AN ROINN SLÁINTE
(DEPARTMENT OF HEALTH)


Meitheamh, 1950.
CONTENTS

INTRODUCTION

SCHEME FOR COUNTY BOROUGHS

Scope
Administration
Specialist Services
Hospital Care
Laboratory Services
Dental Services
Care for women in respect of motherhood
Health care of children - general
Care of infants in neo-natal period
Health care of pre-school child over 6 weeks
Health care of pupils of schools
Health care of the child who has left school
Dissemination of information and advice
Supply of nutritional aids, medicines, appliances, etc.
Voluntary Health Agencies
Records

MAIN DIFFERENCES BETWEEN THE SCHEME FOR COUNTY BOROUGHS AND THE SCHEME FOR OTHER AREAS.

Deferment of introduction of domiciliary medical care. Interim and final periods defined
Differences common to the interim and final periods
Differences applying in the interim period only
Differences applying in the final period only

PROPOSED PAYMENTS TO GENERAL PRACTITIONERS, RAZE OF SERVICE, ETC., UNDER THE MOTHER AND CHILD HEALTH SERVICE

GENERAL

A. County Boroughs

Salary as dispensary medical officer and medical officer of health
Fees payable from other sources
Additional appointments
Maternity and gynaecological care for patients eligible for Medical Assistance
Capitation fees in respect of a general medical care service for children

Limitation on lists

Choice of doctor and choice of patient

Range of service to be afforded under the general medical care service for children

B. Areas other than the County Boroughs

(i) Interim and Final Periods

Salary as dispensary medical officer and medical officer of health, fees payable from other sources, and additional appointments.

Differences in conditions of service applicable to doctors in areas other than the county boroughs and doctors in county boroughs

Maternity care

Capitation fees in respect of maternity care service where a choice of doctor is afforded

Lump sum addition to salary in respect of maternity care service where a choice of doctor is not afforded

Capitation payments to private medical practitioners participating in the maternity care service

Range of service to be provided under the maternity care service

Gynaecological care

(ii) Interim Period

Capitation payments to private medical practitioners participating in the maternity care service

Medical care and advice at district health centres or depots

Domiciliary medical care for children eligible for Medical Assistance

(iii) Final Period

Introduction of domiciliary medical care for children

Aspects of conditions of service applicable to doctors serving in the county boroughs which will apply also in areas other than the county boroughs
Lump sum addition to salary in certain cases in respect of the affording of general medical care for children 63

Cessation of lump sum payment to district medical officers in respect of the affording of medical care and advice at district health centres or depots 63

Care for women in respect of motherhood 64

MISCELLANEOUS

Right of district medical officers to engage in private practice 65

Prohibition on demands for fees other than remuneration provided by the local authority 66

APPENDICES

Estimate of average earnings from public funds of medical officers in county boroughs Appendix A

Estimate of average earnings from public funds of medical officers in areas other than the county boroughs Appendix B

Notes with a bearing on appendices A and B Appendix C
PROPOSALS FOR A MOTHER AND CHILD HEALTH SERVICE

1. Part III of the Health Act, 1947, provides that each health authority shall make arrangements for the safeguarding of the health of women in respect of motherhood and for their education in that respect. It also provides that each health authority shall do in respect of children who are not pupils of any school, and of pupils of schools to which the Act applies, the following things:-

   (a) safeguard and improve their health and physical condition;

   (b) arrange for their medical inspection at schools or other places;

   (c) provide for their education in matters relating to health

   (d) provide for treatment of their illnesses and defects; and

   (e) ascertain cases of mental deficiency.

2. Section 28 of the Act provides that the Minister for Health may make Regulations as to the manner in which and the extent to which health authorities are to exercise their powers under Part III of the Act.

3. Tentative schemes as set out in this memorandum have been prepared by the Minister as the basis on which Regulations will be made by him under the Act.

4. The general pattern of the service throughout the country will be the same. There will, however, be some differences between the scheme for county boroughs and the scheme for other areas. The memorandum outlines in the first instance the proposals for county boroughs and later indicates the main differences between them and the proposals for other areas.
(2)

SUGGESTED MOTHER AND CHILD HEALTH SERVICE SCHEME FOR COUNTY BOROUGHS.

Scope:

5. In general, the scheme will provide for safeguarding the health of women in respect of motherhood and for attendance to the health of children up to 16 years of age. No portion of the scheme is compulsory and facilities under the scheme will be provided by health authorities only with the consent of the persons concerned or, in the case of children, the consent of parents or guardians. There will be no means test.

6. It will be the aim to include provision in the scheme for the following matters:
   (a) maternity care (including ante-natal and post-natal care and attendance at confinement);
   (b) gynaecological care for women in respect of motherhood;
   (c) neo-natal care of the infant;
   (d) health care of the pre-school child;
   (e) health care of pupils of schools to which the Act applies;
   (f) health care of the child who has left school;
   (g) hospital, specialist and laboratory facilities;
   (h) dental care for women in respect of motherhood and for children; and
   (i) ascertainment of cases of mental deficiency.

7. Persons who do not avail themselves of the general practitioner facilities provided under the scheme will not be debarred from participating in any other branch of the service. They will, however, be responsible for the payment of their private doctor's fee.

Administration:

8. The Corporations of county boroughs, as health authorities, are responsible for the making of the arrangements envisaged under Part III of the Health Act, 1947, in so far as their respective county boroughs are concerned.
9. The chief medical officer in each of the county boroughs will be responsible for the immediate direction and supervision of the scheme. All aspects of the health services in so far as they cover mothers and children will be integrated to form a unified service under his control. He will ensure that a close liaison is maintained between the projected service and all other branches of the health services. Admissions to hospital, in the case of children and women coming under the scheme, will generally be provided for by the chief medical officer, in accordance with special arrangements which must necessarily be made to ensure the smooth working of the scheme. In cases of urgency, however, it is proposed that any doctor may secure the admission of a person to hospital and report the matter later to the chief medical officer.

10. It is proposed that medical care for children (as detailed later) will be provided by district medical officers who will be remunerated by capitation payments. To facilitate the provision of this care and the improved functioning of the existing Medical Assistance Service (as provided under the Public Assistance Act, 1939,) it is proposed that each county borough will be divided into district health units (dispensary districts) on a re-organised basis. The existing number of district health units will be increased and each district will be served by one or more district medical officers. Where more than one district medical officer is employed, the district health unit will be divided into sub-units, each served by a district medical officer who will be responsible for domiciliary medical care for patients in his sub-unit who are eligible for Medical Assistance, other than women and children to the extent to which they are catered for under the Mother and Child Health Service Scheme. The medical officer in each unit or sub-unit will attend at the district health centre (dispensary) at arranged days and times for attendance on patients in the category just mentioned. He will afford any necessary attention
attention at the health centre to any such patient resident in the district health unit, even though such person may not actually reside in the sub-unit in which the medical officer is responsible for domiciliary medical care for Medical Assistance patients. Every 2 or 3 or more district health units will form a Mother and Child Health Service District. The district medical officers serving in a Mother and Child Health Service District will provide a general medical care service for children resident in the district. Parents or guardians may register their children for medical care with any of the district medical officers serving in the Mother and Child Health Service District in which they are resident. This arrangement will ensure a reasonably wide choice of doctor, for general medical care for children, in each Mother and Child Health Service District.

11. It is proposed that certain built up areas which lie outside, but immediately adjoin, the county boroughs and are urban in character, e.g. housing areas at Spanglehill and Gurranabraher in Cork and Donnycarney North in Dublin, will be catered for under the scheme for the county boroughs. Some dispensary districts are at present situated partly in county boroughs and partly in adjoining rural areas. The position regarding the rural portions of such districts will be considered when the re-organisation of dispensary districts in the county boroughs has taken place.

12. It is visualised that Dublin County Borough (including certain adjoining areas) will be divided into approximately 25 district health units. The total number of district medical officers will be about 85. The district health units will be amalgamated to form 9 or 10 Mother and Child Health Service Districts. The number of district medical officers in each Mother and Child Health Service District from whom a choice of doctor will be possible for medical care for children will vary between 7 and 10.

13. It is visualised that the county boroughs (including
certain adjoining areas) of Cork, Limerick and Waterford will be divided into 4, 3 and 2 district health units respectively. The number of district medical officers will be about 13, 8 and 5 respectively. Cork County Borough will form one or two Mother and Child Health Service Districts. The number of district medical officers from whom a choice will be possible will depend on whether the county borough comprises one or two Mother and Child Health Service Districts. The county boroughs of Limerick and Waterford will form single Mother and Child Health Service Districts and the number of district medical officers from whom a choice will be possible will be 8 and 5 respectively.

Specialist Services:

14. Specialist services will be provided by hospitals participating in the service, and/or by specialists appointed by the health authority for the purposes of the scheme. Specialist services will normally be provided at hospitals and at central clinics and they will ordinarily be made available on the "reference-appointment" system only. Medical practitioners will normally refer patients for specialist care through the chief medical officer. Specialists will be called upon to provide domiciliary care only in exceptional circumstances.

Hospital Care:

15. Hospital care will be provided in local authority hospitals and in voluntary hospitals which are prepared to co-operate in the service.

Laboratory Services:

16. It is proposed to develop laboratory services generally and to provide that any person eligible for care under the scheme may obtain such services free of direct charge.

Dental Services:

17. Dental attention will be afforded at a central clinic, or clinics, by staff employed by the health authority.
18. This part of the service will provide for ante-natal, intra-natal and post-natal care, and for gynaecological care for women in respect of motherhood.

19. In Dublin it is hoped to make special arrangements under which the maternity hospitals will provide care, as far as possible, for women in respect of motherhood.

20. In the county boroughs (including certain adjoining areas) of Cork, Limerick and Waterford care for women in respect of motherhood will be provided, as far as possible, by staff attached to the appropriate local authority hospital. This staff will normally consist of an obstetrician-gynaecologist and such other medical, nursing and midwifery staff as may be required. Clinics will be held at out-patient departments of the hospitals and/or other appropriate centres. Ante-natal, post-natal and gynaecological care will be provided at the clinics. Cases which present difficulty, or which require gynaecological care which cannot be afforded at the ordinary clinic, will be referred to the obstetrician-gynaecologist either at the hospital, or at special clinics, which will be conducted by him. Women will be encouraged to attend regularly at the appropriate clinics for ante-natal care and they will, where necessary, be visited in their homes by the midwives or other suitably qualified nurses. Domiciliary visits by midwives or nurses will enable them to familiarise themselves with the domestic surroundings in cases in which the patient is to be confined at home, and to give advice on the making of appropriate arrangements regarding the lying-in-room. A midwife or nurse attached to the hospital staff will conduct the normal domiciliary confinement. If any difficulty arises she will call in a medical officer attached to the hospital. Cases in which major difficulty is anticipated at the confinement will be confined in hospital under the supervision of the obstetrician-gynaecologist. The obstetrician-gynaecologist
will be called upon to provide domiciliary obstetrical care only in exceptional circumstances, e.g. in the case of severe post-partum shock and haemorrhage. Owing to the shortage of maternity beds priority in relation to confinements in hospital may, for the present, have to be given to cases in which difficulty is anticipated and to cases where conditions are unsuitable for confinement in the home. Additional beds which it is hoped to provide will have the effect of easing the situation regarding hospital accommodation.

Health Care of Children:

21. The health care proposed for children will vary, to a certain extent, according to the following groups into which children may be divided:—
   
   (a) Neo-natal infants (i.e. infants under 6 weeks);
   (b) Pre-school children over 6 weeks;
   (c) Pupils of schools to which the Act applies; and
   (d) Children who have left school.

In particular instances it may be necessary to provide, for children in one group, a type of medical care which is normally applicable only to children in another group, but, in general, the care proposed for the children in each group is as set out in the following paragraphs.

(a) Neo-natal infants.

22. In Dublin County Borough (including certain adjoining areas) it is hoped to make special arrangements under which the maternity hospitals will provide health care for neo-natal infants participating in the Service.

23. In the county boroughs (including certain adjoining areas) of Cork, Limerick, and Waterford the staffs attached to the local authority hospital will provide any necessary care for infants born in the hospital, or in the county borough area generally. Special units will be provided at the hospitals for the care of premature or sick infants.

/Infants
Infants discharged from hospital, or born outside the hospital, will be visited regularly by a nurse. The nurse will call on the services of a medical officer if his services are considered necessary. In addition to visiting infants in their homes at the request of the nurse, medical officers attached to the hospitals will carry out general examinations of infants either in their homes or at infant welfare clinics held at appropriate centres. It is hoped that there will be at least two such examinations of each infant during the neo-natal stage - one as soon as possible after birth and the other in or about the 6th week of life. Specialist treatment and advice will be given as required at the hospital or at special clinics.

(b) Pre-school child over 6 weeks

24. Provision for the care of this group will include:-

(i) routine domiciliary visiting;

(ii) general medical care;

(iii) periodic medical examination; and

(iv) ascertainment of cases of mental deficiency.

(i) Routine domiciliary visiting

25. Routine domiciliary visiting will be carried out by the public health nurse. It will be her duty to recommend parents or guardians to seek medical care for such children as appear to her to require it. Parents or guardians will be encouraged to bring their children regularly to the clinics conducted by the district medical officers and to the periodic medical examinations. The number of visits which will be paid by the nurse will vary with the age and the needs of the particular child.

(ii) General medical care.

26. Special arrangements will be made, where necessary, for certain measures such as vaccination against smallpox and immunisation against diphtheria and whooping cough, and for the holding of periodic medical examinations. The provision
of any other medical care, at general practitioner level, will be a matter for the district medical officer. He will be required to conduct clinics, at the district health centre (but at times different from the times of the Medical Assistance clinics) to which parents or guardians may bring children who are registered with him for medical care. He will be assisted at these clinics by a public health nurse. The district medical officer will be required, at the request of parents or guardians, to visit sick infants in their homes and to provide any appropriate treatment. It will be his duty to make arrangements for specialist and hospital care as required. He will also be required to provide, for children registered with him, appropriate medical care which may be considered necessary as a result of the periodic medical examinations (see paragraph 27).

(iii) **Periodic medical examination.**

27. Periodic medical examinations will be conducted by medical officers employed on a whole-time or part-time basis by the health authority. This service will supplement the normal medical care provided by the district medical officer. It will be the aim to have each child medically examined at least once a year.

(c) **Pupils of schools to which the Act applies.**

28. The provisions for children in this group will be similar to those for pre-school children over 6 weeks, except that routine domiciliary visiting by the public health nurse will not be carried out. The existing system of school medical inspection, suitably reorganised, will comprise the provision for the medical examination of children.

(d) **Children who have left school.**

29. Provisions, similar to those for pupils of schools, will be made for children up to the age of 16 years who are not pupils of any school. Medical examination sessions for these children on the lines of those referred to in paragraph 27 will be
be held at suitable intervals.

Dissemination of Information and Advice on Matters relating to the Health of Mothers and Children:

30. The health authorities will conduct publicity campaigns to stress the necessity for positive health measures and such campaigns will be suitably co-ordinated with the publicity campaign of the Department of Health.

Supply of Nutritional Aids, Medicines, Drugs and Medical, Surgical, Dental and Ophthalmic or other Appliances:

31. Approved aids, medicines, drugs or appliances will normally be made available at the central health clinics or dispensaries on the recommendations of the medical staff employed in connection with the scheme. Details of the procedure to be adopted in this matter have yet to be drawn up.

Voluntary Health Agencies:

32. The activities of voluntary health agencies, which will be prepared to be associated with the activities of health authorities will be encouraged and assisted.

Records:

33. Health authorities will make arrangements for the keeping of records in connection with the scheme. The record forms or cards will be simple in design and will be designed to facilitate the extraction by modern methods of statistical data. Medical personnel participating in the service will in particular be required to keep records of the illnesses of their patients.
MAIN DIFFERENCES BETWEEN THE SCHEME FOR COUNTY BOROUGHS AND THE SCHEME FOR OTHER AREAS

34. Existing dispensary districts vary considerably in area and population and are, in many cases, unsuitable units for the purposes of the Medical Assistance Service and the Mother and Child Health Service. A reorganisation of dispensary districts will, therefore, be necessary. Pending this reorganisation, which will be carried out as soon as possible, the introduction of a domiciliary medical care service for all children in areas other than the county boroughs will be deferred. It is accordingly necessary to distinguish between:

(a) the proposals which are common to both the interim period (i.e., the period prior to the reorganisation of dispensary districts) and the final period, (i.e., the period after the reorganisation of dispensary districts);

(b) the proposals which relate to the interim period only; and

(c) the proposals which relate to the final period only.

(a) Interim and Final Periods

35. Midwives or other suitably qualified nurses employed by the local authority (but not normally attached to hospital staffs) will provide the maternity care for women which, in the county boroughs will be provided by midwives and nurses attached to the hospital. Each area will have the services of an obstetrician-gynaecologist who will provide a service similar to that provided by the obstetrician-gynaecologist attached to the appropriate hospital in Cork, Limerick and Waterford. The obstetrician-gynaecologist will conduct special clinics at appropriate centres. A smaller natal unit will, wherever practicable, be provided in each county hospital for the treatment of cases needing special attention. Medical care of the infant in the neo-natal period at general practitioner level will be a matter for the doctor providing the
(12)

maternity care service for the mother. Gynaecological care at general practitioner level for women in respect of motherhood will be afforded by the district medical officers, except in cases where the provision of such care is a matter for a private practitioner participating in the maternity care portion of the service in the interim period (see paragraphs 36, 52, 55 and 56). Women needing specialist attention will be catered for by the obstetrician-gynaecologist at the county hospital or at clinics held at other appropriate centres.

(b) Interim Period only

36. Maternity care at general practitioner level will be provided by district medical officers and by private general practitioners who are willing to participate in the scheme. Doctors will be remunerated for this work by capitation payments as detailed later (see paragraphs 52 and 58). A choice of doctor will be possible from any of the medical practitioners participating in the Service.

37. The provision of domiciliary medical care for children (other than those eligible for Medical Assistance) will be deferred pending the reorganisation of dispensary districts. District medical officers will, however, provide a health care service for all children at the district health centre or depot. They will be remunerated for this work by a lump sum payment (see paragraph 59). During the interim period dispensary medical officers will continue to be responsible for domiciliary medical care for children eligible for Medical Assistance.

(c) Final Period

38. Such maternity care and gynaecological care in respect of motherhood, as may suitably be given by general practitioners, will be provided by district medical officers. They will generally be remunerated for this work by capitation payments. Mother and Child Health Service Districts will be formed, as
in the county boroughs, and a choice of doctor will be possible from any of the district medical officers resident in each district.

39. General medical care for children will be provided, as in the case of the county boroughs (paragraph 26), by district medical officers. They will be remunerated for this work by capitation payments, if a choice of doctor is possible, and by a lump sum payment (see paragraph 63(a)) if no choice of doctor is possible.

PROPOSED PAYMENTS TO GENERAL PRACTITIONERS, RANGE OF SERVICE, ETC., UNDER THE MOTHER AND CHILD HEALTH SERVICE.

40. It has already been indicated that the scheme proposed in respect of county boroughs will differ in certain respects from the scheme proposed for areas other than the county boroughs. It is necessary, therefore, to distinguish between the conditions of service, etc., which will apply:

(A) In county boroughs; and

(B) In areas other than county boroughs in:

(i) both the interim and final periods;

(ii) the interim period only; and

(iii) the final period only.

A. COUNTY BOROUGHS

Salary as dispensary medical officer and medical officer of health.

41. The salary as dispensary medical officer and medical officer of health will be unaltered in the case of existing officers. In view of the reduction which will take place in the volume of Medical Assistance work to be performed by dispensary medical officers, consequent on the appointment of an increased number of medical officers, future appointees will enter the Medical Assistance Service on a salary scale of £322. 10 x £16. 2. 6 x £483. 15 per annum, (i.e. £300 x £15 x £450 per annum plus 7½% temporary bonus) - the salary as medical officer of health remaining unaltered.
Fees payable from other sources.

42. The rates of fees payable from other sources will not be affected.

Additional appointments.

43. The additional appointments required under the proposed scheme will be made initially on a temporary basis. An appointee will, in addition to duties under the Mother and Child Health Service, be required to undertake duties as district medical officer and dispensary medical officer. In the making of these temporary appointments a preference will be given to doctors already practising in the districts to which appointments relate.

Maternity and gynaecological care for patients eligible for Medical Assistance

44. Such maternity care and gynaecological care in respect of motherhood as is at present afforded by dispensary medical officers for patients eligible for Medical Assistance, will cease to be the responsibility of the dispensary medical officers, as it is proposed that this work will be undertaken by the maternity hospitals in Dublin County Borough and by local authority hospital staffs in the other county boroughs.

Capitation fees in respect of a general medical care service for children.

45. In view of the intention to permit the exercise of a choice of doctor in respect of general medical care for children under the Mother and Child Health Service Scheme it is proposed that remuneration will take the form of capitation payments. Medical officers will, of course, be already in receipt of a fixed salary in respect of duties, considerably more limited than at present, as dispensary medical officers, and in arriving at the suggested capitation fees to be paid to medical officers regard has been had to this fact. The district medical officers will provide the general medical care service for children from the age of 6 weeks to 16 years. The remuneration payable for this work will be a capitation fee of 10/- per child per annum.
Limitation on lists.

46. It is intended that a maximum upper limit will be fixed regarding the number of children which any individual district medical officer may accept on his list for the general medical care service. A figure of 1,600 to 1,800 is suggested. This figure may require revision when experience has been gained as to the working of the scheme.

Choice of doctor and choice of patient

47. As already indicated parents or guardians will have a choice of doctor from among the district medical officers serving in the Mother and Child Health Service District in which they are resident. Doctors will be entitled to refuse to accept particular children for inclusion on their lists, except those children who fail to find a doctor willing to accept them and whom the local authority finds it necessary to allocate to a particular doctor. A doctor will be entitled to have a child removed from his list, after the expiration of a given period of notice, provided that the parents or guardians of the child have been able to secure acceptance of the child for another doctor's list, or that, failing this, the health authority has allocated the child to another doctor.

Range of service to be afforded under the general medical care service for children.

48. The range of responsibility under the general medical care service will comprise attendance on request of a parent or guardian at the patient's home and the affording of any necessary medical care including the making of arrangements for hospital or specialist care where required; the affording of any necessary medical care or advice at sessions held at the appropriate district health centre; and the provision of treatment found necessary, as a result of the periodic medical examinations (see paragraphs 27, 28 and 29). The clinical sessions referred to will be held on such days and at such hours as may be fixed by the health authority after discussions with
the medical officers. They will be held at times different from the times of the Medical Assistance clinics.

B. AREAS OTHER THAN THE COUNTY BOROUGHS

(i) Interim and final periods.

49. Certain aspects of the conditions of service which will apply to medical practitioners participating in the service in the county boroughs will apply also to medical practitioners operating in areas other than the county boroughs in the interim and final periods, viz:—

(a) salary as dispensary medical officer and medical officer of health (see paragraph 41);

(b) fees payable from other sources (see paragraph 42); and

(c) additional appointments (see paragraph 43).

50. Due to the differences between the schemes proposed for the county boroughs and other areas there will be certain differences between the conditions of service applicable to doctors participating in the service in areas other than the county boroughs and the conditions of service applicable to doctors serving in the county boroughs. These differences are set out in the following paragraphs.

Maternity care

51. Maternity care at general practitioner level for patients who are at present eligible for Medical Assistance will cease to be the responsibility of the dispensary medical officer as part of his duties under the Medical Assistance Service. Such care will in future be provided under the Mother and Child Health Service and it is proposed that a choice of doctor will be afforded, wherever possible, for all women wishing to avail of the service. (This choice, in the interim period will be made possible from district medical officers and private medical practitioners who are willing to participate in the service. In the final period choice of doctor will be made possible from district medical officers only.)

Capitation fees in respect of maternity care service where a choice of doctor is allowed.

52. In view of the proposal to permit, where practicable, the
exercise of a choice of doctor for women in respect of maternity care under the scheme, it is proposed that remuneration will take the form of capitation payments. Medical officers will, of course, be already in receipt of a fixed salary in respect of duties, considerably more limited than at present, as dispensary medical officers, and in arriving at the suggested capitation fee to be paid to district medical officers regard has been had to this fact. It is proposed that the capitation fee will be £4 per case. This fee will be payable both in the interim and final periods.

Lump sum addition to salary in respect of maternity care service where a choice of doctor is not afforded.

53. In areas where a choice of doctor is not afforded and the service is restricted to a particular district medical officer, remuneration will take the form of a lump sum addition to the medical officer's existing salary. The amount of the lump sum will be fixed in conformity with a graduated scale which will vary in accordance with the populations of the districts in question. Details of this scale will be drawn up as soon as all aspects of this matter have been fully examined. It is expected that there will not be many areas in which a choice of doctor will not be possible. This provision will apply both in the interim and final periods.

Capitation payments to private medical practitioners participating in the maternity care service.

54. As this provision will only be made in the interim period details will be found in relation thereto in paragraph 58.

Range of service to be provided under the maternity care service

55. The number of medical and obstetrical examinations required by individuals will vary but as a general rule an initial medical and obstetrical examination will be afforded at or about the 16th week of pregnancy and a further examination at or about the 36th week together with such other examinations and ante-natal care as the doctor thinks necessary or as may be requested by the midwife. Ante-natal care at an earlier stage than the 16th week will be required in certain cases. The doctor will be responsible
for the general supervision of the midwife in relation to the discharge of her duties (including the giving of instructions to the midwife regarding urine testing where the midwife is regarded as suitable to discharge this work); attendance at an abortion or other emergency; attendance at the confinement (if, in the opinion of the doctor, it is required, or if he is summoned to the confinement by the midwife in attendance) and medical care of the mother and child during the post-natal period (up to 6 weeks), including a post-natal examination of the mother at or about the 6th week after the confinement, and such gynaecological care during the pregnancy and post-natal period as may suitably be given by general practitioners. It is intended that the fee to be paid or payment to be made as indicated in paragraphs 52 and 53 will cover the services outlined above. Details of a reduced scale of fees to apply in cases where the full range of care is not given will be drawn up later, but, normally if a doctor can prove that he could not render any particular part of the proposed services for reasons outside his own control no loss of portion of the fee will be involved.

Gynaecological care

56. As intimated in paragraph 55, such gynaecological care during the pregnancy and post-natal period (6 weeks), as may suitably be given by a general practitioner, will be a matter for the doctor (district medical officer or private practitioner) providing the maternity care service. Any other gynaecological care in respect of motherhood, which may suitably be given by a general practitioner, will be a matter for the district medical officer. It will be the duty of the doctor (district medical officer or private practitioner) providing gynaecological care to make arrangements for specialist and hospital care as required.

57. Until such time as experience of the scheme in actual operation has indicated how district medical officers can best be remunerated for gynaecological work not covered by the fees
payable in respect of maternity care, they will each be allowed a lump sum of £20 per annum. This payment takes into account the present obligation on medical officers (in their capacity as dispensary medical officers) to afford medical care for patients eligible for Medical Assistance. The proposed payment will apply both in the interim and final periods unless a change has been decided upon in the meantime.

(ii) Interim Period

Capitation payments to private medical practitioners participating in the maternity care service.

58. Provision will be made in the interim period whereby private medical practitioners will be enabled to participate in the maternity care service. Women will be entitled to choose a doctor from among the district medical officers or other medical practitioners participating in the service. Private medical practitioners will be employed on a capitation rate payment of £5.10.0 per case.

Medical care and advice at district health centres or depots

59. Pending the introduction of a general domiciliary medical care service for all children it is proposed that parents or guardians will be entitled to seek medical care or advice for their children from district medical officers at the district health centres or depots. It is intended that district medical officers will be remunerated for this work by a lump sum payment of £30 per annum. This payment takes into account the existing obligation on medical officers (in their capacity as dispensary medical officers) to afford medical care and advice in the case of children eligible for Medical Assistance.

Domiciliary medical care for children.

60. Pending the introduction of a general domiciliary medical care service for all children, such care for children whose parents or guardians are eligible for Medical Assistance will be provided by the dispensary medical officers as at present.
(iii) Final Period.

General medical care service for children

61. Domiciliary medical care for children will be introduced to supplement the medical care service made available at district health centres and depots.

62. Certain aspects of the conditions of service which will apply to district medical officers participating in the general medical care service for children in the county boroughs will also apply to district medical officers operating in areas other than the county boroughs in the final period, viz. -

(a) capitation fees in respect of a general medical care service for children (see paragraph 45);
(b) limitation on lists (see paragraph 46);
(c) choice of doctor and choice of patient (see paragraph 47); and
(d) range of service to be afforded under the general medical care service for children (see paragraph 48).

63. The following provisions which will not be applicable to district medical officers serving in the county boroughs will apply to district medical officers providing the general medical care service for children in other areas, viz. -

(a) Lump sum additions to salary in certain cases in respect of affording of general medical care for children

In districts where a choice of doctor is not afforded for the general medical care service for children, remuneration will take the form of a lump sum addition to salary fixed in conformity with a graduated scale which will vary in accordance with the population of the district in question. It is expected that there will not be many districts in which a choice of doctor will not be possible.
(b) Cessation of lump sum payment to district medical officers in respect of the affording of medical care and advice at district health centres or depots.

In the interim period pending the introduction of a general domiciliary medical care service for all children, parents or guardians will be entitled, as mentioned in paragraph 59, to medical care or advice for their children at district health centres or depots. Sessions at district health centres or depots will continue in the final period but the special payment of £30 per annum to each district medical officer, provided for in the interim period, will cease to be paid, as the capitation fees, or lump sum additions to salary as the case may be, to be paid in the final period for general medical care for children, will include payment in respect of the clinical sessions to be held at the district health centres or depots.

Care for women in respect of motherhood.

64. In the final period such medical care for women in respect of motherhood as may suitably be given by general practitioners will be provided by district medical officers.

MISCELLANEOUS.

65. The right of district medical officers to engage in private practice will not be affected.

66. Doctors participating in the service will not be entitled to demand or accept any fee or other remuneration (other than that provided by the local authority) in respect of any services afforded in accordance with the provisions of the scheme.

67. Estimates of the average earnings from public funds of medical officers under the present system and under the proposed system are given in appendices A and B. Appendix A deals with medical officers in the county boroughs and Appendix B with medical officers in areas other than the county boroughs. In neither case is any account taken of earnings from private practice. Appendix C contains notes with a bearing on Appendices A and B.
### APPENDIX A

#### COUNTY BOROUGHS

<table>
<thead>
<tr>
<th>Components of estimated earnings from public funds of medical officers</th>
<th>Existing Medical Officers</th>
<th>Future Appointees</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Present Position</strong></td>
<td><strong>Position after general medical care for children scheme has come into operation</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Salary as dispensary medical officer (including temporary bonus of 7 1/2%)</strong></td>
<td>£376. 5s. x £16. 2s. 6d.</td>
<td>£376. 5s. x £16. 2s. 6d.</td>
</tr>
<tr>
<td></td>
<td>£537.10s. Od.</td>
<td>£537.10s. Od.</td>
</tr>
<tr>
<td><strong>Salary as medical officer of health (including temporary bonus of 7 1/2%) (inclusive) (average)</strong></td>
<td>£42. 0s. Od.</td>
<td>£42. 0s. Od.</td>
</tr>
<tr>
<td><strong>Fees from other sources, e.g. vaccination, medical certification, etc. (average)</strong></td>
<td>£333. 0s. Od.</td>
<td>£1250. 0s. Od.</td>
</tr>
<tr>
<td><strong>Fees for domiciliary medical care for children (average)</strong></td>
<td></td>
<td>£700. 0s. Od.</td>
</tr>
<tr>
<td><strong>Total average annual emoluments (exclusive of private practice)</strong></td>
<td></td>
<td>£700. 0s. Od.</td>
</tr>
<tr>
<td>(a) With minimum dispensary medical officer salary</td>
<td>£751. 5s. Od.</td>
<td>£1,368. 5s. Od.</td>
</tr>
<tr>
<td>(b) With maximum dispensary medical officer salary</td>
<td>£912.10s. Od.</td>
<td>£1,529.10s. Od.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>£1,475.15s. Od.</td>
</tr>
</tbody>
</table>
### APPENDIX B

#### AREAS OTHER THAN THE COUNTY BOROUGHS

<table>
<thead>
<tr>
<th>Components of estimated earnings from public funds of medical officers.</th>
<th>Existing medical officers</th>
<th>Future appointees</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Present Position</strong></td>
<td><strong>Interim Period, i.e., before domiciliary medical care for children is introduced</strong></td>
<td><strong>Final Period, i.e., after domiciliary medical care for children has been introduced</strong></td>
</tr>
<tr>
<td><strong>Salary as dispensary medical officer (including temporary bonus of 7½%)</strong></td>
<td>£376.5.0 x £16.2.6-£537.10.0</td>
<td>£376.5.0 x £16.2.6-£537.10.0</td>
</tr>
<tr>
<td><strong>Salary as medical officer of health (inclusive)(average) (including temporary bonus of 7½%)</strong></td>
<td>£60.0.0</td>
<td>60.0.0</td>
</tr>
<tr>
<td><strong>Fees from other sources e.g. vaccination, medical certification, etc. (average)</strong></td>
<td>172.0.0</td>
<td>172.0.0</td>
</tr>
<tr>
<td><strong>Capitation fees from maternity care service (average)</strong></td>
<td>-</td>
<td>154.0.0</td>
</tr>
<tr>
<td><strong>Lump sum payment for affordable medical care and advice for children at district health centres or depots</strong></td>
<td>-</td>
<td>30.0.0</td>
</tr>
<tr>
<td><strong>Lump sum payment for affordable gynaecological care</strong></td>
<td>-</td>
<td>20.0.0</td>
</tr>
<tr>
<td><strong>Capitation fees from domiciliary medical care service for children (average)</strong></td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total average annual emoluments (exclusive of private practice)</strong></td>
<td>£608.5.0</td>
<td>£812.5.0</td>
</tr>
<tr>
<td>(a) with minimum dispensary medical officer salary</td>
<td>£769.10.0</td>
<td>£973.10.0</td>
</tr>
</tbody>
</table>
| (b) with maximum dispensary medical officer salary | }
APPENDIX C.

(a) The reduction shown in certain instances in Appendices A and B in the estimated average earnings of district medical officers from vaccination, etc., arises from the fact that a greater number of medical officers will be participating in the service in the future.

(b) It will be noted that the average earnings from capitation fees in respect of the maternity care service in areas other than the county boroughs (Appendix B) are less in the interim period than in the final period. This arises from the proposal that the maternity care service in the final period will be provided only by district medical officers and that private medical practitioners will not be participating in the service at that stage.

(PREPARED BY THE DEPARTMENT OF HEALTH)
AN ROINN SLAINTE
(Department of Health)

GEARR-CHUNTAS AR MHOLTAI
CHUN NA SEIRBHISI SLAINTE
D’FHEABHSU

OUTLINE OF PROPOSALS
FOR THE
IMPROVEMENT OF THE
HEALTH SERVICES

DUBLIN:
PUBLISHED BY THE STATIONERY OFFICE.

To be purchased directly from the
GOVERNMENT PUBLICATIONS SALE OFFICE, 34 COLLEGE STREET, DUBLIN,
or through any Bookseller.

Price One Shilling.

(P. No. 8400).
PART I.
THE EVOLUTION OF THE HEALTH SERVICES

CONTENTS

PART PAGE

I. The Evolution of the Health Services .... 5

II. The Present Health Services .... 11

III. The Reforms provided for under the Health Act, 1947 .... 19

IV. Further Proposals for the Reform of the Health Services .... 23
This White Paper contains, in outline, certain proposals for the reorganisation and expansion of the health services. The proposals have been approved in principle by the Government and, in accordance with undertakings given by the Taoiseach and Ministers in the Dáil and Seanad, they are now put forward for public information and discussion.

The Paper deals only with those services, agencies and activities which are directly concerned with the prevention and cure of disease and which are, or may come, under the supervision of the Minister for Health. Its contents do not therefore extend to a review of environmental services, such as housing, water supply or sewerage, for which the Department of Local Government remains responsible, nor to income maintenance services, which are now administered by the Department of Social Welfare.

**FOREWORD.**

**WHITE PAPER ON HEALTH SERVICES**

**PART I.**

**THE EVOLUTION OF THE HEALTH SERVICES.**

Publicly organised preventive medicine, in the form of public health administration, is a comparatively recent phenomenon in Western Europe, but its development over the past century has been reflected in the elimination of some of the epidemic diseases of former ages and in the control and diminution of the incidence of others. These achievements, coupled with the general trend of medical science, have for some time indicated the need for close co-operation between the preventive and curative elements of medicine, until it is now recognised that the two elements may be profitably assimilated in an integrated system to preserve the health of the community and the individual.

The idea of public responsibility for community health found gradual expression in the constitution of a series of central and local authorities for health purposes.

The first local health authorities, termed “boards of health”, were set up in 1818. Their activities were not effectively co-ordinated and their success in coping with health problems was very limited. A central Board of Health was established as a temporary measure by the Fever Act of 1846. This Board had wide powers of direction and control over the local authorities dealing with health matters at the time but it was dissolved when the emergency conditions occasioned by the Famine had passed.

Central and local authorities for the administration of services analogous to or related to the rudimentary health services administered at the time by the boards of health had also developed under separate codes of legislation.

An Act was passed in 1865 promoting the establishment of dispensaries for giving medical aid and relief to the poor, but since the actual establishment and management of dispensaries were left to private initiative no uniform development of the dispensary system was possible. Under the Medical Charities Act, 1861, however, dispensary districts were formed and the management of dispensaries was placed in the hands of committees, composed partly of members of Boards of Guardians and partly of qualified...
ratepayers, elected each year by the Guardians. Thus the Boards of Guardians who were charged with administering the Poor Relief (Ireland) Act, 1838, and who were primarily established to provide physical necessaries for paupers, in course of time became responsible for curative health services for those persons and persons of other classes.

Under the Local Government (Ireland) Act, 1898, the entire management of the dispensary system was transferred to the Boards of Guardians. In addition to so administering the dispensary system the Boards of Guardians provided infirmaries and fever hospitals as adjuncts to the workhouses.

Besides the provision for the sick poor made under the Poor Relief Acts, a number of County Infirmaries and County Fever Hospitals had been established under earlier enactments dating as far back as 1765. These hospitals were administered by joint committees appointed triennially, provision being made for the representation of the local authorities upon the governing bodies of the hospitals towards which they contributed. The hospitals continued to be so managed until they were absorbed in most cases into the Public Assistance system after 1921.

As regards the care of the insane, Grand Juries were empowered in the latter part of the 18th and early part of the 19th centuries to raise funds towards the support of lunatic asylums or wards for insane persons connected with Houses of Industry or workhouses, and a parliamentary grant provided for the establishment of the present Grangegeorge Mental Hospital which was opened in 1835. The present mental treatment service evolved from the Lunacy (Ireland) Act, 1821, under which districts for mental hospital purposes were formed. The Lord Lieutenant was empowered under that Act to direct asylums to be erected in the several districts as formed and to appoint local Boards of Governors who managed the asylums in accordance with prescribed rules. A Board of Control was also established which superintended the erection of asylums. Under an Act of 1845 provision was made for the appointment of Inspectors of Lunatics who had both supervisory and administrative functions.

Under the Local Government (Ireland) Act, 1898, it became the duty of the county councils to provide sufficient accommodation for the insane poor and to manage asylums. The Board of Control was abolished, and the powers of the Lord Lieutenant and the Inspectors of Lunatics as to control of staff and regulation of expenditure were transferred to the councils. The powers of the county councils were to be exercised through Committees of Management appointed by them, one-fourth of the members of which might be composed of persons not members of the county councils. In districts composed of two or more counties or county boroughs joint committees were to be appointed. The powers which still remained with the Lord Lieutenant were eventually entrusted to the Minister for Local Government and Public Health in 1934.

Some co-ordination of the preventive and curative services was effected centrally by the establishment, in 1872, of the Local Government Board for Ireland but the separate codes for the two branches of the services remained. New local administrative areas and new local authorities, styled sanitary authorities, were set up by the Public Health (Ireland) Act, 1878, to administer the preventive health services and also certain curative services mainly in relation to infectious disease. This Act also increased the authority of the Local Government Board in relation to health matters. Under the Local Government (Ireland) Act, 1898, the sanitary authorities became elective urban and rural district councils.

County councils and county borough councils were established under the Local Government (Ireland) Act, 1888. In the course of time these councils were charged with the administration of a number of special preventive services, among them the tuberculosis service set up under the Tuberculosis Acts, the venereal disease service established under the Public Health (Prevention and Treatment of Disease) (Ireland) Act, 1917, and the school medical service set up under the Public Health (Medical Treatment of Children) (Ireland) Act, 1919. They also became responsible for the administration of the Sale of Food and Drugs Acts.

In 1920, 1921 and 1922 Dáil Éireann initiated a far-reaching change in the administration of the Poor Law which aimed at amalgamating Poor Law Unions, abolishing Boards of Guardians and centralising administration and institutional relief in each county. Most of the county councils following the lead given by Dáil Éireann, took steps to reorganise the administration of the relief of the poor by means of schemes for their respective counties, while the Local Government (Temporary Provisions) Act, 1923, provided that the councils of counties in which schemes had not been adopted might formulate schemes and put them in force. In pursuance of the aim to establish public hospitals, without overlapping or duplication, in the most accessible centres of population it was provided in the county schemes that there should be one central hospital supplemented where necessary by district or cottage hospitals. This policy was continued and subject to modification, however, as regards the numbers and types of hospitals that were provided. Under the county schemes the control of the dispensary system and of several infirmaries (renamed county and district hospitals) was transferred from Boards of Guardians and Joint Committees respectively to Boards of Health.

The legal and administrative position in connection with the health services before the local government system was reorganised after 1923 was very complicated. The Local Government Board supervised three sets of local authorities, each charged with the administration of certain services and with their
functions overlapping in various instances. The Boards of Health were responsible for the dispensary system and for some fever hospitals and infirmaries. Their activities were governed by the Poor Law code. The sanitary authorities, comprised of urban district councils and rural district councils, were responsible for environmental services such as water and sewerage, some curative health services, including maternity and child welfare, and prevention of infectious disease, which might entail the provision of hospitals. They functioned under the Public Health code. Then, the county councils acted independently from these other authorities in discharging the special health functions mentioned above. The position was somewhat simpler in the county boroughs of Cork, Dublin, Limerick and Waterford where all health functions, apart from Poor Law functions, were discharged by the county borough councils. Outside the control of the Local Government Board and autonomous in relation to the other local bodies, the mental hospital authorities controlled the lunatic asylums, under the supervision of the Inspectors of Lunatic Asylums.

The Department of Local Government and Public Health, established in 1934, absorbed the Local Government Board, the Office of the Inspectors of Lunatic Asylums, and the General Register Office, which dealt centrally with the registration of births, deaths and marriages. At the same time the Minister for Local Government and Public Health was assigned responsibility for the administration of National Health Insurance, and in 1938 all the duties and functions of the Irish Insurance Commissioners were transferred to that Minister.

The Local Government Act, 1925, provided for the abolition of rural district councils and for the transfer of the public health and sanitary duties of these councils to the Boards of Health. The Act of 1933 also provided for the transfer to the Boards of Health of the duties of the county councils relating to special health services in the areas in which they operated.

Further co-ordination of public health activities has since been effected by the appointment in each county of a county medical officer of health, responsible for the administration of public health matters (including the special preventive health services but not the Sale of Food and Drugs Acts) in the whole county. Various engraftments relating to the prevention of infectious diseases which had been permissive or adoptive were made mandatory on the local authorities under the Local Government Act, 1925. The separate urban sanitary authorities, however, still remained in control of the sanitary services and some preventive health services in their respective urban districts so that there is still a double set of authorities concerned with the carrying out of public health duties. The Boards of Health and Public Assistance in turn have disappeared through recent legislation and their functions are now carried out by the county councils acting as public health and public assistance authorities. Boards of Public Assistance have been retained in some districts.

The Minister for Local Government and Public Health continued to be responsible for the administration of the health services until the establishment of the Department of Health under a Minister for Health in pursuance of the Ministers and Secretaries (Amendment) Act, 1946. The functions of the Department of Health may be defined as including the administration and business relating to the preparation, effective carrying out and co-ordination of measures conducive to the health of the people, including in particular measures for the prevention and cure of disease, the treatment and care of persons suffering from physical defects or mental illnesses, the regulation and control of the training and registration of persons for health services, control over the appointment and conditions of service of appropriate local officers, the initiation and direction of research, ensuring that impure or contaminated food is not marketed and that adequate nutritive standards obtain in essential foodstuffs, the control of proprietary medical and toilet preparations, the registration of births, deaths and marriages and the collection, preparation, publication and dissemination of information and statistics relating to health. The discharge of these functions by the Minister involves the supervision of the direct preventive and curative health services which are at present the responsibility of county councils, county borough councils, sanitary authorities and public assistance authorities. In addition to these supervisory functions, the Minister takes direct statutory action in relation to some health services. Under the Tuberculosis (Establishment of Sanatoria) Act, 1945, he is empowered to undertake by direct action the provision of regional sanatoria. He is charged under the Public Hospitals Act, 1933, with the responsibility for the allocation of the Hospitals Trust Fund as between local authority institutions, voluntary institutions and other agencies. This involves the detailed supervision of the financing of the voluntary hospitals and the adoption of a planned hospitalisation scheme. In this work he is aided by the Hospitals Commission, established under the last-mentioned Act to advise the Minister on matters relating to hospital and nursing services and to make recommendations on applications for grants from the Hospitals Trust Fund.

Side by side with the public services and indeed antedating them in some instances, groups of voluntary agencies of various types established and maintained services for the prevention and cure of disease and for the education of the public in relation to health matters. The most important of these agencies were the voluntary hospitals. These began as charitable institutions for the care of the sick poor, the earliest being established in Dublin in the first half of the 18th century. Their work was made possible by the subscriptions, donations and bequests of charitable persons and by the devotion and energy of religious orders, medical pioneers and philanthropic bodies. Royal Charters were
PART II.

THE PRESENT HEALTH SERVICES.

The following review of the existing health services shows the defects which must be remedied before the services as a whole can provide an adequate defence of the community against disease. While these defects are not treated with any complacency, it should nevertheless be borne in mind that, taken in the aggregate, the existing services were considered to compare not unfavourably with those provided elsewhere and that they met fairly, according to the standards of a recent past, the essential needs of the people. The fact that it is now recognised that a higher standard of service should be introduced does not detract from the repute of the various services which have heretofore operated for the protection of health and the relief of the sick.

The health services comprise general practitioner, specialist, hospital and supplementary services. It will be found most convenient to describe the present services under the two broad categories of local authority services and other services.

Local Authority Services.

The local authority services consist of:

(a) a general practitioner or dispensary service administered by public assistance authorities;

(b) district institutions comprising county, district, fever and other hospitals administered mainly by public assistance authorities;

(c) a mental hospital service dealing with the treatment of mental disorders, which is administered by mental hospital authorities, which may be either county councils or county borough councils, or joint boards of two or more such councils; and

(d) a preventive organisation (administered by public health authorities) which, besides furnishing a system of control of infectious diseases, also provides an anti-typhoidelosis service, school medical service and other public health features including sanatoria.

So far as the public assistance services are concerned, free treatment is confined to "poor persons who are unable to provide by their own industry or other lawful means the medical, surgical or dental treatment, or medical, surgical or dental appliances necessary for themselves or any persons whom they are liable to maintain."

Until comparatively recent times the public health services were not much wider in scope. Many public health services are now, however, free of charge to all.
Mental treatment is free in the case of persons who are unable to pay, or contribute towards the cost.

The most obvious shortcoming in the services has been their narrow application but their scope has been widened in recent years and they have come to be availed of by a much larger proportion of the population either as paying, contributing, or free patients. Their primary purpose was to provide for the economically weakest section of the community, and they serve only incidentally that large class of economically independent persons, including wage-earners and others in the lower income classes, who find the full cost of any necessary medical treatment too heavy to be met immediately out of their own resources. In other countries this class is catered for to a large extent by a system of insurance medical benefit. In this country their needs are met partly by the medical assistance service, partly by voluntary hospitals and other voluntary agencies, and in part through co-operative effort among groups of employees or through the action of employers who provide for their staffs' medical needs by private arrangement. It is well to record that provision was made in successive dispensary regulations under the Poor Law and Public Assistance codes, whereby the public assistance authority could invite each dispensary medical officer within its area to furnish a scale of charges for attendance upon persons whose circumstances would not admit of their paying the usual fees of the medical officer in his private capacity. A copy of such scale of fees if furnished by the dispensary medical officer is supplied on application by persons concerned, and the scale of fees remains operative until withdrawn by the dispensary medical officer. These provisions were at one time availed of to a considerable extent. In more recent times formal scales of reduced charges do not appear to have been continued in force, but those previously in operation have, no doubt, been continued informally in many districts.

Medical Assistance Service.

Public assistance authorities (in most cases the county councils) provide this service. It comprises a general practitioners and midwifery service, in which 616 doctors and 694 midwives are employed, and hospital and consultative services. The medical assistance services are free to all those who cannot afford to provide such services out of their own resources. It is considered that these services are available for about one-third of the population, but as eligibility is based on varying criteria of necessity it is difficult to offer a precise estimate of the total number of potential beneficiaries. Participation in the service without charge is subject to a means test, which, although not rigidly applied, deters many people from availing themselves of the benefits of the service. The hospital facilities provided under the service may, however, be availed of on a paying or contributing basis by persons who are not eligible for free treatment.

Hospital treatment is generally provided in "district institutions" which include county, district and infectious disease hospitals and county homes. Public assistance authorities may also make use of the services of "extern" institutions, which include the voluntary hospitals and homes for persons requiring special treatment. Appropriate payments are made to such institutions by the authorities sending cases to them.

Arrangements are made in some districts for providing dental and ophthalmic treatment and appliances. No uniform practice has, however, been adopted and the scope and quality of these services vary considerably between different public assistance districts.

Mental Treatment Service.

The public service for the treatment of mental disorder is administered by eighteen mental hospital authorities, which are either county councils or joint boards consisting of representatives of two or more councils of counties or county boroughs. There was until recently no room for any middle course between certification for detention in an institution and complete freedom, except an unsatisfactory system of trial discharge. The Mental Treatment Act, 1945, which came into operation on 1st January, 1947, has, however, besides furnishing a complete code for the regulation of public and private mental hospitals, provided a more flexible procedure for reception, treatment and discharge. The new approach is intended to lay emphasis on prevention and to facilitate early treatment. The old system of committal by warrant of two peace commissioners is entirely superseded, and that of reception on the application of relatives or other interested persons, which formerly obtained to a limited extent only, has been given universal application, but in a greatly widened and improved form. In ordinary cases may now be effected only by means of a reception order made either by the medical superintendent of the hospital on the recommendation of an authorised medical officer, or, in the case of private patients, on the order of two registered medical practitioners after the patient has been examined by them separately. Patients may also be received as temporary or as voluntary patients into institutions specially approved for their reception. The need for this reform has long been urged. Reception orders in the case of temporary patients may be made by the person in charge of the institution following consideration of a certificate issued by an authorised medical officer where the patient is unable to provide the whole cost of mental hospital assistance, or of a certificate issued by two registered medical practitioners in the case of a private patient. Reception orders in the case of temporary patients hold good for a period of six months, which period may be extended by the Minister for Health, the maximum extension being eighteen months. It is anticipated that the large majority of patients other than voluntary patients will be received
as temporary patients. An important application of this mode of reception enables orders effecting temporary receptions to be made on grounds that the patients concerned are "addicts" and require at least six months' preventive and curative treatment. The term "addicts" covers persons who by reason of addiction to drugs or intoxicants are either dangerous to themselves or others or incapable of managing themselves or their affairs or of ordinary proper conduct; or who are in serious danger of mental disorder through addiction to drugs, intoxicants or perverted conduct. Wide powers to take timely preventive action are thus afforded under the Act.

Arrangements are contemplated for the establishment of clinics either at mental hospitals or at county or other general hospitals, where advice and treatment in matters of mental or nervous illness may be obtained by persons who are not inmates of mental hospitals.

PUBLIC HEALTH SERVICES.

(i) Infectious Disease Service.

A service for the prevention of the spread of infectious disease has evolved over the last century and is now operated in each county under the control of the county medical officer of health and in each county borough under the medical superintendent of health. The arrangements include provision for immediate notification by medical practitioners and others of cases of infectious disease to the county and city medical officers, who see that all requisite precautions are taken when a case occurs, including disinfection and/or disinfection of any persons, premises, vehicles or articles likely to spread infection. They also arrange for the compilation of statistics in relation to morbidity and mortality and for the operation of schemes for immunisation against certain infectious diseases.

While these arrangements have generally operated successfully closer co-ordination is required with the hospital service for infectious cases included in the medical assistance service. There is at present no statutory provision for notification of suspected cases of infectious disease. Furthermore, the legislative provisions under which the several public health schemes are administered required modernisation and codification. These requisites have been met in the Health Act, 1947.

(ii) Tuberculosis Service.

Special measures in relation to tuberculosis were adopted by county and county borough councils following the passage of the Tuberculosis Prevention (Ireland) Act, 1908. These measures include arrangements for the diagnosis and treatment of tuberculosis, and for certain aftercare, domiciliary and case-finding services. Provision is made for the supply to necessitous persons of food allowances, clothing, beds and bedding. In general, the services are free only to those who cannot afford to pay. Tuberculosis authorities make provision for institutional care in their own hospitals and sanatoria or, by agreement, in voluntary institutions. The Government's plans for dealing with the problem of tuberculosis have been set out in a White Paper published in 1946.

(iii) Maternity and Child Welfare Schemes.

A service specially directed towards the needs of expectant mothers and nursing mothers, and children until they are five years of age, has grown up since the enactment of the Maternity and Children Act, 1919, and is known as the Maternity and Child Welfare Service. It has been administered up to the present by urban authorities as well as by county and city councils and by a large number of voluntary associations and agencies working in co-operation with the official bodies. Its purpose is to provide instruction, advice and other forms of help, including nutritious food and treatment for certain defects (including dental defects), for nursing mothers and expectant mothers, and to assist them in the care of their children until they are five years of age. It has, however, developed unevenly over the country as a whole and has not grown beyond the health visitor stage in the cities and a few urban centres. In the cities the service is for all practical purposes confined to the poorer classes. Provision is not included in this service for attendance at childbirth, which is provided by the voluntary lying-in hospitals and the midwifery services, under the Public Assistance Act, 1939, and the Midwives Acts.

(iv) School Medical Service.

The School Medical Service is administered under the Public Health (Medical Treatment of Children) (Ireland) Act, 1919, by county and county borough councils. It provides for the medical inspection of children attending national schools, and for the treatment of defects, particularly dental and opthalmic conditions and dental and adenoidal conditions.

The service is limited in application to children attending national schools. Its benefits are neutralised to some extent by the inadequacy of the arrangements for treatment and the fact that it has not been possible to aim at more frequent inspections of schoolchildren than about once in every three years. The service also suffers from a lack of co-ordination with the Maternity and Child Welfare Service.

(v) Venereal Diseases Service.

The Venereal Diseases Service is operated under powers conferred by the Public Health (Prevention and Treatment of Disease) (Ireland) Act, 1917. Approved schemes for the treatment of
persons suffering from venereal diseases are in operation in the four county boroughs and in seventeen counties. Schemes include—(a) free treatment at clinics; (b) arrangements by which any medical practitioner may obtain free pathological reports on specimens submitted; (c) provision for institutional treatment; (d) consultant advice or assistance, and (e) issue of salvarsan or its substitutes to medical practitioners.

The service is handicapped by its lack of uniform application throughout the country, by the difficulties attending case-finding and the treatment of carriers and by the comparative inaccessibility of adequate hospital and specialist services.

OTHER SERVICES.

In addition to the publicly organised health services a considerable volume of work is carried on by voluntary hospitals, private practitioners (including dentists and opticians) and voluntary nursing and other agencies. These play a large part in the treatment of patients and in alleviating the results of illness. Their activity in the preventive sphere is less prominent, although emphasis on this side of their work has become more marked in recent years, particularly in the case of tuberculosis and maternity and child welfare. In general, however, their function is curative and voluntary effort finds its fullest and clearest expression in the diagnosis and relief of conditions requiring medical or surgical intervention.

Voluntary bodies have a distinct and important group of functions, including the training of doctors, dentists, nurses and midwives, and the provision of a wide range of specialist advice and treatment. They supplement the public services at many points in providing free institutional, general practitioner, or other care for necessitous persons. Private initiative is a valuable element in the health services pattern, and tribute is due to the praiseworthy part which voluntary agencies play in the present medical system. But there should be an effective co-ordinating medium between this body of voluntary and private effort and the broader public organisation. The official services are progressively invading the sphere of voluntary treatment and private practice, and voluntary hospitals and nursing associations are being increasingly associated with schemes subject to official supervision. Moreover, many private practitioners seek part-time employment under local authorities on a salary or fee basis to supplement income from private practice. It is, therefore, apparent that the scope of voluntary and private activity tends even at present to be circumscribed by the normal growth of the public services. The field in which these agencies can continue to operate with complete detachment would inevitably be still further narrowed by a wider programme of expansion in the official sphere. The reform of the health services will involve the infusion of the technique of preventive medicine into every aspect of the medical system, and the full co-operation of both official and individual voluntary effort must be enlisted in that work if it is to succeed. It should, therefore, be the aim to provide full opportunities for the use of the new service of the resources, initiative and energy of these agencies.

What is generally called "medical benefit" in other countries, i.e., general practitioner treatment for insured persons, is not one of the statutory benefits of the National Health Insurance Acts. Since 1942, however, other forms of medical care together with dental and optical benefits are provided for certain insured persons through a scheme of additional benefits drawn up to utilise moneys set aside when the financial basis of National Health Insurance was recast in that year. Arrangements are made under the Additional Benefits Scheme with hospitals and convalescent homes to admit and maintain for treatment eligible members of the National Health Insurance Society, free of cost to such members. Arrangements are also made with dentists and opticians to provide treatment free of cost to eligible members of the Society and, in addition, half the cost of dentures and contributions towards the cost of spectacles and medical and surgical appliances are paid by the Society. It has frequently happened that the applicants for a particular benefit have been so numerous that the fixed amount available for that benefit in a particular year has been exhausted before the end of the year, with the result that no further cases could be admitted to the benefit until money again became available in the following year. Furthermore, the scheme applies only to those members of the Society who have more than three years' membership and are not in arrears and it does not apply to married wives or children.

The scheme was never intended to constitute a comprehensive medical service and therefore it is not to be criticised merely because it fails to provide such a service. When an improved health service has been provided not only for insured persons but for other persons working for wages or salaries, as well as for the great bulk of the self-employed classes the position in relation to the Additional Benefits Scheme may have to be reviewed.

GENERAL.

The foregoing survey emphasises the sectional nature of the present services. Each of the services occupies a more or less restricted sector of the field in the war against ill-health. In combination they provide a reasonably complete defensive and offensive organisation but the connection between the various services is loose and haphazard, and the existing gaps and shortcomings are aggravated by the limited nature of the objective towards which they are aimed. A good many of the services are directed towards the needs of the poorer classes solely. Only a small proportion of them can be said to be free of access to the community as a whole.
This is particularly true of the medical assistance system, eligibility for which is determined by a means test under the Public Assistance Act, 1938. The system has derived from the former Poor Law medical service, and its origin dates back many, even of those legally eligible to participate in it, from availing themselves of it. The result has been that a satisfactory public medical service exists for wage-earners and salaried employees in the lower income grades, not for the greater part of the farming community. The necessity for such arrangements is emphasized by the development of services such as the Mother and Child and Tuberculosis Services which will in course of time supply a widely extended service for persons in special age groups and conditions.

Attendance to the health of the child, for example, will be generally provided for by the health authority from infancy until he has reached the age of sixteen years. The health of the breadwinner, however, on whom the child must depend for sustenance and upbringing might, if the present system were allowed to continue, go without adequate attention. Again, the value of special schemes would be seriously prejudiced if persons were compelled, in the absence of a unified service, to revert to the medical assistance system on passing out of the particular age group or condition for which the special scheme was designed. A child might, for instance, grow to early youth under the favourable conditions created by the Mother and Child Service and on entering the vulnerable age period of adolescence lose touch with the protective organisation at a time when the need for it would still continue.

The need for a new approach to health problems becomes clearly evident on consideration of the present high mortality rate among the younger age groups of the population and of the economic waste involved in illness and disability. In a period when so much emphasis is being laid on national production it is vital that the health of the population should be raised to the optimum level. The mortality rate amongst the younger age groups of the population, particularly the abnormally high rate of infant mortality, constitutes a serious depletion of the natural life stream which should replace the wastage due to old age.

Public opinion has readily conceded the need for a vigorous and sustained attack on the problem of tuberculosis. This is not the only case, however, in which the incidence of a disease is heavier in this country than in others where health services are in a comparable state of development. Our infant mortality rate is still disturbingly high. The higher mortality rates for a number of the most serious diseases are found among our infants, children and adolescents, and an intensive campaign is called for to curb and diminish the ravages of disease. Progress towards the achievement of a population of healthy children is an indispensable foundation for the attainment of a higher level of health in the people as a whole and for this reason the introduction of improved measures for safeguarding the lives and health of mothers and children is the first item in the programme of proposed reform.

PART III.


Under the Health Act, 1947, provision has been made for a considerable measure of reform of the public health services reviewed in Part II of this Paper. The services dealt with in the Act are to a large extent self-contained and their development is not dependent on the implementation of the wider proposals which are outlined later in this Paper, but an understanding of the nature and scope of the changes made by the Act is an essential prelude to proper consideration of the wider expansion and development explained in Part IV.

A résumé of the more important changes provided for in this measure is therefore given below.

RATIONALISATION OF LOCAL ADMINISTRATION.

As explained in Parts I and II of this Paper, the duty of providing and administering the preventive and curative health services which developed under separate legal codes is allocated among different sets of local authorities. This position, in so far as what have hitherto been termed the "public health" services are concerned has been rationalised by the Act. The county borough councils and the county councils have been designated as the authorities responsible for the local administration of all the health services. The urban district councils will not, therefore, be concerned with the administration of any of the services reviewed earlier in this Paper.

CONSOLIDATION AND MODERNISATION OF HEALTH LAWS.

The Act, together with the Mental Treatment Act, 1945, portion of the Public Assistance Act, 1938, and certain self-contained Acts dealing with special matters such as registration of members of the medical, dental and nursing professions, comprise almost all the law dealing with the health services. The provisions relating to these services which are now scattered piecemeal through the Public Health Acts and other codes have been repealed.

THE MOTHER AND CHILD SERVICE.

Part III of the Act provides that a health authority shall make arrangements for safeguarding the health of women in respect of motherhood and for their education in that respect. Attendance to the health of children will also be generally provided for by the health authority. A child is defined for the purposes of the Act as a person who is less than sixteen years of age. The service will represent an integration and expansion of the present maternity
and child welfare and school medical services. The manner in which the service will be operated will be governed by regulations to be made by the Minister for Health. While details of the operation of the service will not be finally settled until representatives of the medical profession and other interested bodies have been fully consulted it may be stated that it is intended that the primary responsibility for inspection and treatment will rest with the district medical officer in each dispensary district and that this officer will also be required to provide for the education generally of mothers and children in his district in relation to health. In each county the county medical officer and his staff will be concerned with the general supervision of the service and its co-ordination with the hospital services. Nurses and midwives will be employed to assist the medical officers.

The Infectious Disease Service.

A complete code of law dealing with the prevention of the spread of infectious disease is contained in Part IV of the Act. A statutory obligation to take reasonable precautions against spreading infection is imposed on persons who know that they are probable sources of infection. Particular precautions are prescribed for persons selling, letting, or ceasing to occupy dwellings and the Minister is given power to make regulations detailing other precautions to be taken and provision to be made against the spread of infection. Such regulations may provide for compulsory measures of immunisation or protection but persons who object to such measures will be exempted therefrom on registering an objection in the prescribed manner. In exceptional circumstances, however, the Minister may declare that all persons of an appropriate class must be immunised so as to ensure that a particular infection will be localised and eradicated.

Power is given under the Act for the compulsory detention and isolation, by order of a chief medical officer, of a person who is a probable source of infection and who cannot be effectively isolated in his home. For the protection of the patient’s rights, there is provision for appeal to the Minister against detention. These provisions will replace those contained in Emergency Powers (No. 46) Order, 1940, which gave similar power of compulsory detention and isolation in pursuance of an order made by the Minister.

Under another section, health authorities are required to make provision for the maintenance of persons who are suffering from an infectious disease or who are probable sources of infection and for the maintenance of their dependants. The Minister is empowered to regulate the amounts of the allowances to be paid.

The Minister is also given power to limit by order the treatment of persons suffering from specified infectious diseases to specified institutions, in order to prevent the spread of infection and cross-infection amongst patients in hospitals.

Food and Drink.

Part V of the Act contains provisions dealing with the protection of the public from food which is dangerous or injurious to health and for the prescription of standards for foods which are of particular nutritious importance. The powers given in this Part of the Act are in addition to those conferred by existing Acts dealing with the control of food supply such as the Sale of Food and Drugs Acts, 1875 to 1936, the Milk and Dairies Act, 1933, and the Slaughter of Animals Act, 1935. It is proposed to codify in a later measure the enactments relating to food.

Other Provisions.

Provision is made for the setting up of a National Health Council to advise the Minister on matters affecting the health of the people. The Act provides, also, that special consultative councils may be established by order of the Minister if at any time he requires special advice or assistance in connection with a particular matter relating to his powers and functions. These councils will consist of persons having practical experience or special knowledge of the matters on which they will be asked to give advice and assistance. Other sections of the Act deal with the control of the advertisement and sale of medical and toilet preparations, the fixing of standards of cleanliness for filling materials used in bedding and upholstery, the dissemination of information and advice on health matters, the acquisition of land by health authorities and the payment of compensation by these authorities in respect of injury to person or property caused in the exercise of their functions under the Act.

Summary.

The aims of the Health Act may be summarised as follows:—

(1) to simplify the local administration of the public health services;

(2) to codify and modernise the law dealing with these services;

(3) to improve the preventive health services comprised mainly of the infectious disease service and the supervision and standardisation of food supplies; and

(4) to establish a comprehensive health service for women in respect of motherhood and for children generally.

Thus when the proposals in the Act have come into operation there will be afforded a preventive service for the whole population and a health service for women in respect of motherhood and for children and for persons who are unable to provide for their own industry or other lawful means any requisite medical attention for themselves and their dependants.
The measures provided for in the Act, when implemented, will represent a great improvement on the present position in so far as the services which they propose to provide are concerned, but they will not cover the full programme of reform. Free medical treatment would still be restricted to women in respect of motherhood and children generally and to the public assistance classes. Legal and administrative integration of all the services and further widening of their scope is the long term aim and the Government's proposals to achieve that end are the subject of the concluding Part of this White Paper.

PART IV.

FURTHER PROPOSALS FOR THE REFORM OF THE HEALTH SERVICES.

The scope of eligibility for a comprehensive medical service and the method of financing such service have been the subject of very close consideration by the Minister for Health, by his predecessors in charge of the Public Health Administration and by the Govern-
ment. These two aspects—scope and method of financing—are inevitably interlinked. From the point of view of affording the optimum benefit without interfering with the normal incidence of the cost of Public Services as between central and local taxation and among the different classes of the community, the simplest solution of the problem would be to make the service available to all citizens free of charge. Many persons, however, who are in a position to meet the cost of medical care for themselves and their dependants would, no doubt, prefer to exercise the right of choosing their own medical advisers and not participate in the scheme. Others in equally comfortable financial circumstances might tend to swell the ranks of the participants and strain unduly the resources of the service in its still undeveloped condition to the detriment of patients in more exigent circumstances.

The reactions of the different elements in the medical profession would be equally divergent: some would wish to remain independent while others participation in the public service would prove attractive. For the former class a very wide scheme might prove financially detrimental until such time as conditions had been fully adjusted to the new position. Generally, therefore, it appears desirable in existing circumstances that a certain upper-income field should be left for private practice.

From the health point of view, however, it is imperative that the full range of medical care should be made available to a very greatly extended proportion of the population, subject, of course, to the right of any individual to retain the services of a private medical practitioner of his own choosing, if he so wishes. In that event the individual would be liable for the fee charged for the personal medical attention of the private practitioner but provision would be made whereby such private practitioner could obtain for his patient the specialist, hospital and other facilities to be provided under the scheme, without charge to the patient if he is eligible in his own right to participate in the scheme.

Having carefully and repeatedly reviewed all aspects of the matter, the Government has now approved of the recommendation to the public of a scheme for the reorganisation and expansion of the health services on the following lines,

(a) that local health administration should be conducted in
each county or larger unit by a specially constituted local health authority;

(b) that existing health services should be extended and supplemented as hereafter proposed, and that these services as so improved should be unified or co-ordinated;

(c) that the comprehensive service to be thus provided should aim, primarily, at measures designed to maintain and protect the health of the community and, secondly, at treatment of disease and that existing services should be developed as found practicable;

(d) that all personal services dealing with the prevention and treatment of infectious disease and the Mother and Child Service Scheme should be provided free of direct charge to individuals of all classes;

(e) that the full scope of the entire range of medical care under the scheme, as progressively expanded in the manner hereafter described, should be made available free for all recipients of home assistance, unemployment assistance, pensions under contributory social assistance schemes and for other similar classes;

(f) that in addition to the classes mentioned in paragraph (e) the full scope of the general practitioner service to be afforded by the district medical officers and the regional services (provision of institutional care and specialist advice and treatment) be made available free, so far as the health authorities are concerned, to cases in which the annual income does not exceed £250 or, in the case of a farmer, where the valuation of the holding(s) does not exceed £25 and the total annual income does not exceed £500, subject, however, to token payments within prescribed rates to the district medical officers (except in the case of the services mentioned in paragraph (d) above), and

(g) that in addition to the classes mentioned in paragraphs (e) and (f) the full scope of the regional services shall be made available, subject, however, to token payments (except in the case of the services mentioned in paragraph (d) above) within prescribed rates to the health authorities, to cases where the annual income exceeds £250 but does not exceed £500 or, in the case of a farmer, where the valuation of the holding(s) exceeds £25 but does not exceed £50 and the total annual income does not exceed £500. This class will not, however, be eligible to participate on a free or token payment basis in the general practitioner service to be afforded by the district medical officers.

Reference has already been made to the dangers, in the present comparatively undeveloped condition of the health services, of unduly swelling the ranks of participants and it will hereafter be shown that the projected developments of institutions, organisation and personnel must necessarily involve a long-term programme of reform and expansion. When these projects have been substantially realised the question of widening the scope of free participation in the services, as expanded, will no doubt arise for consideration.

SCOPE OF SERVICE.

The health services which it is intended to develop will consist of two main sections, viz., a county service and a regional service. The county service will be based on the district medical officer and will be administered under the control of a local health council. It will include the administration of the Mother and Child Service Scheme and measures in relation to the prevention and treatment of infectious disease. The regional service will deal with institutional and specialised functions and will be under the control of regional authorities. To meet its special circumstances a modified scheme, embracing the essential features of the two services, is proposed for the Dublin Area.

THE COUNTY HEALTH SERVICE.

It is intended that each county will be divided into a number of district health units, which must naturally be based on available personnel and organisation and can, therefore, be built up to optimum requirements only gradually. The normal health unit proposed would consist of a doctor (district medical officer), a nurse and a midwife. At the outset the local areas will correspond approximately to the existing dispensary districts but each county will be carefully surveyed to determine the most suitable boundaries for the different local areas in relation both to population and to the natural configuration of the area. In some cases it may be found desirable to establish or maintain local areas which would be larger than the normal areas or to make provision for substantially greater population groups and this objective would be met by the appointment of assistant medical officers and assistant nurses.

Existing dispensary medical officers will, where suitable and willing to serve, become the first district medical officers in the new service. Where an existing officer is held to be incapable of undertaking the extended duties or where he does not desire to enter the new service, provision will be made for superannuation on appropriate terms. As the duties of the district medical officers will be altered an increase in the present rates of remuneration will be necessary. Private practice will be allowed (except in the case of whole-time assistant medical officers), but a recognition of the prior
claim of the public service on the medical officer's time and attention will be essential. It will also be necessary to augment to a considerable degree the existing number of medical officers available from the Dispensary Service but it is not possible to reach firm conclusions as to actual increases in numbers until the survey which is at present in progress has been completed.

As already indicated, private practitioners outside the service, may, in respect of patients under their care who are entitled to participate in the scheme, avail themselves of specialist, hospital and laboratory facilities without cost to the patient. The facilities to be afforded under the new service would also be available to private practitioners in respect of patients who are not entitled to participate therein, on the payment of appropriate fees. Provision is also proposed whereby private practitioners may co-operate with district medical officers in appropriate parts of the service. Any arrangements for participation in the new service by private practitioners will be subject to the approval of the appropriate health authority and the Minister.

Part-time medical officers of district hospitals or other institutions who wish to take part in the service may also be authorised to do so by the appropriate health authority subject to the consent of the Minister. The size of the areas and the number of families in such areas for which these officers would be responsible would be related to the extent of their duties and responsibilities as holders of part-time appointments.

While the normal district health unit will provide for a health clinic and for the services of a doctor, a nurse and a midwife, there will be several variations to suit different population groupings and local conditions, viz.:

(a) a health clinic with two doctors and appropriate nursing and midwifery staff;
(b) a health clinic with three doctors and appropriate nursing and midwifery staff;
(c) certain district health units will have the services of one or more whole-time assistant medical officers; and
(d) private medical practitioners may in certain instances be associated in the new service with the official medical personnel.

For the purpose of achieving a high standard of technical ability in the service it is proposed that steps will be taken to require that practitioners desiring to enter the service as district medical officers will have had post-graduate training in child health, with special reference to the normal child, a Certificate in Public Health and post-graduate training and experience in the practice of obstetrics.

The number of persons for whom any one district medical officer would be ordinarily responsible would be so adjusted as to enable him to undertake the extended series of duties proposed to be assigned to him. These duties include:

(1) provision of free general practitioner service for eligible classes;
(2) provision of ante-natal and maternity service (subject to appropriate arrangements varying according to locality and facilities for the co-operation of maternity hospitals) and an integrated infant and school medical service and supervision of the work of the nurse and midwife;
(3) the conduct of preventive public health work including immunisation measures and co-operation in the case-finding of infectious diseases (including tuberculosis and venereal diseases) and the investigation and control of infection;
(4) registration of births, deaths and marriages, and preparation of vital statistics in respect of his district; and
(5) certification under the School Attendance Act; recommendations and certificates under the Mental Treatment Act, etc.

It is contemplated that the efficiency of the district medical officers in the performance of their duties will be assessed by the local health councils, by medical inspectors of the Department of Health who will be assigned to and resident in districts comprising an appropriate number of counties, by the medical advisers of the regional authorities in so far as the work of the district medical officers is associated with institutional treatment, and by the chief medical officers in so far as public health work and the Infectious Disease and Mother and Child Services are concerned.

It is intended that nurses will visit local schools regularly to give health and hygiene instruction and that they will provide a home nursing service under the direction and guidance of the district medical officer.

It is proposed that the training of midwives will be widened so as to approximate more to that of a general trained nurse and to include special training in infant care so as to provide an effective system of domiciliary visiting for infants in the first year of life.

In the fully developed service local health clinics properly equipped and suitably situated will in most cases replace existing dispensary buildings which will in the meantime be converted for use as health clinics whenever practicable. New or improved clinics are intended to provide accommodation for general medical examination, hygiene instruction, records, pharmacy, waiting rooms and in the larger clinics, X-ray sets. In the association of preventive
and curative medicine clinical sessions for ante-natal consultation, infant welfare, dental and other services will be held in the health clinics.

Major health centres will be provided as circumstances permit at appropriate locations to deal with the more complicated or specialised cases from the local health clinics and they will act in many cases as substitutes for the out-patients’ departments of the hospitals. It is intended that specialist clinics will be afforded at these major centres by visiting specialists from the regional and county hospitals and that tuberculosis clinics will also be held.

The provision in all areas of new or improved health clinics and centres would obviously involve a programme which, however intensively undertaken, could not be completed for a considerable time. A building programme based on the relative suitability of the existing accommodation will be drawn up, however, and implemented as conditions permit.

The fully developed County Health Service will also provide a variety of special services on the following lines, viz.:

(a) Tuberculosis.
Each county service will maintain on the staff of the chief medical officer one or more tuberculosis officers, who will operate the tuberculosis scheme for the county, direct the case-finding campaign and act in association with the district medical officers in the search for early or undetected cases. Through the medium of the district medical officers, family and other contacts can be more easily approached and information regarding infection made more readily available. Steps will be taken to provide improved tuberculosis clinics at the major health centres with provision for a full diagnostic service and, in addition, specialised treatment. Liaison will be maintained between the medical officers of regional sanatoria and the county tuberculosis and chief medical officers. More detailed particulars of the programme in relation to tuberculosis, including the question of institutional treatment and after-care, have already been given in the White Paper on tuberculosis published in 1946.

(b) Infectious Diseases.
The prompt and effective control of infectious diseases will be a prime responsibility of the district medical officer, but, ordinarily, treatment will be the responsibility of the medical officer of the hospital for infectious diseases. Co-ordination of the machinery for the control of these diseases will be secured through the chief medical officer and his staff.

(c) Venerable Diseases.
As already indicated, the district medical officers will assist in the case-finding of venereal diseases. They will, in addition, afford treatment in certain instances. Clinics will also be provided in each county and a central clinic, with beds, at the county hospital or other suitable venue. The control of these diseases at regards case-finding and case-holding (the continuation of treatment until cure has taken place) will be the responsibility of the chief medical officer who will act either directly or through the district medical officers and private practitioners.

REGIONAL SERVICES.

Local Hospitals.
The “county” and “district” hospitals will provide the general medical, surgical and obstetrical service for each local area. Many of these hospitals have been built within recent years and owing to their high reputation and the efficient service they supply to all classes of patients, the demand for accommodation has entirely surpassed expectations and beds are practically always fully occupied. The long-term hospital building programme includes the construction of new hospitals or the extension or reconstruction of existing institutions in all counties where the present accommodation is inadequate or unsatisfactory.

The present normal staffing of a county hospital comprises a surgeon, a physician and one or more house surgeons. It is proposed that this staff will under the scheme be supplemented where necessary by assistant surgeons or other appropriate junior staff in training for higher posts and that the services of an obstetrical specialist will also be made available to the hospital and in conjunction with the Mother and Child Service. Similarly, a rationalised system of integrated local and regional service is contemplated in the sphere of other specialties such as ophthalmic, ear, nose and throat work.

Most counties already possess several district hospitals. These will continue to cater for ordinary medical cases, minor surgical cases and uncomplicated maternity cases.

Where necessary, beds will be reserved in the county hospitals for cases undergoing treatment from specialists in the Regional Service. As a matter of general policy, however, cases requiring specialist treatment will be sent to the regional hospitals where the full range of scientific treatment will be available to them.

By this and similar measures of co-ordination under the direction of the regional authorities the county and district hospitals will be made to constitute an integral feature of the regional system.

The specialist and regional hospital services are proposed to be organised on a wide basis, and will be generally associated with the university medical schools.

Regional Hospitals.

As conditions permit regional hospitals will be provided at Cork and Galway and an auxiliary regional hospital at Limerick. It is
proposed that, with the co-operation of the appropriate teaching and voluntary hospitals, special co-ordinated arrangements providing for regional hospital services will be made in Dublin. Auxiliary regional hospitals at other centres are projected as a later development.

The regional hospitals are to be of teaching standard so as to provide a full range of specialists and to act as centres for medical research. They would accept for investigation or treatment, cases requiring more specialised experience, knowledge, technique or equipment than would be available in county hospitals or in the proposed auxiliary regional hospitals.

Regional Sanatoria.

The provision of regional sanatoria is being undertaken under the provisions of the Tuberculosis (Establishment of Sanatoria) Act, 1945, at Dublin, Cork and Galway. The sanatoria to be erected in Dublin will serve Dublin City and County. The institution at Cork will accommodate cases from the Counties of Cork, Limerick, Waterford, Clare, Kerry, Tipperary (N.R.) and (S.R.), together with the County Boroughs of Cork, Limerick and Waterford. The institution at Galway will make provision for cases from Counties Galway, Mayo, Roscommon, Sligo, Leitrim and Donegal. It may be mentioned that the Counties of Monaghan, Cavan, Leitrim, Meath, Westmeath, Leix, Offaly, Kilkenny, Waterford, Cork, Kilkenny, Wexford and Longford will be served by Peamount and Newcastle Sanatoria, Our Lady of Lourdes Hospital, Dún Laoghaire, and by existing local institutions.

Laboratory Services.

It is hoped in the course of time to develop a more comprehensive range of laboratory services, a public health institute, a bureau of standards and a blood transfusion service. From the consideration that has already been given to the problems involved in the co-ordination and development of the programme set out under this heading, it is evident that, although a beginning has already been made, it will be some time before the full programme can be implemented.

Cancer.

Specialist facilities would be provided at first at regional centres to assist in the early diagnosis of cancer. Later, with developing knowledge and technique, the number of centres will be increased as conditions permit. A Cancer Institute will be required for specialised treatment using radium and the new methods expected to follow recent scientific discoveries. Utilisation of the beds of the existing special hospitals would also be an important consideration and provision of long-term treatment beds of a convalescent type will be considered.

Rheumatism.

It is desirable that facilities for the investigation and treatment of rheumatism and especially for research into this disease be made available in each region. It is hoped also to provide advanced physiotherapy facilities in the regions associated with the university medical schools so as to afford special treatment to patients and training to the medical practitioners of the future in the most modern methods of dealing with this disabling disease.

Mental Hospitals.

Mental hospitals are already partly organised on a regional basis, where two or more counties or county boroughs combine to maintain an institution. The Mental Treatment Act, 1945, ensures their satisfactory future development along the most enlightened scientific lines. Mental treatment services will now be integrated into the regional health service while preserving for the immediate future, at any rate, the existing units of organisation based on county or joint district administration. The holding of psychiatric clinics by medical officers of mental hospitals at convenient centres to which patients suffering from incipient or minor mental disorders can be referred for advice or treatment, and to which patients who have been discharged from mental hospitals will report for guidance, is now well within reach, and it is hoped that this expansion of the service will soon be achieved.

THE DUBLIN SERVICES.

The organisation of the health services of Dublin County Borough and Dublin County (and to a lesser extent those of Cork) presents a special problem. In Dublin the position is complicated by the fact that three public assistance authorities and three health authorities are still in existence and cater for their respective areas (which overlap to some extent). So far as the work of voluntary agencies is concerned there is no proper integration thereof with the work of these six official bodies. The voluntary hospitals maintain outpatient departments, while public assistance dispensaries and institutions are provided and maintained by the public assistance authorities. In addition, both the voluntary and the public assistance services are largely independent of the public health services provided by the Corporations of Dublin and Dún Laoghaire and by the Dublin County Council.

Thus the public assistance, public health and voluntary components of the metropolitan health service have developed and are developing independently. While there is overlapping and redundancy in some services there are other health matters which tend to be overlooked by all the authorities.

It is essential to instil a sense of common purpose and interest in the several constituents of the City's medical system and to smooth out the differences in training, outlook, method of approach and
organisation. The public health services, the voluntary hospitals, and the public assistance medical organisation should no longer work independently. The distinctive qualities of the different branches, i.e., the social and preventive approach of the public health officer, the family influence and interest of the general practitioner and the high standard of scientific medicine of the modern voluntary hospital, should not remain isolated from each other.

It is hoped that a unified health service for Dublin City and County will ultimately be developed which will link together the health services as present carried on by the public authorities and the Corporation, the public assistance and other authorities, the private practitioner groups, in so far as they deal with participants in the scheme, the voluntary hospitals, and the other voluntary organisations engaged in activities relating to health.

Health clinics are projected for Dublin as for provincial areas to provide for a general practitioner service and for the Mother and Child Service. They will be closely linked with the other services operating in the area, and with the co-operation of the voluntary organisations concerned with matters bearing on health, wasteful over-lapping will be eliminated. It is proposed that each health clinic will have the daily services of a district medical officer, up to an agreed hour in the afternoon, together with the whole-time services of such assistant medical staff as may be necessary, with the district medical officer would provide a continuous service. The present dispensary areas will require radical overhaul in one or other of the modes contemplated in the previous observations on health district units generally.

A series of larger health centres is also envisaged to which the health clinics will refer their more difficult cases and in which specialists will provide a service comparable to that now given in a general hospital's outpatient department. The health centres will in turn be associated with a general hospital to which cases requiring further investigation or hospital treatment will be referred. It is not contemplated that patients will attend hospital outpatient's departments as they do now, casually or for trivial complaints, but that they will be referred from health centres or by private doctors and seen by appointment. In addition, dental, paediatric, ante-natal and (separate) tuberculosis clinical sessions will be held, thus associating preventive services hitherto carried on by the Corporation with clinical services. Cases requiring specialist but not institutional attention will be treated in the health centres, and wherever the circumstances would demand, at the patient's home. Within this plan the services of skilled specialists attached to hospitals can be more fully utilised in their specialities.

The problem of infant mortality in Dublin City has assumed such dimensions that a drastic change in the provisions relating to infant welfare is called for. Owing to the particularly heavy mor-

In the integrated administration of the various health activities involved it will be necessary to establish a joint health authority for the city and county which will be representative of the participating bodies and interests. Such a co-ordinated service would not involve the absorption of existing agencies, but rather a grouping of them into a team, each preserving all that is best in its own approach to the problem but influenced by a common purpose and impulse. This scheme will be the subject of prior negotiation with the appropriate authorities. Harmonious co-operation should provide for Dublin City and County, under one authority, a unified complete service. Regional services on the lines already sketched, with full use of the metropolitan hospital and other specialist facilities, would, of course, apply also in the case of Dublin.

TRAINING OF PERSONNEL.

Since the value of any health service depends ultimately on its personnel, particular attention must be paid to the recruitment of properly trained medical and nursing staffs. The nature of the proposed expanded County Health Service will require the medical personnel to possess a wide knowledge of both preventive and curative medicine as the district medical officer will be responsible, under the chief medical officer, for the public health of his district. It is, therefore, intended to bespeak the co-operation of the medical teaching bodies in a gradual raising of the standards and a widening of the curricula of the courses in the medical schools. It is also proposed that with the co-operation of the universities and the medical schools better facilities will be made available for practical, specialist and research work in postgraduate medical studies. With a view to retaining for the medical services the talents of promising graduates it is proposed to develop a system of progressive advancement in the medical (particularly
the regional and specialist) services. This would involve a grading of medical practitioners holding public posts and, in the filling of the higher posts, attention to the records and merits of those who serve progressively in the appropriate junior positions. It would also involve ensuring security of tenure and facilities for "continuous" service in various employments which are now regarded as "temporary" and unrelated posts.

The developments proposed would include provision for periods of in-service training of local authority medical personnel during which they would work with experts in various branches of medical science and also for the training of selected officers by the provision of fellowships at appropriate medical centres to fit them for senior local posts as surgeons, physicians, pathologists, etc.

Preliminary discussions have already taken place with representatives of the General Nursing Council regarding the training and recruitment of nurses for the preventive and curative health services, and proposals for the provision of improved facilities in this respect are at present being formulated.

Efforts will also be made to arrange that midwives will receive, as part of their training, systematic and practical instruction in infant care, and that their training will be broadened so as to bring it more into line with that of a general trained nurse. It is hoped that the services of the Dublin maternity hospitals—and later other hospitals providing specialist maternity service—will be available for the purpose. A high standard should be thereby attained and ultimately extended throughout the whole country.

LOCAL HEALTH COUNCILS.

It is proposed that local health councils will be established to administer the County Health Service under the supervision of the Minister for Health. The majority of each local health council will be composed of directly elected representatives of the county or county borough councils as the case may be. Representation will also be reserved for co-opted members and/or for nominees having special knowledge of, or interest in, health administration other than officers of the local authority or of the local health council.

The health functions of county and county borough councils (excluding the provision of water supplies, sewerage, public cleansing, provision of burial grounds and other environmental services) and boards of assistance in relation to the different services comprised in the County Health Service would be transferred to the local health councils. Provision would also be included to enable joint health councils to be established.

The regional health authorities will present an estimate of their financial requirements to each of the local health councils within their respective areas. The local health councils will be required to include the demands of the regional health authorities in their own estimates and demands on the rating authorities. After the end of each financial year the total expenditure of each regional authority will be apportioned as between the different local health councils within each region on valuation and per capita bases according to the nature of the charges.

It is contemplated that the chief medical officers of the counties and county boroughs will supervise and co-ordinate the Mother and Child and Infectious Disease Services and other public health preventive services. The chief medical officers will submit annually to the local health councils a programme which will outline the extent of the work proposed to be undertaken on the different services for which they have responsibility during the course of the ensuing financial year. The local health councils will examine the proposals of the chief medical officers and include in their estimates provision for a sufficient amount of money to enable the programme as approved by them to be implemented.

Within the limits of the estimate adopted by the local health councils the chief medical officers will have a wide discretion in the administration of the medical and preventive services allotted to their charge.

The ordinary administrative and executive work of the local health council which is not of a strictly medical nature will be discharged by the chief executive officer of the council whose duties will include the control of minor staff.

It is intended that local health councils will also be empowered to appoint visiting committees in relation to all institutions of the regional authority in which they have a local interest. They will thus be in a position to satisfy themselves as to the efficiency of these institutions.

It is to be hoped that the social and scientific preoccupations of the local health councils will leave them detached from controversial topics. The reform of the health services and their gradual expansion is a task that will call for the disinterested service of public-spirited representatives on the local health councils. It is only by harmonious co-operation that the members of the local health councils can achieve progress and advancement towards the solution of the immense problems that will confront them. The betterment of the health services should be the sole objective and no other purpose should conflict with that ideal.

REGIONAL HEALTH BODIES.

For the purpose of co-ordinated institutional and specialist treatment, it is proposed to divide the country into three regions based on the University teaching centres and the regional hospitals, or co-ordinated regional hospital arrangements, proposed to be developed at Dublin, Cork and Galway. Each region will be ad-
ministered by a regional health authority, but it is envisaged that at a later stage a measure of local control will be exercised through regional health councils which it is proposed to establish in sub-regions comprising appropriate groupings of counties.

The functions of the three regional health authorities will include reporting and advice on applications for grants out of the Hospitals Trust Fund for the provision and equipment of institutions and the improvement of health services within the regions over which they will exercise surveillance; the operation of hospitals bureaux; and the coordination and management of all institutional services and specialist arrangements. The proposed delegation to these regional health authorities of advisory functions in relation to grants and institutional development will necessarily affect the present Hospitals Commission, the position of which will require to be further considered.

It is envisaged that the regional health bodies will be composed of representatives and nominees of the local health councils and that representation may also be afforded to other health agencies.

It is proposed that each regional authority will have the services of a regional administrator and a regional medical officer and will have full responsibility for institutional administration in the regional area. The regional administrators acting on the advice of the regional medical advisers will be expected to exercise general supervision of admission lists and medical records in respect of patients discharged.

The chief medical officer in his capacity as supervisor of the Mother and Child Service, Infectious Disease Service and other public health preventive services will have an intimate interest in matters relating to institutional administration and treatment in his area. The control of infectious diseases in fever hospitals and other hospitals dealing with infectious diseases will be co-ordinated with the special functions and interests of the chief medical officer and assistant chief medical officer who would, where necessary, act for the regional authority as the medical officers of such hospitals. The interest of the chief medical officer in local institutions can be further manifested in practice by assessing the effects of the institutional services on the morbidity and vital statistics in relation to his area. The chief medical officer will thus be in a position to report to the local health councils on the regional services and on their value to the county. Such reports will supplement the findings of the visiting committees of the local health councils in relation to institutional administration and treatment in their respective areas and the local health councils will thus be in a position to convey their views on such matters to the appropriate regional authorities through their accredited representatives on the regional health bodies. The regional medical advisers will likewise report to the appropriate regional authorities on matters arising from the administration of the County Health Service in the areas to which they are appointed. The resultant co-ordination of the County Health and Regional Services should ensure an efficient integrated health service.

In order to facilitate institutional administration and to relieve the regional administrator of an undue burden, it will be necessary to have a measure of delegation of authority to either the senior medical officers or the matrons (or both) of all local institutions and the resident medical superintendents and/or chief clerks of mental hospitals to deal with day-to-day matters arising in the administration of the institutions.

FINANCE.

The present annual State and local authority expenditure on health services amounts to approximately £5,248,000 which is distributed as follows:—

<p>| | | | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Local Authorities</td>
<td>State Grants</td>
<td>Total</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>£4,418,000</td>
<td>£230,000</td>
<td>£4,648,000</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The statement of expenditure set out above does not include any provision in respect of payments made from the Hospitals Trust Fund in respect of the deficits and other charges of voluntary hospitals which are at present met from the Fund. It is anticipated that the whole Fund will ultimately be absorbed in capital expenditure, so that in the final development of the scheme revenue from this source would not be available as a contribution towards the annual cost of the health services.

In connection with expenditure on health services a financial scheme is contemplated which will involve a gradual increase in State subventions until they amount to 50 per cent. of the total expenditure of health authorities. It is estimated that this scheme will shield local finances from any increased burden for a considerable number of years. Legislation to give effect to this proposal will be promoted in due course.

It is not considered that the receipts of health authorities from sources other than rates and State grants in respect of expenditure on health services will be considerable since there will be a substantial reduction in the revenue accruing from paying patients' fees. Certain revenue will still continue to accrue to health authorities from private wards in hospitals, sales of farm and garden produce of mental hospital authorities, etc. It is estimated that the receipts from all sources should not be less than £150,000 per annum.

With the gradual improvement and expansion of the health services, it is estimated that the gross annual expenditure on the
scheme will amount to about £3,150,000 at the end of the first ten-year period. The estimated net expenditure on the scheme would then be about £2,000,000 when credit is taken for receipts from sources other than rates and State grants in respect of expenditure on health services. The estimated expenditure on the scheme includes provision for the expanded services authorised under the Tuberculosis (Establishment of Sanatoria) Act, 1945, and the services provided for under the Health Act, 1947.

The net cost of the services at the end of the first ten-year period, including free general practitioner, specialist, hospital (local and regional), mental treatment, infectious diseases, tuberculosis, and domiciliary nursing services would be provided as follows:

<table>
<thead>
<tr>
<th>Local Authorities</th>
<th>£4,500,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>State Grants</td>
<td>£4,500,000</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>£9,000,000</strong></td>
</tr>
</tbody>
</table>

The present estimated expenditure on health services (local authorities and State grants) is £5,249,000. The estimated additional cost involved in implementing the scheme would therefore be £3,752,000 at the end of the first ten-year period and the cost would be distributed as follows:

<table>
<thead>
<tr>
<th>Local Authorities</th>
<th>£3,752,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>State Grants</td>
<td>£3,752,000</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>£7,504,000</strong></td>
</tr>
</tbody>
</table>

The full development of the scheme which has been outlined will involve the provision and equipment of a number of hospitals and health institutions under the control of voluntary agencies and health authorities. For the most part the institutions which will be comprised in the building programme are already in course of planning. It may be assumed that the institutional programme will entail a capital expenditure of about £30,000,000. Furthermore, existing institutional accommodation for the aged and infirm, and persons suffering from chronic ailments, is far from being satisfactory. Improved provision will have to be made in due course for this purpose. Replacement would, however, mean an eventual additional capital outlay in the neighbourhood of £18,000,000. The work cannot, therefore, be undertaken until the most pressing needs of the acutely ill have been met.

There is a sum of over £9,000,000 at present to the credit of the Hospitals Trust Fund. It will be seen that this sum will be sufficient to meet only a portion of the demands which the building programme will make on the Fund. It is hoped, however, that the return to normal conditions will witness an increase in the annual amounts derived from Sweepstakes. In the meantime the constructional programme will be based on the amount of Hospitals Trust Fund money that can be applied towards financing expenditure on the provision of institutional accommodation and equipment and on the amounts which the local rating authorities may be able to provide to enable the health authorities to supplement the grants from the Hospitals Trust Fund.

It will be evident that these considerations necessarily imply that the institutional building programme is a long-term programme and in so far as the implementation thereof is a prerequisite of full implementation of the Health Services Scheme, the scheme will for the time being have to be restricted accordingly.
Teacht An Cuisrim
Baile Átha Cliath

né amháin

Bhí an bhuí an Scór Maigh agus Lúib nua a bheil a fhíon tuigean leis an tír i mbliú chuairt, a bhí an tuath ina n-áthas air an t-ainm sin a cur i gceist, agus mionfháthar eile in aghaí díolta agus bhóinn.

Dhúr an t-aistear de na cuidimh aige agus rochar agus maith ar an eithne sa bhreith beoista agan úr iomhá. Bhí an tuath an féin-bhí domhain sa bháis agus na blianta ag an tuath agus na mhí na huaire. Bhí an tuath an féin-bhí domhain sa bháis agus na blianta. An bhfuil sé crutha freisin a dhéanamh, go hionann na n-éitichte, go n-éirioll na n-éitithe. Ná Stephán Mac an Bhráda?

Dhúr a aonair go bhfuil Scór Maigh faoiimh an Scór Maigh an fhaoi. Bhí ard eolais ar an tír agus trí mhéine de na mihéine a bhí an tuath agus na bhfáthar eile. An bhfuil sé crutha free umh na n-éitichte, go n-éirioll na n-éitithe. Ná Stephán Mac an Bhráda?

Dhúr a aonair go bhfuil Scór Maigh faoiimh an Scór Maigh an fhaoi. Bhí ard eolais ar an tír agus trí mhéine de na mihéine a bhí an tuath agus na bhfáthar eile. An bhfuil sé crutha free umh na n-éitichte, go n-éirioll na n-éitithe. Ná Stephán Mac an Bhráda?

Dhúr a aonair go bhfuil Scór Maigh faoiimh an Scór Maigh an fhaoi. Bhí ard eolais ar an tír agus trí mhéine de na mihéine a bhí an tuath agus na bhfáthar eile. An bhfuil sé crutha free umh na n-éitichte, go n-éirioll na n-éitithe. Ná Stephán Mac an Bhráda?

Dhúr a aonair go bhfuil Scór Maigh faoiimh an Scór Maigh an fhaoi. Bhí ard eolais ar an tír agus trí mhéine de na mihéine a bhí an tuath agus na bhfáthar eile. An bhfuil sé crutha free umh na n-éitichte, go n-éirioll na n-éitithe. Ná Stephán Mac an Bhráda?

Dhúr a aonair go bhfuil Scór Maigh faoiimh an Scór Maigh an fhaoi. Bhí ard eolais ar an tír agus trí mhéine de na mihéine a bhí an tuath agus na bhfáthar eile. An bhfuil sé crutha free umh na n-éitichte, go n-éirioll na n-éitithe. Ná Stephán Mac an Bhráda?

Dhúr a aonair go bhfuil Scór Maigh faoiimh an Scór Maigh an fhaoi. Bhí ard eolais ar an tír agus trí mhéine de na mihéine a bhí an tuath agus na bhfáthar eile. An bhfuil sé crutha free umh na n-éitichte, go n-éirioll na n-éitithe. Ná Stephán Mac an Bhráda?

Dhúr a aonair go bhfuil Scór Maigh faoiimh an Scór Maigh an fhaoi. Bhí ard eolais ar an tír agus trí mhéine de na mihéine a bhí an tuath agus na bhfáthar eile. An bhfuil sé crutha free umh na n-éitichte, go n-éirioll na n-éitithe. Ná Stephán Mac an Bhráda?

Dhúr a aonair go bhfuil Scór Maigh faoiimh an Scór Maigh an fhaoi. Bhí ard eolais ar an tír agus trí mhéine de na mihéine a bhí an tuath agus na bhfáthar eile. An bhfuil sé crutha free umh na n-éitichte, go n-éirioll na n-éitithe. Ná Stephán Mac an Bhráda?

Dhúr a aonair go bhfuil Scór Maigh faoiimh an Scór Maigh an fhaoi. Bhí ard eolais ar an tír agus trí mhéine de na mihéine a bhí an tuath agus na bhfáthar eile. An bhfuil sé crutha free umh na n-éitichte, go n-éirioll na n-éitithe. Ná Stephán Mac an Bhráda?

Dhúr a aonair go bhfuil Scór Maigh faoiimh an Scór Maigh an fhaoi. Bhí ard eolais ar an tír agus trí mhéine de na mihéine a bhí an tuath agus na bhfáthar eile. An bhfuil sé crutha free umh na n-éitichte, go n-éirioll na n-éitithe. Ná Stephán Mac an Bhráda?

Dhúr a aonair go bhfuil Scór Maigh faoiimh an Scór Maigh an fhaoi. Bhí ard eolais ar an tír agus trí mhéine de na mihéine a bhí an tuath agus na bhfáthar eile. An bhfuil sé crutha free umh na n-éitichte, go n-éirioll na n-éitithe. Ná Stephán Mac an Bhráda?

Dhúr a aonair go bhfuil Scór Maigh faoiimh an Scór Maigh an fhaoi. Bhí ard eolais ar an tír agus trí mhéine de na mihéine a bhí an tuath agus na bhfáthar eile. An bhfuil sé crutha free umh na n-éitichte, go n-éirioll na n-éitithe. Ná Stephán Mac an Bhráda?

Dhúr a aonair go bhfuil Scór Maigh faoiimh an Scór Maigh an fhaoi. Bhí ard eolais ar an tír agus trí mhéine de na mihéine a bhí an tuath agus na bhfáthar eile. An bhfuil sé crutha free umh na n-éitichte, go n-éirioll na n-éitithe. Ná Stephán Mac an Bhráda?

Dhúr a aonair go bhfuil Scór Maigh faoiimh an Scór Maigh an fhaoi. Bhí ard eolais ar an tír agus trí mhéine de na mihéine a bhí an tuath agus na bhfáthar eile. An bhfuil sé crutha free umh na n-éitichte, go n-éirioll na n-éitithe. Ná Stephán Mac an Bhráda?

Dhúr a aonair go bhfuil Scór Maigh faoiimh an Scór Maigh an fhaoi. Bhí ard eolais ar an tír agus trí mhéine de na mihéine a bhí an tuath agus na bhfáthar eile. An bhfuil sé crutha free umh na n-éitichte, go n-éirioll na n-éitithe. Ná Stephán Mac an Bhráda?

Dhúr a aonair go bhfuil Scór Maigh faoiimh an Scór Maigh an fhaoi. Bhí ard eolais ar an tír agus trí mhéine de na mihéine a bhí an tuath agus na bhfáthar eile. An bhfuil sé crutha free umh na n-éitichte, go n-éirioll na n-éitithe. Ná Stephán Mac an Bhráda?
Is é Mian an Pobail é...

"Ná tálaíonn an pobal é... agus seanadhíonn go brá a náim san aghus saighdhas a tarraingíonn úile agus do gach nóimh, dc, ag cabhrón go bhfuil a chlaim hide de na máthair man a tháinig..."

póntaíú na teachtaí, 1916.

Faom

Ae Slámé, 1947, cá cé a chuaigh ar gach Úadháis Sláinte socha a tháinig —

Cén sláinte ban ó éabh maitheachta a chaoimh, agus
Cén amh a chabhair do sláinte teanaí
50 morthraidh 18 bhliain ós.

Oibríonn an t-éadé go guimheachtaí an dhaithí amháin agus linn an bun cúige sin. Tá seachtas ac an tiománaí an éabadhís sé a chur ar bun a tuarne is féin. Is iomhá go bhfuil amháin go gcaithfear polaitiriúilce toradh a dhéanamh na scéime is cúige go bhfuil tú a chur an Pobail leat.

Ní don euta níu scéim éiseanach. Na maoime leat ní tháinig sin is sin, na maitheacaí' féin, agus cuí a chumhacht leat. Ni gá dochtúir a tháinig sin, níl aon duine a tháinig sin, níl aon duine a tháinig sin, níl aon duine a tháinig sin. Ní dochtúir a chumhacht leat a chumhacht leat, ní dochtúir a chumhacht leat, ní dochtúir a chumhacht leat.

Mar sin, máthair te sláinte ban ó éabh maitheachta, agus sláinte teanaí,

Ní gá aon billi Dochtúra.
Ná ligmis do na leanai bás o'fáil!

An méid leanai a fágann bás as an 1,000 a beirneach beo.

An fáth a bhfuil sa leith an tSeirbhís Nua

ANURAIÓ, SMA SÉ CONRADH LEAGAD, PÚNT 3,893 NAIONANN AN LEAGAD, PÁD STUN BISAIN, BÁS, AGUS CUNNH 4,700 LEANAÍ PÁI DUN 18 BISAIN. DÁIR LÍNA, ÓSÉADHRÁI A TÁN TIOB A SBÁIAL.

An eolóirín

An eolóirínís do na leith an tSeirbhís Nua le fágann bás i gceimhreacht leas an geimhriocht uíonra éise?

Rogha an tuaisceart a d'fhéadfadh an tSeirbhís Nua le fágann bás i gceimhreacht leas an geimhriocht uíonra éise? Tarpeáin nan sé 50 hpaí a thugann 34 Aithne bás i gceimhreacht leas an geimhriocht 34 Saoránaí agus sa Dheacaim 34 agus 25 Saoránaí. Cúimhinigh an-son síos go mór an méid leanai a fágann bás sa tús bás na taoiseach a bhí oifigiúil. Gníomhaíonn sí an fáth a bhfuil sa teideal?

An feidir an tuaisceart a thabhairt a thuiscint leis an geimhriocht uíonra bás sa taoiseach? Ní raibh bás ar an tuaisceart a thabhairt a thuiscint leis an geimhriocht uíonra bás sa taoiseach. Scith léi an tuaisceart a thabhairt a thuiscint leis an geimhriocht uíonra bás sa taoiseach. Tá an geimhriocht i gceimhreacht leas an geimhriocht uíonra bás sa taoiseach a thuiscint leis an tuaisceart a thabhairt a thuiscint leis an geimhriocht uíonra bás sa taoiseach.
bhunna na

Beas te páil ag 15 cheine a bainfrais leas as an eisitís.

Seirbis Nua...

Aine osciódh águs amharc thicka
1. Teirbhe seo do Mhaitreacá

1. Teirbhe seo do Mhaitreacá

Seánaise an tíre a bhí ag an domhan sa lá atá ag domhan é, é, é.

Díonn Maitreaca Toch na hAire o'faoi

Díonn Maitreaca Toch na hAire o'faoi
Olionn Leanai Toğa an Ċuraim d'fáil

Tar éis teabhracht a bhaint, tháinig an tábhairt do chearta i bhflíomh ag an mbéal an comhánta is fearr eile. A léirte is fearr é, go fhaigheann an teabhracht cosné an léanamh a dhéanamh i mbéal. San am a bhíonn an mbéal agus an teabhracht is faoi na bhfíomhainte sin a bhíonn a bhearradh anois ar a bhall.

2. Tarbth na Seirbhise do na Leanai

Caithearmos a mhúin a chéanna a bheannaigh an leanabh ná a bhíonn é tábhachtach eile leis an tábhairt agus a bhis an tábhairt a léirte ar a bhfuil is fearr leis. An tábhairt, trí eolas agus trí dtionchar, is féidir leis an leanabh a bhíonn an tábhairt a léirte a bhíonn a bheáradh ar a bhfuil is fearr leis. An tábhairt, trí eolas agus trí dtionchar, is féidir leis an leanabh a bhíonn an tábhairt a léirte a bhíonn a bheáradh ar a bhfuil is fearr leis.
lá leis an leanbh Sláinteáil . . .

An Trácht asus an tSíl a solátrófar an tSeirbhís

Tá a lán le ndeachaí sin a mbeadh an tSeirbhís ar fáil ma hiontái i ngáir córtais. Ni moir riomh n’fhiú asus ceannaire i ndámaí i ná d’iomáintear. Eacasmhacht i ndámaí, agus eacasmhacht i ngáir córtais, ní folta an tSeirbhís saothar a dhéanamh agus immhacrtadh na bpróinte. Déarfadh an tSeirbhís go hiontái i ngáir córtais, chumaí é, de bhrón. Ise, amháin, is féidir liom a fháil a dháil, i ngáir córtais, asus ceannaire agus a sheachtadh go minic a sheachtadh, lena léann, linn, i nduaitear an éigse amháin. Le linn chomh thugann iad ar lorg é an éigse amaí an aithne.
In aon Íochal amáin

Cuimhne aon tSeirbhís nua Mheánaí agus Louis uirthi do dhó, ospeoí agus bannaítear ar fáil do gach mheánaí roimh liom saothar, le na tinn agus na n-íontóidh.

Fáoin tSeirbhís sin, beoí seánfhi na ngnó-dhócoirí, na seóláidí, na bpólíse, na sásáile, na bhí agat, na n-íosóideach agus na scoileamh le fáil i mBaile Átha Cliath.

Agus beo an t-ionas óg ó Lá a dhéanamh agus le haghaidh na líoflaí scoile. Sa stóirí a ghríobh le Meánadh naochóireachta sin a eachaí, dhéanann an tSeirbhís seo dhuine de na bhfásfaigh na dúshlán ógá ag an lá atá ar an fear ag teacht in maith oíche.

A Muintir na hÉireann is húise an tSeirbhís seo, hainí sé lán féin aisti!
trí pingne

Anna foilsíodh roimh Sláinte as Oíphi an choláis i, dart é an Chlúad: le cosnamhímí é Oíphi Diolaithe polnseachtí Réitírí, 3/4, Spáir
an Coláiste, dart é an Chlúad, nó éi son tlochóin leabhar.

Cláir i gCéolam Dóllár, dart é an Chlúad.