THE REPORT

KIERAN HICKEY (CHAIRMAN)

HUGH DOLAN

DERRY O'DWYER

BRIAN O'HERLIHY

TADHG TANSLEY

JAMES H. WALSH

PAULINE M. MOREAU (SECRETARY)

APRIL 1990

## **APPENDIX A**

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## **A P P E N D I X   B**

### **SUBMISSIONS**

The Working Party received written submissions from the following:

1. Professor James S. McCormick, T.C.D.
2. Professor Geoffrey Bourke, U.C.D.
3. Dr. Brendan O'Donnell, Dublin Medical Officer of Health
4. Doctors currently undergoing higher specialist training in community medicine
5. Dr. R. P. Browne, Acting D.C.C./M.O.H., Eastern Health Board
6. Doctors in Community Care, Area 5, Eastern Health Board
7. Dr. R. Corcoran, Acting D.C.C./M.O.H., Eastern Health Board
8. Dr. M.T. O'Mahony, A.M.O., Mid-Western Health Board
9. Dr. P. Cushman, A.M.O., North-Western Health Board
10. Dr. D. de la Harpe, Temporary A.M.O., Eastern Health Board
11. Dr. S. Ryan, D.C.C./M.O.H., Midland Health Board
12. Dr. C. Buttanshaw, Acting S.A.M.O., Midland Health Board
13. Dr. M. Tempany, A.M.O., Eastern Health Board
14. Dr. H. Joyce, A.M.O., Eastern Health Board
15. Dr. M. Burns, A.M.O., North-Eastern Health Board
16. Dr. E. Shelley, Project Leader, Kilkenny Health Project



17. Dr. J. Behan, Public Analyst, Southern Health Board
18. Dr. F. Hill, Public Analyst, Eastern Health Board
19. Association of Clinical Biochemists in Ireland
20. Irish Society of Medical Officers of Health
21. Faculty of Community Medicine, R.C.P.I.
22. South Leinster Branch, I.S.M.O.H.
23. Dr. Zachary Johnson, Eastern Health Board
24. Dr. A. Noonan, Acting D.C.C./M.O.H., Eastern Health Board
25. Ds.C.C./M.Os.H., Eastern Health Board
26. Dr. C. Hayes, A.M.O., Midland Health Board
27. Dr. T. Fitzpatrick, Mid-Western Health Board
28. Ms. R. Dempsey, Superintendent Public Health Nurse, Eastern Health Board
29. Doctors in Community Care Area 8, Eastern Health Board
30. Professor Irene Hillary, U.C.D.
31. Institute of Community Health Nursing
32. Dr. R. Watters, Acting D.C.C./M.O.H., Eastern Health Board
33. Dr. J. Kiely, D.C.C./M.O.H., Mid-Western Health Board
34. Dr. C. F. Warde, D.C.C./M.O.H., Eastern Health Board
35. Community Care Team, Area 7, Eastern Health Board

36. Dr. M. Corbett, A.M.O., Midland Health Board
37. National Association for the Mentally Handicapped in Ireland
38. Simon Community National Office
39. Dr. M. Coffey, Ophthalmologist, Western Health Board
40. Irish Veterinary Association
41. National Council for the Aged
42. Community Medicine Group, Irish Medical Organisation
43. Irish College of General Practitioners
44. Mr. M. Duffy, Programme Manager, Community Care, Mid-Western Health Board
45. Environmental Health Officers Association
46. Dr. B. Foley, Consultant Bacteriologist, University College Cork
47. Local Government and Public Services Union
48. Dr. D.L. Murphy, Director of Occupational Medical Services, Department of Labour

## APPENDIX C

The Working Party met with the following persons and representatives of these groups:

1. Faculty of Community Medicine
2. Graduates of the Faculty of Community Medicine
3. Students of the Faculty of Community Medicine
4. Irish Society of Medical Officers of Health
5. County and City Managers Association
6. Professor John Flynn, Professor of Bacteriology, University College, Galway
7. Dr. Bridget Foley, Consultant Bacteriologist, University College Cork
8. Professor Irene Hillary, Professor of Virology, University College Dublin
9. Environmental Health Officers Association
10. Post-graduate Medical and Dental Board
11. Irish Veterinary Association
12. Dr. F. Hill, Regional Public Analyst, Eastern Health Board
13. Dr. J. Behan, Regional Public Analyst, Southern Health Board
14. Dr. J. Feely, Regional Public Analyst, Western Health Board
15. Irish College of General Practitioners
16. Local Government and Public Services Union

## **IN LONDON**

Sir Donald Acheson, Chief Medical Officer, and colleagues, Department of Health

Mr. Strachan Heppel, Deputy Secretary, and colleagues, Department of Health

Dr. Sue Atkinson, Director of Public Health, and colleagues, Lewisham and North Southwark District Health Authority

Dr. Jane Jackson, and colleagues, Director of Public Health, Newham District Health Authority

Dr. Kearns, Director of Public Health, North-East Thames Regional Health Authority

Dr. Chris Bartlett, Director, and colleagues, Centre for the Surveillance of Communicable Diseases, Colindale

## **IN NORTHERN IRELAND**

Dr. James McKenna, Chief Medical Officer, Department of Health

Dr. Gabriel Scally, Chief Administrative Medical Officer, and colleagues, Eastern Health and Social Services Board

Dr. Jane Wilde, Director, Northern Ireland Health Promotion Unit

## **IN SCOTLAND**

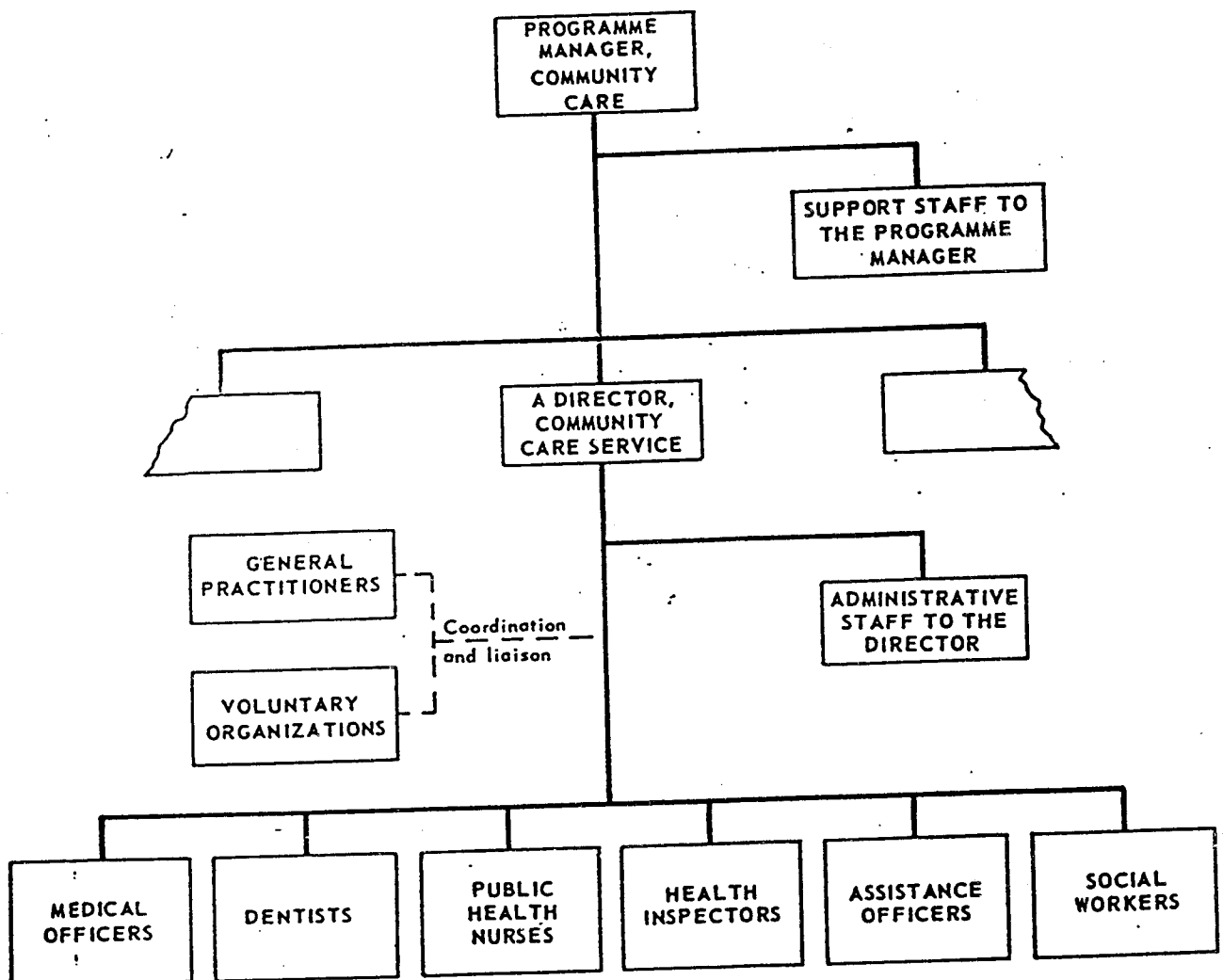
Dr. J. Forwell, Chief Administrative Medical Officer, and colleagues, Greater Glasgow Health Board

Dr. J. Emslie, Communicable Diseases (Scotland) Unit, Ruchill.

Dr. J. Wall, Chief Administrative Medical Officer, and colleagues, Ayrshire and Arran Health Board

## APPENDIX D

### PROPOSED ORGANIZATION FOR COMMUNITY CARE IN HEALTH BOARDS



## APPENDIX E

### JOB DESCRIPTION PROPOSED BY MCKINSEY AND CO FOR THE POST OF DIRECTOR, COMMUNITY CARE SERVICE\*

#### PURPOSE OF JOB

The director, community care service, manages all health care services in the community. His principal duties and responsibilities are

- 1 To assess and agree priorities for health care needs and services in the community with the programme manager, community care
- 2 To develop targets and plans for services in the community
- 3 To ensure that plans for the community, when agreed, are put into action appropriately
- 4 To follow up and report on performance of services
- 5 To establish a high level of efficiency in the services in his community.
- 6 To enhance the effectiveness of the senior members of his community care team and their staff.

\* Community care service includes primary medical care (e.g. GP, public health nurse services), environmental protection, preventive care (the collective and individual prevention of disease by immunization, health education and early diagnosis) and social services.

#### REPORTING RELATIONSHIPS

1. Reports to: Programme manager, community care
2. Supervises: Senior and superintendent professional officers (e.g. medical officers, superintendent public health nurses), or, in their absence, professionals working in the field (e.g. public health nurses) Administrative officers.

## **WORKING RELATIONSHIPS**

- 1 Works with the personnel officer to assess his team's needs for training and career development, and promotional prospects.
- 2 Works with the finance officer to monitor expenditure against budget and to isolate variances requiring remedial action.
- 3 Works with the planning and evaluation officer to determine key information requirements for the community team, and to formulate ways of gathering the information needed by the community team and by the programme manager, community care.
- 4 Works with other directors of community care service to identify mutual problems and opportunities and to communicate tested approaches.
- 5 Works with family doctors
  - 5.1 To co-ordinate the services provided by family doctors and other community care agencies
  - 5.2 To encourage family doctors to support efforts to keep people out of hospital, for example, by not bypassing assessment procedures
  - 5.3 To gain their commitment to and support for the community's plan.
- 6 Works with voluntary organizations and local organizers
  - 6.1 To encourage the expansion of needed voluntary services or their creation where none exists
  - 6.2 To encourage them to work together and with Health Board staff (e.g. public health nurses, assistance officers) in providing services.

## **PRINCIPAL DUTIES AND RESPONSIBILITIES**

### **1. To assess and agree priorities for health care needs in the community with the programme manager, community care, by**

- 1.1. Determining information required to assess these needs**
- 1.2 Collecting this information, for example, by means of survey or assessment techniques and analysis of existing records**
- 1.3 Relating the community need to the services currently available for providing community care and assessing the need for services that are not currently available**
- 1.4 Identifying gaps in, or over-provision of, each element of the service and deciding on priorities for correcting them.**

### **2. To develop targets and plans for the services in the community by**

- 2.1 Analysing the major targets to be achieved in the community, and estimating the resources required to supply the services involved**
- 2.2 Determining the feasibility of the alternative ways in which the major targets can be achieved**
- 2.3 Drawing up, costing and, where appropriate, selecting action plans with his senior and superintendent officers to achieve the major targets\***
- 2.4 Specifying the people responsible for specific parts of the plan and agreeing the dates by which they should be accomplished and how performance will be measured**
- 2.5 Drawing up an overall plan for the community and presenting this plan, action plans, targets and budget to the programme manager for discussion, modification and approval.**

\* In most cases, the director should discuss targets and plans with his superintendent/senior professional officers and then let them decide in detail what targets would be appropriate. However, he may have to intervene where he feels that targets or plans resulting are not



**3. To ensure that plans for the community, when agreed, are put into operation appropriately by**

- 3.1** Discussing each step of each action plan with the people involved, so that they understand clearly their responsibilities, the targets to which they are directed, the methods and dates by which these should be achieved and the resources available
- 3.2** Reviewing, on a regular basis and with the people involved, the progress of each step of each plan
- 3.3** Discussing and agreeing targets and the means of reaching them with voluntary agencies and offering advice, encouragement and professional services where appropriate
- 3.4** Ensuring that the work of providing for the disadvantaged is carried out as sensitively as possible
- 3.5** Publicizing community care services to those for whom the services are made available.

**4. To follow up and report on performance of services by**

- 4.1** Determining on a regular basis the major targets that are not being met, as well as any related problems and opportunities
- 4.2** Monitoring actual expenditure against budget
- 4.3** Agreeing with the officers the major causes for the targets not being met and the significance of related problems and opportunities
- 4.4** Consulting the programme manager, community care, and other officers as to whether reallocation of resources is necessary to achieve targets, to cope with related problems and to exploit opportunities
- 4.5** Agreeing with the programme manager and his senior and superintendent officers what changes, if any, should be initiated

- 4.6 Amending the action plans and discussing each change with the people involved
  - 4.7 Reviewing regularly the performance of the services in which these changes have been made
  - 4.8 Reporting annually to the programme manager on the performance of health care services in the community.
5. To establish a high level of efficiency in the services in his community by
- 5.1 Preparing and submitting to the programme manager, community care, regular reports on the performance, in output and financial terms, of the services in his community
  - 5.2 Seeking constantly opportunities to improve performance and release resources for further improvements
  - 5.3 Co-operating with pilot projects aimed at improving the efficiency of community care services at Health Board and national levels.
6. To enhance the effectiveness of the senior members of the community team and their staff by
- 6.1 Ensuring that each section and activity has a clear purpose, that tasks are balanced and performance in the community is reviewed periodically during the year
  - 6.2 Planning the needs of his administration for personnel and encouraging officers and staff to keep their knowledge and training up to date so as to ensure a supply of suitable qualified and trained people and satisfy their career expectations whether within or outside his administration
  - 6.3 Ensuring, where appropriate, that field workers co-operate and plan their casework rationally to provide the most effective and economical service on a community basis
  - 6.4 Identifying, with the planning and evaluation officer, his major information requirements and those of his team, and determining how to collect this information

### **LIMITS OF AUTHORITY**

The director, community care service, is responsible for all matters relating to medical and social services in his community except those involving direct clinical responsibility. Thus, he does not control directly much of the actual delivery of health care services in his community and must rely upon persuasion and close working relationships to obtain participation in and support for plans to improve the services. In exceptional circumstances he would have recourse to the support of his programme manager to achieve plans for the community.

### **PERFORMANCE MEASURES,**

- 1      Achievement of targets and plans agreed with his officers and with the programme manager, community care
- 2      Ability to keep expenditure within budget
- 3      Success in developing effective working relationships with his team, family practitioners and voluntary organisations.

# APPENDIX F

## SURVEY OF TASKS CARRIED OUT BY AREA MEDICAL OFFICERS PERCENTAGE OF RESPONDENTS WHO CITED EACH ACTIVITY

	EAST-ERN	MID-LAND	MID-WEST-ERN	NTH-EAST-ERN	NTH-WEST-ERN	STH-EAST-ERN	SOUTHERN	WEST-ERN	TOTAL
DEVELOPMENTAL PAEDIATRICS	85.3	66.6	100.0	90.0	90.0	80.0	92.3	92.9	87.1
SCHOOL HEALTH EXAMINATIONS	79.4	83.3	100.0	90.0	90.0	80.0	100.0	85.7	86.2
OPEN ACCESS CLINICS	8.9	-	-	-	-	5.0	7.7	-	3.4
CHILD GUIDANCE SERVICES	-	-	-	-	-	-	-	-	0.9
ASSESSMENTS FOR FOSTER CARE	5.9	-	-	-	-	-	-	-	1.7
ADVICE FOR DEVELOP. DELAYED CHILDREN	-	16.7	-	-	-	-	-	-	0.9
SERVICES FOR PROBLEM CHILDREN	-	-	-	-	10.0	-	-	-	0.9
VISITS TO PRE-SCHOOL CENTRES	-	-	-	-	-	5.0	-	-	1.7
PSYCHOLOGICAL SCREENING	5.9	-	-	-	-	-	-	-	25.0
ASSES OF NAI AND CHILD SEX ABUSE CASES	29.4	33.3	66.7	20.0	10.0	20.0	15.4	14.3	1.7
AUDIOLOGY CLINICS	-	-	11.1	-	-	5.0	-	-	0.9
SCOLIOSIS SCREENING	-	16.7	-	-	-	-	-	-	-
ASSESS M+I CARE CLAIMS	5.9	66.7	-	-	-	-	7.7	-	6.0
WOMENS HEALTH CLINICS	8.8	-	-	-	10.0	5.0	-	-	4.3
CERVICAL SMEAR TESTING	-	-	-	-	10.0	25.0	-	-	5.2
FAMILY INTERVENTION	11.8	-	-	-	10.0	-	7.7	7.1	5.2
SERVICES FOR TRAVELLERS	8.8	33.3	11.1	-	-	5.0	-	7.1	6.0
G.P. LOCUM SERVICE	-	-	-	-	-	-	-	-	0.9
SERVICES FOR THE ELDERLY	5.9	16.7	22.2	-	10.0	5.0	-	-	6.0
HEALTH EDUCATION	17.6	-	33.3	20.0	20.0	45.0	-	14.3	20.7
HEALTH PROMOTION	8.8	33.3	11.1	-	10.0	5.0	-	-	6.9
AIDS EDUCATION PROGRAMME	5.9	33.3	11.1	-	40.0	15.0	23.1	14.3	14.7
DRUG ABUSE EDUCATION	2.9	-	-	-	-	-	-	-	0.9
ATTEND TB CLINICS	8.8	50.0	77.7	20.0	10.0	45.0	46.2	21.4	29.3
BCG VACCINATION	2.9	66.7	22.2	30.0	20.0	25.0	15.4	42.9	21.6
RUBELLA SCREENING	2.9	16.7	-	20.0	-	20.0	38.5	42.9	16.4
GENERAL IMMUNISATIONS	20.6	100.0	88.8	90.0	60.0	70.0	69.2	50.0	56.9
HEPATITIS B IMMUNISATIONS	-	-	-	-	10.0	15.0	15.4	-	5.2
COORDINATION OF MEASLES CAMPAIGN	5.9	-	-	-	-	40.0	69.2	78.6	43.1
CONTACT TRACING	23.5	66.6	44.4	30.0	30.0	5.0	7.7	7.1	5.2
STD CLINICS	-	-	33.3	-	-	5.0	-	-	0.9
COMPUTERISED VACCINATION RECALL SYSTEM	-	-	-	-	-	-	-	-	-
ASSESS CASES FOR DPMA	82.3	50.0	88.9	70.0	80.0	55.0	92.3	100.0	78.4
ASSESS CASES FOR DCA	78.5	33.3	88.9	70.0	80.0	50.0	84.7	92.9	73.3
ASSESS CASES FOR HOUSING GRANTS	5.9	66.7	77.8	60.0	60.0	35.0	61.5	64.3	42.2
ASSESS CASES FOR MOBILITY GRANTS	14.7	16.7	11.1	10.0	10.0	15.0	30.8	35.7	19.0
ASSESS CASES FOR APPLIANCES	-	-	11.1	-	-	-	-	-	0.9
ATTEND CASE CONFERENCES	26.5	16.7	11.1	-	10.0	15.0	7.7	7.1	14.7
LIAISE WITH OTHER HEALTH PROFESSIONALS	17.6	-	-	-	-	-	-	14.3	6.9
LIAISE WITH VOLUNTARY ORGANISATIONS	11.8	-	-	-	-	-	-	7.1	4.3
LIAISE WITH GENERAL PRACTITIONERS	8.8	-	-	-	-	5.0	15.4	7.1	6.0
INSPECT NURSING HOMES	8.8	-	-	-	10.0	-	15.4	14.3	6.0
COORDINATE SERVICES FOR THE HANDICAPPED	23.5	50.0	11.1	20.0	50.0	25.0	23.0	21.4	25.0
LIAISE ON VOCAT/REHAB PLACEMENTS	-	-	11.1	-	-	5.0	7.7	-	3.4
VISIT CENTRES FOR HANDICAPPED	2.9	-	-	-	-	5.0	-	-	0.9
PREPARE STATISTICS	11.8	-	11.1	10.0	-	5.0	-	-	6.0
CARRY OUT SURVEY AND EVAL. EXERCISES	11.8	33.3	11.1	-	10.0	5.0	7.7	14.3	10.0
KEEP REGISTERS OF ELDERLY	2.9	-	-	-	-	-	-	-	0.9
KEEP REGISTERS OF HANDICAPPED	23.5	50.0	22.2	20.0	30.0	10.0	7.7	7.1	19.0
KEEP OXYGEN REGISTER	2.9	-	-	-	-	-	-	-	0.9
KEEP REGISTER OF CHILD OBSERVATIONS	2.9	16.7	-	-	-	-	-	-	1.7
KEEP TB REGISTER	2.9	-	-	-	10.0	-	-	7.1	2.0
KEEP REGISTER OF INFECTIOUS DISEASES	-	-	-	-	10.0	-	-	-	0.9
KEEP REGISTER OF CONGENITAL ABNORMALITY	-	-	-	-	-	-	-	7.1	0.9
NUMBER OF REPLIES EXAMINED [N=]	34	4	9	10	10	20	13	14	1

# APPENDIX G

## WORKING PARTY ON COMMUNITY MEDICINE

### SURVEY OF DOCTORS WORKING IN COMMUNITY MEDICINE AND PUBLIC HEALTH

HEALTH BOARD

NUMBER OF POSTS AND DOCTORS IN POST ON 1ST MAY 1989

	COMPLEMENT	POSTS FILLED			VACANCIES
		WHOLE TIME	PART TIME	TEMPORARY	IN WTes
D.C.C./M.O.H.					
S.A.M.O.					
A.M.O.					
OTHER (SPECIFY)					
OTHER					
TOTAL					

Please complete and return to Ms. P. Moreau, Department of Health,  
Room 174, Custom House, Dublin 1

8. MAY 1960

SURVEY OF DOCTORS WORKING IN COMMUNITY MEDICINE AND PUBLIC HEALTH  
NAMES AND WORK ADDRESSES OF DOCTORS

	HEALTH BOARD	COMMUNITY CARE AREA
NAME	WORK ADDRESS	GRADE
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		
16.		
17.		
18.		
19.		
20.		

Please complete and return to Ms. P. Moreau,  
Secretary,  
Working Party on Community Medicine,  
Room 174,  
Department of Health,

WORKING PARTY ON COMMUNITY MEDICINE

SURVEY OF DOCTORS WORKING IN COMMUNITY MEDICINE AND PUBLIC HEALTH

NAME \_\_\_\_\_

WORK ADDRESS \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_

SEX \_\_\_\_\_

MARITAL STATUS \_\_\_\_\_

PRESENT POSITION \_\_\_\_\_

HELD SINCE \_\_\_\_\_

WHOLE TIME \_\_\_\_\_

PART TIME \_\_\_\_\_

IF PART TIME, HOW MANY HOURS WORKED WEEKLY? \_\_\_\_\_

QUALIFICATIONS	AWARDED BY	DATE

PREVIOUS CAREER

FROM	TO	BRIEF OUTLINE

Please complete and return IN STRICTEST CONFIDENCE to  
Department of Health, Room 174, Custom House, Dublin 3

# SURVEY OF DOCTORS WORKING IN COMMUNITY MEDICINE AND PUBLIC HEALTH

## BRIEF DESCRIPTION OF PRESENT POSITION AND WORK ACTIVITIES

This image shows a single sheet of white paper with horizontal blue or grey ruling lines. The lines are evenly spaced and run across the width of the page. There is no handwriting or printed text on the paper.

Pauline M. Moreau,  
Secretary,  
Working Party on Community Medicine,  
Department of Health,  
Room 174,  
Custom House,  
Dublin 1.  
Phone 01-735777 extension 167



## APPENDIX H

### INFECTIOUS DISEASES NOTIFIABLE UNDER HEALTH ACT, 1947

Under section 29 of the Health Act, 1947 the Minister for Health

*'may by regulations specify the diseases which are infectious diseases'.*

The current specification, in article 6 and the schedule to the 1981 regulations (as amended by the 1985 and 1988 regulations), is:

acute anterior poliomyelitis	sexually transmissible diseases
acute encephalitis	- syphilis
acute viral meningitis	- gonorrhoea
anthrax	- chancroid
bacillary dysentery	- lymphogranuloma
bacterial meningitis (including	venereu
meningococcal septicaemia)	- granuloma inguinale
brucellosis	- non-specific urethritis
cholera	- chlamydia trachomatis
diphtheria	- trachomoniasis
food poisoning (bacterial other	- candidiasis
than salmonella)	- pediculosis pubis
gastro enteritis (when	- ano-genital warts
contracted by children	- molluscum contagiosum
under two years of age)	- genital herpes simplex
infectious parotitis	
infective mononucleosis	smallpox
influenzal pneumonia	tetanus
legionnaires disease	tuberculosis
leptospirosis	typhoid and paratyphoid
malaria	typhus
measles	viral haemorrhagic diseases
ornithosis	(including lassa fever and
plague	marburg disease)
rabies	viral hepatitis
rubella	- type A
salmonellosis (other than	- type B
typhoid or paratyphoid)	- type unspecified
	whooping cough
	yellow fever

## APPENDIX I

### HEALTH FOR ALL BY THE YEAR 2000

#### ENGLISH AND WELSH HEALTH AUTHORITY TARGETS

(RECOMMENDATIONS OF THE FACULTY OF COMMUNITY MEDICINE OF THE ROYAL COLLEGE OF PHYSICIANS)

By 2000, achieve health related goals which:

- add life to years, by ensuring the full development and use of physical and mental abilities;
- add health to life, by reducing disease and disability;
- and
- add years to life, by reducing premature death.

These can be achieved by:

- reducing by at least 20% the perinatal mortality rate;
- reducing by at least 20% the infant mortality rate;
- reducing by at least 15% the mortality and disability from such preventable infections as measles, whooping cough and congenital rubella;
- reducing by 10% the prevalence of severe mental handicap;
- reducing by 15% the prevalence of severe physical handicap at birth and as a result of accidental trauma;

- reducing by at least 30% the mortality rates from both stroke and heart disease in those aged less than 75 years;
- reducing by 50% the incidence of stroke by the control of hypertension;
- reducing by at least 20% the mortality rate from cancer in those aged less than 75 years;
- reducing by at least 20% the mortality rate from all causes of accident at all ages;
- reversing and then reducing the rising incidence of sexually transmitted disease;
- reducing the prevalence of mental illness to the extent that there is a 25% reduction in the prescription of hypnotics, sedatives and tranquillisers;
- reducing by 50% the prevalence of total tooth loss in adults;
- maintaining a low level of maternal mortality; and
- reducing by at least 25% the number of unwanted pregnancies, particularly amongst women aged less than 20 years.

*Source: Health for All by the Year 2000: Charter for Action.  
Faculty of Community Medicine, June 1986.*