

NESC REPORT NO. 84

**COMMUNITY CARE SERVICES:
AN OVERVIEW**

Price: £5.20

NATIONAL ECONOMIC AND SOCIAL COUNCIL

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1. The main task of the National Economic and Social Council shall be to provide a forum for discussion of the principles relating to the efficient development of the national economy and the achievement of social justice, and to advise the Government, through the Taoiseach on their application. The Council shall have regard, *inter alia*, to:
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NATIONAL ECONOMIC AND SOCIAL COUNCIL

Community Care Services: An Overview

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by
Sile O'Connor

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There has long been general agreement that community care should be a central feature of health service policies. In 1975 the then Minister for Health stated: "my objective is to bring about a shift in resources in favour of community services, in the belief that this will lead to a better health service overall". Further, in 1976 the Minister stated: "I would like to say at this stage that I regard the development of community care services as an area of very high priority." (1) Subsequent official statements re-iterated the importance of community care within the health services, and the need to shift the orientation of health provision and the allocation of health care resources towards community care (2).

Concern has frequently been expressed at the slow pace of development of community care services, notwithstanding the apparently universal acceptance of the community care approach (3). The redistribution of health care resources towards community care has not been implemented. In 1976 Community Care accounted for 22.2% of non capital health expenditure, and general hospitals expenditure for 48%. In 1982 the corresponding figures were 23.1% and 51.0%. It is against this background that the Council commissioned a study of community care services: this study, which was undertaken by Sile O'Connor, is published as Part II of this report.

The terms of reference of the project were "to provide an overview of the whole field of community care by examining the objectives and expenditure on programmes, the implementation of services on the ground and gaps in their provision". In addition, the consultant was invited to examine organisational aspects of the health services, to investigate variations between national norms and local levels of provision and to assess the reliability of statistical information.

Two factors constrained the scope of the project. Firstly, the enormous complexity and diffuseness of "Community Care" services which are administered by Health Boards, voluntary organisations, local authorities and, secondly, the absence of representative data on many aspects of community care. The consultant's report is therefore confined to the Community Care Programme of the Regional Health Boards and is represented as an initial, descriptive overview.

The consultant's report was first commissioned by the NESC in 1982; the basic research for the report was undertaken in 1983 and the report was drafted and completed in 1983 and 1984. For administrative reasons the publication of the report by the NESC was unavoidably delayed. The Secretariat of the NESC has updated many of the Tables and figures in the report and made corresponding changes in the text. Other modifications and additions to the Report have been made to take account of changes and developments since the consultant carried out the research. It has not been possible to update every specific item and therefore developments since 1983/84 may have superseded particular data or observations in the report. However, the general analysis and conclusions are not superseded by the time lag between initial research and publication. On the contrary, since the consultant's research was carried out the official

(1) *Dail Debates*, 20 May 1975, Column 60, Volume 281, No. 1, and 29 April 1976, Column 377, Volume 290, No. 3.

(2) *Programme for National Development, 1978-1981*, Government Publications, Stationery Office, page 84; *Second National Understanding for Economic and Social Development*, October 1980, page 8.

(3) A. Dale Tussing, *Poverty and the Development of the Health Services in Sister Stanislaus Kennedy* (ed.) *One Million Poor*, Turco Press, 1981, pages 217-231.

1 Sile O'Connor, Assistant Professor, Department of Sociology, McMaster University, Ontario.

commitment to a community care approach has been further repeated, and the merits and feasibility of developing community care have continued to be central to discussions of health policy.

Currently debate about the long term development of the health services is focussed on the consultative document *Health — The Wider Dimensions*, published by the Department of Health in December 1986. The NESC were invited by the Department of Health to respond to this document. The Council welcomes the publication by the Department of Health of the consultative document and urges that the debate it is intended to stimulate should take place. In the Council's view a crucial aspect of this debate should be the role and development of community care within the health services, and the Council's response to the consultative document therefore is to offer the report, *Community Care Services: An Overview*, and the Council's comments on this report, as contributions to the debate on the health services.

PART 1

THE COUNCIL'S COMMENTS ON COMMUNITY CARE SERVICES:

AN OVERVIEW

INTRODUCTION

1. In the paragraphs below the Council outlines its views on the general issues affecting the development of Community Care *. The discussion outlines the general strategy required to effectively implement a community care approach and draws on the evidence of the consultant's research. This general discussion does not focus on the specific recommendations of the consultant, although the thrust of the Council's remarks support and incorporate the consultant's conclusions. A summary of the consultant's recommendations is given in paragraphs 58-59 below.

IMPORTANCE OF COMMUNITY CARE POLICY

2. The importance of community care within health services and the need to effectively develop this approach is determined by a number of factors. First, the widespread acceptance that non institutionalised (or 'normalised') care is in general more appropriate and preferable for children, the elderly, disabled and handicapped persons.
3. Secondly, community based care is potentially superior in cost/benefit terms for many categories of chronically sick and dependent persons**. It is important to note, however, that specific analyses are required to identify particular modes of care and particular conditions under which community care is more cost-effective. Simple generalisations that community care is more economical are misleading. For particular categories of clients with very special needs residential rather than community care may be more efficient. Furthermore, the economies resulting from restructuring health services towards community based services may only be attainable in the long run, as the effective switch to community services away from institutional services must be phased in, and may require the prior development of alternative community based services. A discussion of the costs and benefits of modes of care is given in paragraphs 37-44 below.
4. Thirdly, demographic and other developments are increasing the number of persons for whom community care is most relevant. Medical advances have greatly extended the life expectancy of congenitally handicapped and disabled persons. Demographic trends in many OECD countries are bringing about an ageing of populations and this will also increase the demands on community-based services and health services in general. In Ireland, the population in the very oldest age groups, the most intensive users of community based services, is projected to grow: the population of those aged over 75 will increase by 12.5% during the 1981-1991 period***
5. This growing demographic 'demand' for services contrasts with general social and demographic trends which may diminish the potential 'supply' of informal care in the community:-

Social and geographical mobility tends to weaken the community and

* Following discussions by a Working Group and by the Council of the NESC these comments were drafted by Tony McCashin in the Council's Secretariat.

** Ken Wright, *The Economics of Community Care*, in Alan Walker (ed), *Community Care*, Basil Blackwell and Martin Robertson, London, 1982, pages 161-178.

*** Central Statistics Office, *Population and Labour Force Projections, 1986-1991*, C.S.O. 1985.

neighbourhood ties which are the basis of community organisations and informal networks of care.

Traditional rural communities with strong networks of reciprocal support and care have been increasingly replaced by more urbanised, private patterns of life.

The elderly and dependent relatives increasingly tend to live independently of, and geographically distant from, the nuclear families of their sons and daughters.

There are, therefore, certain features of contemporary society which are inimical to the universal presence of completely informal systems of care, although, of course, there is considerable variation in the social structure of specific areas and communities*. An important implication of the foregoing is that "community care" cannot be presumed to exist; specific policies and interventions are required to create and sustain it.

6. A specific aspect of current social and economic developments is the evolution of labour force participation among women. Family care, which is the single most important dimension of community care, has traditionally depended largely on women to care for children and elderly and handicapped relatives. Married women in recent years have increasingly participated in the labour force, that is in paid work outside the home, rather than in unpaid work at home. The number of married women in paid employment in Ireland, although low by international standards, is rising fast. The participation rate for married women rose from 13.9% in 1975 to 20.0% in 1985. This rise in the participation rate may continue, as the participation rate has increased most rapidly for younger women. This trend correlates with a rapid fall in the birth rate. The birth rate per 1000 married women has fallen from 175.9 in 1975 to 162.4 in 1981 and to 139.2 in 1983, an annual rate of decline of some 2.3% per annum from 1975 to 1983. Ireland, it seems, is moving towards European norms which involve many women in lifelong participation in the labour force and with fewer children.

7. Fourthly, the serious state of the public finances in Ireland, the very rapid growth of social expenditure, and the significant level of national income devoted to public expenditure on health (8.0% of GNP in 1986) require that health services be structured in the most efficient manner**. The public finance constraints therefore provide an economic imperative for the development of community care.

COMMUNITY CARE — CONCEPTUAL ISSUES

8. The word 'community' and the concept 'community care' evoke positive reactions, yet these reactions have not been effectively translated into specific policies. The difficulty in putting the concept into practice arises to some extent from the following:

- Residential versus Community: this distinction is often discussed as if they were alternatives whereas in fact a continuum of modes of care is required;

* Alan Walker, Introduction, in Walker (ed) *op.cit.*, page 7.

** NESC, Report No. 83, *op.cit.*, chapters 3 and 9.

- Professional versus Lay: community care is often related to the notion of participation by the 'ordinary' public in the care of children, the elderly and the handicapped. The real issue is how the expertise of professionals can support and develop the potential of informal systems of care;

- Voluntary versus Statutory: allied with the professional-lay distinction, it is widely held that Community Care requires a greater role for voluntary organisations. Simple contrasts between 'statutory' and 'voluntary' ignore the actual and potential diversity of arrangements between voluntary and statutory organisations;

- Local versus Central: as the economic, social and demographic mix of communities varies, with consequent variations in needs and resources, it is held that the planning and delivery of Community Care services should be 'locally based' or 'area based' rather than centralised. Although particular services must be delivered and implemented in local communities there is also a need for central, national frameworks of planning, resource allocation and legislation;

- Clinical/Medical versus Non Clinical/Social: advocacy of community care is often presented as a departure from 'traditional' medicine: the source of illnesses, the diagnoses of illness, and the dimensions of 'care' are defined in broader social terms. Community Care may require not so much a substitution of a social approach to diagnosis and treatment for a medical approach, as a multi-disciplinary approach to the planning and delivery of health care.

9. The inter-relationship between these distinctions, and the tendency to discuss them as simple alternatives, has prevented the emergence of clear, specific policies to implement community care. In the paragraphs below the Council outlines its views on the major issues regarding the future development of community care. These views are outlined under four headings:

- complementarity
- models of service provision
- incentives and eligibility structures
- organisation and management

COMPLEMENTARITY

10. Recent commentaries on community care consistently advert to the failure to support and develop existing sources of care: "If the objectives of our social services are largely crisis orientated then we are not faring to badly. If they are largely aimed at supporting individuals, families and the community to help themselves then we have not even started".* The Council believes that an essential principle which should inform discussion of community care is the complementarity between the State on the one hand and the community, family and voluntary organisations on the other. Community care, in the view of the Council, is not simply self-help. It entails an active role for the State in providing

* Sylda Langford, How Personal and Community Social Services Can be Developed, in *Social Services in Crisis*, Conference Papers, Campaign for the Development of Social Services, Dublin, 1984, page 23.

a framework of services to families, communities and voluntary organisations to allow them to provide various forms of care.

11. It has been pointed out by the consultant that at present the family is significantly involved in the provision of care for the elderly, the handicapped and children; yet the State more frequently intervenes to *substitute* for the family when family care is absent or breaks down, than it does to offer practical support to families to ensure the continuation of family care. A more explicit and uniform policy regarding supports (income maintenance, domiciliary supports, home helps, medical appliances) for caring families can complement the caring role of the family, alleviate the significant stresses on carers and their families, and thus prevent the need for more expensive and inappropriate care such as long-term hospitalisation or residential care. In this regard the Council endorses the views of the National Planning Board: "Most of the care given to those in need whether elderly, disabled or otherwise dependent on others is given within the family and, to a lesser extent, by neighbours It would be foolish to build a strategy of community care on the assumption that existing levels of informal care will continue to be available without taking steps to facilitate and support its provision. It is unlikely that informal care of elderly and other relatives will be forthcoming in future without some minimum guaranteed access to support services in the community such as more extensive home nursing, social work and home help services. To cut back on support services for families caring for their sick or handicapped members at home is a false economy"*
12. The Council regards it as essential therefore that specific, explicit eligibility criteria be established for those services (home helps, meals on wheels, income maintenance, public health nursing, medical appliances) which complement the care offered by the family: these criteria should reflect the costs, and the degree of stress borne by carers and the need to prevent hospitalisation or institutionalisation. It is not necessary that the eligibility criteria be incorporated in legislation. For example, eligibility criteria for community care services could be specified in the form of administrative guidelines drawn up, and administered on a uniform basis, by all the Regional Health Boards. Eligibility for General Medical Services is determined on this basis.
13. The consultant has documented the extent of community based child care services in the light of the Report of the Task Force on Child Care Services. The analysis indicates that although the philosophy underlying the Task Force Report has apparently been accepted the level of community based services for children remains very limited and varies greatly between areas. In the view of the Council, public policy should offer resources at community level to develop the potential of community initiatives and to complement the efforts of community organisations. Such policies can offer more cost-effective long-term provisions than fully state-provided services, including institutional services, which usually come into force in the absence of such community-based preventive services.
14. The consultant has referred to the role of voluntary organisations. It is clear that voluntary organisations at present make a significant contribution to the financing and delivery of community-based services. However, the present pattern of relationships between the statutory and voluntary sectors is not satisfactory. The consultant's analysis reveals that the level and pattern of voluntary services is very uneven, with some voluntary organisations/voluntary services prominent in some

* National Planning Board, *Proposals for Plan 1984-87*, Stationery Office, Dublin, 1984, pages 313-314.

areas and absent in others. Additionally, there is no systematic pattern of innovative developments in the voluntary sector being adopted and generalised by the State, nor, the consultant points out, are voluntary organisations which provide services effectively involved in the planning and evaluation of services.

15. The Council believes that greater co-operation in the planning and delivery of services in the voluntary and statutory sectors is necessary if the complementarity between them is to be achieved. However, the Council also believes that greater accountability for the publicly funded services of voluntary organisations is essential: the Council supports the view of the National Planning Board* that in involving voluntary organisations in the planning and delivery of services, statutory funding should be on the basis of funding for particular services for periods of 3-5 years, with accountability for the level and quality of services. Voluntary organisations which obtain statutory funding should also adopt policies and provide services consistent with a community care approach. Therefore, the need to alter the pattern of care away from institutions and towards community care applies to the voluntary as well as the statutory sector. Voluntary hospitals, and voluntary organisations providing services for the elderly, the handicapped and children have traditionally provided extensive institutional services**. If an overall policy of non-institutional, community care is to be pursued fully it should incorporate the voluntary hospitals, and voluntary organisations, as well as the statutory sector.

APPROPRIATE INCENTIVES AND ELIGIBILITY STRUCTURES

16. The Council regards it as essential to the effective development of community care that the pattern of eligibility to community care services and the framework of incentives encourages the use of community based care where appropriate. The first issue which arises here is the limited and discretionary entitlement to some community services in contrast to hospital services for which there is universal entitlement***. At present, access to many Community Care services is not determined by reference to explicit, statutory provisions. The 1970 Health Act is an enabling instrument which allows Health Boards to provide various services, but the legislation is not specific about entitlement to home help services, meals on wheels, day care facilities for the elderly and other services. If, as the Council recommends, services should complement and support the care given by the family, then it is necessary to give more uniform, and much wider eligibility to those particular services which support family care. The consultant has reported, for example, that access to home helps, public health nursing and meals-on-wheels services is limited and appears to vary considerably within and between Health Boards. Consideration should be given, in the Council's view, to specifying in more precise terms, and on a broader basis than at present, the entitlement to services which can prevent the need for more expensive clinical or hospital care at a later time. It is recognised that laying down eligibility criteria in legislation could have expenditure implications as it may increase the use of services.

* National Planning Board, *op.cit.* page 314.

** A significant element of bed provision in hospitals is in the private and voluntary sectors: in 1983 there were 1,525 beds in acute private hospitals, 2,646 in Voluntary public special hospitals, and 5,412 in voluntary public general hospitals. (*Statistical Information Relevant to Health Services*, Department of Health, 1985).

*** In the 1987 Budget it was announced that charges would be applied in respect of the use of hospital out-patient services and public beds in hospitals. The charges are £10 and £10 per day respectively.

17. The need for support services (such as public health nursing, home helps and para-medical facilities) is determined by the extent of dependency of clients, severity of illness or disablement, degree of stress imposed on caring relatives, and similar factors*. These and other relevant criteria should be used in establishing eligibility. At present it appears that general "rules of thumb" determine access to services - for instance home helps appear to be available to the elderly, and social work services in Health Boards are overwhelmingly directed towards families with children.
18. Specific consideration is also required of the eligibility for social welfare schemes which offer financial support where very severely dependent persons are being cared for in the home. The Prescribed Relatives Allowance is paid to recipients of certain social welfare payments if they are being cared for in their home and if the caring relative is the only other resident (and is not a married woman). It has been argued that this payment should be made directly to the carer; the Commission on Social Welfare recommended that the PRA should be incorporated into a general social assistance scheme, which would entail independent entitlement, subject to a means test, to all persons caring for dependent persons in the home and who therefore cannot have an income. It should be pointed out that a separate allowance, Constant Attendance Allowance, payable at three rates determined by the "rate" of disablement, is available exclusively to disabled recipients of Occupational Injuries Benefit. The existence of two separate schemes of payment in respect of the home nursing/caring needs of the very dependent with differential eligibility and rates of payment should be reviewed. If care in the community for very elderly and disabled persons is to be facilitated it may require a more uniform approach.
19. There is a significant disparity between the stated aim of development of community based services and the actual structure of eligibility to medical services. The entire population is entitled, free of charge, to hospitalisation, with the exception that category III eligibility, 17% of the population, is not entitled to free in-patient access to medical consultants. About 37% of the population are in category I, the "medical card" category, which renders full entitlement to all medical services including general practitioner services. The Budget (31 March 1987) has modified this eligibility structure slightly, as charges will apply to the use of hospital outpatient services and public hospital beds; the charges will be accompanied by the introduction of a VHI insurance scheme to cover patients who will be subject to them**. It has been pointed out that effectively this pattern of eligibility entails widespread access to the most expensive, and most institutional services, and selective access to the cheaper, community-based primary system (General Practice)***.
20. Insurance arrangements for health care do not in general include the specific services which are required to encourage community care. Health care choices by patients are determined to some extent by eligibility for services and by the relative

* It has been pointed out that: "Variations in need are often the result of the severity rather than the type of condition" (Alan Walker, *The meaning and Social Division of Community Care*, in Walker (ed), *op.cit.*, page 20).

** Certain categories of persons will be exempt from these charges - notably medical card holders and their dependants, children up to six weeks of age, children suffering from prescribed diseases, children referred from child health clinics and school health examinations.

*** A Dale Tussing, *Irish Medical Care Resources, An Economic Analysis*, ESR1 Paper 126, 1985.

costs of different forms of care. For example, if a patient is entitled to subsidised in-patient hospital care but is not eligible for free or subsidised or insured home based care, such as nursing support, home visits by GP's, home helps and so on, then the patient is more likely to choose hospital care. The resource costs of hospital care are greater than non-hospital care. These related points regarding the pattern of eligibility to health services and the insurance arrangements have been recognised by the Department of Health in its recent Consultative Document: "it is reasonable that the incentive structure under the eligibility system should encourage consumption of health care compatible with the policy direction adopted. There is an inherent bias towards hospital care in the existing eligibility code particularly in its interaction with Voluntary Health Insurance"*

21. A related issue is the remuneration and incentives systems which impinge on the suppliers of medical care. Health care choices are affected not only by patients, who face particular eligibility patterns and insurance arrangements, but also by the providers of medical care. The latter do not themselves bear the cost of decisions to refer patients to hospital for in-patient care. Specialists and consultants who refer patients to hospital will be influenced by the eligibility of patients for free hospital care or by the fact that patients have Voluntary Health coverage. This pattern of eligibility and insurance and financial arrangements may lead to an excessive and uneconomic use of hospital care. If the decisions of health care consumers and providers are to become more consistent with a community care approach it may require, in the view of the Council:

- changes in the eligibility system to publicly provided community-based health care.
- changes in the range of health care amenities for which health insurance is provided.
- development of more appropriate remuneration, budgetary and incentives systems for providers.

22. In the view of the Council the eligibility to health services and the remuneration systems of medical care suppliers must be jointly considered. It has been argued above that it is necessary to alter eligibility so that people have wider eligibility to community based services such as G.Ps. However, an extension of entitlement to the free GP schemes (GMS, choice of doctor scheme), for instance, would not be appropriate under the existing fee-per-item of service remuneration system for GMS doctors. Research evidence suggests that under the present remuneration system for doctors under the GMS scheme, the providers (GPs) may encourage utilisation of the scheme as their income is affected by the number of items of service**. This in effect means that the total cost of the GMS scheme is difficult to control. Any extensions of eligibility to the GMS scheme to encourage the use of primary care rather than hospital care must also incorporate a different form of remuneration for GPs. The Department of Health has acknowledged this; "it would be difficult to contemplate a comprehensive general practitioner service operating on the basis of a fee-per-item of service, given the experience to date with the cost of the General Medical Service choice of doctor scheme"***.

* Department of Health, *Health - The Wider Dimensions* (A Consultative Statement on Health Policy), 1986, page 31.

** A Dale Tussing, *Physician Induced Demand for Medical Care: Irish General Practitioners*, *Economic and Social Review* vol. 14, 3, 1983.

*** Department of Health, *op. cit.* page 32.

Extensions to eligibility for GMS services would need to be considered in the context of eligibility for hospital services. If the objective is to ensure greater use of primary care, a diminished use of hospital care and greater economy in health services overall, then extend access to the GMS would need to be co-ordinated with specific steps to reduce hospital admissions (such as more rigorous admissions criteria, or appropriate use of hospital charges).

23. The issue of budgetary and financial arrangements applies also to para-medical personnel, and social care workers such as social workers and public health nurses. These groups are involved, for instance, in decisions about the care to be received by the elderly, the disabled, children and the handicapped - whether home based care, hospital admission or long-stay institutional care. There have been a number of apparently successful attempts to alter the financial arrangements so that more appropriate and economic social care services are provided. For instance, in one experiment, involving clients with a high probability of admission to institutional care, social workers were given resources to promote community care and did so successfully. The social workers were allocated a budget to ensure that clients remained as long as was practically possible in their own homes. On the whole the caseworkers involved appear to have been successful in reducing reliance on institutional care, in improving the quality of care, and in providing a more economic mix of health and social care •
24. The Council is not recommending that the procedures of this particular project be adopted, but it is clear from this illustration and from the experience and research elsewhere, that it is possible to alter the present arrangements by shifting responsibility for budgets towards case workers in such a way that community care is favoured in terms of money spent, services delivered and clients' welfare. Clearly, such ideas need careful implementation and evaluation on a pilot basis to see what budget constraints should be set, how services used should be charged for, and how the security and welfare of the person being cared for is to be monitored.

MODELS OF SERVICE PROVISION

25. It is essential, in the view of the Council, that specific, practical models of community care be developed for the needs of particular health care clients. Such models can be developed on the basis of existing experience in Ireland and elsewhere, combined with an experimental approach to innovative schemes. To consider how such models of care can be developed the first step is to distinguish between broad categories of client and care settings, as illustrated in Figure (i)**.
26. Figure 1 indicates that a distinction needs to be drawn firstly between the needs of different client groups — children, the elderly and so on — and, secondly, between the various 'settings' in which community-based care may take place. Care services may apply to persons living alone, to persons who live with their families, or to persons in 'alternative' families such as adoptive or foster families. By approaching the problem in these terms, it is possible to identify more specifically the needs which arise in particular circumstances and the types of community care 'solutions' for these situations. It is clear from Fig. (i) that

* See D J Challis and B P Davies, *Matching Resources to needs in Long Term Care*, University of Kent, Personal Social Services Research Unit, 1985.

** See R Gilligan, *New Possibilities in Health and Social Care*, in *Future Directions in Health Policy*, Council for Social Welfare, 1984, pages 53-76.

sufficient practical experience and research now exists to translate the concept of community care into specific, workable models of service provision.

27. This point can be illustrated with examples. The first example is of a local scheme based on voluntary services, which provides a service to complement and sustain family care — the pilot Care Attendant Scheme initiated by the Irish Wheelchair Association. Entailed in the scheme is the deployment of trained volunteers who offer to relieve the families of disabled persons at times of crisis, illness, or holidays, and to do so at short notice, and at unsocial hours. This pilot scheme, to which the consultant referred, showed the potential of a planned use of trained volunteers in providing flexible, practical support to families caring for relatives -

Figure (i):
Examples of Services

Type of Client	Community Care Setting			
	Living Alone	Living with Family	Alternative Family	Group Homes, etc
Mentally ill	Supportive Group Work			
Mentally Handicapped		IWA Care Attendant Scheme		Residential Hostels
Disabled				
Elderly	Home Helps, Public Health Nursing		Boarding Out Schemes For The Elderly	-----
Children	-----	Neighbourhood Youth Projects	Foster homes Adoption	-----

in this case for severely disabled persons, but the scheme may be a proto-type of a more general service: "it is an important example of the type of supplementary support and new type of service which we should be considering when we talk of community care. Most exciting, however, is its potential, for it could be extended not simply to other areas but to other groups" •

28. A second example given in the chart refers to Neighbourhood Youth Projects. These schemes arose out of the recommendations of the Task Force Report of Child Care and a pilot scheme of three such projects was initiated incorporating an action-research evaluation of one project. The evaluation research on this scheme has not been published. If the research suggests that these schemes have the potential to provide effective community-based care as an alternative to social work with individual children, or institutional care for children, then projects such as these might be established on a wider scale as part of the Community Care provisions for children.

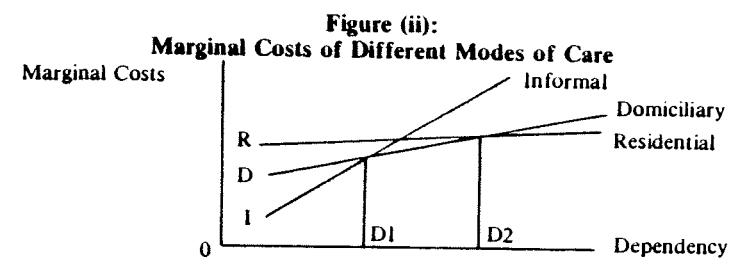
• Pauline Faughnan, *Independent Living for Physically Disabled People*, in Council for Social Welfare, *Future Directions in Health Policy*, 1984, Page 154.

29. Thirdly, in a number of Health Board regions, 'boarding-out' schemes for the elderly have been attempted successfully. In these schemes elderly persons were placed with families and resided with, and were cared for, by families. Some of the clients would otherwise have been hospitalised. The evaluation of this scheme by the National Council for the Aged indicates that these schemes offer potential to provide care in communities and families for the elderly. A set of guidelines regarding selection, placement, quality of care and other issues would be required to develop these schemes as a routine part of community care services*. In relation to the elderly and the handicapped a wide variety of innovative 'group living' and 'group home' schemes now exist; British schemes, for instance, support, through home helps and social work, group homes for mentally handicapped adults, and in Ireland such schemes have been initiated for the elderly and the mentally handicapped. It is necessary, in the view of the Council, to plan, administer and evaluate services in a framework which distinguishes different client groups and different care settings.
30. A number of points should be borne in mind in developing particular types of services. Firstly, the clientele for community based services are necessarily restricted to their localities — because of infirmity, disability, low income or other factors and services must be localised and accessible. This in turn suggests that maximum use be made of immediate support systems in neighbourhoods and communities. In some UK schemes, for instance, local residents and neighbours are deployed as wardens for the elderly in particular streets and areas. Secondly, a continual process of evaluation and adaptation is required if appropriate, effective services are to be developed. This is especially the case in community care because many of the needs are personal: for instance families who are caring for handicapped children or adults can give essential feedback on the effectiveness of particular services which impinge on their situations. An essential element of evaluation, therefore, is consumer experience and opinion. Finally, in view of the rising participation rate of married women in the labour force consideration will have to be given in the future to the link between employment obligations and the need to sustain family care. The organisation of work may require some flexibility to allow people in the workforce to combine work with caring for elderly or dependent relatives.
31. The consultant has identified, in the analysis of services for the elderly, that effective geriatric assessment schemes are now in operation in some parts of the country. Such schemes ensure that any admissions of elderly to hospital are necessary, and are based on a multi-disciplinary assessment of the patient's medical, housing, financial, familial and social circumstances. The assessment procedure can act as a vehicle for ensuring the appropriate duration of hospital stay and the effective liaison with the patient, the family, and other local services, when the patient leaves hospital. The consultant has recommended that each community care Health Board area should have a Geriatric Assessment Unit: the Council does not make specific recommendations as to the exact deployment of such units but recommends that, on a scale appropriate to local conditions and needs, such units should be a central part of each Health Board's community care services for the elderly.

* National Council for the Aged, *Home from Home, Report on Boarding Out Schemes for Older People in Ireland*, Dublin 1985.

ORGANISATION AND MANGEMENT

32. The consultant's account of the community care programme which indicates significant deficiencies in organisation and management is consistent with the management consultants' report of 1982 — preceding her research — and with the later criticisms of the programme by some of the professional groups involved in the services*. It appears that there is an absence of basic information and planning, appropriate management and training, and adequate organisation. These deficiencies contribute to the very wide variations in the level of services throughout the country identified by the consultant. In the paragraphs following these issues are discussed separately.
- (1) Information
33. The consultant's research was limited considerably by the dearth of basic data on client groups, services provided, and their costs, and services utilised, at local, regional, and national level. Only one Health Board was identified by the consultant as having an information system (the Community Care Information System in the North Western Health Board) which facilitated monitoring and planning of services. The Council regards it as essential that an information and data base be developed for community care services in all regions.
34. A specific, and vital, dimension to the information needs of community care, is information on the relative costs of different forms of care. It is popularly argued that community care is 'cheaper' or that in the 'long run' it is 'better value', yet no detailed, specific analyses have been undertaken of the costs of care for different client groups and care settings. The figure below illustrates this point in relation to the costs of different forms of care for clients with different levels of dependency.
35. As Figure (ii) illustrates, the costs of care cannot be simply generalised as being 'cheaper' under one mode of care. Economic analysis of cost functions in social



Source: Martin Knapp, *The Economics of Social Care*, page 145.

care suggests that for clients with low levels of dependency marginal costs of care are lower when care is informal i.e. within the family (0-D₁ on the horizontal axis of the figure); conversely, when dependency is very high because of the age or illness of the client, for example, then marginal costs may be lowest in residential

* Inbucon Management Consultants, *Community Care Review Report*, Dublin, 1982 (unpublished); Campaign for Development of Social Services, *Social Services in Crisis*, Dublin, 1986.

care (to the right of D₂ on the horizontal axis) * . A similar figure could be drawn in respect of the marginal *benefits* of care and the intersections of the benefits and costs functions used as a guide to the most economic mode of care. The important points are that (a) 'community' care and 'residential' care are not categorically different in respect of costs — a continuum of modes of care exists and (b) a range of factors determine the actual costs of care in specific circumstances; for example, the characteristics of clients, their degree of need, the capital — labour mix in services, levels of skill among service providers.

36. The analysis of costs must be based on comprehensive definitions of costs and distinguish between budgetary or expenditure costs on the one hand, and opportunity costs on the other. Further, when costs are properly defined and measured the distribution of costs entailed in any mode of care, or mix of services, should be identified. For example, although the costs of care provided informally by the family may be significant, these costs may not be borne by the State. Policy questions arise, therefore, not only about the amounts of costs/benefits attributable to modes of care but also about who should bear these costs.
37. The Council recognises that such information and analyses are difficult to collate but, in the Council's view, they are essential to the planning of cost-effective modes of care. Such analyses should proceed in parallel with the development of models of service provision discussed earlier. It should also be recognised that the development of cost-effective modes of care as alternatives to institutional care, requires careful planning and implementation over a period of time.
38. In relation to the relative costs of community care and institutional care, the Council considers that problems may be encountered in making the long transition to a more community-based health service from a largely institutional service. In particular, the financial problem of simultaneously developing community-based services and scaling down institutional services is difficult to resolve. It may be necessary in the short term for additional resources to be made available, in particular instances, to begin the development of alternative, non institutional services.
39. The National Council for the Aged has shown, for example, that the weekly costs of long stay admission for elderly patients in 1982 (£210 weekly in one Dublin hospital, £125 weekly in a hospital in the Western region) were far in excess of the weekly cost of visits to day centres (£18.50 and £14.50 per visit respectively)** . This comparison indicates that the use of Day Centres by the elderly living in the community is significantly less costly than long term hospitalisation, but the comparison requires a number of qualifications:
 - (a) capital expenditure on sites, buildings and equipment may be required to initiate Day Centre services — unless existing hospital facilities can be adapted to meet the full requirements of the alternative care services.
 - (b) a phased transfer from hospital care to the alternative services would, presumably, be necessary and thus two sets of services would be required for a period of time.

* Martin Knapp. *The Economics of Social Care*, Macmillan, 1984 Chapters 8, 9, 10. Figure (1) is hypothetical although it is based on findings about costs of care, as discussed by Knapp.

** National Council for the Aged, Report No. 1, *Day Hospital Care*, Dublin, 1982.

- (c) because of the economies of scale in the provision of long stay hospital services, significant reductions in the cost of hospital services might only arise when large scale transfers out of hospitals take place, thus allowing economies through (for example) the closure of wards or buildings.

This analysis applies generally to comparisons between costs of institutional and community care.

40. In the view of the Council, additional resources for particular community care developments should only be made available where the resources are used to provide services which will reduce institutional services, and where the savings to be made from reduced institutional services are identified and quantified. Such savings may arise in the medium term and long term, while the provision of alternative services is often immediately necessary. The Council recommends that Health Boards and the Department of Health should undertake detailed planning in relation to the costs of community care services, and the phasing in of these services.

(2) Management and Training

41. The consultant's research indicates deficiencies in management and training which were also outlined in detail in the Inbucon report * . In essence the conclusion to be drawn from these studies of the community care programme is that the intended multi-disciplinary, teamwork approach at area level has not been implemented. The development of this approach will require, as proposed in the Inbucon Report, the initiation of specific training programmes for all of the groups and professions involved in the Community Care structure. Additionally, a professional management ethos is apparently absent in the overall management of the services and in the operation of the sub-programmes within community care. At the regional and area levels, and at the level of individual teams (of social workers, public health nurses etc), it is essential that services are routinely managed on the basis of prior specification of resources, statements of objectives and priorities, collation of adequate information, and monitoring and evaluation of performance. This methodology will in turn require proper, multi-disciplinary planning, sufficient professional autonomy and responsibility for all of the disciplines, and accountability by all of the professions for the attainment of objectives and targets, and the expenditure of resources.

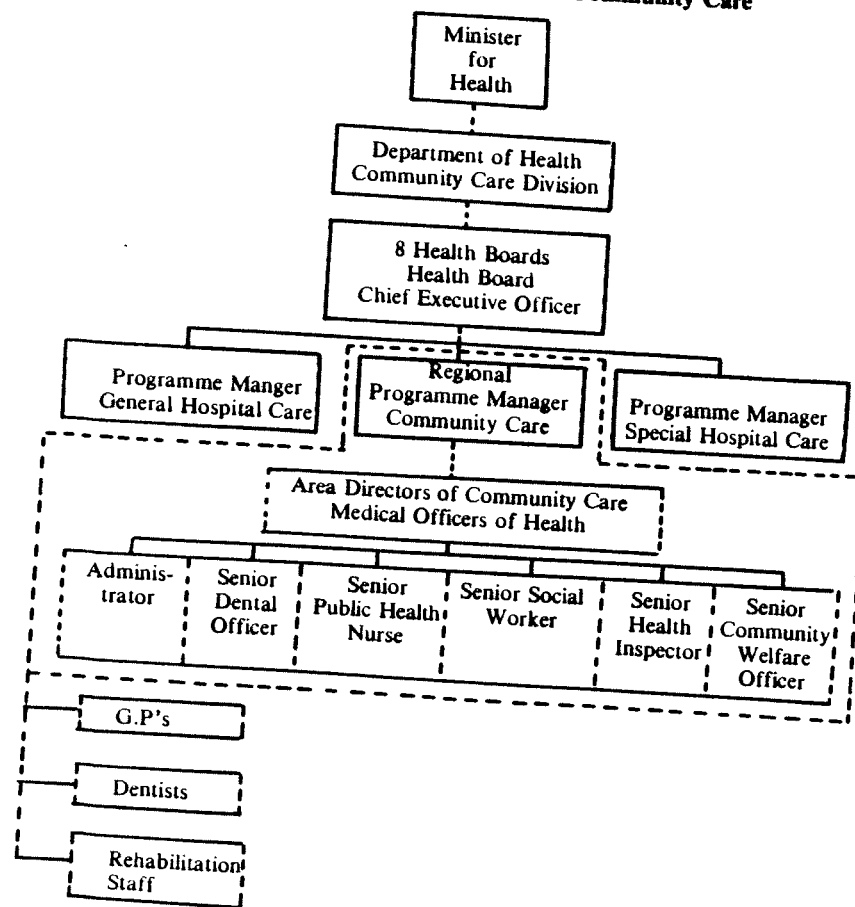
(3) Organisational Issues

42. On a macro scale, at least four main organisations are involved in providing community-based services, namely Health Boards (Community Care Programme), Local Authorities (local authority housing), Voluntary Bodies (a range of services) and the Department for Social Welfare (income support to the aged, the ill, and caring relatives). The consultant's study was confined to the Community Care Programme of the Health Boards. Figure (iii) summarises the administrative structure of the Community Care Programme. The programme consists of a range of services provided by different groups: Public Health Nurses, Community Welfare Officers, Dentists, Medical Officers, Rehabilitation personnel, and Social and Community Workers. General practitioners, both those working under the GMS and those working independently, provide an

* Inbucon Management Consultants, *op.cit.*

element of community-based care, but are not members of the Community Care Programme's team and were not included in the consultant's study. Similarly, although dentists and rehabilitation staff provide community-based services, they are not part of the formal Community Care structure at local level. The diffuse nature and organisation of the Health Board Community Care Programme, let alone community care in general, clearly poses formidable management problems. A number of organisational issues require resolution and these may be considered under two sub-headings.

Figure (iii):
The Administrative Structure of Community Care



Units between the broken line are part of the local administrative structure of Community Care.

(i) Organisational Structure

43. At present, Regional Health Board Programmes are classified into General Hospital, Special Hospital, and Community Care programmes. As Figure(iii) shows, the latter in turn are subdivided in each region into areas — usually counties — each of which has an area Director of Community Care, to whom, in turn, the senior professionals of each specialist service report (Fig. iii). The consultant has proposed that the organisational structure should be based on client groups (the elderly, children, handicapped, and so on); in its consultative document the Department of Health envisages that "health service management at local level should move from a programme to a geographic basis to encourage a more integrated and coherent approach to local planning and decision making"

44. The Council would argue that any *one* dimensional organisational structure based solely on areas, on programmes, or client groups is likely to be inadequate. The consultant's analysis shows clearly that community care services - relative to other areas of the Health services - are underdeveloped, and any consideration of organisational structures must reflect this. If Community Care services are to develop, then the organisational and administrative structure for Community Care and for the Health services overall must facilitate:

- (i) the planning at national level, and the delivery at local level of specific, *workable models of care for different client groups*;
- (ii) the attainment of a *uniform level and quality of Community Care services throughout the country*;
- (iii) the achievement of the necessary *resource allocation* away from other programmes and towards Community Care.

At local level the structure for the planning and delivery of services should facilitate full co-operation between the various voluntary and public service agencies involved. In the development of new structures, existing demarcation lines between functions of public services agencies and between professional staff should not be regarded as immutable.

45. In the view of the Council, therefore, more centralised planning and management will be necessary in a number of ways. Firstly, in the area of resource re-allocation some central mechanism is required which will ensure that health care resources are redirected towards Community Care. At present the system of resource allocation between programmes and between regions appears to be ad hoc; the Department of Health has acknowledged for instance that "the current system for allocating resources on a geographic basis owes more to history than to any scientific methodology"^{**}, and the discussion of budgetary procedure in the ESRI study on medical care resources concluded: "How budget decisions are made is obscure, and so necessarily is the degree of efficiency or rationality of the resulting mix of services"^{***}. Resources cannot be reallocated, in the view of the Council, unless specific instruments are devised at national level to translate the

* Department of Health, *op. cit.*, page 71.

** Department of Health, *op. cit.*, page 80.

*** Tussing, *op. cit.* 1985 page 139.

rhetoric of community care into reality. The Council believes that the stated commitment to community care and the reallocation of resources which this requires should be expressed by the Department of Health as specific, quantified targets; for example, that the percentage distribution of health expenditure between community care and other programmes should be of a specific magnitude by a particular date. If, at present, the Department of Health does not have the powers to articulate such targets and to implement them in conjunction with the Health Boards, then it should take steps to acquire them. In the absence of such reforms it is difficult to see how resource reallocation can be effected or even how progress in this regard can be monitored.

46. It is recognised that reallocation of resources is more difficult in a context of resource constraints, and that this constraint may be compounded by opposition to change from professional and occupational interests. However, one cause of this opposition may lie in the absence of adequate, alternative community-based services. Thus, reallocation of resources and services from institutional to community care may require the prior development of accessible community services.
47. Secondly, the attainment of more uniform levels and quality of services may also necessitate more centralised direction initially. The Council notes the analysis in the consultant's report which shows very significant variations between regions, and between areas within regions. In a health service which is overwhelmingly funded by the Central Exchequer such variation is unacceptable; the variation effectively means that two people with identical needs in different parts of the country will have access to different services. One source of this variation is the absence of national eligibility criteria in relation to services such as home help, meals on wheels, day care services and public health nursing, and the consequent reliance on ad hoc rules. The Council considers that there is merit in specifying the entitlements to Community Care services, or developing guidelines to be applied uniformly in all Health Boards as in the case of GMS eligibility. If this were done it would require at national and local level specific assessment regarding need for services, and specific decisions in relation to the resources required to provide services to the eligible population.
48. Thirdly, as discussed in paragraphs 29-35 above, sufficient examples of Community Care services for the various client groups and care settings are now available. However, there does not appear to be any centralised policy of selecting appropriate modes of care for specific needs and clients, and then ensuring the establishment of these services on a general basis throughout Health Board regions. This failure, at national level, to establish viable community-based modes of care not only results in the regional variations in services referred to above, but also sustains opposition to de-institutionalisation (of the mentally ill, handicapped and so on) because of the absence of alternative community based services.
49. The above paragraphs argue for greater central direction in relation to overall policy. However, the delivery and administration of health services, and of community care services in particular, should be at a local level. Comments on the functioning of area teams were made in paragraph 41 above.
50. A specific aspect of the community care organisational structure concerns the role of G.P's. The consultant's remit did not include the GP services under the GMS, or the non GMS general practitioners. However, the Council notes that G.P's have a pivotal role in the functioning and organisation of community care because of their 'gatekeeper' function. Patients generally approach a GP first when they

are ill, and the GP makes the initial decision on the nature of the care. Clearly, the scope for community care will be significantly enhanced where there is co-ordination between GPs and other community care personnel, and where the eligibility and incentive structures facilitate appropriate choices of care. It is striking however that GPs work largely independently of community care personnel such as nurses and social workers. The Council regards it as essential that the relationship between GPs and the community care programme be developed: detailed proposals in this area are incorporated in the GMS review and in the discussion document of the Irish College of General Practitioners **. These analyses offer a basis on which the system of general practice can be strengthened and co-ordinated within the general structure of health services.

51. The main recommendations of the GMS review report regarding community care — GP co-ordination are:
- emphasis in health policy on primary care with the G.P. as the key figure in the provision of appropriate health care in each community, working with other community based staff to stimulate self help and community participation in health care;
 - promotion of effective liaison between G.P's and public health nursing staff, preferably through attachment of public health nurses to general practices, including a number of experimental schemes;
 - local monitoring and encouragement to G.P's to improve and develop their practices, improvements to include better training, group practice;
 - branches of the Irish Medical Organisation based on community care areas should be consulted regularly by the Programme manager and his staff in preparing local services, and the Chairman should be in regular contact with the Director of Community Care and his team on matters of concern to both general practitioners and the Health Board;
 - each health board should prepare, in consultation with general practitioners and other professions, a planned approach to the development of primary care services in their region, which would specify objectives to be met and specify the tasks to be performed by different groups and professions, while outlining the steps to be taken by each of the parties in order to achieve these targets;
 - a National Review Body should be established which would meet on a continuing basis at regular intervals to review progress towards the achievement of the overall objectives for general practice which are outlined in the Report.
52. The Council accepts that these recommendations, the thrust of which are consistent with the views of the Irish College of General Practitioner's document, could do much to improve and develop the organisation of community care. However, the Council would not support the re-organisation of community care around the G.P's, both because of the medical orientation implied, and also

* Report of the Working Party on the General Medical Service, Department of Health, 1984.

** The Irish College of General Practitioners, *The Future Organisation of General Practice in Ireland: A Discussion Document*, Dublin, 1986.

because G.P.s in the GMS scheme are contracted by the General Medical Services on a part time basis, with the remainder of their work being performed on a self-employed basis. This point was recognised by the Department of Health in its recent statement on health policy: "The position of G.P.s as independent contractors, largely isolated from the other community services, poses a problem in terms of service integration and, allied to weaknesses in some of these other services, probably leads to a medicalisation of some problems *" It is clear that if general practice is to play a role in the development of community care and if, in the future, primary health care is to be regarded as "the central component of the health care system,"** then decisions are urgently required on its structure, financing and organisation.

(ii) *Organisational Problems*

53. The consultant's report adverts to difficulties which have inhibited the proper functioning of the community care teams (see Figure (iii)). Firstly, there has been considerable contention over the Director of Community Care post (the DCC's are responsible within Health Board areas, usually counties, for the management of community care in one area, with the Seniors of the various professions reporting to him/her, i.e. Senior Public Health Nurse, Senior Social Worker, Senior Community Welfare Officer and so on). This post has been the exclusive domain of doctors; other professions in the community care programme cannot become directors. The medicalisation of this post may have contributed to the uneven development of effective multi-disciplinary community care teams. The consultant did not examine this specific issue. However, the Council is of the view that it is difficult in principle to justify the exclusion of non-medical personnel from the management of community care services. The managers of community care should have a broad knowledge base and have planning, analytical and organisational skills.
54. Secondly, the workload of Community Welfare Officers (CWOs), who operate the provisions of the Supplementary Welfare Allowances Act (1975) and determine eligibility for means tested health services, is considerably determined by delays and inadequacies in the structure and administration of social welfare payments***. The Council regard it as inappropriate that a segment of the community care personnel are preoccupied with issues more appropriately dealt with by the Department of Social Welfare. In this regard the Council endorses the recommendations of the Commission on Social Welfare**** that (i) the Supplementary Welfare Allowance scheme be subsumed within a reformed Social Assistance scheme and that (ii) the administration of Social Welfare schemes be decentralised and integrated at a more local level. It is accepted that if these proposals are implemented some arrangements will be necessary to ensure the continuation of the non-income maintenance aspect of the CWOs work in the community care team (largely means-testing for health services).

* Department of Health - *op.cit.* page 59.

** *Ibid.*, page 56.

*** CWO's and Superintendent CWOs have, since 1977, refused to formally report to Directors of Community Care in their areas in protest at the medical doctors' monopoly of DCC posts. As a result these personnel do not all participate in the local community care structure and report directly to the Regional Programme Manager of Community Care.

**** *Report of the Commission on Social Welfare*, Government Publications, Stationery Office, Dublin, 1986, chapters 19 and 20.

55. Finally, there is evidence of other organisational difficulties; dentists are not co-ordinated with the community care team; rehabilitation personnel (physiotherapists and occupational therapists) are largely hospital based; social/community work services in voluntary and Health Board sectors are not adequately co-ordinated in all areas.

SUMMARY AND CONCLUSIONS

56. The Council has proposed four general sets of considerations which should govern the development of community care:
- (i) **Complementarity:** A basic strategy in the development of community care should be the support of care given informally in the family and the community. This will require more specific and standardised eligibility to services such as home helps, public health nursing, and medical appliances; in addition consideration should be given to extending the provision of income maintenance services in respect of care given in the home to the handicapped, disabled and the elderly.
 - (ii) **Eligibility and Incentive Structures:** The consumers and suppliers of medical care should function in an eligibility and incentives framework which allows, and encourages, the choice of community based care. To this end the range of services for which insurance coverage may be obtained should be extended to include primary care and community care; the eligibility for free general practitioner services could be widened and combined with a simultaneous control on the access to hospital care and reform of the remuneration system for GPs; the remuneration systems of medical care suppliers should reward the use of cheaper, primary care and discourage the inappropriate use of hospital care.
 - (iii) **Models of Service Provision:** The planning of community care now requires more detailed specification of specific services for client groups. In relation to the elderly, children, physically disabled and mentally handicapped, there are proto-types of schemes and services which are practical ways of implementing the concept of community care.
 - (iv) **Organisation and Management:** Significant organisational changes are required in a number of areas. Basic data on clients, services and activities must be collated and used; in particular studies and analysis must be undertaken of the specific costs and benefits of various modes of care to identify services which are actually more economic than traditional, institutional care. Two key issues affect the organisational framework — the actual management structure, and the integration of GP's into the wider community care network. In the former case greater central direction is required in relation to resource allocation, eligibility for services and development of services. In the latter, decisions are now required on the basis of the general thrust of recent reports. Additionally, the community care teams in Health Boards would benefit by the reform of the community welfare service as envisaged by the Commission on Social Welfare, greater voluntary/statutory co-ordination among social/community workers, and greater community-based (as distinct from hospital-based) use of rehabilitation personnel.
57. The Council regards these four elements as essential, inter related elements of a strategy for community care. Adoption of any one element, or only some

elements, will be insufficient.

58. The consultant made thirteen specific recommendations and of these:

- six involve reviews of current service provision,
 - of pre-school and school services,
 - of the school psychological service,
 - of services for elderly people by community care area,
 - of the relevance of diagnostic, assessment and rehabilitation units for the elderly
 - of the services for the handicapped, and
 - of the relations between voluntary and statutory bodies).
- three involve setting service guidelines:
(for services for the elderly, the handicapped and children).
- two involve planning:
(resource implications of community care, and for development of personal social services).
- two involve establishing new units:
(a community care information system in each Health Board, and a community care based Geriatric Assessment unit for each area).

59. The consultant's recommendations entail reviews of current services provision, establishment of service guidelines and greater planning and information — gathering. Their general thrust is supported by Council and would be implemented as a matter of course if the overall strategy proposed by Council were adopted.

60. The Council does not attempt to quantify the cost implications of the consultant's recommendations (which are probably negligible) or of the general strategy it has outlined. Clearly, the cost implications of the development of community care can only be clarified as part of the development of service models and cost/benefit analysis which the Council has recommended as part of the wider strategy. In the current state of the public finances the Council cannot at present recommend additional public expenditure on health services. The total budget allocation for the health services in 1987 is £1,230 millions: approximately 54% of this budget is devoted to general hospital services * . Additional resources for community care will require reallocation of resources from the hospitals sector.

* The Sources for the budget figures and the programme allocation respectively are taken from the Budget Booklet, Budget 1987, Stationery Office, 1987 and *Comprehensive Public Expenditure Programmes 1986*, Stationery Office, 1986.

PART II

COMMUNITY CARE SERVICES :

AN OVERVIEW

by

Sile O'Connor

INTRODUCTION

The terms of reference for this report are as follows:

To provide an overview of the Community Care Programme, *excluding the GMS and Drugs Supply and Refund Schemes*, by examining the objectives and expenditure on programmes, the implementation of services on the ground and gaps in their provision.

To this end, the focus of the study is service oriented, rather than organisational, though organisational problems are repeatedly identified as having negative effects on service planning and delivery.

Scope of the Study

The Regional Health Boards are subdivided into three programmes - Community Care, Special Hospital Care and General Hospital Care (see Figure 1). In this study the range of community care services for children, elderly people and handicapped persons are discussed. These are the three target groups for whom the Health Boards, under the Community Care Programme, provide services. The Community Care Programme does not cover all community based health and social services; specifically it does not include community based psychiatric services, or some community based mental handicap services, which come under the aegis of the Special Hospitals or General Hospitals programmes depending on the Health Board concerned. Despite this the range of services provided under the Community Care Programme is broad.

The concept of "Community Care" implied in the Community Care Programme context covers a considerably broader range of services than what is generally identified as community care in the social policy literature. In this literature community care services often refer only to personal social services provided in or by the community. The broader focus has considerable merit in that it implicitly acknowledges that decisions relating to primary health care services, to personal social services and to cash support services are inter-related.

The limitation of the study to those services provided at present is not meant to suggest that the focus of the Community Care Programme is or could ever be comprehensive in terms of the provision of community services. Those services provided under the Community Care Programme are only one element of the total range of services necessary if community care is to be effective. "Community Care" in this sense refers not only to community based health and social services but also to the provision of support services to dependent people at a level that will allow them to live a life as near as possible to that which is perceived to be normal for other members of society. This level of community care is dependent on co-operation not only in the provision of the whole range of health services, both residential and community-based, but is also dependent on co-operation between health and other services notably housing, income maintenance and transport.

The interdependence between services is important for each of the target groups who are the concern of this report - children, the handicapped and the elderly. However, the interdependence is even more evident in the case of certain minority groups, notable travelling people and the homeless. The Report of the Travelling People Review Body (1983) points out that a great deal of ill-health among travellers is associated with overcrowded caravans and insanitary conditions. While community-based health services

COMMUNITY CARE — GENERAL ISSUES

are essential to meet these needs, an effective preventive orientation is dependent primarily on housing and environmental policies and services. Apart from homeless single persons, another group with significant housing problems, which adversely effect health and welfare, are the victims of family violence, family breakdown and marital desertion. Emergency accommodation for these groups is extremely limited. It may be argued that the emergency accommodation needs of these groups should be the responsibility of housing authorities.

However, this responsibility is not accepted at present and neither do Health Boards have a statutory responsibility in this regard. Thus, despite the wide spectrum of services covered under the present community care programme, the range of community service needs of some groups is not met. A study of these needs would necessitate a considerably broader focus than the present community care programme. Such a study should consider the impact of other services on health and welfare in the community and it should identify the extent to which a *community care perspective* permeates other social policies, notably housing, transport and income maintenance.

The present report is aimed at delineating the more limited issues associated with the services currently provided under the Community Care Programme for the elderly, the handicapped and children.

The report contains six chapters as follows:

In Chapter One, "*Community Care - General Issues*", the development of community care in Ireland since 1970 is outlined, including conceptual issues related to the term community care, issues related to statutory-voluntary relations and resource and service issues.

In Chapter Two, "*Health Expenditure and Employment Trends*", changes in expenditure on the Community Care Programme since the mid 70's are outlined, with reference to expenditure on other health programmes. Employment patterns in the health boards are discussed as are service-related employment issues.

In Chapter Three, "*Services for Children*", are considered under two broad headings: Child Health Services and Personal Social Services for Children and Families. The former covers pre-school and school services. In the second part of the chapter, the following personal social services are discussed: Social Work Services, Domiciliary Support Services, Day Services, Community Projects, Adoption, Fostering and Residential Care.

In Chapter Four, "*Services for Elderly People*" are considered. Demographic and social factors are outlined in the first section. In the second, the range of services available are discussed under four headings: Domiciliary Services, Day Services, Accommodation and Assessment Services.

In Chapter Five, "*Services for Handicapped People*" are discussed with reference to changes since the 1980 NESC Report, *Major Issues in Planning Services for Mentally and Physically Handicapped People*, and with reference to the 1984 Green Paper on Disabled People.

Finally in Chapter 6, A Summary, Conclusions and Recommendations based on analysis in the previous chapters are presented.

1. INTRODUCTION

"Community Care" is a very widely used but rarely defined concept; furthermore, the differing policy implications associated with different definitions are rarely spelt out. The present framework of community care services in Ireland is based on the 1970 Health Act and associated documents. The 1966 White Paper on *The Health Services and their Future Development* and three Reports published during the 1960s on psychiatric services, mental handicap services and services for the elderly provide the background within which the Act was formulated (1). This discussion will focus on the original objectives of community care as reflected in the 1970 legislation and these documents. These objectives and the associated policy implications will be considered with reference to the contemporary debate on community care in health and social services literature.

This chapter is divided into four sections as follows:

- (I) The Development and Scope of Community Care in Ireland.
- (II) Community Care — Conceptual Issues and Assumptions.
- (III) The relationship between statutory and voluntary organisations.
- (IV) Resource and Service Issues

2. DEVELOPMENT AND SCOPE OF COMMUNITY CARE IN IRELAND

From an organisational point of view Community Care in Ireland includes those services which are co-ordinated by Programmatic Managers for Community Care at Health Board level and by Director of Community Care at the local level. In this sense the present community care structure dates from 1971 when the report of McKinsey and Company on the management structure of the health boards was adopted (2). This report recommended that the work of the boards be divided into three programmes related to the main groups of services, Community Care Services, General Hospital Services and Special Hospital Services, rather than to target groups. It was recognised that the latter might be better for analytic purposes but it was considered inefficient for management purposes since it would entail each senior officer dealing with the whole range of services. The present arrangement of services means that not all community services are included under the Community Care Programme, notably community based psychiatric services are part of the Special or General Hospitals Programme. In addition, many community based mental handicap services are part of the Special Hospitals Programme.

The objectives of the Community Care Programme were identified as follows:

- (i) To enable all members of the community to enjoy a high level of personal

health in a healthy environment.

- (ii) To pay for those health and welfare services that are required for those who cannot themselves afford them.

The structure proposed implied a commitment to plan and deliver services on a multi-disciplinary basis at the local level with a Director of Community Care as a co-ordinator. The rationale for this was a 'client centred' approach as opposed to a fragmented approach. It was considered vital that health and welfare services should operate in a single, integrated service at the local level and it was envisaged that a typical team would include area medical officers, public health nurses, dentists, health inspectors, social workers. The role of the Director of Community Care would be to assess the needs of the community care area, to identify major needs and to compile a plan in consultation with the heads of each service group.

The Community Care Programme covers a wide range of services which are organised into three sub-programmes:

- (i) *The Community Protection Sub-Programme* covers prevention of infectious disease, child health examinations, immunization, drug controls, health education and other preventive services.
- (ii) *The Community Health Services Sub-Programme* covers general practitioner services, including drug supply and refund schemes, home nursing services, dental, ophthalmic and aural services. These services can be classified as primary health care services and include services by general practitioners, public health nurses, dentists, ophthalmologists.
- (iii) *The Community Welfare Sub-Programme* covers cash payments, grants to voluntary welfare agencies and personal social services. Cash payments include those to disabled persons and to persons with certain infectious diseases. The term "personal social services" is used to refer to all those social services, other than health, education, income maintenance, housing, which are directed towards meeting people's social support needs, usually on a community basis. Included under this heading are services provided by social workers, home helps, meals-on-wheels organisers and the staff of day-care services.

The Community Care Programme covers a considerably broader range of services than what is typically referred to as Community Care in the Social Policy literature. There the term is used frequently to refer only to those elements of personal social services provided *in or by* the community (3). The decision to include the broader range of services under the community care heading as in Ireland, has considerable merit. Apart from the fact that primary health care decisions have consequences for personal social services and cash support services and vice versa, the broader focus implicitly recognises that health is not just about health services, but must be seen in a much broader context. It is suggested in this report that a comprehensive focus on the factors that facilitate community living for dependent people demands an even wider conception of community care than is implied under the present programme. Issues related to housing, transport, social welfare, pensions, taxation and social insurance policies need to be considered in planning community care provision. Effective community care is dependent on a *community care perspective* in the provision of all services and not just on a limited set of services defined as 'community care'.

The establishment of the Community Care Programme provided an administrative

framework for the emphasis on community care which has been evident in official reports throughout the 1960's. As already mentioned four reports published during the 1960's are notable for their dual emphasis on community care and the role of voluntary bodies (4).

Three themes run through these reports and subsequent debates on community care:

- (i) community care is better than institutional care;
- (ii) community care is probably cheaper;
- (iii) the voluntary sector has a significant contribution to make and should be fostered.

These three themes are almost invariably evident in discussions of community care not only in Ireland but elsewhere. This points to the fact that community care as a policy comprises resource (input) policies, services (output) policies and policies relating to the role of government (both central and local) and to the role of voluntary bodies (5). A recognition of this triple nature of community care is important since it is necessary to consider whether or not the policy streams are effectively reconciled. It cannot be assumed that because the resource policy is efficient that the service policy is effective or adequate. These issues will be considered in Section IV of this chapter. Issues related to statutory voluntary relations will be considered in Section III.

3. COMMUNITY CARE — CONCEPTUAL ISSUES AND ASSUMPTIONS

Discussions of community care are characterized by a diversity of assumptions about social policy in general and about the needs of particular target groups; such diversity also relates to the role of government, statutory bodies, voluntary bodies, families and the wider community. In fact, both elements of the 'community care' concept are open to a wide range of interpretation.

The term 'community' is used to imply a variety of meanings. Apart from the administrative meaning, referring to the community care area structure, four usages are relevant in the present context:

- (i) Community as a setting; In this regard community is often used to connote the positive alternative to residential care.
- (ii) Community as territory; Community here refers to a geographical entity defined by natural boundaries; a number of levels of territorial community can be identified - neighbourhood, parish, country, regional, national. In discussions on community care the neighbourhood and parish levels are the two with most relevance. Reference to community in this sense is notable in discussions on localisation of services.
- (iii) Community of interests; For example, voluntary groups are organised on parish (e.g. some Social Service Councils and Care of the Aged Committees), county (e.g. County Associations for the Mentally Handicapped), regional or national levels, (e.g. Ally, Cherish, Irish Wheelchair Association).
- (iv) Community as Relationships; This refers to networks of reciprocal social relationships which provide mutual aid. Most discussions of community care are based on the assumption that these networks exist to some degree for most dependent people. The validity of this assumption will be questioned later in this report.

'Care' as used in the concept 'community care' also covers a wide range of meanings. These range from formal care i.e. specialised care/ treatment/counselling provided by professional staff in primary health care, personal social service and cash support services to informal care which includes help/support/aid provided by family and friends. Intermediate to these two types of care is that provided on a quasi-formal basis by organised volunteers.

A further important distinction is the source of care. Four sources of care can be identified:

- (i) Statutory sources - services provided by professional/specialist staff employed by health boards.
- (ii) Voluntary sources: (6)
 - (a) Non-statutory organisations which employ full-time professional and other workers; apart from fund-raising, the activities of these groups are funded by the Department of Health or by Health Boards through Section 65 grants (e.g. Irish Wheelchair Association) (7). Organisations included under this heading vary considerably both in terms of the percentage of funding they receive from statutory sources and in the range of their operations. These organisations have been referred to as "Non-Statutory Welfare Bodies" (8) in a 1983 National Social Service Board report. This terminology will be adhered to in this report.
 - (b) Voluntary bodies providing services either totally or mainly through the use of volunteers and being funded through Section 65 grants or fund-raising. Included under this heading are Social Service Councils and Care of the Aged Committees. They vary considerably in size and in the range of services they provide. These will be referred to as "Voluntary Community Organisations" (9).
 - (c) The unorganised voluntary sector as represented by foster parents who are paid by Health Boards.
- (iii) Commercial Sources - this element will not be considered in this report due to absence of information. However, it is notable that in a national survey of persons aged 65 and over, conducted in 1977 by the ESRI, 4% stated that they would pay a helper in the event of influenza, and 5% stated that they would pay someone to help with various household tasks (10). These figures may be indicative of a willingness among some of the elderly to pay for domiciliary services.
- (iv) Informal sources:
 - (a) Aid assistance support provided by family.
 - (b) Aid, assistance, support provided by friends and neighbours.

It is notable that there is a significant difference between medical and paramedical services on the one hand and personal social services on the other with regard to type and source of care.

Personal social services are characterised by what has been referred to as "a mixed economy of welfare"; this refers to the fact that such social care is provided by families, friends, and neighbours, and in addition the voluntary sector may be significantly involved (11). In contrast medical and paramedical services are provided

almost exclusively on a formal basis. Effective community care is dependent on the successful linking of both elements. Much of the following discussions will focus on the issue of social care, in particular the implications of community social care. This is justified since effective social care is the basis on which community care, in the broad sense implied by the Irish administrative definition, depends. For example, if community based medical and paramedical services, as in day hospitals, are to be provided at an effective level, then comprehensive domiciliary supports are essential. The provision of medical and paramedical services in the community is very frequently the focus of attention in official statements relating to community care. This is understandable given the costs of these services; however, it is associated with a tendency to consider community care as better because it may be cheaper. This may not be true if a comprehensive range of support services are provided.

The most basic distinction arising with regard to community care is that made by Bayley (12) between care *in* the community and care *by* the community. The former is a global term which refers to care outside of institutions. Community care in this sense may refer to the provision of a comprehensive range of professional and specialist services in the community, however, it may also be a euphemism for family care without any support services. In both of these senses the term community is used to refer to a setting. In contrast, care by the community implies that the community is actively participating in care - in this sense the term community is used to refer to resources. Such a notion of a community implies the existence of a network of reciprocal social relationships, which among other things ensure mutual aid and give those who experience it a sense of well being (13). It cannot be assumed that the community is an adequate resource. In fact, the existence or not of informal caring networks other than family networks is a matter of considerable debate. If by community care it is meant that members of the community, untrained and unaided, should have total responsibility for the provision of care to dependent people, then community care, as a form of care, may be inadequate.

According to Bayley, adequate care by the community implies the interweaving of the informal help and care processes, which he argues are active throughout society, together with the contribution of the social services (14). The policy implications for community care when community is considered as a setting are quite different from those arising when community is considered as a resource. In the latter instance the relationship between the various levels of care is crucial and the implication for policy is that one of its primary aims should be to enhance and develop informal caring networks.

The distinction between care in the community and care by the community is important in that it illustrates the necessity of considering *the assumptions implicit in discussions on community care*. The most important point that needs to be stressed in this regard is that community care policies are based on a number of assumptions that are rarely made explicit. Two are of particular importance in the present context: The first is that the family has primary responsibility for the care of its dependents. The implications of this assumption in terms of support for families, in particular support for women who are the primary care givers, are rarely reflected in policy formation and implementation. This assumption is questionable for another reason - namely that families are not always available to dependent people; this is not necessarily due to family neglect but rather to social factors such as migration of families away from their community of origin.

The second assumption on which community care policies are based is that the community is actually caring through informal care networks and that these are spontaneous. With regard to the British situation, Abrams argues that community care in the limited sense of care by informal networks is not a reality in many areas (15). In

support of this argument he instances the unobserved deaths of elderly people in the community, and the unobserved abuse of wives and children. Similar evidence can be cited with regard to the Irish situation (16).

There are no published studies available in Ireland relating specifically to informal care, however a number of studies present findings relevant in this area. A study on adult mentally handicapped people living in the community in the Dublin area indicates that community care effectively means family care for the majority of mentally handicapped adults, and concludes that there is a loss of integration of mentally handicapped adults with the local community (17). With regard to elderly people, there is evidence to suggest that a minority receive care neither from family nor informal caring networks. The ESRI study on people aged 65 and over, conducted in 1977, indicates that 29% of single people in this age group would have nobody to look after them in the event of influenza. The figure for rural areas is 35% and for urban areas 24%. Approximately 15% of this age group would not have anyone to help with a variety of household tasks (18). A national study conducted by the St. Vincent de Paul Society on people aged 65 and over living alone found that only 50% of the people interviewed would be able to get help in a sudden illness (19). While 75% believed that if they were out of view for a day someone would come to investigate their disappearance, it emerged that 36% of the old and alone were not in touch with people on a daily basis.

Rather than supporting the assumptions relating to informal networks, the evidence available indicates that:

- (i) One cannot conclude that an effective network of informal care exists for all dependent people in the community.
- (ii) What is referred to as community care is, in the majority of instances, care by families.
- (iii) Where effective community care involving informal networks takes place such care is not spontaneous, rather it is regular and organised to fit in with the family's structure for coping (20).

In view of the questionable nature of the assumptions on which community care policies are based, social care policies, and in particular the day to day implementation of policies, need to be evaluated in terms of how individual dependent people are supported and how families are supported. The crucial question relates to how the various levels of care are inter-related to provide an enabling structure for community living for the individual dependent person. It is necessary to ask whether or not community care services adopt a positive, preventive role or a residual approach of crisis or casualty intervention (21). The latter in effect means, as has been argued by Moroney with regard to the British system, that families face a penalty if they care and a reward if they cease caring (22). Moroney argues that the *substitute function* of community care services is more likely to be developed than is the *support function*, where the support function refers to support to families or informal caring networks who are providing care. This situation is not surprising since it is easier to plan for services that substitute for the family assuming that resources, both capital and staff, are available. These services lend themselves to a structured approach while family support services create a range of programming difficulties (23). The issue of flexibility in services is central to the idea of an enabling structure. Flexibility is central not only to the provision of community care services but is related to one of the fundamental dilemmas of social policy, viz., how to provide a range of services that are flexible enough to meet a variety of needs and yet allow for structuring and planning.

Basic to the promotion of individual welfare is information on the range of needs not only of dependent people but also of those who are providing informal care, in particular families. Information on dependent people in terms of services that facilitate community living is limited (24). Information on informal care, and on the motivation and expressed needs of those who provide it, is non-existent in Ireland. Similarly, information on the voluntary sector in Ireland is limited. This will be considered in the next section.

4. VOLUNTARY — STATUTORY RELATIONS

The value of voluntary services has repeatedly been stressed, notably by successive Ministers for Health and in official reports throughout the 1960's. More recently the Final Report of the Task Force on Child Care Services advocated voluntary involvement in the provision of social support to families and children with difficulties (25). A number of publications have identified the need for, and advantages of, voluntary community organisations, particularly in the area of personal social services (26). These reports emphasise the elements of flexibility and creative potential of voluntary organisations. It is argued that these elements can facilitate the identification of new needs, the exercise of a pioneering role with regard to the provision of services and the development of community self-help.

The same points that are emphasised in these publications are evident in the Wolfenden Committee Report (1978) on voluntary organisations (27). In that report an important point is made in relation to the limits of voluntary organisations. It is pointed out that a clear strength of the voluntary sector is that it can undertake spontaneous, speedy and autonomous action. However, it is also stressed that these features mean that there is no guarantee that voluntary effort will materialise where need is greatest, that standards will be maintained or that the sector as a whole will operate in a co-ordinated manner (28). These potential weaknesses may, to a considerable extent, be avoided if there is an agreed framework for the relationship between voluntary and statutory organisations.

Despite the size of the voluntary community organisation sector in Ireland (29), and the repeated acknowledgements of its role and the emphasis on the need for "co-ordination and liaison", no framework has been developed within which the contribution of voluntary community organisations can be evaluated; neither have there been studies of how co-ordination and liaison is to work out in practice. The studies available indicate considerable variation in practice in different areas and point to the importance of personal factors (30). This is not surprising given the absence of an agreed framework for relations between voluntary and statutory sectors.

There has been considerable criticism of the implementation of the Community Care Programme by spokespersons for voluntary community organisations (31). These criticisms relate to a number of associated issues:

- the concept of 'community' implied by 'community' care as implemented in the Community Care Programme;
- consultation between statutory and voluntary services;
- funding of services provided by voluntary organisations;
- the employment of social workers and community workers.

Much of the criticism by the voluntary sector puts the blame almost exclusively on the statutory side; however, the implications of the fact that co-ordination and liaison may

not be easy to realise have not been identified by either side. As the Report on the Care of the Aged acknowledged, some voluntary organisations may be reluctant to join with others in an area to form social service councils; existing social service councils rarely fulfil a co-ordinating role but rather operate at the level of service provision. Without co-ordination at the local level it is difficult to envisage how liaison with statutory authorities is to operate.

It has been argued in a report by the National Social Service Board that the issue of voluntary/statutory relationships must be seen within the wider context of policies relating to personal social services:

A major impediment to maximizing existing resources is the lack of a policy framework for the development of the personal social services Central to such a policy framework will, undoubtedly, be a clear statement on the relative roles of statutory and voluntary agencies and how they can best work together (32).

In proposing that voluntary bodies should be directly involved in the planning and decision-making processes which affect them, the NSSB document outlines a three-level structure for the planning and delivery of personal social services. The three levels are:

- (i) *community/neighbourhood level* (a structure similar to that envisaged for social service council) (33);
- (ii) *community care level* for the purpose of exchange of information between the Director of Community Care and representatives of voluntary organisations on needs and services and agreeing a joint approach to personal social services;
- (iii) *health board level* for information sharing on health board plans between the Programme Manager and Director of Community Care and representatives of voluntary bodies.

At present, there is considerable variation between health boards in voluntary/statutory relations. The above structure is not markedly different from what operates at present in some areas.

Funding

Funding of voluntary organisations by health boards is carried out through grants under Section 65 of the 1953 Health Act. This section allows the funding of organisations who provide services 'similar or ancillary' to those provided by the health board. An exact definition of 'similar or ancillary' has never been stated and there have been considerable differences between health boards in the interpretation of this section. The total grants provided by all health boards in 1985 amounted to about £9.4m involving a considerable number of voluntary bodies (34). Because of its discretionary nature this type of funding has been the subject of much criticism; these criticisms relate to the absence of guarantees of funding from year to year which creates planning problems, and delays in decision making relating to services.

In summary, despite repeated statements at official level relating to the importance of the voluntary sector there are as yet no agreed structures relating to liaison and funding. However, in the 1984 Green Paper on Services for Disabled People, where the contribution of voluntary organisation is acknowledged, it is stated that consideration is being given by the Community Care Review Committee as to how voluntary organisations and the health boards can best work together to contribute to the development of community care services (35).

5. RESOURCE AND SERVICE ISSUES

The shift in focus from residential to community care since the 1960's can be associated with a number of factors:

- (1) The evidence of the often negative impact of institutional living (36).
- (2) The recognition of the civil rights of minority groups as reflected in the UN declaration on the rights of handicapped people.
- (3) Official sensitivity to the rising costs of institutional care.

The overall impact of these three factors is that the social care element of community care is frequently conceived in a negative fashion. Indeed, the ideal of community care

..... rests upon the conviction that all human beings have the right to live a life as near as possible to that which is perceived to be normal by the society in question and that this is unlikely to be achieved in a large institution (37).

However, there is increasingly a recognition that it cannot be assumed that this ideal will be achieved automatically because someone is resident in the community. While there is considerable evidence to suggest that the majority of dependent people in the community, even very incapacitated people, are cared for at public costs below those of residential care, the authors of these studies tend to place reservations on this conclusion (38). For example, Opit in a study of very dependent old people in Birmingham concluded:

"It is quite possible to keep many seriously disabled old persons at home, but to do so without neglect will require a large investment in support services. Even then the quality of life for some of these patients or their families may be far from compatible with any civilized/humanitarian standards (39)."

What Opit's study and similar studies indicate is that community care is not necessarily better but is *potentially better* than residential care. If the focus is primarily on the resource side as opposed to the service side there is a danger that community care may be considered better because it is cheaper from a public expenditure point of view.

Considering the resource side first, the usual approach is to focus on public expenditure. This is inadequate because public expenditure is only a partial reflection of the costs of community care since the input of informal carers is not included. An opportunity cost approach would acknowledge such input. While the measurement of opportunity costs is difficult, an acknowledgement of the existence of such costs would at a minimum facilitate the recognition that community care is not just a matter of the provision of services in the community but is also dependent very often on the activities of informal carers. There are no published studies on informal carers in Ireland. However, there is considerable evidence from literature on community care indicating that the task of caring for a dependent person is arduous and may involve not only financial costs (direct labour and opportunity costs of earnings foregone) but also other costs in terms of physical and emotional health (40). This evidence indicates that policies must be evaluated not only in terms of how they apply to dependent people but also in terms of their implications for informal carers.

Focussing on the service side, the measurement of the success or failure of community care policies is not merely a matter of quantity of services. It would be desirable to consider services along four dimensions:

- (i) Levels of utilisation;
- (ii) Impact on reduction of inequalities, i.e. between socio economic groups and across the life cycle.
- (iii) Impact on risk reduction, i.e. risk of disability and of dependency in terms of need for long term residential care.
- (iv) Efficiency in terms of meeting the objectives laid down for the service.

This type of four-fold evaluation is not possible because of the types and quality of information available. The McKinsey Report put considerable stress on the importance of "adequate indicators" for sub-programmes and the need to have agreement on these indicators between the Department of Health and the health boards. Apart from quantity indicators (41) there appear to have been no developments in this area. Even the quantity indicators are limited and those available have severe limitations. Consistency between health boards is not guaranteed. The quality of some of the information is questionable and there are, on average, two years delay on availability.

While the development of quantity indicators presents problems, the development of appropriate indicators relating to inequalities, risk reduction and efficiency present considerably greater problems, yet their importance demands that attempts be made to develop them. For example, there is now considerable evidence available, from literature on inequalities in health status and services utilisation, that occupational position and associated factors such as income and housing are of central importance with regard to health service utilisation, morbidity, and mortality (42). A review of this evidence and the information available in Ireland indicates that information is not available on many of the key variables which are necessary for a comprehensive approach to service evaluation and planning.

A similar pattern is evident if one considers risk reduction either in terms of prevention or early identification of disabilities or in terms of prevention of admission to residential services. Among the services relevant to risk reduction are preventive services such as Child Health Services. Services relevant to prevention of admission to residential services are Personal Social Services, (preventive social work, child care in the family home and home help services), Public Health Nursing Services and community-based Medical and Paramedical Services. Some of the information necessary for evaluation of the preventive effectiveness of these services can be identified only through in-depth research in specific areas. Research on health and social services in Ireland in terms of inequalities, risk reduction and efficiency is almost non-existent. While such research should be encouraged, attempts should also be made to collect as much basic evaluative information as is possible in the ordinary course of service delivery. Such a project has been undertaken in the North Western Health Board region and a Community Care Information System is now in operation. The notable point about this system is that most of the information being used is already routinely collected by professionals in the course of their work.

6. CONCLUDING REMARKS

The definition of 'Community Care' in Ireland is broader than that usually given in the literature, including as it does, health services, cash welfare services and personal social services; however, the implications of such a definition have not been sufficiently explored. A multiplicity of usages of the "community" concept were identified as were a variety of sources and types of care.

Despite repeated official statements relating to the importance of the voluntary sector in community care, there is no agreed framework for relations between health boards and voluntary bodies relating to liaison and funding.

Problems associated with a resource focus and in particular a public expenditure focus on community care were identified. This focus results in failure to acknowledge the central role of informal caring and in particular the opportunity and other costs of this type of care. Finally, the limited range of indicators available and the quality of some of those available has been questioned.

CHAPTER 1

FOOTNOTES AND REFERENCES

- (1) *The Health Services and Their Future Development*, Dublin, Stationery Office, 1966.
Report of the Commission of Inquiry on Mental Handicap Dublin, Stationery office, 1965.
Report of the Commission of Inquiry on Mental Illness Dublin, Stationery Office, 1966.
The Care of the Aged, Report of an Inter-Departmental Committee, Dublin Stationery Office, 1968.
- (2) *Towards Better Health Care*, Volumes I to IV, McKinsey & Co, 1970-71.
- (3) These distinctions are discussed in Section III.
- (4) See ref 1. Major points relating to Community Care arising in these reports are outlined in Appendix 1.
- (5) Webb A & Wistow G, "Public Expenditure and Policy Implementation: The Case of Community Care". *Public Administration* Vol 51, No 1, 1983, P. 21-44.
- (6) The term voluntary is used in two senses with regard to organisations, firstly to refer to organisations composed of volunteers and secondly, to refer to non-statutory organisations. In the former sense it may refer to small Care of the Aged Committees operating at parish level or to national pressure groups such as AIM and CARE. In the second (ie. non-statutory) sense, the organisations included vary considerably in size, structure, range of services offered, sources of funding, relationship to the statutory sector, involvement of religious and lay personnel. They range from large voluntary hospitals to special interest community oriented service groups operating on a national basis, such as the Irish Wheelchair Association and the ISPPC. Some of these organisations are funded almost entirely by the Department of Health, for example, voluntary hospitals and voluntary bodies providing services for the mentally handicapped. In contrast, some voluntary bodies are dependent to a considerable extent on support from the public. This is generally the case with regard to organisations in the sphere of physical handicap, particularly where the services are community based; for example the Irish Wheelchair Association had a budget of over £1m in 1982 and only 10% came from statutory sources.
- (7) Section 65 of the 1953 Health Act allows the funding of organisations who provide services similar or ancillary to those provided by health authorities (see text)
- (8) National Social Service Board, *The Development of Voluntary Social Services in Ireland*, Dublin, NSSB, 1982.
- (9) The distinction between voluntary community organisations dependent on volunteers and non-statutory bodies does not fully reflect the range of voluntary organisations since many of the non-statutory bodies do make extensive use of volunteers, for example IWA and some of the mental handicap organisations. Many of the (volunteer) voluntary organisations employ professional and specialist staff, e.g. large social service councils. The voluntary community organisations are of great importance in discussions of the personal social services element of community care.
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- (17) Walsh J and Mulcahy M "Service Requirements of Adult Mentally Handicapped Persons Living in the Community" *Irish Medical Journal*, Vol 75 No 1, January 1982, pp 13-15.
- (18) Whelan & Vaughan, *Op cit.* Tables 9.3., 9.4.
- (19) Power B, *Old and Alone in Ireland*, Dublin, St. Vincent de Paul Society, 1980.
- (20) Bayley M.J, 1973, *Op.cit.*
- (21) Walker A (Ed) "The Meaning & Social Division of Community Care", *Community Care*, Oxford, Basil Blackwell & Martin Robertson, p25.
- (22) Moroney R M, *Families, Social Services and Social Policy*, Washington, US Dept of Health and Human Services, 1980 p.2.
- (23) *Op. cit.*, 123.
- (24) A notable exception is the study of Irish Wheelchair Association Members by Faughan P, *Dimensions of Need* Dublin, IWA, 1975.
- (25) *Task Force on Child Care Services Final Report*, Dublin Stationery Office, 1980, p. 142-152.
- (26) Curry J "The Context of Caring in the 1980's" in *A Chance to Care in the 1980's*, National Federation of Social Service Councils; National Social Service Board, 1982, *Op. cit.*
- (27) *The Future of Voluntary Organisations*, Report of the Wolfenden Committee, London, Croom Helm, 1978.

- (28) This issue is discussed with regard to services for handicapped people in NESC Report No. 50, pp. 29-34.
- (29) *Extent of voluntary community organisation sector:* The 1980 edition of the NSSC *Directory of Social Service Organisations* indicates that there were 223 social service organisations operating throughout the various health boards, under a variety of titles including social service council. In theory a social service council is "a council representative of the voluntary organisations in an area; its usual aims are defined as fostering *co-operation* and *co-ordination* in the delivery of services and developing *new services* to meet newly identified needs" (National Social Service Board 1982 op cit). Many organisations with the title social service council do not meet the criteria of this definition. Many confine their activities to the provision of services for one set of dependent people, frequently the aged. Most of the organisations included in the Directory are dependent totally on volunteers and vary considerably in the numbers involved - from less than 10 to over 150. Many of the 25 organisations which employ full-time staff have also a considerably greater number of volunteers (approximately 900 in the case of Clare Social Service Council). The number of full-time employees in these 25 organisations ranges from one employee to a whole team of professional and support staff, as in Kilkenny and Clare Social Service Councils - both of these councils are involved in the co-ordination and provision of services throughout the entire counties concerned. In fact both of these social service councils are diocesan in scope and have considerable input in terms of personnel and financial resources from Catholic diocesan clergy and religious orders.
- (30) Kennedy S, 1981, Op. cit. Lavan A, *Social Need and Community Social Services*, Dublin, Tallaghi Welfare Society.
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- (32) National Social Service Board, 1982, Op. cit., p.5.
- (33) See footnote 29.
- (34) Reply by Minister for Health to Dáil question - June 28 1984.
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- (36) Bowlby J *Child Care and the Growth of Love*, Harmondsworth, Penguin, 1963. Goffman E. *Asylums*, New York, Doubleday, 1968. Townsend, P *The Last Refuge*, London, Routledge & Keegan Paul, 1962.
- (37) Stevenson O *The Realities of a Caring Community*: the 26th Elanor Rathbourne memorial lecture delivered at the University of Reading on 4th Nov 1980. Liverpool, University of Liverpool.
- (38) Wright K "The Economics of Community Care" in *Community Care*. In Walker A, (Ed) Oxford, Basil Blackwell & Martin Robertson, 1982, p. 165.
- (39) Opiu, L, "Domiciliary Care for the Elderly Sick: Economy of Neglect?" *British Medical Journal*, 1, 1977, p.33.
- (40) Bayley, M, J, 1973 Op. cit; Equal Opportunities Commission: *Caring for the Elderly and Handicapped; Community Care Policies and Women's Lives*", London, EOC, 1982. Nissel M & Bonnerjea L, *Family Care of the Handicapped Elderly: Who Pays?*, London, PSI, 1982.
- (41) For example, employment levels and utilization of services.
- (42) Townsend P. & Davidson, N. *Inequalities in Health: The Black Report*, Harmondsworth, Penguin, 1982.

HEALTH EXPENDITURE AND EMPLOYMENT TRENDS

1. INTRODUCTION

This chapter is concerned, for the most part, with employment trends within the Community Care Programme and service related employment issues. Before considering these issues some significant points relating to expenditure are outlined.

2. EXPENDITURE TRENDS

Expenditure on health services has increased consistently since 1970/71. In that year net non-capital health expenditure was £61 million or 3.7% of gross national product. In 1980 it had reached £701 million or 8.2% of GNP and by 1985 it has risen to £1,115 million or 7.3% of GNP. However, not all elements of health expenditure have increased to the same extent. Expenditure on the Community Care Programme has increased slightly less than the average.

Since 1976, the Department of Health has made available non-capital health expenditure data on the basis of programmes and services, identifying five programmes: Community Care;

Psychiatric;
Handicap;
General Hospitals;
General Support;

The Community Care Programme is further subdivided into three sub-programmes — Community Protection, Community Health and Community Welfare. If expenditure on these three sub-programmes is taken as the indicator, the overall share of expenditure on community care has remained virtually constant since 1976 (Table A2.1). It has fluctuated from a high of 23.4% of gross non-capital health expenditure in 1976 to a low of 20.5% in 1980; since 1980 the share has increased slightly and stood at 22.2% in 1985. By contrast, the General Hospital Programme has also fluctuated but increased its share from 48% in 1976 to 53.8% in 1980 and was 51.2% in 1985. The Programme for the Handicapped has increased consistently from 7.6% of the gross total in 1976 to 9.9% in 1985. A clearer picture of expenditure patterns since 1976 is given by considering expenditure in constant prices. As Table A2.3 shows, real health expenditure grew rapidly in the period up to 1982; thereafter some contraction in real expenditure was affected. The divergences between Community Care and other programmes in this respect should be noted; Community Care increased gradually and cumulatively while other programmes have reflected the retrenchment of the period since 1983.

Health expenditure in current and constant 1980 prices for each of the sub-programmes between 1976 and 1985, and percentage changes in expenditure between 1976 and 1985,

are outlined in Tables A2.2 and A2.3 respectively. Total expenditure on the Community Care Programme increased by 36.7% between 1976 and 1985, that is somewhat less than the increase for Gross Expenditure on Non-Capital Health services (45%), and considerably less than the growth in the General Hospital Programme (52.3%) and the Programme for the Handicapped (84.6%).

Considerable variation in real expenditure trends between the three Community Care sub-programmes is evident in the period 1976-85; the Community Welfare sub-programme increased by 90% (Tables A2.3 and A2.5), while the Community Protection sub-programme expenditure increased by only 12% (Table A2.3 and A2.7), and the Community Health Services expenditure increased by 20% (Tables A2.3 and A2.9).

In addition considerable variation between sub-programmes and between specific services within sub-programmes is evident. Expenditure on some services increased considerably more than the average; within the Community Health sub-programme the Home Nursing service grew rapidly and the increase largely took place in the years to 1980 — since then real expenditure has been constant (Table A2.9). Similarly with the Home Help service within the Community Welfare sub-programme (Table A2.5). In contrast, real expenditure on some services decreased, for example within the Community Protection sub-programme expenditure on Child Health Examinations has been decreasing since 1979 and the 1985 figure was 32.5% less in real terms than the 1976 figure (Table A2.7). This item is indicative of the more general trend that, in contrast to stated policies regarding priority for preventive services, Community protection programmes grew by only 9% (1976-1985) while the General Hospitals programme increased by 52.3%.

Comparisons between Health Boards in terms of expenditure throughout the 1970's are not possible because of differences in accounting procedures. Information from the Department of Health for the period 1981 to 1983 suggests that the shares of expenditure for particular sub-programmes do not vary from year to year. While Health Boards have discretion in apportioning funds within these headings, it is clear that given the high labour content of many services there is in effect very limited discretion with regard to the greater part of programme budgets which tends to be historically determined. This has been evident since 1980 and particularly so since 1982. A further discussion of expenditure trends on specific services is given in Appendix 2.

Expenditure under the three community care sub-programme headings does not cover all expenditure by the Department of Health on services in the community. In particular, it does not include expenditure on care in day centres for mentally handicapped people or psychiatrically ill people, the child or adult community psychiatric service or care in day hospitals for elderly or handicapped people. At a more general level it does not include expenditure by other government departments, state agencies and local authorities on services that are relevant to community care, for example, expenditure on special housing and sheltered housing for elderly people, telephone rental service for elderly people living alone, free public transport for elderly and handicapped people, cheap fuel and electricity and income maintenance services. Each of these services are essential elements in a comprehensive range of community services.

3. EMPLOYMENT LEVELS AND SERVICE-RELATED EMPLOYMENT ISSUES

The remainder of this chapter focusses on differences in professional staff posts in different Health Boards, and on service-related employment issues.

The categories of staff considered are:

- Public health nurses;
- Medical officers;
- Social workers and community workers;
- Community welfare officers;
- Home helps;
- Rehabilitation personnel;
- Dentists.

(i) Public Health Nurses

Level of Provision

Public health nurses comprise the largest professional group, and also one of the longest established groups, working as part of the Community Care Programme. In 1985 there were 1,153 posts available nationally. This figure does not include superintendent public health nurses — or the additional nurses for specialist duties in the Eastern and Southern Health Boards.

The Working Party on the Workload of Public Health Nurses, whose report was published in 1975, (4) estimated on the basis of a comprehensive public health nursing service to all population groups that the total requirement was (on the basis of 1971 population figures), for 1,152 nurses or on average 1 per 2,616 population, (varying from 1:2,233 in Leitrim to 1:3,014 in Dublin City) (5). In 1985 the number of approved posts had reached the target: however, because of the population increase this number of posts does not meet the recommended nurse population ratio of 1:2,616 (Table A2.10). If the ratio of 1:2,616 is applied to the 1986 population then 1352 nurses are required, 199 more than the current total.

The level of approved posts varies considerably between Health Boards as the data in Table A2.10 reveals. Some Health Boards have a higher nurse population ratio than that recommended in 1975 and in 1985 five Health Boards had not attained the recommended population: nurse ratio. The difference between the 1975 recommended level and the present approved level is particularly marked in the Southern Health Board area (6). There is no evidence to assess whether or not these variations are attributable to variations in need.

Preventive/Curative Elements

There are two essential elements to the public health nursing service — a preventive one and a curative one. It is reasonable to assume that if there is pressure on the service the preventive element will be the first to suffer. The public health nurse/population levels recommended in 1975 have not been reviewed in the intervening period. A review was initiated by the Department of Health in 1986 and is continuing at present. Moreover, the curative nursing demands may have increased considerably in this period because of an increased emphasis on early discharge from hospital and the increased emphasis on community care of elderly people. The number of people aged 75 and over has increased over the past 10 years and will continue to increase at least up to 1990; this group is likely to have relatively high nursing needs.

In addition to probable increased demands on the curative side, increased demands on the preventive side of the nurses' work are also being made; for example, the Working Party on the Maternity and Infant Care Service recommended an increased involvement of public health nurses in health education related to Maternity Services (7). On the basis of the preventive/curative distinction, the Working Party on General Nursing (8) recommended that in addition to increasing the number of public health nurses and thus

improving nurse/population ratios, the employment of SRN's without a public health nursing qualification, specifically for a home nursing service, should be considered on a pilot basis; this was envisaged as freeing the public health nurse for preventive care. In the survey of nurses conducted by the Working Party, only 45% of public health nurses agreed with the proposal that there is room in the community for registered nurses in a supportive role to the public health nurse; 75% of hospital nurses agreed with the proposal. To date the pilot schemes — one urban and one rural — advocated by the working party have not been initiated.

Hours of Service

The 1975 Survey of the Workload of Public Health Nurses indicated that 87% of district public health nurses' working time was between 8a.m. and 6p.m., Monday to Friday. About 5% was between 6p.m. and 11p.m. on these days and a further 5% was on Saturdays. Less than a half of 1% took place between 11p.m. and 8a.m. There is no information available to indicate that the picture has changed since 1975. The Working Party on General Nursing recommended that a 24-hour community nursing service should be provided and that the nurses providing such service outside normal working hours need not necessarily be qualified public health nurses. No progress has been made to date towards the implementation of this recommendation. A twilight service (6-11p.m.) has been in operation in one community care area in Dublin for over 5 years. The type of people availing of this service are terminally ill people of all ages, and severely dependent elderly people (9).

In some other community care areas a pre-arranged service outside of regular working hours is provided to a limited number of people with handicaps, for example, people with multiple sclerosis and strokes. However, this service is extremely limited and is dependent on the good will of the personnel involved rather than on a right to service. There are serious problems about the introduction of a 24 hour service particularly in rural areas because of distances involved. In this context the Working Party recommendation on the use of registered nurses has considerable merit, in that the possibility of recruiting a nurse in a local area to provide a service on a part-time basis could be considered. It is possible that a twilight service coupled with a nursing attendant service may meet the need (10). This issue has particular relevance not only in terms of community care for elderly people with disabilities, but also for younger terminally ill and seriously handicapped people.

Support Services

It is notable that public health nurses, even Superintendent Public Health Nurses, have very limited clerical support in some areas. This may be false economy since it can result in inappropriate use of nurses' time. As a domiciliary service certain problems arise under the present arrangement, for example, in some urban areas nurses report a high number of "no access" calls. This is clearly wasteful of limited professional time. The feasibility of introducing appointment cards in those areas where no access calls are a problem should be explored. It is acknowledged that an alternative interpretation of "no access" calls may be that they reflect non-availability because the person concerned did not need or did not expect a service. However, given the preventive nature of much of the public health nursing service, particularly in relation to children, it should be established that alternative services are being availed of before any decision is taken to limit public health nursing services to those who actively seek them or readily avail of them.

In summary, the present level of the public health nursing service varies markedly from area to area; when considered with reference to the 1975 nurse/population guidelines, the service is markedly understaffed in some areas. In view of the likely increased demands on the service due to demographic changes and the numerous

recommendations of increased involvement of public health nurses in various services, the adequacy of the present recommended nurse/population ratios should be reviewed. Such a review need not necessarily lead to the conclusion that more public health nurses are needed; it should consider issues such as the involvement of SRN's in curative nursing, the participation of nursing assistants in the service, and the availability of clerical assistance to public health nurses. The focus should be on flexibility and the most efficient use of limited and expensive professional resources.

(ii) Medical Officers

Though the medical officer post has long been established in the Irish health system (11) the development of this aspect of the community care team has been relatively slow. This slowness was in part associated with controversy relating to the Director of Community Care position. This controversy centred on whether or not the position was essentially a managerial and co-ordinating post and open to all disciplines, or whether a medical qualification was essential. The latter position was adopted by the Department of Health. Following the final report of the *Working Party on Public Health Medical Service* (Walshe Report) issued in March 1976 (12), combined Director of Community Care Medical Officer of Health (DCC MOH) positions were advertised (13).

In addition to the difficulties related to the Director of Community Care position there were no specialised training facilities in community medicine in Ireland up to 1976 when the Faculty of Community Medicine was established. Directors of Community Care/Medical Officers of Health were not appointed in some areas until 1978; in addition, up to recently there was considerable mobility of DCCMOH's between areas and, even more so, of area medical officers. In fact, the area medical officer position was filled in many areas on a temporary basis due to the absence of appropriately qualified personnel. Furthermore, in some community care areas the complement of area medical officers was below the approved level for considerable periods. At this stage the majority of area medical officers have training in public health; by May 1983 there were 107 posts filled and by 1987 the total was in excess of 150. (Table A2.11).

The Walshe Report identified the three aspects of health with which medical officers would be involved: child health services; care of the handicapped and care of the aged. A wide range of functions were identified (14).

It was recommended that the functions of the community care team should be carried out on a geographical basis. To achieve this it was recommended that area medical officers should have responsibility for local areas with populations of 20 to 25,000. While it was recommended that 2 Senior Area Medical Officers to each community care area be appointed, the present position is that there is one approved post in each area. Senior area medical officers are responsible for planning, organisation and review of community medical services. Most of the work relates to Child Health Services i.e. school medical services and development clinics, both of which are diagnostic and advisory services.

The employment position of public health medical personnel in 1987 is that there are 32 posts of Director of Community Care Medical Officer of Health, and 175 area medical officer posts, including seniors. The area medical officer/population ratio varies considerably from approximately 1 to 15,000 population in the South Eastern and Western Health Boards to 1 to 25,000 population in the North-Eastern Health Board (Table A2.11). In recent years the ratio of personnel to population has improved considerably and the variation from region to region has diminished.

In addition to having overall responsibility for public health activities the Director of Community Care is co-ordinator of the community care team and has responsibility for planning and organisation of services in co-operation with the senior staff of other disciplines: Senior Public Health Nurse, Senior Social Worker, Senior Community Welfare Officer, Senior Health Inspector, Senior Dental Officer and Senior Administrator. There have been considerable problems about the operation of these teams. In particular, some professional groups have objected to the confinement of the Director of Community Care position to medical officers. To date Senior Dental Officers have not been part of the team, nor in some areas have Senior Community Welfare Officers or their staff. The dispute relating to the Director of Community Care position was intensified in the Eastern Health Board in July 1984 when members of the Local Government and Public Service Union "blackened" Directors of Community Care Medical Officers of Health in protest at what the union regards as government failure to carry out a review of the qualification requirements for the Director of Community Care positions.

This particular contention may be resolved if the re-organisation of the DCC/MOH posts proposed by the Department of Health were implemented (15). This would entail the abolition of the joint DCC/MOH post and the filling of higher management posts on a "non disciplinary" basis.

There is widespread agreement that the potential of the multi-disciplinary focus of the community care teams has not been realized. The organisational problems of the teams and of the Community Care Programme in general are the subject of a Department of Health review at present.

(iii) Social Workers and Community Workers

Level of provision

There has been a considerable increase in the number of social workers employed since the early 1970's. In 1974 there was a total of 235 social workers employed by all of the agencies concerned, 145 by statutory agencies and 90 by voluntary agencies, whereas by 1981 — Health Boards alone employed 298 (including 22 community workers); in addition in 1981 11 social workers, employed by social service councils, were formally involved with community care teams (16). Between 1981 and 1987 there was a marginal increase in the number of social workers and a slight improvement in the ratio of personnel to population (Table A2.12).

There are considerable differences between Health Boards in the social and community worker/population ratio, which varies from 1: 7,436 in the North Western Health Board to 1: 9,000 in the Midlands to 1: 22,000 in the North Eastern Region (Table A2.12). The magnitude of the difference suggests that the variation in level of service possible in the different areas is considerable. However, a comparison between areas should take into account not only such factors as population density, and demographic structure but also level of need. This is not possible at present. Criteria for estimating the appropriate level of staffing to meet need in particular areas is a task which must be carried out at national level and should be undertaken in co-operation with specialists in social work. The failure to do this means that there are no national guidelines on social worker/population ratios (18).

In addition to these factors identified above, social work activities by other agencies, statutory and voluntary must be taken into account in deciding on Health Board provision. The statutory agencies involved are the Department of Justice, which employs 163 probation officers (and seniors) throughout the country, and local authorities (Table A2.13). There are 70 social work type posts in local authorities:

about half are filled by Dublin Corporation housing welfare officers and the rest are filled by social workers with travelling people in individual local authorities. Social work by the voluntary sector covers a wide range of agencies, from those involved exclusively in professional social work services, to those involved exclusively in services by volunteers (Appendix 3).

Voluntary social work activity could have a considerable impact on services within a particular community care area. However, there are no structures which ensure co-operation between voluntary and statutory services. In a study of services in a Dublin area in 1975, there were indications of both a lack of co-ordination between agencies and a duplication of services (18). It is believed that duplication of services is no longer widespread. This is partly because of increased awareness of the possibility on the part of social workers, but mostly because of the intense pressure on social work services. In addition greater specialisation by voluntary bodies, other than social service councils, limits the probability of duplication of services.

Social Caseworkers

Most Health Board social workers are employed as caseworkers, i.e. their focus is on the social and emotional problems of individuals and families. In addition, they may adopt a group work approach, i.e. work with a group who share a common problem and some elements of their work may involve a community work orientation. With regard to the work of Health Board social caseworkers four broad elements can be identified:

- (a) Tasks related to Health Boards' statutory responsibilities relating to children;
- (b) Preventive work — this covers social work with families, single mothers, psychiatrically ill people and their families, handicapped people, and the elderly;
- (c) Information and guidance on services;
- (d) Advisory role to voluntary organisations.

Most social workers work on a geographical basis, though in a minority of areas a social worker may specialise in adoption and fostering. There is no information available at a national level on social work activities, on the length of waiting lists, if any, or on the adequacy of services in different areas. There is evidence that the Health Boards' social work service is under considerable pressure in some areas and that as a consequence most social work time is taken up with the statutory responsibilities in relation to children. The Health Boards' submissions to the National Manpower Planning committee on the employment of social workers indicate that their services at present show a bias towards dealing with children at risk or in care and with unmarried mothers, due to statutory obligations, with other target groups being dealt with only on an ad hoc basis. This pattern is likely to be particularly marked in those areas with low social worker/population ratios.

Training and Experience

Apart from the number of social workers in an area an additional factor which is of central importance is the level of training and experience of those employed. The Task Force on Child Care Services Report expressed concern that:

"... the concentration of the best social work skills in the more specialised services has often resulted in a dearth of such skills at the crucial point of initial referral to an agency (19)."

This is probably linked to the present social work structure and in particular the level of

supervision available to basic grade social workers. At present the social work career structure is very limited, being confined to Senior Social Worker level and Social Worker — Professionally Qualified or Basic Grade. At the present time there is some variation in the ratio of seniors to social workers. The desirable standard is one Senior to five social workers.

Support Services

A further organisational problem which militates against effective services is the non-availability of adequate office space or interviewing rooms in many areas. In addition, clerical support is extremely limited in most areas.

Evaluation of need

On the basis of Health Board views regarding future expansion the National Manpower Planning committee estimated Health Board social work requirements using a 1: 9,000 population ratio (20). One Health Board (North Western) has a ratio more favourable than this, and two Health Boards (Midlands and Western) have ratios very close to it. Based on the 1: 9,000 ratio, Health Boards should increase their social work complement to 393, i.e. an increase of 84. The social worker/population ratio varies greatly at present. Even taking the lower density of population in the North-Western Health Board and Midland Health Board areas into account, it is clear that the level of services possible in these areas is considerably greater than in the North Eastern, Southern, and Mid Western Board areas.

Community Workers

There is often a community element in the work of social caseworkers, however, it is not their primary orientation (21). Community work, as its name implies, has as its focus communities, which may be geographically based or which may be "communities of interest" (groups of people with common problems not necessarily from common location). Definitions of community work vary but all emphasise the element of bringing people in a community together to identify and solve problems in their community through the development of community resources and services.

In 1977 the Department of Health created 30 community work posts. The guidelines relating to these posts allowed considerable flexibility to individual Health Boards in the deployment of these workers. The functions of community workers were identified as possibly including the following:

- To assess needs;
- To develop awareness of needs;
- To advise on priorities;
- To promote, maintain and develop the potential of voluntary groups who were promoting or providing social services;
- To develop and maintain liaison between these groups and relevant statutory agencies.

Different functions have been stressed in different Health Boards. In some areas there has been considerable disagreement and controversy about which of the functions should take primacy; in particular, there has been conflict relating to the emphasis by some Health Boards on the assessment of service needs in an entire community care area, while most community workers favour a community development role within a limited geographic area. There has also been conflict about the reporting relationship of community workers. The Department of Health circular specified that the workers appointed were to be accountable to the community care area Senior Social Worker. However, not all community workers have come from a social work background and some have argued for an alternative reporting relationship.

The Department of Health does not distinguish between social workers and community workers. In some Health Boards (South East, Midlands and North East) no community workers have been appointed. In some other areas, some community worker posts have been converted to social work posts (Mid-Western and Eastern Health Boards).

The employment of community-workers has not been controversial in all areas. It has worked well in some Health Board areas; for example, in the North Western and Southern Health Board areas where the focus is on community development. Even within the Eastern Health Board, where much of the controversy about these posts arose, the arrangements worked well in some community care areas. In the Western Health Board, in contrast to other areas, community workers are involved in liaison work with voluntary organisations and service development.

An additional source of conflict relating to the employment of community workers has been the criticism by representatives of some voluntary community organisations who have argued that the community development role is more appropriate to voluntary organisations (23). The circular from the Department of Health to the Health Boards on the employment of community workers outlined three options for employment: (i) Direct employment by Health Boards; (ii) Secondment to voluntary bodies and (iii) Grants to voluntary bodies for employment. The National Federation of Social Service Councils advised the Department of Health that options (ii) and (iii) were preferable. However, these types of arrangements were adopted only in a minority of areas.

The employment of community workers should be reviewed in the light of the experience to date, with particular reference to those areas where the service has either not been a success, or has not been taken up at all.

Social Care Workers/Community Workers

Most Health Boards have plans to increase their number of social workers but to what extent is not known, nor is it known what mix of case workers/community workers is proposed (23). Given the experience to date it is probable that the increase in most areas is likely to be exclusively in the social work complement. This highlights one of the dilemmas relating to community work. The combination of financial stringency and Health Boards' statutory responsibilities may result in a tendency to substitute social case workers for community workers. This approach is likely to be counterproductive (24). The emphasis on voluntary participation in services and the aspiration towards a community focus evident in Irish policy documents, and most recently affirmed in the Task Force Report on Child Care Services, (25) suggests that a strong community development orientation is appropriate in the Irish situation. The small amount of Irish literature relevant to this issue is strongly supportive of a two-pronged approach that would be responsive, not only to immediate need, but would focus also on the identification of resources to meet needs. Some of these resources are available within local communities (26).

(iv) Community Welfare Officers

The present Community Welfare Service is based on the 1975 Supplementary Welfare Act which came into force on July 1st 1977 and replaced the Home Assistance Scheme. There are two elements in the service:

- (a) The relief of distress through the provision of financial support and other supports in kind.
- (b) Determination of eligibility for means-tested Health Board services notably DPMA and Medical Cards.

The Supplementary Welfare Allowance, while administered by the Health Boards, is strictly speaking a social welfare payment and has a means test similar to that for Unemployment Assistance (27). Apart from the basic allowance there is a discretionary element to the Supplementary Welfare Payment payable in certain circumstances, for example where there are high rent payments, special heating needs, or special dietary needs. This aspect of the scheme has been the subject of criticism due to the fact that there is no agreed interpretation of the Act; thus, there are still variations between areas with regard to discretionary payments. To date there have been no annual reports on the Community Welfare Scheme and information on recipients of Supplementary Welfare Allowances is very limited.

The structure of the Community Welfare Service is such that community welfare officers report to a Superintendent Community Welfare Officer, one to each community care area outside the Dublin area; in parts of Dublin the boundaries are different to those of community care areas. The community welfare officer/population ratio varies considerably by Health Board (Table A2.15). Information on numbers of applicants and caseload size is not available for different areas. The relationship of the Superintendent Community Welfare Officer to the community care team varies from area to area. The FWUI members do not accept the McKinsey recommendation that the Superintendent should participate in the team, while a medical qualification is mandatory for the Director of Community Care position.

Some of the problems that characterise the social work service in some community care areas are evident with regard to the Community Welfare Service, and usually in the same community care areas; these are poor office accommodation, the absence of clerical support and a peripheral role in the community care structure.

The Report of the Commission on Social Welfare recommended a significant change in this scheme. In its analysis the Commission pointed out that the number of recipients of Supplementary Welfare had grown rapidly from 28,000 to 54,000 over the 1977-1985 period, that this was to a considerable extent due to high unemployment and a high incidence of deprivation among the families of the unemployed, and that a significant portion of the work of CWOs arose from delays and inadequacies in the system of social welfare; also the Commission noted variation from area to area in the operation of the scheme. The Commission recommended that the scheme be integrated into a reformed and decentralised scheme of Social Assistance, and that the new scheme should incorporate in a uniform manner the functions of supplementing incomes, meeting exceptional needs, and acting as a referral system (28).

(v) Home Help Service

Section 61 of the 1970 Health Act empowers but does not require Health Boards to provide a home help service (29). No income group is precluded nor is any income group specified as eligible for the service. Some guidelines in regard to the service were outlined in a circular from the Department of Health to Health Boards in 1972. Noting that the Act permits a charge to be made, it is stated that the service should be provided free of charge to those with full and limited eligibility for health services. In other cases the desirability of making a charge would be considered by the officer recommending the service, taking into account ability to pay. The importance of local assessment of need by public health nurses, community welfare officers, doctors, social workers, voluntary workers, was stressed.

From 1976 to 1980, expenditure on the home help service had increased consistently in real terms: from £0.7m to £4.3m in constant prices (Table A2.5). Since 1981

expenditure in real terms has been constant. Despite the 1981 decrease in real expenditure the number of home helps employed (Table A2.16) and the number of beneficiaries, has increased consistently since the mid-seventies, though there have been marked fluctuations in some Health Boards. The number of beneficiaries in 1981, the latest year for which data are available was over ten thousand (Table A2.17). Eighty three per cent of these (8,514) were aged 65 and over.

The information available on the home help service does not allow an adequate representative appraisal of the service. Expenditure on the service is mostly a wages element. While there are no nationally agreed rates of pay for full-time home helps, most home helps are part-time and their hourly rates vary considerably and are mostly low — in some areas less than £1 an hour. Furthermore, in some areas there are variations between the rates paid to home helps organised by voluntary groups and those organised directly by Health Boards — even within the community care area. Information on the number of hours worked by part-time home helps is not available. Basic information which should be collected relates to the number of visits per week and the number of hours per visit to each beneficiary. Without this information it is not legitimate to conclude that an increase in the number of home helps or the number of beneficiaries, as in 1981, reflects an increase in the level of service.

Recently published research on the home help service, based on data collected in the Eastern Health Board area in 1983, shows a number of difficulties in the operation of the service (30). Firstly, eligibility was established on a "case-by-case basis", and the organisers used "intuition in the selection of recipients." Secondly, analysis of the number of home helps and amounts of expenditure in the different community care areas indicated "large variations in resource distribution." Thirdly, the Health Board did not give sufficient training and support to the personnel, and "evaluation of the service does not seem to have been a high priority of the Eastern Health Board." Finally, the researcher suggested that the very low rates of remuneration deterred many qualified persons from working as home helps, and that it might be desirable to introduce higher payment rates to home helps performing particularly onerous tasks.

Arrangements for the provision of home help services vary not only between Health Boards but within Health Boards, and even within particular community care areas. In the 1972 circular already mentioned, it was emphasised that Health Boards should utilise voluntary agencies and social service councils to the optimum extent in the provision of home help services, and that only where it has been established that voluntary groups cannot provide the service should home helps be directly employed by Health Boards.

Increasingly Health Boards are employing or grant-aiding the employment of home help supervisors and full-time home helps, though the vast majority, according to the most recent data available, are still part-time (Table A2.16). In the Western Health Board area there is a commitment to develop a "professional" home-help service and (as can be seen from Table A2.16) a large number of full-time home helps are now employed. In contrast, in the Eastern Health Board the service is almost entirely run by voluntary agencies funded by the Health Board. In some areas home helps are still recruited and supervised by local public health nurses.

This variety of administrative arrangements for the provision of the home help service reflects the fact that it is very much a discretionary service. It is discretionary in two senses; firstly, there are no clearly specified criteria of eligibility and; secondly, it is in large part provided by voluntary groups whose funding is subject to the discretion of the Health Boards. This second point is part of a much broader issue related to

statutory/voluntary relations which is outside the scope of the present discussion. With regard to the first point the key issue is the relationship between a paid home help service and informal help by neighbours. It has been argued in the National Social Service Council's report on the home help service that: "the essential basis of the Home Help Service is a good neighbour response to need and the paid Home Help service should be seen as supplementary to this" (30).

As has been pointed out, the information available on the home help service is inadequate. In addition, there is only limited information available on the extent and nature of help by neighbours and unpaid volunteers (31). The planning of an effective service is not possible without adequate information on both formal and informal helping. The absence of this information, and the assumption that paid service automatically has a negative effect on voluntary 'good neighbour' activity, can easily lead to the justification of and inadequate and poorly-paid formal service, a danger noted in the aforementioned NSSC document.

At present the home help service is available almost exclusively to elderly people living alone. There is considerable reluctance to provide a service to people living with relatives. This reflects the widespread reluctance, evident not only in Ireland but also in Britain, to support caring relatives. Moroney (32) has characterised the contradiction in policy as penalisation of families while they care for their dependents and rewarding them when they cease to care. The former is reflected in failure to support families caring for dependent people, while the latter is reflected in the payment of the entire cost of residential care once family caring systems have broken down.

The information available allows only a very limited description of the home help service and is inadequate to gauge whether or not all those in need of home help service are getting it, whether or not the level of service provided is adequate, and whether there are variations in eligibility criteria from one area to the next. There is no national policy on eligibility. The nature of the service is such that a flexible approach at local level is essential, however general guidelines covering eligibility should be made available. In addition a policy on availability of services to "non-eligible" applicants on the payment of a contribution should be developed.

(vi) Rehabilitation Personnel

Occupational therapists, speech therapists and physiotherapists all have essential roles to play in an effective rehabilitation service. If this service is to be community-based these specialists must be available on a community basis. Rehabilitation personnel are in short supply and this is particularly true at the community care level. The employment position within Health Boards is outlined in Tables A2.18, A2.19 and A2.20. A breakdown of those employed exclusively in community care teams is not available. While overall the numbers of approved posts has increased, this has not happened in all Health Boards, and in some areas the number of posts filled has decreased. Considerable variation in the therapist/population ratio in different Health Boards is evident in 1987.

Speech Therapists

Speech therapists are involved in the provision of service across all three Health Board programmes. The number of posts per 100,000 population varies considerably between Health Boards, from 7 in the North Western region to 1 in the Mid Western, North Eastern and Southern regions. While referrals may be made to therapists employed by voluntary bodies in those areas where the level of Health Board provision is very low, it is improbable that the major differences in levels of provision evident from Table A2.18

could be made up in this way. Evaluation of the level of service in different areas is not possible at present due to the fact that there is no information available at a national level on referral rates, priority groups or waiting lists. However, information from specialists in the field indicates that waiting periods of up to 4 years are not uncommon for specific non-priority categories.

There are no national guidelines on the employment of speech therapists. Information on the incidence of communication disorders is limited as there has been no national survey of incidence. Two studies which focussed on primary school children indicate that 3% of that population have disorders of communication (33). The Department of Education does not employ speech therapists, with the result that these children are dependent on the Health Boards for services. Looking at the overall picture and given the absence of Irish data, reliance must be placed on recommendations from other countries to arrive at estimates of appropriate levels of provision of speech therapists. The British Department of Education and Science recommended a *minimum* of 6 speech therapists per 100,000 population and this suggests that 212 therapists would be needed in Ireland in 1986 (34). Currently the total complement of therapists in the Health Boards is 106.

In terms of basic facilities and equipment it is evident that employment by Health Boards in some areas compares unfavourably with employment by voluntary bodies. Many health clinics are not adequately constructed in terms of control of noise levels and many are devoid of the basic equipment, i.e. tests, tape recorders and treatment aids. The careers structure for speech therapists has up to now been confined to basic grade therapists. A new community care-based structure is now being introduced in some Health Board areas, whereby community-based therapists would also provide services to other programmes. This structure does not conform with that proposed by the Irish Association of Speech Therapists, which recommended a structure based on each programme under the direction of a Director of Speech Therapy in each Health Board. The Association argues that such a structure is essential if effective planning and organisation is to take place (35).

Occupational Therapists:

The actual number of occupational therapists, and their number relative to population, has increased in recent years — the total number employed rose to 127 in 1987 from 97 in 1981. (Table A.19). There is variation between Health Boards in the employment of occupational therapists: the provision varies from 18 per 100,000 in the North West to 2 per 100,000 in four other Health Board regions. In the North Western region where provision is relatively high, there is a community focus in the service as a whole. Occupational therapists from day and district hospitals provide some domiciliary services; in addition, the Regional Rheumatology and Regional Orthopaedic service provide a limited domiciliary service directly, or arrange for such a service through local centres.

A domiciliary occupational therapy service is an important aspect of community services for people with handicaps, not only for assessment of housing modifications and assessments for wheelchairs, but also to advise on other aids to independence and advise on activities of daily living for children and adults with disabilities. The Irish Wheelchair Association has been providing a service in these areas to its members for many years and its services are used by Health Boards for home adaptation and aids assessment. With one occupational therapist per Health Board this service is limited. Some Health Boards are now initiating a community occupational therapy service.

Physiotherapists

The trends in relation to physiotherapists are similar to those affecting occupational

therapists: an improvement in provision in recent years and a significant variation between Health Boards in the level of provision (Table A2.20). Comparisons between regions may not be meaningful in the present context since the vast majority of physiotherapists are employed in hospitals. Community physiotherapy services are extremely limited and non-existent in most areas. Services to people in the community are available mostly at hospital out-patient departments and day hospitals. Though information is not available at national level the indications are that the level of provision is inadequate. Also, access is being adversely affected by cut-backs in transport. Even if these out-patient services were adequate they would not be appropriate for all persons living in the community (36). A domiciliary service is necessary for certain categories such as severely disabled people, those who suffer distress because of travelling, and those whose relatives need advice on home management. A domiciliary service can have considerable advantages not only to the recipients but also in facilitating participation of experienced physiotherapists who would not be able to work regular clinic hours. This is important because of the limited number of physiotherapists in full-time employment at present and also because experienced therapists are essential for a domiciliary service.

There have been no studies in Ireland of the appropriateness of different approaches to provision of physiotherapy. Evidence from Britain (37) indicates that three levels of provision are essential; hospital, community and domiciliary. The criteria that determine the choice of patients to be treated in community and domiciliary services are clinical, social and geographical factors. The determinants may change during the course of an illness or disability. Consequently close co-operation between the three levels of service is essential. Indications of appropriate levels of physiotherapy are difficult to get (38). One study is useful with regard to domiciliary service (39). It is estimated that in a district population of 220,000 the service could be run with 1 senior and 3 whole-time equivalent physiotherapists. This assumes monitoring of all referrals, and treating on a domiciliary basis only those patients who are not able to travel without distress, either physical or mental, and where carers require advice. On the above basis, 64 therapists (including seniors) would be required to provide the domiciliary element of a physiotherapy service in Ireland. It is not possible on the basis of present information to estimate the staff requirement for all elements of a comprehensive service. Because of the limited information available studies should be undertaken of areas and types of services to establish guidelines on appropriate provision. Such studies should identify the number, and extension of duration, of hospital stays because of the absence of a community based physiotherapy service.

(vii) Dental Service

It has been acknowledged repeatedly in official reports that the public dental service is under-staffed (40). In a report published in 1979, the Working Party on Dental Services identified the sources of the public dental services' inability to fulfil its role as due to:

- (a) the absence of a sustained preventive approach;
- (b) shortage of dentists.

In 1984, there were 329 practicing dentists in the Health Boards (Table A2.21). This represents a significant improvement on the figure for 1981. The ratio of 1 dentist : 16,090 population in 1981 declined to 1 : 10,751 in 1984. In this area of Community Care also there are regional variations in provision relative to population. The figures in Table A2.21 show that the Midland, Western and Mid Western Health Boards are above the national average provision, while the South East is markedly below the

average.

The severe shortage of dentists in the public dental service is associated not only with an unsatisfactory structure within Health Boards, but also with a national shortage of dentists. Ireland has a relatively low ratio of dentists to population: among the EEC (9) countries Ireland's ratio of 27 dentists per 100,000 population is the second lowest. In comparison the rates for France, Germany and Denmark were 51, 52, and 88 per 100,000 population respectively.

Data on the volume of treatments are reported in the Appendix (Table A2.22). Nationally over three quarters of the treatments are in respect of children; the ratio of treatments is 281 per 1,000 population — although there is significant regional variation in this figure (41).

In 1979, a choice of dentist scheme for eligible adults was introduced. Eligible adults are medical card holders and their dependents. About 60% of private dentists agreed to participate, but participation varied from area to area and in some areas no private dentists opted into the scheme — often these areas coincide with those where the public service is most limited. There have been long administrative delays in establishing individual eligibility for this service. In most areas this service appears to be restricted to elderly people.

It has already been pointed out that dentists do not take part in the community care team structure. The Irish Dental Association has proposed the establishment of a separate dental programme. Within this programme a Chief Administrative Dental Officer would have overall responsibility for community and institutional dental services. This type of structure runs counter to the present administrative structure within Health Boards.

In summary, the public dental service continues to be severely limited if measured in terms of the percentage of the eligible population treated. This situation is unlikely to change until the administrative difficulties associated with the service have been resolved.

4. SUMMARY AND CONCLUSIONS

Since 1976 total non-capital expenditure on the Community Care Programme has increased less than overall non-capital health expenditure. In particular, it has increased less than expenditure on the General Hospital Programme and the Programme for the Handicapped. While expenditure on particular community care services has increased considerably more than the average, in all instances these services started from an extremely low expenditure base.

Expenditure comparisons between Health Boards are not possible. Focussing on employment levels in terms of particular services, there are considerable variations between Health Boards in the levels of employment of community care personnel.

While there is widespread acknowledgement that there are shortages of particular personnel, notably rehabilitation personnel in all areas and social workers in some areas, there are no national guidelines on what the appropriate level of these services, as reflected in personnel/population ratios, should be. As a result people in objectively similar circumstances may get a service in some areas and not in others. Even where guidelines with regard to professional/population ratios are available, as in the case of public health nurses, there are indications that they may now be outdated. There are no

consumer studies relating to community care services; as a consequence the adequacy of present services from the point of view of the consumer is not known. Many of the difficulties identified in this chapter relate to organisational issues. Until these are resolved service delivery is unlikely to develop in the way required to provide an adequate service.

CHAPTER 2

Footnotes and References

- (1) There is no price index available for health expenditure, however current expenditure on health can be translated into expenditure at constant prices by using the price index for public authorities' current expenditure developed by the Department of Finance. It is recognised that there are limitations associated with the use of this measure. The main limitation of this method is that current health services expenditure is comprised of a larger wages element (66%) than is current public expenditure (50%). However, it is clearly preferable to the Consumer Price Index. The only other alternative is the Eurostat Price Index for Medical Care and Health Expenses. Eurostat, *National Accounts* ESA, 1983, p169. While the use of this index might be desirable it is available only up to 1980.
- (2) The decline was 1.9% in 1982 and less than 0.2% in 1983.
- (3) An outline of the expenditure changes in services with each of the 3 sub programmes is given in Appendix 2.
- (4) *Survey of Workload of Public Health Nurses*: Report of a Working Party, Dublin, Stationery Office, 1975.
- (5) In June 1978 there were 1,091 Public Health nurse posts approved by the Department of Health. Only 1,010 of these posts were filled.
- (6) The number of public health nurses in training decreased markedly between 1982 and 1983 from 65 to 27. The 65 who entered training in 1982 completed their course in September 1983. It is improbable that the employment of this group has led to any significant change in the employment position outline in (Table A2.7 (ii)). At least some of the 65 are likely to have replaced retiring nurses; in addition 34 posts were filled by temporary nurses in February 1983 and a further 10 posts were vacant. Furthermore 11 of the senior public health nurse posts were vacant.
- (7) *Health Care for Mothers and Infants*: a Review of the Maternity and Infant Care Scheme, Department of Health, 1982.
- (8) Department of Health: *Report of Working Party on General Nursing*, Dublin, Stationery Office, 1980.
- (9) This service is staffed by a part-time nurse from Monday to Friday and by the duty public health nurse at week-ends. Most calls come between 9.00 and 11.00p.m. and the average number of calls per night is 4.
- (10) A limited number of nursing attendants were introduced in the Eastern Health Board in 1982; the scheme met with opposition from the nurses' professional organisation and has been discontinued in most areas.
- (11) It was first established by the 1925 Local Government Act.
- (12) Department of Health, *Public Health Medical Services*: Report of Working Party, (The Walshe Report), March 1976
- (13) Despite this, controversy relating to the Director of Community Care position continues.

- (14) The functions relate to the following areas:
- Infectious Diseases (including T.B.)
 - Food Hygiene
 - Health Education
 - Epidemiology of Non-Infectious diseases
 - General Practitioner, Maternity and Infant Welfare Services
 - Child Health Services
 - Care of the Handicapped
 - General Medical Services
 - Care of the Aged
 - Liaison with hospital services
 - Welfare Services
 - Environmental Health Services
- (15) Inbucon Management Consultants, *Community Care Review Report* Department of Health, March 1982; Department of Health, *Future Organisation of Community Based Services, Proposals for Implementation*, n.d., unpublished.
- (16) 3 seconded from Athlone Social Service Council to Westmeath/Longford Team; 8 from Clare Social Service Council, which provides social work services in the Clare area, on an agency basis for the Mid-Western Health Board.
- (17) Work on appropriate case-load size is being carried out in one community care area in Dublin.
- (18) National Manpower Planning committee for Personal Social Services, *Interim Report on Employment of Social Workers*, April 1981.
- (19) *Task Force on Child Care Services Final Report*, Dublin, Stationery Office, 1980, p.116.
- (20) In Britain there is approximately one local authority field social worker for every 3,200 of the population. This ratio excludes management staff. National Institute for Social Work (1982), *Social Workers — Their Role and Tasks* (The Barclay Report), London, Bedford Square press.
- (21) See Chapter 3 on Social Work Services for Children.
- (22) Kennedy, S, *Who Should Care? The development of Kilkenny Social Services*: Dublin, Turro Press, 1980.
- (23) National Manpower Planning Committee, *op. cit.*
- (24) Kennedy, S, Address to the Social Services Council Conference (1976), quoted in Curry, J. *The Irish Social Services*, Dublin, IPA, 1980, p.223. In this address, the need for case workers was acknowledged but it was argued that they should be complemented by group and community workers: "community workers who will represent the interests of the local community, who will provide a vehicle for the community to assess its local needs and enable it to participate in the planning, provision and delivery of services to meet these needs". Without such a dual focus, it was argued that social workers may become the dumping grounds and scapegoats for social problems.
- (25) Task Force on Child Care Services, 1980 *op. cit.*, pp.142-152.
- (26) Lavan, A, *Social Need and Community Social Services*, Dublin, Tallaght Welfare Society 1981; Mollan, C, *Families and Children*, Dublin, CARE, 1983.
- (27) Unlike other social assistance services, recipients do not need to come within particular categories such as unemployed, but certain categories are excluded: students, people living in institutions, those engaged in a strike, (but not their dependants) and people who are employed longer than 15 days.
- (28) *Report of the Commission on Social Welfare*, Government Publications, Stationery Office, Dublin, 1986, Chapter 19.
- (29) A Health Board may make arrangements to assist in the maintenance at home of:
- a sick or infirm person or a dependent of such a person,
 - a woman availing herself of a service under Section 62 or receiving similar care, or a dependant of such a woman.
 - a person who, but for the provision of a service for him under this Section, would require to be maintained otherwise than at home, either (as the Chief Executive Officer of the Board may determine in each case) without charge or at such charge as he considers appropriate.
- (30) National Social Service Council, *Report on Home Help Service*, 1978, Dublin, p.12.
- (31) Whelan, B J and Vaughan R N, *The Economic and Social Circumstances of the Elderly in Ireland*, ESRI Paper 110, Dublin, 1982; Power B, *Old and Alone in Ireland*, Dublin, St Vincent de Paul Society, 1980.
- (32) Moroney, R M, *The Family and The State*, London, Longman 1976.
- (33) Collins, Sr Geraldine, "Survey of Communication Disorders in the School Population of Clare, Ireland", Unpublished, 1978; Supple, Sr Marie de Montford, "Survey of Speech Defective Children in the Primary School Population of Ireland comparison of same with distribution of Speech Disorders seen in the Childrens' Hospital, Temple St, Dublin Ireland." *Journal of Australian College of Speech Therapists*, 1963.
- (34) Department of Education and Science, *Speech Therapy Service* (Quirk Report), London, HMSO, 1972.
- (35) Irish Association of Speech Therapists, *Speech Therapy in the Service of the Community, a Policy Document*, 1979.
- (36) There are 2 Schools of Physiotherapy in Dublin, each of which has 30 entrants per year. The training period has now been increased from a 3 year diploma course to a 4 year degree course. Because of this transition there were no graduates in 1985.
- (37) Partridge, C.J. and Worren, M.D. *Physiotherapy in the Community*, Health Services Research Unit, Canterbury, Kent, University of Kent; Glossof, S and Smith, D.S. *Domiciliary Physiotherapy: A Research Project 1976-1978*; A Report to the Department of Health and Social Security from Brent and Harrow Area

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- Health Authority, London; 1979.
- (38) Partridge and Worren, *op. cit.*
- (39) Despite studying 14 community based schemes and affirming the need for such services, Partridge and Worren were not able to come up with guidelines on service provision.
- (40) Glossof and Smith, *op. cit.*
- (41) Department of Health, Statistical Information Relevant to Health Services, 1985, Table H3, page 78.
- (42) Glossof and Smith, *op. cit.*
- (43) *Dental Services Report*, Department of Health — Irish Dental Association — Health Boards, Joint Working Party, Dublin, 1979; *National Health Council, Report for 1976*, Dublin, Stationery Office, 1976.
- (44) National Health Council, *op. cit.*
- (45) Department of Health *Statistical Information Relevant to the Health Services*. Dublin Stationery Office, 1982, Table H4.

1. INTRODUCTION

The services provided for children as part of the Community Care Programme fall into two broad categories: Child Health Services and Personal Social Services. The principal services in each category will be considered in this chapter. Child Health Services are preventive and diagnostic in orientation and are provided primarily by public health nurses and area medical officers. In addition to Pre-school and School Health Services, the role of the public health nursing service for children will be considered under this heading as will the role of psychologists in the School Health Services. Personal Social Services refer to those social support services to individuals and families other than health, education, housing and income maintenance. These services are provided by social workers, child care workers, home helps and include Domiciliary and Day-Care Services, Adoption, Fostering and Residential Care.

2. CHILD HEALTH SERVICES

Child health services can be considered under two headings viz; Pre-School Services and School Services. Under Section 66 of the 1970 Health Act a Health Board is obliged to make available without charge a health examination and treatment service:

- (a) at clinics, health centres and other prescribed places for children under the age of 6 years;
- (b) for pupils attending national schools.

Treatment services include dental, ophthalmic, aural, specialist services and hospital out-patient services. Out-patient services are available without charge, to children irrespective of parental income in respect of:

- (1) specified diseases of a permanent or long standing nature;
- (2) defects noticed at child health clinics and school medical inspections (Section 56, 1970 Health Act).

(i) Pre-School Services

Health examinations are provided for pre-school children through developmental paediatric clinics and child welfare clinics.

Development Clinics

Health Boards are obliged to provide developmental clinics only in centres of population of 5,000 or more. This service provides for developmental examinations at 6-10 months, 12-18 months and 2 years. 67% of eligible children (i.e. born in centres

where the developmental clinics are held) had a first examination in 1984. The figure for 1982 was 75% (Table A3.1). There is no information available on eligible children who do not attend child development clinics, specifically on whether or not particular population sub-groups are not taking up the service.

The 1984 figure for attendance at child development clinics represents 51% of all births, and the 1982 and 1983 figures are 50% and 56% respectively of all births, and the 1980 figure 44% of all births. These figures for the early years of the nineteen eighties indicate a general improvement over time in the coverage of developmental examinations. However, the percentage of eligible children examined varies markedly between Health Boards and from year to year (Table A3.1).

In recent times approximately a quarter of the children who are examined at the examinations require further attention, (Table A.3.2). The action taken is either referral to a specialist, referral to a general practitioner, or retention under observation (Appendix Table A3.3). The latter course of action is taken in the majority of cases.

In the 1967 report on the Child Health Services it was recommended that: "In rural areas and in towns without clinics, the scheduled medical examination for pre-school children should be undertaken by general practitioners under agreements with the health authorities" (1). This recommendation has not been acted on. The present procedure in areas outside the range of developmental clinics is that children are screened by public health nurses as part of their home visiting programme and referred to child welfare clinics, where these exist, or to family doctors. No information is available on the number of children identified by public health nurses as in need of further attention, or on the percentage who take up referrals to family doctors. Given that there are costs involved for those families who are not medical card holders it is probable that uptake of referrals to family doctors may be influenced by economic factors, particularly in the case of families in marginal economic circumstances.

Since approximately 50% of children do not have access to child development clinics it is worth considering whether or not the level of service they are getting is appropriate. If the level of service is appropriate, then it must be asked whether or not the developmental clinic is an essential service. No evaluation of this service on a national basis has to date been carried out. A report on the service by Eastern Health Board Directors of Community Care concluded that "no generally accepted list of risk factors has as yet been established which would confine examinations to a selected group of children, while at the same time ensuring detection at an acceptable level of defects among the child population generally" (2).

Child Welfare Clinics

In addition to developmental clinics, child welfare clinics are held extensively in some areas, primarily urban areas (Table A3.4). Practice relating to the holding of these clinics varies considerably around the country as does the frequency of clinics. In many community care areas no community welfare clinics are held: Kerry, Mayo, Roscommon, Laois/Offaly, Clare, Cavan/Monaghan, Tipperary South Riding, Kildare, and in the Leitrim part of the Sligo/Leitrim community care area. These clinics pre-date the child developmental clinics. The 1953 Health Act mandated the holding of these clinics in towns of 3,000 population and over; they were intended to be primarily diagnostic and advisory. It was envisaged that they would be reduced in number or phased out with the advent of child development clinics. This has not happened to any significant extent. In 1984, 38,482 children were seen at community welfare clinics, 65% of whom were from the Eastern Health Board area.

There is no breakdown available of the number of type of defects identified at these clinics or the percentage of children identified as in need of further attention. A study of the operation of child welfare clinics in one Dublin community care area indicated that only a minority of mothers used the clinics in their diagnostic and advisory capacity; 71% of the children were attending because of a specific complaint or condition (3). Excluding children attending at the clinics at the request of the clinic doctor or nurse, 50% of all children were attending because of a medical condition or suspected medical condition. Only 5.5% required referral to a specialist (4). The Eastern Health Board working party on Child Health Services concluded that the advisory and health education functions performed at these clinics do not require the presence of a doctor, that these clinics should be replaced by (a) Child Health Clinics operated by public health nurses and (b) Referral Clinics staffed by area medical officers. These changes have now been effected in the Eastern Health Board area and the new arrangements should be evaluated with regard to their appropriateness for application in other Health Board areas.

In some areas there are neither development clinics nor child welfare clinics. In this regard it is notable that in a review of the Maternity and Infant Care Services conducted in 1980 by the Department of Health and the Medico-Social Research Board, 23% of infants had not been examined by a doctor before 10 to 12 weeks after discharge from hospital; the percentage was 33% in the case of category 1 mothers (i.e. medical card holders), who used the scheme. The operation of the scheme allows the general practitioner to limit his/her involvement to looking after the mother and to opt out of providing services for the infant. The Working Party responsible for the study recommended that a full developmental examination at 6 weeks should be an integral part of the scheme and that carrying out the examination or ensuring that it is carried out should be the responsibility of the general practitioner. Because of the crucial importance of the early detection of defects it is essential that this recommendation be implemented. The 1980 study found a marked regional variation in the percentage of infants not examined, from 51% in the North Western area to 10% in the Eastern Health Board area, which suggests that accessibility of hospitals and clinics is probably of major significance.

Variation in availability and accessibility suggests a significant question about services: if services such as developmental and child welfare clinics are considered to be essential services in some areas, it must be established whether or not they are essential in all areas. It is not justifiable that children are deprived of an essential service simply because of geographical location. Thus, it is necessary that the present range of services be evaluated and compared in terms of needs (which may vary considerably by area), objectives, availability, accessibility and outcome.

(ii) School Health Services

The aim of these services is to offer:

- (a) a comprehensive medical inspection to all children between their sixth and seventh birthdays;
- (b) routine annual screening by the district nurse for vision, posture and cleanliness, audiometric testing of special groups;
- (c) selected medical examination of nine year old children;
- (d) examination in any year of a child referred by the parent, teacher, or district nurse, or a child due for re-examination (5).

It was envisaged that the doctor would visit each school at least once a year and that the nurse would visit more frequently; but this level of visiting has not been realised. During the years 1980—1984 about 40% of all schools were visited and 24% of the national school population were examined (Table A3.6). The percentage of the national school population examined in 1984 varied from 18% in the Midland Health Board area to 30% in the South Eastern Health Board area (Appendix Table A3.6). Fortyfive percent of the examinations were of new entrants — 54,766 (Appendix Table A3.7). This represents approximately three quarters of new entrants in 1984.

In 1984, 35% of new entrants required further attention; the corresponding figure for 1979 is 40%. The percentage in need of further attention varied considerably by Health Board area in 1984 (Appendix Table A3.8). The action taken can entail referral to specialists, referral to family doctors and/or retention under observation (Table A3.9)

The referral to specialist category includes referral to a psychologist or speech therapist in addition to medical specialists; however, the breakdown of the category is not available. The largest categories of defects identified at school medical inspections are visual, aural, speech, mental handicap/'slow learning' and head infestation. It is not possible to ascertain whether these defects could have been detected at an earlier age and whether detection at school age is too late. There are problems about the adequacy of the information collected on the school medical services. It has been suggested by experienced professionals involved in the service that there may be variations in practice about categorisations for returns in different areas. A significant limitation with the data is the failure to identify whether or not figures relate to prevalence or incidence of disorders, whether or not the disorders have already been discovered by general practitioners or child development or welfare clinics, or whether the disorders are originally discovered at school medical inspections.

A study of the school medical service covering a broad range of community care areas is now being planned by the Research Committee of the Faculty of Community Medicine (6). The results of this study should facilitate an appraisal of the efficiency and effectiveness of the service. Such an appraisal should be linked to a similar appraisal of The Child Developmental Clinic Service. The need for a school medical service as operated at present, which absorbs a high proportion of the time of area medical officers, must be considered with reference to the operation of the child developmental clinics. There are variations in the practices relating to child health services between different community care areas. Within the limitation imposed by the statutory framework for the services, some Directors of Community Care put more emphasis on school medical inspections, while others emphasise the extension of child development clinics. These variations could provide useful bases for comparisons of effectiveness and efficiency of various arrangements.

In conclusion, there is a need for a review of all child health services in terms of needs, objectives, means and outcome.

The Role of Psychologists in School Health Services

A key element of the school medical services at present is the arrangements made for psychological assessment of children identified as having learning difficulties within the school system. It has repeatedly been pointed out that a school psychological service on the lines envisaged by the *Commission of Inquiry on Mental Handicap* (1965), i.e. a team comprising a school medical officer, school psychologist and a social worker, has not been set up. (7) However, Health Boards are increasingly employing psychologists, though the numbers are still very limited. Diagnostic Assessment and Advisory Services under the auspices of voluntary bodies providing services for mentally handicapped people and Child Guidance Clinics are widely used for psychological assessments. In

some Health Board areas these services are used only where mental handicap is suspected and following assessment by a Health Board psychologist. In other areas where Health Board psychologists are limited in number or non-existent, Diagnostic Assessment and Advisory Services, Child Guidance Clinics, or sessional psychologists, are used for first line assessments. Statistics are not available on the number of referrals to psychologists in different areas, on the number of referrals made through the school medical service and at other times by teacher, general practitioners, and parents.

It is not clear that the present service which has evolved in the absence of a school psychological service is adequate or appropriate. The Department of Education employs psychologists as guidance counsellors at the post-primary level. There are no indications that it proposes to provide a psychological service for primary schools. The present Health Board provision should be evaluated. In the study of the school medical inspection already referred to, the take-up of referrals to Child Guidance Clinics/Psychologists was only 56%, which was lower than the take-up of referral to any other service (8). It is probable that if an educationally oriented psychological service were integrated into the school system to a greater extent take-up would be greater. The present situation is conducive to referral for psychological assessment when the need may be for advice on classroom management. Apart from the expenses involved in the frequent use of sessional assessments, the present arrangements militate against an overall assessment of the needs of particular areas, schools or population sub-groups.

(iii) The Role of the Public Health Nurses in Child Health Services (9)

The *Survey of Workload of Public Health Nurses* (1975) found that while children comprised 4.7% of district nurses' patients in 1972, they accounted for 25% of nurses' home visiting time. Most of the nurses' work with regard to children is preventive:

"The primary aims of home visiting by Public Health Nurses are the promotion of positive health in each child, the early discovery of defects or other physical, mental, social and emotional problems and the prevention of avoidable physical, mental, social and environmental deprivation" (10).

In complying with these aims a wide range of activities are undertaken by public health nurses:

- A nursing service for infants up to 6 weeks;
- Home visiting of handicapped children;
- With regard to children aged 6 weeks to 2 years — home visits and attendance at developmental and child health clinic;
- Developmental paediatric work with children aged 2 to 5 years;
- School health work with children aged 5 to 15 years.

In the current Department of Health guidelines to public health nurses on home visiting of children it is recommended that each child should be visited at least 6 times during the first year of life, and, more frequently in the case of children who appear to be vulnerable (11).

Further visits are recommended at 18 months, 2 years and 3 to 4 years. The successful operation of this visiting scheme is dependent on early notification to the nurse of infants born in her area. A study of the Maternity and Infant Care Scheme, carried out by the Department of Health and Medico Social Research Board in 1980, showed that 45% of babies were not visited in the first week after discharge from hospital: the

percentage varied from 11% in the Midland Health Board area to 62% in the Southern Health Board area (12). This variation is probably due to differences in notification procedures and also may be associated with public health nurse/population ratios — the Southern Health Board has the highest population to public health nurse ratio in the country.

The domiciliary development work of the public health nurse is particularly important in those rural areas which are outside the range of developmental and child welfare clinics; in these areas the public health nurse is the key person in the community care service, in the detection of developmental delays and handicap during the pre-school period.

A considerable part of nurses' time is devoted to school medical services. This involves screening for hearing and visual defects and attendance at school medical inspections.

The public health nurse is the potential source of a considerable amount of basic information necessary for planning and evaluating maternal and child health services. At the present time this information is not recorded in any centralised system. Recent developments in the North Western Health Board are of interest in this regard. In that area a Community Care Information System has been developed, which facilitates the recording and utilisation of basic but essential information routinely recorded by professional workers.

It is not possible to evaluate the adequacy of the present approved level of public health nurse provision in terms of services for children, since there is no information available at national level on visiting patterns of public health nurses or of any other community care personnel. There are no consumer studies which could indicate the adequacy of the service from the point of view of the consumer. The curative nursing demands on the public health nursing service are increasing due to earlier discharges from hospitals (13). What, if any, negative impact this having on primarily preventive elements of the nurse's work, such as her work with children, is not known at present.

In summary, considerable variation in the availability of child health services has been identified and a review of these services recommended. The absence of a school psychological service has been noted and some associated problems have been identified. The public health nursing services for children have been outlined and the increasing curative nursing demand on the service noted in terms of the possible pressure on the primarily preventive child health services.

3. PERSONAL SOCIAL SERVICES FOR CHILDREN AND FAMILIES

The term "Personal Social Services" refers to those social services which essentially entail a personal relationship between client and service provider. The sub divisions of the personal social services are:

- (i) Social Work Services:
- (ii) Services supplementary to family care:
 - (a) Domiciliary services, i.e.
 - Child care workers with families
 - Home help services
 - Home management advisers

- (b) Day-Care, i.e.
 - Day-Nurseries/child minding/playgroups
 - Day-Fostering

- (c) Community Projects

- (iii) Alternatives to family care:
 - Adoption
 - Fostering
 - Residential Care

A major review of personal social services for children was undertaken by the Task Force on Child Care Services which was set up in October 1974 following a Government decision allocating to the Minister for Health the main responsibility in relation to child care. An interim report was issued in September 1975 and the final report in September 1980 (14).

No major action relating to the recommendations in the final report has been taken at Health Board level to date. The Task Force recommendations have major administrative implications for Health Boards. The implementation of these recommendations would extend considerably the role of Health Boards through their designation as Child Care Authorities (C.C.A.). It is envisaged that the work of the C.C.A. will be assigned to the Community Care Programme. However, the report emphasises that child care services, with family support services, should constitute a separate body of services distinguishable from health services (15). The primary emphasis of the report is on considering the child within the context of his/her family and local community and an extensive range of recommendations embodying such an emphasis is made. In the following sections those services for children which are part of the present responsibility of health boards through the Community Care Programme will be considered with reference to the recommendations of the Task Force. A review of these recommendations indicates that there are serious shortfalls in the present range and level of services. The focus on the Task Force recommendations is adopted because the Task Force Report is the only comprehensive official discussion document on children and it is believed to be the framework for official proposals for the development of services. An additional official report on adoption has also been published and used as the basis of adoption legislation — the Report of the Adoption Review Committee (16).

Personal social services to children provided under the Community Care Programme can be categorised broadly as either supplementary or alternative to family care.

Services supplementary to family care may be directed towards all children, for example, community pre-school playgroups. Alternatively they may be restricted to those who present identifiable special needs or who are assumed to be at special risk of family breakdown — the key fact about services of this second type is that they are directed towards children who continue to live in their own homes.

Alternative care refers to help for children away from the family home which should aim:

"... at avoiding the worst consequences of child actually having to spend long periods in substitute care ... It would include preventing his remaining in care unnecessarily or in forms of care which were not appropriate to his needs" (17).

Services under each of these headings will be considered in turn. Since the social work

service is involved at both levels, issues related to it will be considered first.

(i) Social Work Services for Children (18)

One of the key elements in the implementation of the Health Boards' personal social service responsibilities for children is the social work service. Furthermore, the major part of Health Board social workers' functions relate to children, in particular to the Health Boards' statutory responsibilities for children. These responsibilities relate to the following areas:

- Adoption enquiries, assessment and placement (19)
- Long and short-term fostering enquiries, assessment and placement (20).
- Children at nurse - supervision of children so placed (21).
- Admission to care of children whose parents are not in a position to care for them, either temporarily or permanently and follow-up work with child and family (22).
- Fit Person Orders which entail supervision of child placements and follow-up work with parents (23).

Apart from work associated with these statutory responsibilities Health Board social work services relating to children can be broadly categorised as (a) advisory and casework services and (b) development of community resources for children. Advisory and casework services can cover a broad range of activities — assessment of needs, individual counselling of child and/or family members and organising appropriate services. This may involve attempts to mobilise community resources in the development of support services such as community play groups or day-fostering.

(ii) Supplementary Services

Supplementary services to families include Domiciliary Services, Day Care Services and Community Projects. Each of these will be considered in turn.

Domiciliary Services

Services which help families to care for children in their own homes are limited in availability; such services could involve child care workers and /or home helps and/or home management advisers.

As regards child care workers in the family home, the Task Force Report identifies certain situations in which the assistance of a specially trained worker could be instrumental in enabling some deprived children to continue living at home e.g. in parental illness, because of severe family problems or where family care is being re-established after residential placement. This type of service is almost non-existent at present (24).

There are six training courses for child care workers (25). Most of the emphasis in these courses is on working with family sized groups in residential settings. The training needs of child care workers with families have not been identified either at Department of Health or Health Board level to date.

In relation to the home help service, the Department of Health guidelines on the service issued in 1972 identified the priorities for service as families where children would otherwise have to be placed in residential care, and elderly people; the present position is that the service is oriented almost exclusively towards old people (26). In 1976, 612 families benefited from the services, including approximately 2,000 children. In 1981 the most recent year for which data are available all the non-aged recipients amounted

to just over 1,700. This figure includes not only families, but also handicapped people. The present service is deficient in two respects. It does not exist in all areas and where it does exist it is inadequate; furthermore, the skills needed to work with families experiencing severe difficulties have not been developed in most areas.

A home help service was identified by the Task Force on Child Care Services as one of the most effective ways of helping children in their own homes. The role of the home help within the context of child care services was seen as the provision of help at various levels to families who experience special difficulties. This can vary from temporary breakdown of normal arrangements due to illness of the mother to longer term problems resulting from limited capacity on the part of parents to care adequately. The service proposed was seen as being different and distinct from the present home help service. The new service would be part of the overall child and family services and would require specially trained home helps. The kind of training was not specified. To date action to develop this type of service has been limited. In a few community care areas "home-makers" have been recruited. These services are at present dependent on individual initiatives. This is an undesirable situation — if the service is considered essential, it should be available to people with similar need irrespective of location.

In the case of home management advisers, a small number are employed by Health Boards to provide a domiciliary and community oriented advisory service to families as part of the community care team. Outside of the Western Health Board where there is one adviser in each community care area, the service is very limited and non-existent in most areas.

Day Care Services

Day care covers a wide range of services: Child-minding, day-fostering, creches, day nurseries, nursery schools, playgroups. Comprehensive information on the present level of services is not available. The Department of Health collects information on the number of children attending "day centres" financially aided by Health Boards — for the most part day nurseries but also some creches and community pre-school playgroups (27). The Irish Pre-School Play-groups Association collects information on the services provided by its members.

At a general level a distinction can be made between day care services provided on a commercial basis (the vast majority of child-minding at present) and those provided by voluntary groups; a further distinction can be made between those voluntary groups who are and are not aided by Health Boards. The involvement of Health Boards in the provision of day care services is generally indirect and limited in scope.

Under Section 65 of the 1953 Health Act Health Boards may contribute towards the running costs of day services operated by voluntary agencies. In recent years the Health Boards' support has increased. Thus, in 1980 the number of assisted centres was 87 and in 1984 it was 234. These centres cater for 6,100 children out of a total of 20,000 children attending all day care centres throughout the Country (27). In practice the types of services aided are creches, day-nurseries, a limited number of community pre-school playgroups, and the specialised pre-schools run by Barnados and the I.S.P.C.C.

The level of provision of these services varies enormously from one area to another; in most areas, however, the number of places is increasing (28). The provision of day care services presents considerable problems in rural areas because of transport problems (29). Consequently, even in Health Boards with relatively high overall provision the distribution is uneven. A further contribution to the uneven development is the fact that provision is exclusively by voluntary bodies with the financial aid of Health Boards, thus in most areas there is no overall plan for the development of services, rather their

development is dependent on the initiative of voluntary groups. In a minority of areas community workers have been instrumental in getting services established (30). In most areas there is considerable pressure on day care services and attendance is limited solely to children having special needs and even for these there are long waiting lists. This is a very undesirable pattern and runs counter to recent thinking on service provision and the thrust of the Task Force Report, which implies a policy of normalisation and the non-identification of services with special needs group.

Apart from the distribution and character of services, two additional factors need to be considered with regard to the adequacy of services: firstly, the time periods over which services are provided each day and secondly, the quality of service provided. Although the Department of Health does not collect information on hours of service it appears that the majority of day care centres operate on the basis of relatively restricted hours, i.e. within the period 9a.m. to 5p.m. This type of service does not facilitate someone who works full-time and runs a household single-handedly whether on a temporary basis (for example, due to illness of spouse) or permanently, due to being a single parent.

There is no information available at a national level on the quality of services (for example, staff training and staff/child ratios), nor are there any official guidelines relating to provision. The Task Force Report recommended compulsory registration with the Child Care Authority for both creches and day nurseries. It recommended that these centres should be organised in accordance with a planned programme designed to provide, as far as possible, the care which a child could expect in a normal family (31). The Department of Health's Committee which was set up to examine the minimum legal requirements and standards which should apply in the regulation and registration of day care services for children reported in 1985. As a result of this report the Child (Care and Protection) Bill 1985 provides new powers for the Minister to register and regulate all forms of Day Care, and other Child Care Services. This Bill has yet to become law. The only set of recommended standards available at present relate to pre-schools, and have been developed by the Irish Pre-School Playgroup Association; this association operates a system of voluntary registration for its members.

The Working Party Report on *Child Care Facilities for Working Parents* (1983) has made general recommendations calling for the extension of day care facilities:

"The overall aim of official policy should be the provision, as soon as possible, of a comprehensive day care service in each Health Board Region to cater for the needs of working parents and others who have difficulty having their children looked after" (32).

Congruent with the Task Force recommendations, it recommends that all child care services should be provided through, or under the aegis of, the Community Care Programme.

Neither the Task Force nor the Working Party on Child Care Facilities for Working Parents specified guidelines relating to the level of day-care provision. The Task Force recommendations are based on the principle that the cost of day care should be borne by it users as far as they can afford to do so. The extent to which the C.C.A. should provide services should be related to the needs of parents and children in each area:

"taking into consideration factors such as the overall environment, the number of families in need of support of this nature, and the extent to which it is considered that the particular service will prove to be effective in preventing stress situations which would endanger the welfare of the children or place them at risk" (33).

The Task Force concluded that there is "a significant need" for the provision of day care services to prevent and to alleviate deprivation, and recommended that the C.C.A. in each area should survey the need for day care and should devise a plan for the provision of the required service. The extent to which day-nurseries would be provided publicly or by voluntary bodies would depend on the circumstances of each locality.

With regard to playgroups it is specified by the Task Force that the CCA should not be involved in provision but that the efforts of voluntary groups could be supported and that grants should be made available to organisations such as the Pre-School Play Group Association towards the remuneration of area organisers. Further, it was recommended that for playgroups and private child minding services there should be a system of voluntary registration with the CCA.

At present the IPPA is funded through the Eastern Health Board for a national organiser and by the Southern Health Board for a regional adviser. In 1982 there were approximately 14,400 children aged 3 — 5 years attending the 1,046 play-groups affiliated to the organisation; 685 of these playgroups were Home Playgroups, 265 were Community Playgroups and 101 were in some other categories (34). Home playgroups are run by individuals on a commercial basis. Community playgroups are those which are organised and financed co-operatively by parents and other members of the community. A minority of community playgroups are aided by Health Boards. Because of the self-help nature of these playgroups their success is dependent on community resources, notably such resources as premises and equipment. Thus, the provision of pre-schools by the community may be most difficult in areas of greatest need and in particular for those with greatest needs within these neighbourhoods (35).

Where voluntary groups identify a need for day care services provision, the funding of such services presents considerable difficulties. Some of the services provided at present are subsidised to a considerable extent by the voluntary groups involved in provision; this subsidy element is not always made explicit even by the groups involved — this was the case notably with regard to some services provided by religious orders in the past. Often this fact is not acknowledged by Health Boards in discussing the funding of facilities proposed by community groups.

It is recognised that the provision of effective day care services may be expensive, but an evaluation of this expense must take into account the purpose of day care and the cost of alternatives. Whether or not a particular day care service forms part of a range of services aimed at preventing permanent separation of children from their families, or whether it is a discrete service with more limited aims should be considered. If a preventive focus is taken the purpose must be considered not only from the standpoint of the child but also from the standpoint of the family. The emphasis in debates on day-care services is very often focussed almost exclusively on the effects of the emotional, intellectual and social development of the child; however, from a preventive point of view it is equally important to view day care as a means of assisting parents (36). In this regard "day" care may not be sufficient to meet the needs of many parents. Evening, night time, or weekend supplementary care may make the difference between ability to cope and the need for residential care for children. In this regard the whole range of supplementary services must be considered. Care outside the home may not be the most effective provision rather the option of a home help of home maker may be more appropriate. These options should be considered in those areas where day-care services are not feasible.

As regards day-fostering, this service differs from ordinary fostering in that the children involved do not reside in the foster homes. The arrangement is comparable to a specialised kind of child-minding arrangement for children with special needs for whom

the Health Board has undertaken responsibility. The Health Board is accountable for the suitability of the arrangement and responsible for the standards of care. The day foster parents are selected and trained to provide care for children from families where there are specific problems or crisis. The objective is to prevent initial breakdown of the family unit.

Day fostering operates in two community care areas, both in Dublin. A report compiled on the service, in one of the areas, indicates that it has been remarkably successful in preventing family breakdown (37). Of 65 children fostered over an 18 month period three quarters were described as at risk of family breakdown. It was concluded that half of the children would have been placed in residential care if day fostering was not available.

The Task Force on Child Care Services identified Day Fostering as a necessary option in the range of supplementary care services. It was stated that the need for this type of care would arise only in a minority of cases. This may be a conservative view of the potential of this type of service. In urban high density communities the potential of day fostering may be considerable. (High population density is important since the foster home must be within easy access of the natural home). Day fostering is appropriate in situations where it is necessary to care for children at risk, and yet desirable to avoid total separation from family of origin. It may also be appropriate in the event of sickness or hospitalisation of full-time carers and in providing relief to parents of mentally or physically handicapped children.

Community Projects

The concept of community in the sense of neighbourhood is central to the approach advocated by the Task Force which stressed that:

"services for children and their families should, where possible, respond to the needs of defined communities, that the communities concerned should be encouraged to participate in the identification of needs and in the operation of the services, and that the maximum involvement of children's families should be encouraged and facilitated" (38).

The Task Force recommended that the appropriate structure should be "a locally-based system which aims to provide as far as possible a comprehensive service to a given area" (39). It was envisaged that such a system should create a meeting ground and potentially a pooling of resources between the CCA and the community. Two of the services advocated by the Task Force have an explicit neighbourhood orientation, viz Neighbourhood Youth Projects and Neighbourhood Resource Centres. In its Interim Report (1975) the establishment of three Neighbourhood Youth Projects was recommended. At present there are four of these projects in operation, one each in Cork and Limerick and two in Dublin (40). The services provided are aimed primarily at children from 10—16 years who need supervised care of a non-residential nature, but are not reached by traditional youth club activities. Apart from the core group of young people these projects have a lower level of involvement with a wider fringe group of children — in fact it is explicitly recommended that they should not focus solely on delinquent children.

In its Final Report the Task Force recommended the establishment of Neighbourhood Resource Centres which would be focal points at which people in the community could meet together with CCA workers to identify the need for services for children and families in the area:

"Its functions would be to mobilise community resources on behalf of children and

their families and, by combining the resources of the community, voluntary organisations and the CCA to maximise their impact on the well-being of children and families in the area" (41).

The exact form of the centre would depend on the size of the area, local needs and existing services — in some instances it is envisaged the CCA services would operate from it. In order to avoid stigma the Report suggests that the centres might provide some facilities or services needed by the community as a whole, for example, meeting rooms. One project similar to the recommended Neighbourhood Resource Centre has been established by a Health Board. This project — The Family Resource Centre — is in Cork City and its project emerged out of the activities of a Neighbourhood Youth Project which had been established in the same community in the wake of the Interim Report of the Task Force. There are operating at present a limited number of other centres, similar to the proposed resource centre, under the aegis of voluntary organisations, for example, the four ISPCC Family Centres and Barnardo's two Neighbourhood Resource Centres. While none of these centres fits exactly the prototype outlined in the Task Force Final Report, in that Health Board employees have little direct involvement, all of the centres have one of the distinguishing characteristics emphasised in that Report, viz, community involvement. In some of the centres there is a high level of co-operation between professionals and volunteers. All of these centres were established to provide support for families with a particular focus on those with multiple needs. Consistent with the community orientation, each of the centres tailors its approach to local circumstances, consequently each centre differs from the others in the services provided. The range of services include family counselling, day care, toy libraries, pre-teen and youth groups, mothers' groups and community information services.

These centres are aided by Health Boards, but most of the funds come from the voluntary organisations involved. Just under 50% of the cost of the ISPCC centres is met by Health Boards. The Barnardos Centres are not directly funded, but the organisation is grant-aided centrally for its services. If the costs of these services are evaluated purely on the basis of the core group of children involved and in relation to conventional social casework services the costs appear high. However, the relevant criteria are outcomes of involvement, not in the short term but in the long term and in particular the prevention of future difficulties. This points to the importance of ongoing evaluation of services. The ISPCC Family Centres are being evaluated and results to date (since 1979) are encouraging (42).

The development of community projects is not an easy task. Issues that need to be teased out before such development takes place on a wide scale include the following three:

- How is local community involvement to be realised?
- How is the relationship between staff, the employing body and the community to be structured?
- On what basis are priority areas to be identified?

The experience to date in the limited number of projects and centres provides essential information for this review.

In summary, supplementary services to families are limited in availability at present. Ideally each community care area should have a comprehensive range of such services — this is not the case in any area and some services are particularly limited.

(iii) Alternative Care Services

The present range of alternatives to family care for children are adoption, fostering and residential care. Each of these will be considered in turn.

Adoption

Adoption services are governed by four Adoption Acts — 1952, 1964, 1974 and 1976 and Adoption Rules published in 1976. Between January 1953 when the 1952 Adoption Act came into force and December 1982, there were over 35,000 adoption orders. In recent years, as the data in Table A3.10 shows, there has been a consistent decline in the number of adoptions, although the number of illegitimate births has been increasing. By 1985 the figure was down to 882. The decrease reflects the fact that fewer children are now being offered for adoption. In other countries such a decrease has been associated with a broadening of the range of children being adopted so that children with physical, sensorial and mental handicaps and children with other special needs are now being adopted.

Under the 1952 Act, health authorities were authorised to act as adoption agencies. Some have established separate registered adoption agencies. In other areas Health Boards act through local registered voluntary adoption societies. Only a small minority of adoptions are arranged directly by Health Boards.

Since January 1983 adoption services have come under the aegis of the Department of Health. An Adoption Review Committee was set up by the Minister for Health comprising representatives of the Department of Health, voluntary organisations and experts in the field of adoption. This committee reported in July 1984. The Report recommends significant changes in present adoption legislation and regulations. The present law is relatively restrictive in the sense that a legitimate child with living parents cannot be adopted nor can the child of an unmarried parent who does not give consent. The Report of the Review Committee addresses both issues. It recommends the establishment of an Adoption Court, the adoption in certain circumstances of legitimate children whose parents are still alive, and in certain circumstances of dispensation of agreement to placement for adoption in certain instances. This report forms the basis of draft legislation. The Adoption Bill was presented to the Dail in November 1986 and a Private Member's Adoption Bill was discussed in the Dail in May 1987.

Since 1978 the Department of Health has collected annual statistics on the activities of Health Boards relating to children in care. On the basis of figures for 1983 it is evident that there is considerable variation between Health Boards in the use of the various types of alternative care (Table A3.12). Overall, 3,595 children came into care in 1983; thirty-four per cent were placed in long term foster care, 16% in short-term care, 3% in private foster care and 47% in residential care. Private foster-care is confined almost exclusively to the Eastern Health Board area. This category includes children placed with families prior to adoption and other children 'at nurse' on a more long-term basis. In 1983 the percentage of children fostered by the Health Board was highest in the Midland region (74%) and lowest in the Eastern Health Board region (26%) (43).

Overall, the percentage of children placed in foster care appears to have been increasing. The final column of Table A3.12 shows that nationally the percentages of children in short-term and long term foster care respectively are 16.4% and 33.7%. These figures have increased gradually in recent years and indicate that on a national basis there is a shift towards increased use of foster care (Data for successive years are given in Table A3.13). However, it must be noted that the figures refer to care episodes, and the short-term (i.e. periods of less than 6 months) foster-care figures may therefore

refer to repeated episodes for some children.

The gradually increasing use of fostering is also reflected in the figures relating to children actually in care in 1980, 1981, and 1984 (Table A3.13). In 1980 there were 2,456 children in care, of whom 45% were fostered through the Health Boards and 8% were privately fostered. By 1984, the number in care had increased to 2,552, of whom 50% were fostered through the Health Boards and 3% were privately fostered.

Fostering

When fostering is arranged and paid for by Health Boards, it is referred to as "boarding-out"; when it is arranged by private individuals or voluntary organisations it is identified as placing children "at nurse". The former is legally governed by Sections 55 and 56 of the 1953 Health Act. The regulations relating to boarding out by Health Boards are set out in the Boarding out of Children Regulations, 1983 (44). The document states that a Health Board shall not send a child to residential school "unless such a child cannot be suitably and adequately assisted by being boarded out" (45). Despite this statement it is important to recognise that there are legal impediments to placing certain children in fosterage; in particular, a Health Board cannot legally place in foster-care without the consent of a parent, a child who is in the Board's care with the parents' agreement, nor is it legally entitled to refuse to return a child placed in foster care to his/her parents at their request (46).

In Ireland, to date, foster care has been considered an option almost exclusively for younger children (i.e. up to about the age of 6). The risk of breakdown in foster care arrangements is, on the basis of evidence from Britain, much greater in the case of older children. The Task Force Report, acknowledging the absence of research into foster care breakdown in Ireland, stated that;

"the impression in the Department of Health is that breakdown is infrequent. There is, however, no reason to believe that the situation would continue if a wider range of children were placed in foster care under our existing foster care system" (47).

The Task Force recommended that fostering should be one of the options for every child irrespective of age, health and behaviour. In this respect it notes the success of the Special Family Project in Kent. This project was set up in 1975 as a demonstration and research project designed to test the assumption that adolescents with severe problems can be fostered. This project has been remarkably successful and has led to the establishment of similar projects in other areas. This experience, and experience elsewhere, suggest that given sufficient care and planning, older children can be placed successfully and beneficially. Fostering of older children has been initiated in some community care areas in the recent past. Experience from these areas should provide valuable guidelines towards more extensive development in this area.

The Task Force Report identified four factors which have impeded the development of foster-care:

- The absence of integration in child care services
- Social attitudes to foster-care
- The complexity of foster care and the diversity of responsibilities which different types of foster-care entail
- Insufficient resources for foster-care services within child care agencies and insufficient commitment to the principle of family placement.

The absence of integration in child care services, particularly up to the early '70's,

meant that "whether or not family placement was considered for a child depended on the system through which he went into public care rather than on decisions as to what care was most suitable for him" (48). Negative social attitudes also militated against fostering; these were due partly to ignorance of what fostering entailed, but also result from a proprietorial view of children. With regard to the third point it is notable that considerable expertise in fostering has been built up in certain areas.

The Fostering Resource Group is a team of five social workers who act in a resource capacity to area teams in the Eastern Health Board area. The fourth point is of particular importance; it is essential that acceptance of the principle of family placement for the majority of children in alternative care entails a commitment to allocate resources with the express purpose of developing foster-care services. An essential element for this development is social work expertise; in this regard the Task Force recommended that "in each Child Care Authority an adequate number of professionally qualified social workers should have special expertise in the area of foster care" (49). In two Health Board regions a specific team of Social Workers has been allocated to develop foster care services. No attempt was made to quantify the number of social workers needed and such quantification is not possible at present because of the limited nature of the information collected by the Department of Health on child care services in general and foster care in particular. For example, information is not collected on a national basis on: the number of children on waiting lists for foster care; the length of waiting time before fostering is arranged; whether or not residential care is a first choice for those so placed (50). Information on each of these points is important for an appraisal of the present level of services.

Residential Care Services

Historically, legal responsibility for residential care for children has been divided between the Department of Health, which approves certain childrens' homes, the Department of Education which had responsibility for reformatories and industrial schools, and the Department of Justice which has responsibility for probation hostels.

Almost all residential services for children are provided by voluntary bodies and financed through public funds. Up to January 1984 the two main categories of centres were "certified industrial schools" which were administratively under the aegis of the Department of Education, and homes approved by the Department of Health. The "certified industrial schools" changed considerably in their operation throughout the 1970's following the recommendation of the *Report on the Reformatory and Industrial Schools System* (Kennedy Report, 1969) (51). The Report recommended a family group home approach instead of the traditional institutional approach. Considerable progress was made in this regard, both through modification of existing homes and the construction of new homes. In addition, the number of children in these homes decreased considerably from 2,000 in 29 schools (which had 3,750 places) in 1969 to 755 children in 23 schools (which had 786 places) in 1982. By that year the majority of places in these schools were occupied by children referred by Health Boards. In 1982 there were 20 homes approved by the Department of Health catering for 465 children, compared to 658 in 1969. The considerable decrease in numbers in both types of homes probably reflects the availability of community supports — social work and supplementary services and the greater use of adoption and fostering in the later period.

With the exception of the special residential school at Clonmel which should continue to be run under the aegis of the Department of Education, the Task Force Report recommended that all residential services for children should be the responsibility of the Department of Health and the CCA in each region. In August 1982, the Government took a decision to act on this recommendation. The implications of this change were explored by a joint Department of Health/Department of Education working party. Responsibility for these services was transferred to the Department of Health with effect

from January 1 1984. Residential services are now operating on a budget system; the budgets are negotiated with local Health Boards on the basis of national guidelines.

If the other recommendations of the Task Force are to be implemented considerable changes in the present structure and range of services will be necessary. The recommendations entail a range of residential services within, or within easy access of, each community care area:

- Community residential centre, which would cater for the ordinary needs of the area through the provision of short and medium term care for children of all ages from the area, and should have not more than 24 places. It was envisaged that given adequate resources in terms of staff, support services and financing many of the existing residential homes would be prepared to provide this service by revising their existing role. In addition to being a residential resource these centres would be community oriented and might provide day care services, including after school care for children in the neighbourhood, and facilities for youth groups;
- Small residential units for five or six children were recommended for children with serious personal problems who require intensive personalised care including seriously delinquent children;
- Long-term residential care would be provided in centres operating on the lines of existing group homes which developed subsequent to the Kennedy Report. These centres would cater for children who would spend not less than 12 months in residential care and who can be catered for in an informal setting in a mixed group of all ages up to 17 or 18 years;
- Special residential facilities for children who are severely deprived emotionally and socially and who may also be educationally retarded are provided at present under the aegis of the Department of Education at St. Joseph's Special School, Clonmel, Scoil Ard Mhuire, Lusk and St. Lawrence's and St. Michael's, Finglas. The Task Force Recommended that the latter two centres should come under the aegis of the CCA.

Finally, the Task Force recommended that the CCA should be responsible for ensuring the adequacy of the range of residential facilities in its area and the appropriateness and quality of the services provided in them. A comparison of the above recommendations with the present level of provision indicates serious shortfalls in provision with regard to the first two. The revision of existing roles referred to in the first recommendation is not a simple matter. The needs of children coming into care have already changed. If other recommendations of the Task Force are implemented this trend will continue. With increased support for parents on a domiciliary and day care basis and a commitment to use fostering as a first option for all children, (52) those children needing residential care are likely to have very special needs, consequently staff training and support are going to be increasingly important. In addition, the present residential homes are not evenly distributed throughout the country, thus if residential centres are to be available within easy access of each community care area within the foreseeable future planning needs to start immediately. The urgency of the need for progress in the provision of the range of services is highlighted by the fact that there are still a minority of children for whom there are no residential places available at present.

With regard to small residential units, a pilot project has been launched in the centre city area of Dublin under the auspices of the St. Vincent de Paul Society and with the support of the Eastern Health Board. This project has been evaluated over a three year trial period and it has indicated the potential of small scale residential units to meet very

specific needs in a non-family context without resorting to traditional residential care (53). In addition to the special needs of the children concerned, the community orientation of the proposed new residential services will mean that the costs of residential care are likely to be considerably greater than at present. This must be acknowledged in any cost comparison between present and proposed centres. A consideration of the basis on which costs should be compared reveals important and difficult issues: for example, can avoidance of negative consequences be costed? A realistic appraisal of costs must be based on a long-term preventive perspective, that is a perspective that focusses on services, not merely as a response to immediate need, but also as preventive of future difficulties.

In summary, there has been a shift in the nature of alternative care since the early 1970s. A marked decrease in numbers in residential care is evident. Fostering has been increasing, especially since 1980. The changing needs of children coming into residential care were noted as were the implications of this for residential services. This change is associated with a marked shortage of appropriate residential services.

4. SUMMARY AND CONCLUDING REMARKS

With regard to pre-school health services considerable variation between areas in availability and accessibility was noted. Similarly, considerable variation in the scope of the medical service and problems relating to the statistics collected were noted. Despite questioning of the effectiveness of this service, research on it is limited. It was concluded that there is a need for a review of all child health services, in terms of objectives, needs, means and outcome.

Personal social services for children and families were considered under the headings of; social work services; services supplementary to family care (domiciliary services, day care services and community projects) and alternatives to family care (adoption, fostering and residential services). The development of services is uneven and no community care area has a comprehensive range of services for children. In general services tend to be established in a piecemeal fashion in response solely to immediate need without taking a preventive orientation or considering the range of services needed in an area. A number of reasons for the present difficulties can be identified:

- The relatively recent development of statutory personal social services in Ireland. Traditionally the focus of health authorities was on the delivery of medical services. The Task Force Report on Child Care Services was the first comprehensive, published discussion document at an official level on personal social services for children;
- Coupled with the above, the unsatisfactory level of information relating to personal social service needs and the limitation of resources even where needs have been identified have both militated against development of a comprehensive range of services;
- The nature of relations between voluntary and statutory agencies; collaboration between Health Boards and voluntary bodies varies enormously from area to area. Many voluntary bodies since the mid-'70s have adopted a preventive community approach to their work — this often involves intensive work with a core group of children and lesser involvement with a wider group. This type of approach is relatively expensive if costs are considered in the short term. There is a marked tendency to use such a short term focus in considering the costs of proposed projects — this may be understandable given a situation of limited resources for statutory authorities and the absence

of comprehensive plans for services in individual community care areas;

The Report of the Task Force on Child Care Services provides the framework within which personal social services for children are likely to develop. In considering progress since the publication of the report two elements need to be distinguished: on the one hand, the philosophy underlying the report and, on the other, the administrative structure proposed. At this stage it appears that there is broad agreement on the philosophy, viz. that the child must be viewed within the context of his/her family and community and that children's services must be seen as part of family welfare services. With regard to the administrative structure no such agreement is evident. The focus of this report is on services, however, and it is clearly evident that inadequacies in the present development of services are in many instances associated with inadequacies in administrative structure. Because of this a brief outline of the main positions relating to administrative reform are outlined here.

A substantial Supplementary Report published with the Final Report of the Task Force on Child Care Services argues that the objectives of the Report cannot be achieved within the present administrative structure. In this supplementary report a fourth Health Board programme — Family and Child Care — is proposed. Within this programme it is proposed that there would be two assistant programme managers, one with responsibility for Child Care Authority functions and one with responsibility for Other Welfare functions. It appears that to date there has been no widespread discussion of this proposal. It is argued by some people within the health and social services that it is premature to abandon the existing structure — that the reasons for the present underdevelopment of services relate to failure to implement the structure proposed in the McKinsey Report. As already mentioned, the Department of Health commissioned a management consultants report on the Community Care Programme. This Report was submitted to the Community Care Review Steering Committee in March 1982. It is clear that until the present administrative issues have been resolved the development of services will be impeded.

CHAPTER 3

Footnotes and References

- (1) *The Child Health Services*: Report of a study group appointed by the Minister for Health, Dublin, Stationery Office, 1967.
- (2) Eastern Health Board Community Care Programme, *Report of the Child Health Committee of Directors of Community Care and Medical Officers of Health*, January 1981.
- (3) O'Herlihy, B (1977), "Visiting Patterns at Child Welfare Clinics", *Journal of the Irish Medical Association*, Vol. 70, No. 5: p.168-171.
- (4) *ibid.*
- (5) *The Child Health Services*, Report of a study group appointed by the Minister for Health, Dublin, Stationery Office, 1967: 51.
- (6) Buttimer, J, *Irish Medical Times*, 1981.
- (7) NESC, Report No. 50, *Major Issues in Planning Services for Mentally & Physically Handicapped People* (1980) p.71-72. Swan, D. "A Psychological Service in National Schools in Ireland — a Dream that is Dying?" *Irish Educational Studies* Vol 1, 1981 p.143-155.
- (8) Buttimer, J, *Op.cit.*
- (9) General issues related to the public health nursing service are discussed in Chapter 2. Issues related to the service for elderly people are discussed in Chapter 4.
- (10) Explanatory memorandum on the Public Health Nurses Visiting Card for Pre-School Children, Department of Health, 1978.
- (11) The recommended timing of visits is as follows:
 - (i) as soon as possible after the birth is notified;
 - (ii) at 3 months;
 - (iii) at 5 months;
 - (iv) at 7 months;
 - (v) at 9 to 10 months;
 - (vi) at 12 months.
- (12) *Health Care for Mothers and Infants*, A review of the Maternity and Infant Care Scheme, Department of Health, 1982.
- (13) Department of Health *Working Party on General Nursing Report*, Dublin, Stationery Office, 1980, p.57.
- (14) *Task Force on Child Care Services Interim Report*, Dublin, Stationery Office, 1975. *Task Force on Child Care Services Final Report*, Dublin, Stationery Office, 1980.
- (15) *Op cit*; p.91.
- (16) Report of the Review Committee on Adoption, Department of Health, 1984.
- (17) Parker, R. A. (ed.) 1980, *Caring for Separated Children*, London, National Childrens Bureau, The Macmillan Press, p.45.
- (18) General issues related to Social Work Services are discussed in Chapter 2.
- (19) (Legal basis: Adoption Acts 1952, 1964, 1974, 1976).
- (20) (Legal basis: Health Act 1953, Boarding out Regulations 1983).
- (21) (Legal basis: Children Act 1908, as amended by Children Acts 1934 and 1957).
- (22) (Legal basis: Health Act 1953 (Sections 55 and 56) and Boarding Out of Children Regulations 1983).
- (23) (Legal basis: Children Act 1908 — voluntary commitment made to court).
- (24) In more detail these situations are as follows:
 - (i) where they cannot be cared for at home because their mother is ill or absent for other reasons and their father is either in full-time employment or absent;
 - (ii) where the parents, because of severe or perhaps, multiple problems are unable to give the children the care they need and where the provision of specially skilled, intensive help in the home for a limited period of time, would be the best means of ensuring their welfare;
 - (iii) where having spent some time in residential care as a result of severe problems, they are ready to return home but they and the family need continuing intensive help for a time to enable them to maintain the progress already made.
- (25) The six centres are Cathal Brugha St., the Regional Technical Colleges in Waterford, Sligo, Athlone, Galway and Cork. Each of these centres takes 15-20 students on a three year course which has a major in-service component. Entrants are required to have at least one year's experience in working with children in an approved child care centre, not necessarily a residential home; an approved centre could be a centre for handicapped children or a closed unit for young offenders.
- (26) The Home Help Service is discussed in chapter 2 (expenditure), chapter 4 (Service for Older People).
- (27) A day nursery is a centre for the care on a day basis of children below compulsory school age, whereas a creche is a centre for the care of infants; it is notable that some centres designated as creches provide care for children up to the age of 4 or 5.
- (28) In 1982 there were over 20 places per one thousand 0-4 year olds in the Western, Southern and Mid-Western Health Board areas, 12 per 1,000 in the South Eastern area, 11 per 1,000 in the Eastern and Midland areas and less than 5 per 1,000 in the North Western and North Eastern Health Board areas. These figures refer only to those services aided by Health Boards.
- (29) Transport problems need not necessarily be an unsurmountable barrier. In this regard, it is notable that the idea of the mobile library and bank are widely accepted as appropriate means of delivering services in rural areas.
- (30) See chapter 2, regarding community worker posts.
- (31) Task Force Report *Op. cit.*, p.134-135.

- (32) Working Party on *Child Care Facilities for Working Parents*, Report to the Minister for Labour, Dublin, Stationery Office, 1983, p.5.
- (33) Task Force Report, *Op. cit.*, p.138.
- (34) Source: Irish Pre-School Play Groups Association.
- (35) Finch, J., "Can skills be Shared? Pre-School Play Groups in 'Disadvantaged' Areas", *Community Development Journal*, Vol 18, No. 3, 1983, p.251-256.
- (36) Parker, R. A., *Op cit.*
- (37) Magee M., *Day-Fostering — A Pilot Scheme in a Densely Populated Dublin Housing Scheme* — Unpublished Report, EHB Social Work Team in Finglas area.
- (38) Task Force Report, *Op. cit.*, p.142.
- (39) *ibid*, p.143.
- (40) The projects in Cork and Limerick operate under the control of local management committees involving community interests, as well as others involved in providing services in the area, for example, teachers, clergy, social workers, school attendance officers, youth workers, health board officials. The projects in Dublin are under the control of the Health Board.
- (41) *ibid*, p.145.
- (42) Nic Giolla Choille, T., *The Wexford Family Centre Report*, Dublin, ISPCC, 1983.
- (43) The number of children coming into care in the Eastern Health Board area is almost eight times higher than the number coming into care in the Midland Region.
- (44) *Boarding Out of Children Regulations*, S.I. No. 67 of 1983, Dublin, Stationery Office.
- (45) *Op. cit.* p.1.
- (46) The same legal ban on refusal relates to residential care. In practice a health board may refuse and force the parents to get a court order.
- (47) Task Force Report, *Op. cit.*, p.167.
- (48) *ibid*, p.163.
- (49) *ibid*, p.171.
- (50) Some of this information is available for *some* Health Boards at present.
- (51) *Report on the Reformatory and Industrial School System*. (Kennedy Report), Dublin, Stationery Office, 1969.
- (52) *Boarding Out of Children Regulations*, 1983.
- (53) Gilligan, R., *Children in Care in Their Own Community*, Dublin, St. Vincent de

Paul Society, 1983. It is notable that the objectives of this unit are considerably broader in scope than are those of conventional services; notably, its objectives include:

- Involvement of the families of the children concerned in the work of the project;
- The promotion of more positive attitudes among the local community towards the problems of at-risk children and their families;
- Action research.

SERVICES FOR ELDERLY PEOPLE

1. INTRODUCTION

Community care for people aged 65 and over covers a wide range of services and brings into sharp focus the importance of the interweaving of the informal, voluntary and statutory sectors if an effective range of services is to be provided. Much of the discussion in relation to community care during the 1960s related to services for elderly people. The most explicit and wide ranging document in this regard is the 1968 report on *The Care of the Aged* (1). The present range of services stems from the recommendations of that report. Before considering these services some key social and demographic characteristics of the elderly will be outlined.

2. DEMOGRAPHIC AND SOCIAL FACTORS

The percentage of the population aged 65 and over fell from 11.1% in 1971 to 10.7% in 1981. This percentage is low by international standards and is expected to continue falling at least up to 1991. This decreasing percentage is related to the marked increase in the younger population; the *number* of persons aged 65 and over actually increased from 329,719 in 1971 to 368,864 in 1981 — an increase of 11.9%. Population projections based on the 1981 census indicate that the number of persons aged 75 and over is likely to increase much faster than the population as a whole up to 1991 (2).

The population aged 65 and over is not homogeneous in terms of income, housing conditions, disability, or need for health and welfare services. A useful distinction is between those aged 65-74, frequently referred to as the 'young old' and those 75 and over. The former comprise 6.9% of the population and the latter 3.8% (Table A4.1); the latter group are more likely to have high levels of disability and need for health and welfare services. Reflecting the longer life expectancy of women, fifty-seven per cent of those aged 65 and over, and sixty per cent of those 75 and over, are women. Forty-eight per cent of the women 65 and over are widowed, compared to 17% of the men. The corresponding figures for those 75 and over are 60% and 27%.

There are marked variations in the percentage of the population aged 65 and over between different health board areas; the percentages range from 14.5% in the North Western Health Board area and 14.3% in the Western Health Board area to 8.5% in the Eastern Health Board area (Table A4.2) Leitrim is the county with the highest percentage of people aged 65 and over at 17.6%; in contrast the figure for Kildare is 7% and that for Dublin County is 4.8%. As Table A4.2 shows, six community care areas have relatively high percentages of their populations aged 65 and over: Sligo/Leitrim; Donegal, Mayo, Roscommon, Kerry and Area 1 in the Eastern Health Board area (i.e. Dun Laoghaire and environs).

Almost one-fifth (18.4%) of the population aged 65 and over live alone; this ranges from about a quarter (23.6%) in Dun Laoghaire Borough to 13.3% in Galway. All of the County Boroughs have above average percentages of elderly people living alone. In

addition, each of the following counties has 20% or almost 20% of its elderly population living alone: Monaghan, Cavan, Leitrim, Louth, Waterford and Wicklow (Table A4.3). An ESRI study conducted in 1977 on the economic and social circumstances of the elderly indicates that the elderly who live alone are no more healthy than the rest of the elderly — over 60% reported a long term illness (3). Furthermore, single person households tend to have fewer amenities and durable goods than do other households (4). Over 13% of those living alone reported that they would have no one to help with a series of household tasks. Thirty-five per cent of single persons in rural areas would have nobody to look after them in the event of heavy influenza and would have to go into hospital; the corresponding figure for those in urban areas is 24% (5). About two-thirds of all respondents had some children living, but this falls to about half in the case of elderly people who live alone. In urban areas 56% of respondents had at least one child living within ten miles of home, the corresponding figure for rural areas was 48%. It was concluded that "In general, the children of rural parents appear to be more scattered than those of urban dwellers" (6).

A further factor that can influence the need for, and delivery of, services is population density. Nine counties have population densities of less than 30 per square kilometre; six of these have less than 40% of their population living in towns with defined boundaries: Cavan, Donegal, Leitrim, Mayo, Roscommon, Kerry (Table A4.4). All of these counties have higher than average percentages of their populations aged 65 and over (Table A4.2).

Much of the focus on service development since the Care of the Aged Report has been on the development of welfare homes and the improvement of long-stay geriatric hospitals; however, the vast majority of elderly people live in the community. Taking into account residents in all long-stay units, psychiatric hospitals, mental handicap centres, district hospitals and other general hospitals, about 92% of the elderly population are living in the community (7). There are no comprehensive studies of the disability levels of elderly people either in residential facilities or living in the community. However, there is considerable evidence to support the conclusion that over a quarter of those in long-stay units have been admitted because of social reasons. Table A4.5 shows that 21.9% of patients in all long-stay geriatric units were admitted for social reasons; the percentage for Health Board Voluntary Homes, however, is 65.2% (8).

In a study published in 1975 on admissions to County Homes in three Western counties it was found that 39% of male patients and 20% of female patients scored high on measures of self care and could reasonably be regarded as suitable for care in the community; 41% of residents were living alone prior to admission (9). In a more recent study of one geriatric hospital (formerly a county home) it was found that 37% of the patients were fully capable of managing their own self care needs, and that 35% of the study population were living alone prior to admission (10). In contrast, the ESRI study indicates that the functional capacity of a significant minority of persons aged 65 and over living in the community is impaired as measured in terms of getting on or off a bus, climbing a flight of stairs, walking half a mile, taking a bath without help, dressing without help, hearing and seeing to read a newspaper. The first three of these show the most marked association with age; about one third of 65-69 year olds report difficulties, about a half of those aged 70-79 and two thirds of those aged eighty and over. There is no substantial difference evident between those who live alone and the rest of the elderly population (11). Almost 60% of the 65-69 year olds and 67% of those aged 80 and over reported a long standing illness (mostly problems associated with the circulatory system and the muscular skeletal systems). A study by a medical doctor in a Dublin parish indicates that there is a significant amount of undetected treatable illness among some elderly people living in the community (12).

In summary, while the percentage of the population represented by elderly people is decreasing, their number is increasing and this is expected to continue, particularly the number aged 75 and over, at least up to 1991. The vast majority of elderly persons live in the community and the vast majority of these live with family members. However, a significant minority of the elderly population are living in isolated conditions.

Furthermore, the latter group are over represented among the residents of long-stay hospitals and homes, and at least a quarter of the residents of these long-stay are admitted because of social reasons.

3. RANGE OF SERVICES

The report on *The Care of the Aged* made recommendations relating to a very wide range of community services which were dependent for provision on Health Boards, local authorities, voluntary groups and the Department of Social Welfare. Many of the services and the activities of the various groups are interlinked. However, given the focus of the present report attention will, for the most part, be confined to those services provided directly, or funded under, the Health Board Community Care Programme. While categorical divisions cannot be made, for the purposes of this report community services will be discussed under four headings: Domiciliary Services, Day Services, Accommodation and Assessment Services.

(i) Domiciliary Services

The three principal domiciliary services are the public health nursing service, the home help service and meals-on-wheels service.

Public Health Nursing Service (13)

The Report on the Care of the Aged identified the provision of a domiciliary nursing service as a vital part of the services for the aged. The public health nursing service provides both a preventive health service and a domiciliary nursing service (14).

The survey conducted for the Working Party on the *Workload of Public Health Nurses* (15) showed that while 68% of all public health nurse patients were aged over 65 years, these patients accounted for only 39% of nurses' home visiting time. Overall, under 9% of nurses' time was spent on social work, however 51% of this was related to the aged, compared to 22% for other adults. The survey showed that 3% of those aged over 65 were getting intensive nursing attention. The Working Party recommended a substantial increase in involvement of public health nurses with the elderly (16). It was also recommended that each nurse on district duties should keep a register of elderly persons on the district. To what extent these registers are used for evaluating adequacy of present services or planning new services is not known. However, it is notable that there was no centralised information system relating to the elderly in any of the health boards up to the recent past (17). While there is no comprehensive information available on the adequacy of public health nurse activity relating to the elderly there are indications that the public health nursing service in some areas may be under considerable pressure. The report on *The Care of the Elderly* by a sub-committee of the South Eastern Health Board is significant in this regard; having examined the workload of public health nurses the committee concluded that in many cases the public health nurse is not in a position to give the elderly the level of care that she would wish (18). The St. Vincent de Paul Society survey of the Old and Alone in Ireland indicates that only 19% of this group were being visited regularly, i.e. at least once per month, by nurses (19).

On the basis of the above information and the conclusion of the Working Party on General Nursing, that in some areas the caseloads of the public health nurses are too

great (20), the indications are that the 1975 Working Party guidelines should be reviewed. A key focus of such a review should be on identifying the level of public health nursing service and support services needed if institutionalisation is to be prevented. Such a review needs to take into account the evidence indicating that despite an over supply of long-stay beds relative to recommended levels there are in most areas waiting lists for long term care. With regard to prevention of long-term hospitalisation two issues should be considered:

- (a) Prevention of admission and;
- (b) Liaison between hospitals and community services to facilitate discharge once acute admission or short-term admission has taken place.

In considering the first of these issues the whole range of community services and in addition the adequacy of geriatric assessment and short-term care provision should be considered. However, central to this review must be the adequacy of the present level of the public health nursing service. The South Eastern Health Board report, already referred to, emphasises the key role of the public health nurse if community care is to become a reality:

"The importance of the district nurse as a provider of services for the elderly and as a link with the voluntary or statutory services cannot be over emphasised. The extent to which a policy of maintaining the elderly in their homes in the community for as long as possible can be pursued, is dependent on the extent to which the public health nursing service can respond to the demands made on it" (21).

Liaison between hospital and community services is important for all people who are hospitalised. It is particularly important for people aged 65 and over since their average duration of stay in hospital is considerably longer than that of people in other age groups (22). Liaison is a significant problem at present: eighty-four per cent of public health nurses surveyed by the Working Party on General Nursing agreed that "co-ordination with hospitals is a problem for public health nurses". The Working Party recommended that designated liaison nurses with public health nursing qualifications should be appointed in all areas, the number to be determined by the sizes and types of hospitals in the area, size of population and other relevant needs. A similar recommendation has been made in a recent National Council of the Aged Report (23). Problems relating to liaison have long been recognised and liaison nurses had been appointed in some areas prior to the Working Party Report. Arrangements for liaison vary. Some liaison nurses continue to have a district caseload, though reduced in accordance with the requirements of the liaison position. In at least one area a social report form is issued to all hospitals throughout the community care area; the purpose of this being that hospital staff would acquire a social report from public health nurses on each patient's social condition and on back-up services being provided in the community; but these reports are not always sought prior to considering and planning discharges. In the South Eastern Health Board area full-time liaison nurses are attached to community-based Geriatric Assessment Teams, which consist primarily of a liaison nurse and area medical officer. The role of the nurse is central to the team. She examines the home conditions of the elderly person to ascertain what community services are needed either to avoid the need for hospitalisation or to facilitate discharge from hospital. During hospitalisation the nurse participates in the hospital discussion on the patient's progress (24). This team concept has worked very well and is being developed in some community care areas in the Western Health Board.

Issues relating to liaison tend to be discussed in terms of liaison from hospital to community rather than hospitalisation being conceived as an episode. *Until a community care perspective is adopted by both hospital and community personnel it is likely that problems will continue in this area.* Problems arising in this area and others that affect the public health nursing service cannot be solved in isolation. They must be

considered in association with questions relating to the range of services needed to provide an effective community service to elderly people.

Home Help Service (21)

In 1981, the most recent year for which data are available, there were over ten thousand beneficiaries of the home help service; 83% (8,514) were aged 65 and over; this represents 2.8% of the population aged 65 and over. There is considerable variation between Health Boards in the percentages in receipt of home help services (Table A4.6). In the North Western Health Board area 4.2% of the population aged 65 and over, compared to 1.5% in the North Eastern and 1.7% in the Southern Health Board areas, were in receipt of home help services in 1981. Information on the home help service is inadequate. Information is not available on waiting lists, on number of visits per week, on number of hours per visit to each beneficiary. In addition, there is only limited information available on the extent and nature of help to elderly people by neighbours and unpaid volunteers.

The ESRI study, conducted in 1977, indicated that while the majority of elderly people living alone get help from relatives and neighbours in illness and with a variety of tasks, a significant minority have nobody to help (26). In addition, this study found that only just over 1% of urban elderly people living alone, and just over 5% of rural elderly people living alone, were getting a home help service. These figures are consistent with the St. Vincent de Paul Society Study, which indicates that only 5% of the elderly living alone were in receipt of a home help service. It appears, therefore, that a significant minority of elderly people living alone get help neither from neighbours, from relatives nor from the formal home help service despite being in need of assistance. The planning of an effective service is not possible without adequate information on both formal and informal helping.

A further issue that needs to be considered in a review of the home help service is that of service to dependent elderly people who are living with relatives. There is at present considerable reluctance to provide a service if the person, even though aged and dependent, is living with younger relatives. This is understandable if taken solely within the context of the limited resources, but may in fact be a very short-sighted approach. There have been no studies in Ireland on the costs of caring to relatives. The Equal Opportunities Commission in Britain has issued a number of publications on this aspect of caring (27). Their studies of the carers of dependent elderly and handicapped people identify the very severe demands made on some carers, the need for supports and the very great difficulty of obtaining supports for carers. It is pointed out in these reports that there is considerable reluctance to give adequate supports to caring relatives; yet when these arrangements break down because of lack of support the State has to bear the entire costs of residential services for the dependent individual and very often the costs associated with impaired health of the carer. Thus, in the Irish context the costs of a home help service to caring relatives needs to be weighed against significant costs of welfare home or geriatric hospital services (Table A4.7). In this regard it is notable that both the *Care of the Aged* report and the 1966 White Paper on the health services recognised the need for support to families.

Meals on Wheels Service

This service is provided almost exclusively by voluntary groups, grant-aided by health boards through Section 65 payments (28). The number of beneficiaries of such services is not known: it is accepted that the vast majority of recipients of these services are 65 and over.

In the St. Vincent de Paul survey it was estimated that only 5% of the elderly living alone were getting a meals service. In 1985 £1.5 million was spent on meals on wheels

services by health boards: this figure may not reflect total public expenditure as some of the grants to the voluntary agencies may also be apportioned to meals-on-wheels.

Information on the nutritional status of elderly people in Ireland is also limited. Data available from studies by the National Prices Commission indicates that the nutritional status of some elderly people gives cause for serious concern. A study conducted during May 1975 on a sample of old people drawn from residents of a low-income, central city area of Dublin indicates that the diets of 73% of the sample were deficient in one or more essential components (Table A4.8). Six per cent of the sample were deficient in energy and all nutrients; while this percentage is small it is of "considerable public health significance since the risks of these subjects developing some form of overt malnutrition is high" (29). Dietary problems of the elderly are not solely an income problem, they are also associated with income related factors such as housing, amenities, and also life-long life-style practices. In a further study conducted in two areas of Dublin by the National Prices Commission on *Old Age Pensioners: Shopping Behaviour and Attitudes Towards Prices*, it emerged that many pensioners have only limited food storage space; less than two-fifths of those interviewed had a fridge. In addition, limited income means that the purchase of large sizes of products to avail of cheaper prices is frequently impossible. It was concluded that:

"The majority of pensioners seem to exist on a fairly monotonous series of meals, highlights being provided by either eating out with friends or at a local community centre. Inevitably this lack of variety is in part due to the fact that limited income restricts the choice of foodstuffs available to the pensioner, but it is also due to individuals living alone tending to bother less about meals as well as becoming creatures of habit" (30).

Given this limited information the questions that need to be answered are whether or not the meals-on-wheels service is an effective way to meet dietary deficiency in old people and if so do those most in need of a service get a service. Neither of these issues has been explored in Ireland. Information available from Britain indicates that:

- (a) there is need for regular assessment and re-assessment of the need for a service;
- (b) the quality of food provided must be monitored for nutritional adequacy and;
- (c) in the provision of meals a balance needs to be struck between the creation of dependency and meeting a real need.

The possible alternatives to meals on wheels for meeting the needs of elderly people with dietary deficiency are:

- (a) lunch clubs or day centre meals — generally appropriate only in urban area;
- (b) use of home helps to cook meals;
- (c) payment of neighbours to provide meals — this is particularly appropriate in isolated areas;
- (d) an income supplement to those elderly people whose diet is deficient because of poverty.

Evaluation of the effectiveness of the meals-on-wheels service must be considered with reference to the aims of the service, the needs for the service, the alternatives available to meet the needs and the outcome associated with the various alternatives. This type of evaluation is not possible with the information available at present. As a first step towards evaluation it is essential that basic descriptive information be collected on the present service, for example, quantity and quality of service, and the social, health, and economic characteristics of recipients.

(ii) Day Services

The Care of the Aged Report identified a need for a range of day services: Day Hospitals, Day Centres, Clubs.

Day hospitals

The objective of day hospitals is to provide on a day basis some services usually available only on an in-patient basis. In addition to medical care, services such as physiotherapy, chiropody and occupational therapy are usually provided. Day hospitals are administered as part of the Hospitals Programme. However, attenders at these centres are likely also to be in receipt of, or in need of, Community Care services, for example general practitioner services, public health nursing, home help services. Development of day hospital facilities, which are usually attached to general hospitals, has been confined to the North Western Health Board (10 Centres), Eastern Health Board (4 Centres) and Western Health Board (1 Centre and 3 planned). Some of these units do not fit the full day hospital model in that medical and laboratory services are limited or non-existent. All of the units provide a wide range of nursing and paramedical services; often it is the need for these services that result in admission to hospital for elderly people.

The costs per patient visit to day-hospitals indicates that this type of facility has merit from a cost perspective. In the North Western Health Board the cost per visit in 1982 (the most recent year for which figures are available) ranged from £12.50 to £15.10 per day (31). These figures compare with weekly costs in 1981 of £128 for in-patient care in one of the hospitals concerned. In 1981 the costs per visit to one of the Dublin units was £18.50 while the weekly cost for in-patient care was £210 (32). In terms of a comprehensive community based service these day hospital costs reflect only one element of services which must be backed up by Community Care services. Taking these into account, for example public health nursing and home help the cost of a community based range of services, including attendance of 2 days per week at a day hospital, is likely to be less than in-patient weekly hospital costs.

The National Council for the Aged has recommended that day hospitals be regarded as an essential element in the provision of a comprehensive service for the elderly. It was proposed that locations for these units, to serve defined catchment populations, should include general hospitals (both Health Board and voluntary), geriatric hospitals, and district hospitals (33). These recommendations illustrate the importance of liaison and co-operation across Health Board programme boundaries if an effective range of services for elderly people is to be provided. At present the level of liaison and co-operation between services in different programmes is very limited in some areas.

Day centres

The essential difference between a *day centre* and a day hospital is the fact that in the former no medical care or investigation is carried out. The Care of the Aged Committee envisaged that such services as physiotherapy, occupational therapy, chiropody and a mid-day meal would be provided in day centres. In addition, an important function was seen as the relief of relatives, "particularly those who have to go out to work, of the responsibility of looking after elderly persons during the day" (34). While it was recommended that Health Boards should arrange for the provision of day centres in populous areas, no recommendations were made regarding the appropriate level of provision and no national guidelines have been developed since. The Eastern Health Board proposes a level of 1 per 18,000 population and at present over half the recommended number are provided in that area. Information on day centres is very limited. The level of provision differs considerably between Health Boards and there are no day centres in many areas (35).

The aims of day services may vary from broadly social aims to the relief of caring relatives and/or rehabilitation. Rehabilitation is particularly important at present because of the limited availability of rehabilitation personnel on a community basis. Day services, particularly day hospitals and to a lesser extent day centres, serve an

important function in providing access to rehabilitation personnel, such as occupational therapy, and to a more limited extent physiotherapy and speech therapy. These specialists are in short supply particularly in community care services (36), thus attendance at day services may provide the only access to these specialists for elderly people in many areas. The position relating to chiropody is similar. There is a marked shortage of chiropodists outside of the Eastern Health Board area (Table A4.9). Most chiropodists are in private practice and work for Health Boards on a sessional basis only. This service is often provided at clubs for the elderly run by voluntary organisations. However, the level of provision of these clubs varies enormously and is totally dependent on the initiatives of voluntary groups (37).

A number of factors can be identified to explain the low level of development or absence of day care services in many areas:

- There are considerable problems associated with the provision of day centres in sparsely populated rural areas — these relate to transport costs and the length of travelling time that would be involved for many elderly people.
- The low level of employment of rehabilitation personnel by most health boards (38) means that essential personnel for day services are not available. In addition, voluntary organisations often experience difficulties in employing professional personnel because of the discretionary nature of their funding (39).
- An important influence in some areas is the absence of pressure from voluntary groups and/or the low priority of day centres as a service from the health board's point of view.
- The present division of responsibility for services by programme rather than target group means that the overall level of provision of day services for elderly people is dependent on action from a number of sources: General Hospital Programme, Special Hospital Programme, Community Care Programme and Voluntary Organisations. A comprehensive range of services is dependent on the co-ordinated action stemming from all these sources. A basic step in this direction is a clear specification of the aims of particular day care facilities and their role within an overall structure of services, not only day care services, but the whole range of services for elderly people both residential and community. Such a specification of aims and roles is absent in most areas at present.

(iii) Accommodation

Much of the focus of service provision since the Care of the Aged Report has been on residential services, in particular the improvement of long stay hospitals and the development of welfare homes. This is understandable, given the pressure for admission to these centres. However, as has been pointed out, only a small minority of elderly people live in long stay units or welfare homes. Further, the need for residential services is inextricably linked with the provision of community services. It is inadequate to consider any one element of service in isolation.

Living arrangements for elderly people can be conceived as a continuum from ordinary housing through to special housing, sheltered housing, welfare homes and long-stay hospitals. Such a range encompasses activity by private individuals, voluntary organisations, local authorities and health boards. The only element of living arrangements that comes within the Health Board's Community Care Programme is welfare homes and this is the case at present in only four Health Boards: Eastern, North Eastern, Midland and North-Western. In the Western and South Eastern Health Boards welfare homes are administered as part of the Special Hospitals programme; in the Southern region they are administered as part of the General Hospital programme; in

the Mid-Western region they are administered as part of the Hospital Programme — in that area one programme manager has responsibility for all hospitals.

Welfare homes

Welfare homes were proposed by the care of the Aged Committee as substitutes for ordinary homes for those elderly people who were not in need of intensive nursing care (which would be provided in long-stay geriatric hospitals) but could not be maintained in their own homes even with the aid of home helps or in sheltered housing. The term sheltered housing is applied to:

"... housing accommodation which gives each person a separate and independent dwelling or flatlet with some common facilities such as dining and recreation rooms, storage space and facilities for laundry. Such housing is particularly useful for elderly persons who need a little supervision and help and may have some difficulty in ordinary homes, but it can suitably be used for any elderly person" (40).

In theory, the essential difference between sheltered housing and welfare home facilities relates to the individual's ability to look after his/her needs. The sheltered housing resident should be able to do this with only minimal supervision provided by a warden, while a welfare home resident is frail or infirm and though not in need of extended nursing care is in need of assistance with daily living activities. In practice, the distinction between these types of facility is not as clear cut as the above comments imply.

Welfare homes were envisaged as community facilities that would be operated as homes rather than as hospitals; Chief Medical Officers (now Directors of Community Care/Medical Officers of Health) would have overall responsibility for determining whether an individual's needs could or could not be met adequately in a normal home and whether a need existed for admission to a welfare home. It was concluded that the reasons for admissions were more likely to be social rather than medical (41). Provision of units of 40 beds on the basis of 20 places per 1,000 persons aged 65 and over was recommended. On this basis present provision should be about 7,500. If attention is confined to designated welfare homes provided by health boards, present provision is very limited — only 2,167 places or less than 6 per 1,000 persons aged 65 and over (Table A4.10). However, voluntary bodies and voluntary hospitals provide significant welfare home type accommodation, and Health Boards are involved in decision-making on admissions to these units. Taking this additional source into consideration, the total number of welfare places at 13 per 1,000 of the elderly population is still inadequate, furthermore, the hospital locations are not structurally suited to the 'home type' welfare accommodation envisaged by the Care of the Aged Committee.

There is considerable questioning about the appropriateness of welfare home provision for many of those admitted to date. In some homes extended nursing care needs are greater than was originally envisaged; this may be explained partly by the fact that many of the people initially admitted to welfare homes were admitted from long stay geriatric and psychiatric hospitals where patterns of institutionalisation and dependency may have been established which could not be overcome by transfer to a welfare home. It may be difficult to transfer residents whose needs change from welfare homes to extended nursing units. (Whether or not such a transfer should take place is a matter of debate — some experts argue that services should be modified to meet the changing needs of the individual). It is notable that there is considerable evidence to indicate that a significant minority of residents in long-stay hospitals are admitted because of social reasons rather than because of any disabilities (42). Statistics on long-stay geriatric units compiled by the Department of Health Planning Unit indicate that over one-sixth of the residents in geriatric units were admitted because of social reasons. It would seem that

this group would appropriately be accommodated in welfare homes, where at present 65% of the residents are admitted because of social reasons, or in sheltered housing.

Despite the reservations about the present operation of some welfare homes it is generally accepted that there is need for a facility intermediate to sheltered housing on the one hand and extended nursing care on the other. In some areas extensive welfare home developments are envisaged (e.g. the target for development by the Eastern Health Board is 30 welfare homes, of which 4 have been provided); in these areas it is believed that with adherence to the original criteria for admission and a non-institutional philosophy in operation the welfare home concept has merit. In some other Health Board areas there is a move away from the original concept towards the provision of self-contained units with the option for residents to use communal facilities. Services for the elderly in the North Western Health Board are being developed around the concept of Community Nursing Units incorporating a range of integrated services: (a) long-stay nursing units for elderly people, (b) long-stay nursing units for young chronic sick, (c) welfare residential provision and (d) day care. The welfare accommodation is provided in single and double bed-sitters, equipped with cooking, dining and bathroom facilities. Residents are encouraged to furnish these units with their own furniture and personal belongings. In the South Eastern Health Board a development at Clonmel has provided welfare accommodation in the form of self-contained flatlets with communal facilities. It is envisaged that those in need of extended nursing care will move to long-stay units. Thus, three distinct types of welfare provision are being provided at the present time. This range of provision affords an opportunity to evaluate outcomes on a comparative basis. In order to evaluate the effectiveness of different kinds of accommodation each must be evaluated in relation to other types of provision; thus, not only must different types of welfare home provision be evaluated relative to one another, but also relative to sheltered housing.

Sheltered and special housing

Sheltered and special housing are the responsibility of housing authorities but can involve Health Boards in a number of ways: Firstly, community care personnel often identify a need for sheltered housing for individual elderly people. Secondly, if priority rating is requested by a local authority housing applicant the Director of Community Care/Medical Officer of Health, or Chief Medical Officer in Dublin, will be required to make an assessment of need and health inspectors make assessments of conditions. Thirdly, in some areas, Health Boards make a contribution towards the running costs of sheltered housing schemes to voluntary bodies, or co-operation with local authorities through the provision of sites for sheltered homes (43).

Information on the number of sheltered housing units provided by local authorities and voluntary bodies is limited. The Care of the Aged Report recommended that housing authorities should reserve specifically for elderly persons a percentage of all dwellings provided and that initially 10% should be the aim. Since 1970, this target has been met in most years (Table A4.11). In addition, voluntary bodies, grant-aided by local authorities, were responsible for the provision of 842 special houses from 1970 to 1981. A survey by the Housing Centre indicates that in 1983 there were approximately 1,300 housing units for the elderly available for rent under the auspices of voluntary bodies (44). Some of these special housing schemes, both local authority and voluntary, are sheltered housing schemes. Outside the Dublin area, where Dublin Corporation provides about 1,500 sheltered housing units in 32 warden schemes, the number of sheltered units provided by local authorities is quite limited (45).

The statistics available do not allow a comprehensive evaluation of the effectiveness of housing provision for elderly people. The Department of the Environment does not

publish information on the size of waiting lists in different areas nor on the social and demographic characteristics of those on waiting lists. Consequently, it is not possible to identify the number of elderly people who are on waiting lists for houses. In addition to this information, the number of elderly applicants who do not get on the housing waiting lists is relevant from the point of assessing the housing conditions of the elderly.

Housing Conditions

There is considerable evidence that at least a minority of elderly people are living in deplorable housing conditions. With regard to the Dublin area only, the Alone organisation estimates that 1,000 old people are living in markedly sub-standard conditions (46). The full extent of housing problems among the elderly is not known. However, there is evidence from both the ESRI and St. Vincent de Paul Society surveys that the extent of poor housing conditions among the elderly is widespread. In the ESRI study it was found that 32% of elderly households did not have an inside toilet, and almost 40% lacked a fixed bath of shower; 43% of the respondents complained of draughts and 33% of dampness (47). In the *Old and Alone* study it was found that 53% of the elderly living alone were in pre-1920 houses and only a fifth were in houses built later than 1944. Fifty-seven per cent of respondents had no bath or shower, 32% had no flush toilet and 16% had only an outside flush toilet. Nine per cent of respondents had no electricity; these tended to be single males from unskilled labouring and farming backgrounds living in old detached houses in rural areas (48).

In April 1982, the Government established a special Task Force representative of the Departments of Health and the Environment, local authorities and voluntary organisations to deal with the problems of unsanitary and unfit housing conditions of old people living alone. The criterion for eligibility is that the old people are not in a position to have the work carried out themselves. The types of work covered by the scheme are provision of water and sanitary facilities, necessary repairs to make the home habitable for the life time of the occupant, refurbishing, necessary cleaning and redecoration, fireplace installation and food storage facilities. The scheme is administered by Health Boards in co-operation with local authorities and voluntary bodies. The 1982 allocation was £1 million allocated between Health Boards as follows: 50% on the basis of the percentage of the population aged 65 and over, and 50% on the basis of the number of houses without sanitary services. In 1983 similar amounts of money were allocated. The scheme is continuing on a year-to-year basis and £1 million was allocated in 1984.

Information on the schemes to date is that it has worked exceptionally well in most Health Board areas. The key element in this success appears to be the flexibility and commitment to speed in decision-making that characterises the scheme. A further important factor is that unlike other schemes, notably the Essential Repairs Scheme and Disabled Persons grant, the total funding comes from central government sources — this is important at a time of financial stringency; the other two schemes mentioned are in part funded by local authorities, thus pressure on their budgets can have adverse effects on these schemes. The Report of the National Council for the Aged on Housing of the Elderly in Ireland recommended that the Task Force Scheme be established on a long-term basis. In addition, this report suggested that the essential Repairs Grants Scheme be extended to include a special scheme, with 100% grant aid — for structural repairs of houses of the elderly (49).

Boarding Out

There has been some experimentation with the boarding out of elderly people with families. In some areas the service evolved as a response to the accommodation needs of relatively independent people in geriatric hospitals, whereas in other areas it emerged as a relatively informal arrangement between neighbours and is regarded by the Health

Board as a full-time home help service. The arrangements have varied from the boarding out of one person to a family to 5 or 6 people to a family; most schemes entail a payment by the Health Board to the families. In some areas, the people concerned attend day centres.

A description and evaluation of Boarding Out schemes has been completed by the National Council for the Aged (50). This study indicates that: in 1984/85 a total of 144 people were placed in eight such schemes, under the care of 63 persons; five of the eight schemes were in Connaught and Ulster; the schemes developed in an ad hoc fashion; organisational arrangements regarding payment, staffing, selection of clients and other matters varied greatly among the schemes. The National Council for the Aged recommended that the schemes should be developed and that guidelines should be drawn up and implemented; guidelines, it was recommended by the Council, should cover procedures for selection, deployment and training of carers and the matching of clients and caring families. Notably, the study indicates that the costs to Health Boards of the schemes compare very favourably with the costs of alternative schemes; the payments to carers in the boarding out schemes were in the range £6-£30 weekly in contrast to weekly costs of £268, £159, £86 and £50 for District Long-Stay Hospitals, Health Board Long-Stay Geriatric Places, Health Board Welfare Homes, and Private Nursing Homes, respectively.

In summary, the possible range of accommodation services for elderly people is broad and involves activity by private individuals, voluntary organisations, local authorities and Health Boards and within Health Boards it may involve each of the three programmes. Activity by all of these elements must be included in any comprehensive review of plans for services. This does not occur at present. This failure to adopt a comprehensive approach to accommodation services is evident in the present pressure on long-stay hospital services, despite the fact that the supply of these beds grossly exceeds the recommended level (51). This pressure indicates that either the original total number of beds recommended is inadequate or that, because of the present mix of accommodation and/or the present level of community services, many elderly people are being admitted inappropriately to long-stay hospitals. Support for the latter suggestion resides in the fact that at a minimum up to 20% of admissions to long-stay units are made because of social reasons (50).

(iv) Assessment Services

The programme arrangement of services means that many services relevant to community care are part of the Special Hospital Programme or the General Hospital Programme. Particularly relevant to the appropriateness of decisions relating to community care versus residential care, and to the type of residential provision are geriatric assessment units. As envisaged by the Care of the Aged Committee, these are units of general hospitals devoted to investigation, assessment, short-term treatment and rehabilitation of the elderly people who are not clearly in need of acute treatment; where rehabilitation is not possible assignment would be made to the most appropriate accommodation for those in need of long-term care. This element of services is grossly underdeveloped (Table A4.10). If the recommended ratio of 4.5 beds per 1,000 population aged 65 and over was to be achieved, the level of provision, based on the 1981 population, would be 1,660; the actual provision in 1984 is 391. Given that 75% of the original provision was intended as rehabilitation beds it is evident that rehabilitation services for elderly people are severely limited.

Given the low level of development of geriatric assessment units, the development by the South Eastern Health Board of an Admission, Assessment, Treatment and Rehabilitation Unit, attached to the geriatric hospital in Cashel, is of considerable

interest. This service is closely linked to the Community Care Geriatric Assessment team. The team consists of an area medical officer and a full-time public health nurse; it is envisaged that an occupational therapist and physiotherapists will be included when these staff become available. The home help service is seen as an integral part of the service offered. The orientation of this Admissions, Assessment, Rehabilitation unit is towards rehabilitation and return to the community. The expectation is that people will be discharged, and re-admission at short notice is guaranteed if it is essential. Everyone admitted to the hospital goes through the unit. The role of the public health nurse from the Geriatric Assessment Team is central to this project — she acts as liaison person between hospital and community and mobilises necessary domiciliary resources for the person being discharged. This approach to assessment and rehabilitation appears to be markedly successful. It is estimated that between 75% and 80% of elderly people admitted are discharged home. The key factors characteristic of this service are its orientation to the community as the base from which services are planned and flexibility between programmes and services. Lack of flexibility characterises many residential services for elderly people. In most areas once an elderly person is admitted to a long-stay hospital or other long-stay residential facility there is little likelihood of discharge.

4. CONCLUDING REMARKS

The present range of services for elderly people has been outlined under four headings: Domiciliary, Day Care, Accommodation and Assessment Services. The central role of the public health nurse in domiciliary care was outlined. It is not possible to establish the adequacy of this or most other services due to the absence of appropriate indicators. Some indications that the service may be under considerable pressure, due to increased curative nursing demands, were noted. The other major domiciliary service is the home help service; this is available only to a minority of elderly people and then primarily to elderly people living alone. The absence of appropriate information does not allow an evaluation of the service. Similarly, information on the meals-on-wheels service is too limited to allow for evaluation.

Significant short-falls in day services were identified both in day-hospitals (not part of Community Care Programme) and day-care centres; the shortage of these services are significant, particularly since they afford the only access to rehabilitation personnel on a community basis for elderly people in many areas.

The number of Welfare Home places available is considerably below the level recommended in the Care of the Aged Report. In addition, sheltered housing places (provided by voluntary bodies and local authorities) are limited. The inadequacy of these levels of accommodation is reflected in pressure on long-stay hospital accommodation, the supply of which is well over double the recommended level.

Geriatric Assessment unit places (responsibility of Hospital Programme) are grossly under-supplied and non-existent in some Health Board areas. A significant development in the South Eastern Health Board is the development of an Admission Assessment and Rehabilitation Service attached to a geriatric hospital. This service is operated in close association with a community-based Geriatric Assessment Team.

A key theme which emerged in this overview of services is the division of responsibility for services, not only between voluntary bodies and Health Boards, but also between Health Boards and local authorities, and within Health Boards between different programmes. This means that the range of services is dependent on isolated action from diverse sources. The present development of services reflects a failure to co-ordinate the action of the various sources. At present a Working Party on the elderly convened by

the Department of Health, is examining the services and their administration and management.

A further major problem with present services is the absence of a preventive orientation. This is reflected in the failure to focus on factors associated with the creation of dependency in old age and the resulting need for community care services. A comprehensive, preventive approach to dependency in old age would have to take into account the structural causation of economic and social dependency in old age. Factors that have been identified as of central importance in this regard are labour market structure, life-time work experiences, income distribution, and retirement policies (52). These findings clearly demonstrate that inequalities created during the pre-retirement years persist and are increased in retirement, and that the success of social policies aimed exclusively at alleviating dependency in old age is severely limited. Effective community care is dependent on the prevention of dependency and on the provision of services once dependency has developed.

CHAPTER 4

Footnotes and References

- (1) *The Care of the Aged*, Report of an Inter-Departmental Committee, Dublin, Stationery Office, 1968.
- (2) *Population and Labour Force Projections 1986-1991*, Central Statistics Office, 1985.
- (3) Whelan, B. J. and Vaughan, R. N., *The Economic and Social Circumstances of the Elderly in Ireland*, ESRI Paper 110, Dublin, 1982.
- (4) *Op. cit.*, p.73.
- (5) *ibid* p.91.
- (6) *ibid* p.88.
- (7) On the basis of *Statistics on Long-Stay Patients* 1980 and 1981, published by the Department of Health, it can be concluded that about 4% of those aged 65 and over are resident in these units. About 1,400 beds in district hospitals are long-stay; it is reasonable to assume that the majority are occupied by elderly people; this would amount to less than 0.5%. In the *Psychiatric Hospital and Units Census* conducted by the Medico-Social Research Board (1971), 5,067 people were aged 65 and over, i.e. about 1.5% of the population aged 65 and over. A further 1% of elderly people are in acute hospitals at any one time (calculated on the basis of MSRB Hospital In-Patient Enquiry>Returns). At most, a further 1% can be added for elderly people in homes of various types for handicapped people.
- (8) Department of Health, *Statistical Information relevant to the Health Services 1985*, page 75.
- (9) McDevitt, D., Brett, T. and O'Connor, M., *Admissions to County Homes: A Study of the Aged in Three Homes and Three Counties in Ireland*, Medico Social Research Board, 1975.
- (10) Powell, F. and F., "Too fit for Hospitals", *Community Care*, 16 October, 1980, p.19-21.
- (11) Whelan and Vaughan, *Op. cit.* Table 8.6, p.85.
- (12) Walsh, B., "Previously Unrecognised Treatable Illness in an Irish Elderly Population". *Journal of the Irish Medical Association*, Vol. 73, No. 2, February 1980, p.62-67.
- (13) General issues related to the public health nursing services are discussed in Chapter 2 and the role of the service in relation to children is discussed in Chapter 3.
- (14) At present domiciliary services are available to the aged in the following categories:
Category I — persons with full eligibility for all health services, i.e. medical

- card holders. It is estimated that 83% of the elderly are medical card holders; the percentage is considerably higher in some community care areas.
- Category II — persons other than those in Category I whose annual income in the year ended 5th April 1987 was less than £14,500.
- Category III — persons whose income is over the amount specified for Category II but only to the extent that the nurse's duties in relation to persons in categories I and II permit.
- (15) *Survey of Work Load of Public Health Nurses*, Report of a Working Party, Dublin, Stationery Office, 1975.
 - (16) An increase from five and a quarter to ten hours per week for a population of 4,000 was recommended. In addition, one and a half hours per week was recommended as necessary for nursing the terminally ill.
 - (17) A client-based *Community Care Information System* has been implemented in the North Western Health Board area.
 - (18) South Eastern Health Board, *Care of the Elderly*, Report of Sub-Committee, March 1979.
 - (19) Power, B. *Old and Alone in Ireland*, Dublin, Society of St. Vincent de Paul, 1980.
 - (20) Department of Health *Working Party on General Nursing Report*, Dublin, Stationery Office, 1980.
 - (21) South Eastern Health Board, *Op. cit.*, p.3.
 - (22) In 1981, the average duration of stay for patients in hospitals included in the Medico-Social Research Board Hospital In-Patient Inquiry Scheme was 10.3 days; for people aged 65-74, the average was 16 days and for those 75 and over it was 20.8 days.
 - (23) National Council for the Aged, *Community Services for the Elderly*, Dublin, 1983.
 - (24) See Section 3(iv) of this chapter on Assessment.
 - (25) See chapter 2 for discussion on general issues related to the Home Help service and Chapter 3 for issues related to a service for families and children.
 - (26) Whelan and Vaughan, *Op. cit.* Tables 8.3 and 9.4.
 - (27) Equal Opportunities Commission; *The Experience of Caring for Elderly and Handicapped Dependents: A Survey Report 1980*; *Caring for the Elderly and Handicapped — Community Care Policies and Women's Lives*, 1982; *Who Cares for the Carers? Opportunities for Those Caring for the Elderly and Handicapped*, 1982.
 - (28) See Chapter 2 re Expenditure.
 - (29) National Prices Commission *Monthly Report* No. 58, January 1977, p.53.

- (30) National Prices Commission *Monthly Report* No. 76, September 1978, pp.57-58.
- (31) The breakdown of these costs is as follows:

Staffing	66%
Other	18%
Transport	16%
- (32) National Council for the Aged, *Day Hospital Care*, Dublin, 1982.
- (33) *Op. cit.*
- (34) *The Care of the Aged*, Dublin, Stationery Office, 1968, p.68.
- (35) In the Midland Health Board Region day centres are provided and run by the Health Board in 8 locations. In other areas day centres are run in conjunction with geriatric hospitals, welfare homes or community nursing units.
- (36) See Chapter 2.
- (37) There is no training facility for chiropodists in the Republic of Ireland. There is one in Northern Ireland. While there is no registration of chiropodists, the Department of Health does issue a list of persons with qualifications suitable for public service employment. In 1983, there were only 89 names on this list.
- (38) See Chapter 2.
- (39) Section 65 Grants.
- (40) *The Care of the Aged. Op. cit.*, p.55.
- (41) The majority of admissions were expected to come from the following five categories:
 - (i) frail and infirm old persons who are not in need of continuous medical or nursing care, but who may need periodic medical and nursing care of the kind normally given by the public health nurse and the family doctor;
 - (ii) elderly persons who require terminal care but do not need, or could not benefit from, hospital care;
 - (iii) elderly persons suffering from minor illness who need institutional care for a short period and who require medical and nursing care, but not beyond that normally given by the public health nurse and the family doctor;
 - (iv) persons discharged from hospital but who, because of family circumstances, need a short period of adjustment before they can resume their place in the community;
 - (v) elderly persons who need help for a short time because of the illness of relatives, or because the relatives need a break from the provision of continuous care, for example to enable them to take a holiday (Care for the Aged Report p.82).
- (42) Department of Health, Planning Unit, *Statistics on Long-Stay Geriatric Patients* 1980, 1981; McDevitt et al, *op. cit.*; Powell and Powell, *op.cit.*
- (43) An example is the special housing development by Leitrim County Council on a North Western Health Board site at Manorhamilton.

- (44) 66 voluntary organisations are recognised by the Department of the Environment as approved bodies for financial assistance for "housing of deserving categories of housing need"; 56 of these have an interest in housing for elderly people. Not all approved bodies have undertaken housing activity.
- (45) The scheme at Vizes Court, Limerick (for 23 persons) is notable as one of the earliest schemes to be developed after the Care of the Aged Report. The average size of warden schemes in Dublin city is 44 dwellings — thus when the cost of one warden per scheme is averaged out over all the units the additional cost per unit is modest. Few rural areas would have need for schemes of this size — schemes already developed outside the Dublin area are considerably smaller e.g. Manorhamilton (12 dwellings), Castleblayney (12 dwellings), Cavan (6 dwellings). Apart from average cost differences it is clear that the level of support that can be provided by one warden is more limited in the larger size schemes. The level of support available in sheltered housing complexes varies; in some a twenty-four warden service throughout the year is provided, whereas in others, for example those in Dublin, a resident warden is provided, but is not replaced during time-off or holiday periods. In Dublin the wardens are employed by local voluntary committees who are funded by the Corporation for the salary. Thus, in addition to the warden service, support services to the residents are available from these groups.
- (46) Bermingham, W. and O Cuanáigh, L, *Alone Again*, ALONE, Dublin, 1983.
- (47) Whelan and Vaughan, *Op. cit.*
- (48) The interviewers on this study were asked to comment on housing conditions; the conclusions from these comments were that over half the homes were "in less than good repair" and were "less than comfortably furnished" and that half the buildings were not of good quality. Power, B., 1980, *Op. cit.* p.112.
- (49) The Care of the Aged Report recommended 15 long-stay beds per 1,000 people aged 65 and over; the 1981 provision was 37.7 per 1,000 (21.5 per 1,000, or 7,777, in Health Board hospitals and homes and 16.2 per 1,000, or 5,840, in private and voluntary locations). Source: Department of Health, *Statistics on Long-Stay Geriatric Patients*, 1980 and 1981.
- (50) National Council for the Aged, *Home from Home? Reports on Boarding Out Schemes for Older People in Ireland*, Dublin, 1985.
- (51) Department of Health, *Statistics on Long-Stay Geriatric Patients*; the McDevitt et al and Powell and Powell studies already referred to suggest an even higher percentage of admissions because of social reasons.
- (52) Guillemard, A.M., "Old Age, Retirement and the Social Class Structure" in I. K. Harrevaan (ed.) *Ageing and Life Course Transition*, New York, The Guildford Press, 1981; Walker, A., "The Social Creation of Poverty and Dependency in Old Age", *Journal of Social Policy* 9, (1) 1980, p.49-75. Townsend, P., *Poverty in Old Age*, London, Allen Lane, 1979; Myles, J.F., "The Aged — The United Kingdom", London, Allen Lane, 1979; Myles, J.F., "The Aged, the State and the Structure of Inequality" in J. Harp and J. R. Topley (eds) *Structural Inequality in Canada*, Scarborough, Prentice Hall, p.317-342. Estess, C. L., *The Ageing Enterprise: A Critical Examination of Social Policies and Services for the Aged*, San Francisco, Jossey-Bass.

SERVICES FOR THE HANDICAPPED

1. INTRODUCTION

In NESC Report No. 50, *Major Issues in Planning Services for Mentally and Physically Handicapped Persons* the position relating to services for handicapped people as of 1980 was outlined in considerable detail. In this present chapter the sections of that report relating to community care and the relevant recommendations are reviewed in terms of changes in the intervening period. In 1984 a Green Paper on services for disabled people, entitled *Towards a Full Life* was issued. That paper covers all disability groups and the whole range of services. Those of its conclusions that have relevance to the community care services under review are outlined.

Section 2 of this chapter deals with general organisational and funding issues relating to the development of services since 1980. In Section 3, the present position relating to four service areas is reviewed:

- (i) Domiciliary Care
- (ii) Day Care
- (iii) Support Services
- (iv) Rehabilitation Services

These areas were identified in 1980 as being in need of particular attention, in terms of community care for the handicapped.

2. INFORMATION, ORGANISATION AND FUNDING

The central problem identified in the NESC report was the absence of basic information on physically and sensorially handicapped people in each community care and Health Board disability and need for services. In 1983, the NRB was assigned responsibility for advising on the establishment of and monitoring of a record system relating to physically and sensorially handicapped people. A review of progress indicates that the system has been initiated in most areas and substantial progress has been made in some areas. The Green Paper on Disabled Persons states that the Health Boards will be provided with the necessary resources to ensure the development and continuing operation of an efficient information system. The advantages of such a system are clearly evident from the fact that the mental handicap record system has facilitated the undertaking of a census in 1981; this has provided information, not only on numbers in each community care area, but also on the degree of handicap, service provision and need for services. Such information is essential for effective planning.

A second significant difference identified between services for mentally handicapped people on the one hand and physically and sensorially handicapped on the other was the existence of structures at Health Board and at Department of Health level whereby attempts are made to co-ordinate and plan services. These structures are a Liaison Committee between voluntary bodies and Health Boards which exist in most regions,

and at Department Health level a section relating to mental handicap services. Such structures have still not been developed with regard to physical and sensorial handicap.

A third differentiating factor between the services for mentally handicapped people and services for other handicapped groups was the higher level of statutory financial support made available to voluntary bodies providing services for the mentally handicapped. While much of this higher level of support related to residential services, it is also evident in the case of community services. With regard to these services it is notable that the types of organisations involved differ as between those involved with mental handicap and those with physical handicap. In the case of mental handicap, service organisations tend to be geographical in focus and involved in the provision of facilities, and in the majority of cases are funded directly by the Department of Health. In contrast, organisations involved in community services for the physically and sensorially handicapped tend to be national in focus and concentrate on specific aspects of service or particular handicaps; also, they tend to be involved almost exclusively in personal social services, rather than the provision of facilities; finally they are for the most part funded by Health Boards through Section 65 grants (1). The latter arrangement allows for considerable variation in the level of funding throughout the country. This results in organisations being funded for the provision of services in some Health Board areas and not in others.

3. SERVICES

Four service areas relating specifically to an enabling structure for community living for handicapped people were identified in 1980 as in need of particular attention:

- (i) Domiciliary Care
- (ii) Day Care
- (iii) Support Services, including social work services.
- (iv) Rehabilitation Services

In terms of Health Board activity, there has been very little change in any of these areas. However, some initiatives, mostly by voluntary organisations, are of interest, particularly with regard to domiciliary care.

(i) Domiciliary Care

A flexible form of domiciliary care is an essential element of a comprehensive community care service. The main domiciliary services available to handicapped persons requiring assistance or support are home nursing and the home help services. The home help service is geared at present almost exclusively towards elderly people (2).

However the Green Paper makes a commitment to, the steady extension of the home help and meals on wheels services as key elements in our community care provisions. Health Boards and voluntary organisations involved will be encouraged to pay special attention to the needs of disabled people living at home and, as soon as resources permit, additional funds will be made available for that purpose (3).

With regard to the public health nursing service the Green Paper states that the Government will consider the need to improve the public health nurse/population ratio in order to enable the service to play a more active part in the domiciliary care of the disabled. In this regard the relevant recommendations of the Working Party on General Nursing (1980) are being reviewed i.e. those relating to an increase in the number of

public health nurses, the employment of SRN's in a supportive role and the extension of coverage to a 24 hour basis. While an increase in the public health nursing service will undoubtedly be beneficial for some disabled people the service is not geared towards providing the constant care and assistance often at "unusual hours" which a severely handicapped person may need. A twilight nursing service, available in one community care area in Dublin is clearly an essential element of a comprehensive service and could prove adequate for some dependent people. However, the type of help needed by a handicapped person will often not be curative nursing, but nursing aid. Thus, a category of support different from the public health nursing service and the home help service is necessary for many severely dependent handicapped people. There is evidence that *care attendants* can provide such a service on a very effective basis. The evidence available indicates that such a service is beneficial not only for handicapped persons but also for the *carers* of handicapped people (4).

Pilot Care Attendant Scheme

Early in 1983, the Irish Wheelchair Association introduced a 6 month pilot Home Care Attendant Scheme in the north Dublin area (5). The aim of the service was to give caring relatives relief at the time they identify as essential. This service was made available to severely physically disabled people and their families. The essence of the scheme which is similar in concept to the Crossroads Scheme in Britain (6), is that it is;

available at unsocial hours, at short notice if necessary, and that it can be relied on to provide a well trained and competent service to severely disabled persons and their families. It complements the service of the Public Health Nurse and the Home Help Service. The Care Attendants act as a substitute for the relative to enable them to do whatever they want to do or need to do (7).

Forty-one families availed of the scheme, 26 on a regular basis (Table A5.1) and 15 on an occasional or emergency intervention basis (Table A5.2). Many of those getting the service were also in receipt of other community care services: 11 were in receipt of the home help service and 13 were visited by public health nurses on a regular basis. Five availed of both the home help and the public health nursing service. These figures indicate that the levels of disability of those availing of the scheme was high. Family reaction to the scheme was uniformly favourable (8).

The scheme was funded almost totally by the Irish Wheelchair Association. The service was co-ordinated by a social worker (9). The care attendants were recruited from a variety of backgrounds and participated in a one month AnCO training course. Attendants were paid £2 per hour plus travelling expenses (10). The costing of the service for the 6 month period in 1983 is outlined in Table A5.3. The major costs of the service relate to the initiation, organisation and administration of the scheme. These costs could be offset to a greater extent than happened in the Pilot Scheme by increasing the amount of service hours available. As operated, the cost of the scheme works out at just over £10 per week per recipient (or about £11.50 per week in 1985 if a public expenditure deflator is applied). It is clear from the response to this limited service that there is a need for this type of service from families looking after severely physically handicapped persons. This is not surprising, given the findings of an earlier study by the IWA, which indicated that almost 20% of the members are severely disabled, i.e., require help with dressing, toileting and feeding, a further 23% require help with dressing and toileting (11).

This kind of service cannot be funded on an extensive basis by voluntary organisations, consequently a response from statutory authorities is essential. There is considerable evidence to indicate that statutory authorities are less likely to support caring families

than to provide services where these networks have broken down (12). The evidence from the IWA scheme and studies by the Equal Opportunities Commission in Britain (13) suggest that this may be a very short-sighted approach since many caring families are under very considerable pressure and need assistance if they are to continue caring on a long-term basis. Community care services, not only in Ireland, but also in Britain, have to date been characterised by a reluctance to support families on a flexible domiciliary basis. This is the case, not only with families of handicapped people, but also with families of elderly people and of children. Yet, a considerably greater amount of resources will be expended on residential services in the event of family breakdown. A further cost factor that should be taken into account in this regard is the longterm impact of stress on caring relatives (14).

The indications from the limited experience with the IWA scheme are that this type of service "appears to be an important component of a comprehensive community care service for physically disabled people and their families" (15). It is flexible and supports the network of reciprocal social relationships of caring relatives and meets the criteria suggested by research in this area (16). The feasibility of extending the scheme should be explored by statutory authorities in co-operation with voluntary bodies. It is probable that the scheme would prove equally effective for severely and profoundly mentally handicapped people and incapacitated elderly people. The Green Paper acknowledges that this type of scheme could well have a significant role to play in the future in helping to keep disabled people in the community rather than in institutions (17), but no commitment of resources is made to the development of such a scheme. It may be argued that in the present situation of economic stringency that this type of scheme cannot be introduced. However, in evaluating the costs of this type of scheme the costs of alternatives must be taken into account — costs such as opportunity costs to carers, both present costs and those associated with development of disabilities, and the alternative costs of long-term residential care for the disabled person.

Family Support through Short-term Alternative Family Care.

An essential element of a comprehensive support system to families caring for handicapped members in the community is a short-term alternative care system. Short-term residential care has been offered on a limited basis by many mental handicap special residential centres for about 10 years. This service was operated mostly for children and mostly during the summer. More recently, a small number of special short-stay centres have been opened. However, short-stay accommodation is still extremely limited. In view of this, an initiative taken by social workers in mental handicap services in the Dublin area in 1981 is of considerable interest (18). They initiated the *Break Away* scheme through which mentally handicapped children were placed for a one or two week holiday with host families in the community. These families were paid £50 per week in advance by the agency already providing services to the child and family. Legally this placement was formalised through a short term fostering arrangement.

In 1981, 28 children between the ages of 2 and 14 years were involved. Both host families and families of origin reacted very favourably to the scheme. It was concluded by the social workers that family placement could be developed (a) to include a variety of forms of care and (b) to include a range of people other than the mentally handicapped children. In 1982 and 1983 the numbers of children involved in the scheme were increased considerably (19) and similar schemes have been initiated in other areas, e.g. in the Midland Health Board where the Health Board undertakes the payment to the host families.

Apart from the alleviation of family stress and the possible prevention of the need for long-term residential care, these projects are significant in a number of other respects:

- (a) They indicate that there are community resources that can be tapped if an imaginative approach is adopted;
- (b) They are inexpensive — the weekly cost of this service is £50, plus the professional support costs. The 1983 weekly costs in special residential centres were on average £196;
- (c) They offer flexibility — these projects were initiated for summer placement but have also been used to a limited extent for short-term crisis care throughout the year. It is possible that this aspect could be developed.

(ii) Day Care Services

Serious shortfalls in day care services were identified in NESC Report No. 50 (20). In that report it was recommended that the need for such services should be assessed in each community care area. In addition, it was recommended that means of providing services be investigated within the context of using existing resources, e.g. community workshops, training centres, special residential centres and available paramedical personnel, where possible.

There has been very little development by Health Boards in this area — the absence of comprehensive information on physically handicapped people in each community care area has militated against assessment of their needs for services up to the present.

Services continue to be particularly limited for older mentally handicapped children (i.e. over 10 years), mentally handicapped adults, physically handicapped adults and sensorially handicapped adults outside the Dublin area. Day care services for all of these groups are provided almost exclusively by voluntary bodies. Thus, given the absence of a comprehensive plan for each community care area, an uneven pattern of development is inevitable.

Day Care Services for Mentally Handicapped People

Some indication of the need for day care for mentally handicapped children and young adults is evident from the fact that in 1981, of the 607 severely handicapped persons in the 0-19 age group, 56% were not attending day centres; the corresponding figure for the 100 profoundly handicapped people in the same age group was 61%. Since the vast majority of moderately handicapped children attend special schools from the age of 5 or 6, it is evident the vast majority of children without a service are severely or profoundly handicapped older children.

Day care facilities for mentally handicapped adults, i.e., "Occupational Centres" are even less developed than services for children (21). While there has been a considerable increase in provision since 1976 when the total attending these services was 161, there is still a major shortfall in provision. The extent of the need is evident when the findings of the 1981 Census of mentally handicapped people are considered: In that year, there were 306 severely mentally handicapped persons and 40 profoundly mentally handicapped persons aged 20 and over living outside of residential centres; 84% of the former group and 99% of the latter group were not attending day centres. Many of these people are likely to have severe physical handicaps and/or severe behavioural disorders, thus intensifying the difficulty of providing day services. While the majority of these adults are, or will be, in need of long term residential care, they are the group for whom such facilities are most limited. This is not meant to suggest that the overall level of provision of residential places is limited. It was demonstrated in the 1980 Department of Health Working Party Report on Services for the Mentally Handicapped that there are, on the basis of need related to degree of handicap, an

adequate number of residential places. Despite this there is pressure for admission to residential services. This paradoxical situation has developed because of inappropriate placements in the past — that is admissions to residential centres of people who could, with appropriate support services, continue to live in the community. These inappropriate placements are likely to have arisen because of inadequately developed community services both day and domiciliary support.

A study conducted by the Medico-Social Research Board in 1979 (22) on adult mentally handicapped people in the Dublin area indicates that, even where services are relatively well developed and easily accessible, the majority of mentally handicapped adults do not attend day services or are not productively occupied. This study was conducted in 2 community care areas in Dublin (23). While five percent of the study population were working in open employment only 41% were attending day services. The following reasons were put forward for not attending a service: The person was too old, would prefer to be at home, did not consider the service advantageous financially or in terms of level of care and extent of work; 4% of respondents were unaware that day service facilities were available. Projecting on the basis of this survey to the entire Eastern Health Board area, it was estimated that there were 1,450 persons not attending any day service or involved in occupational activity.

Services were found to be insufficiently developed, not only for those in need of day care and sheltered opportunities, but also for those mentally handicapped people with relatively high ability (23). It was concluded that some undefined dimension of projected employment or some special supports to obtain open employment should be considered "as it is apparent that this group has some difficulty in adjusting to most of the present services and to existing employment opportunities" (24). Consequently, meeting their needs in the community must be considered a priority.

Day Care Facilities for Physically Handicapped Adults

Outside of the Dublin area, there are very few centres provided specifically for physically or sensorially handicapped people and even in Dublin the number of centres and places is very limited (Table A5.4). In some areas, physically handicapped people attend day centres for the elderly and mixed day care units attached to welfare homes, hospitals and community nursing units, though availability of these are also limited. There are major problems about the provision of day care services in rural areas because of small numbers and geographical dispersion. However, it may be feasible to use both transport and day care facilities for a limited period each week for a variety of groups, either in terms of handicap or location. This is done to a limited extent in the case of elderly people from different areas at present. Specifically, with regard to handicapped people, the Resource Centre developed in Galway City by the Western Health Board in co-operation with the Galway Social Service Council provides one option that could be considered in other areas. This centre provides a service for about 50 people, most of whom attend on a weekly basis as part of homogenous groups (26).

It is not possible to make an assessment of the need for, or adequacy of, present provision of day care facilities until information becomes available on physically and sensorially handicapped people in each community care area. However, if the commitments in the Green Paper to the development of an information system and the drawing up of a programme for the development of day care services in each Health Board area are acted on such an evaluation will be possible.

(iii) Support Services, Including Social Work Services

It has already been pointed out that there has to date been no comprehensive review of the adequacy of the present social work service; also the present Health Board service is

involved, for the most part, in the provision of a service to families and children, i.e. in fulfilling the Health Boards' statutory responsibility to children. There is no national policy on generic versus specialised social work services. Many voluntary organisations in the fields of mental handicap, sensory handicap and physical handicap employ social workers to provide a community based service. The funding arrangements for these services vary depending on the type of handicap served and Health Board location (Tables A5.5 and A5.6). The different requirements of people with different degrees of handicap was discussed in the NESC report and it was recommended that:

The development of a framework for a comprehensive social work service for handicapped persons with provision for the various levels of specialisation needs to be examined jointly by the relevant statutory and voluntary agencies.

Such an examination has not taken place in most Health Board areas to date, consequently, whether a social work service is available to a handicapped person still depends on:

- (a) the type of disability and extent to which a voluntary organisation catering for that group provides a social work service;
- (b) geographical location of the person and the availability of a social work service from statutory and voluntary sources in the area.

Social work and support services are relatively well developed for some groups of handicapped people, viz mentally handicapped children within the catchment areas of Diagnostic Assessment and Advisory Services (27) and blind people. Apart from services for these groups, availability of services tends to be limited in many areas and non-existent in some.

Social work services for mentally handicapped adults, particularly those not attending a day service are not well developed. The majority of this group, especially those aged 30 and over, are likely never to have been in contact with an advisory service; an indication of this is the fact that 77% of the 1338 moderately mentally handicapped people and 72% of the 296 severe and profoundly handicapped people living in the community in 1981 had never had a psychological evaluation (28).

There are considerable problems relating to social work services for physically handicapped people. The provision of services by voluntary organisations varies considerably between Health Board areas. A major problem associated with voluntary provision in the absence of uniform funding arrangements for such provision. In most areas, Health Boards claim that they are providing a service: however, the adequacy of this service is questioned by voluntary organisations.

The position relating to some groups with special needs is particularly bad. For example, social work services for deaf people are available only in the Eastern Health Board area, where the National Association for the Deaf employs two social workers who are subvented by the EHB. In other parts of the country, there are virtually no social work services for profoundly deaf people (29) since generic social workers do not have the communication skills. It is acknowledged that the numbers involved are small: however, at least one social worker with the necessary skills should be available in each Health Board area.

In the Green Paper a commitment is made that the Minister for Health will "as soon as resources permit" provide for an increased level of resources for the development of

social work services to ensure that a professional social work service will be available to all disadvantaged persons including the disabled who require it. A further commitment is made to review arrangements for counselling services for the parents of handicapped children. Both of these commitments are important first steps; however, they are limited because the resource implications have not been specified.

Often the support needs of handicapped people may not be for a specialised social work or counselling service but for practical advice and assistance in obtaining benefits and services. Information provision relating to health and social services in general is limited and that relating specifically to handicap is almost non-existent. Thus, the recent development of resource centres in two of the health boards has considerable merit. Provision of information on entitlements, aids and appliances is part of the brief of the Galway Resource Centre already referred to. In the North Western Region, one Resource Centre in Sligo has been opened and others in major towns throughout the region are planned. These centres are oriented specifically towards the provision of information and advice on aids and appliances. Experience in these centres should be reviewed with a view to developing appropriate information packages for health centres and other health facilities.

(iv) Rehabilitation Personnel

Occupational therapists, speech therapists and physiotherapists are all essential elements of an adequate rehabilitation service, however, these specialists continue to be in short supply (30). There is considerable variation in provision between Health Boards. In some health boards there are marked differences between the number of posts approved and the number of posts filled, but more significantly, there is a vast difference in the level of service aspired to, as reflected in posts approved per 100,000 population, in different areas. This pattern means that people in objectively similar positions in terms of need have access to vastly different levels of service.

Aids and Appliances: It is difficult to assess the exact position due to absence of information. Variations between areas relating to assessment and supply continue to exist. Considerable delays are experienced in some areas. Problems often relate to the voluntary/statutory mix — in many areas the rehabilitation personnel are employed by voluntary agencies while the supply of aids is the responsibility of health boards who may not issue any guidelines about what is and is not available. In addition, delays in assessment are linked to shortages of rehabilitation personnel.

4. CONCLUDING REMARKS

Apart from the development of resource centres by two Health Boards, there has been little significant changes in their provision of community services for the handicapped since 1980. However, some interesting initiatives relating to domiciliary care have been undertaken on a limited scale; these are, a Care Attendant Scheme for physically handicapped people and a short-term alternative family care scheme for mentally handicapped children. Both schemes have been evaluated and the indications are that as support to families they have considerable potential.

The 1984 Green Paper on Services for Disabled People acknowledges that services are inadequately developed in a number of areas. It makes a number of commitments towards the development of services which, if followed through in terms of resource allocation, would improve the situation of some handicapped people to a considerable extent. However, in terms of the issues discussed in this chapter the only development

to which a commitment of resources is made is to the establishment of an information system. Apart from this all commitments are made subject to the availability of resources. Given the present economic situation it can be argued that a commitment subject to the availability of resources is understandable. Such an argument is, however, effectively an acceptance of a continuation of the present situation which is acknowledged as unsatisfactory in the Green Paper.

A realistic official commitment to the development of services must be accompanied by an estimate of the cost implications. In addition an outline of the various options relating to funding sources should be specified. In a situation of static or falling levels of resources devoted to health and social services the issue of resource shifts, not necessarily from health services, is one option that must be considered. The most effective and efficient use of limited resources must provide the framework within which services are planned and evaluated. A commitment to community care services is worthless without the necessary resource commitment.

CHAPTER 5

Footnotes and References

- (1) Under Section 65 of the 1953 Health Act health authorities may make grants to voluntary organisations involved in the provision of services similar or ancillary to those provided by Local Authorities.
- (2) See Chapter 2, Section 2 (v).
- (3) *Towards a Full Life*, Dublin Stationery Office 1984, p.77.
- (4) Bristow, A., *Crossroads Care Attendant Schemes*, Rugby, England, 1980.
- (5) Faughnan, P. *Home Care Attendant Scheme*, Report on Pilot Project, Dublin, Irish Wheelchair Association, 1983.
- (6) Bristow, A., *Op. cit.*
- (7) Faughnan, P., *Op. cit.* p.2.
- (8) "Many of the relatives commented on the security of knowing they could call on someone they know can cope when the occasion arises; others on the benefits to them and to the disabled person of someone who cares coming into the family on a regular basis; the freedom of being able to go out with ease and others of having been at the "end of their tether" before the scheme was launched and the extent to which it is a "life line" for them" (Faughnan, P., *Op. cit.* p.23).
- (9) Most of the British schemes have been coordinated by people with nursing backgrounds. The report on the IWA scheme concludes that, given the absence of a widely based community social work service to physically handicapped people, a back-up social work service to the scheme would be essential, if the coordinator is not a social worker.
- (10) Contributions from the disabled persons and their families amounted to £150. The element of payment of the care attendants was considered important by some recipients: "I feel under no compulsion in asking her to come — it's a job for her".
- (11) Faughnan, P. *Dimensions of Need*, Dublin, I.W.A. 1977, p.18 and p. 64.
- (12) Moroney, R. M., *The Family and The State*, London, Longman 1976, Ch. 5, pp.92-115.
- (13) Equal Opportunities Commission, *The Experience of Caring for Elderly and Handicapped Dependents: Survey Report*, London, 1980.
- (14) Equal Opportunities Commission, *Who Cares for the Carers?* London, 1982.
- (15) Faughnan, P., *Op. cit.* p.28.
- (16) Bayley, M., *Mental Handicap and Community Care*, London, 1973.
- (17) *Towards a full life*, p.78.
- (18) Walsh, J., *Break Away: A Study of Short Term Family Care for Children with Mental Handicap*, Dublin, 1983.
- (19) In 1982, 73 children between the ages of 8 months and 15 years were involved in the scheme — 4% of these children were severely mentally handicapped. Up to September 1983, the number involved was 107, between the ages of 3 and 16; 54 of this group were severely mentally handicapped and 53 were moderately mentally handicapped.
- (20) NESC No. 50, *Major Issues in Planning Services for Mentally and Physically Handicapped Persons*.
- (21) The report on *Training and Employing the Handicapped*. (Dublin Stationery Office) 1975 proposed that Occupational Centres should be provided for those mentally handicapped persons who would not be able to go into open employment or engage usefully in sheltered employment. In 1980, there were 277 people over the age of 16 attending day care centres — 50 were attending centres attached to residential services and 227 were attending special day centres. Department of Health *Statistical Information Relevant to the Health Services 1982*, Dublin, Stationery Office, Table F9.
- (22) Walsh, J. and Mulcahy, M., "Service Requirements of Adult Mentally Handicapped Persons Living in the Community". *Irish Medical Journal*, Vol. 75, No. 1, January 1982, p.13-15.
- (23) The primary care givers of all known mentally handicapped people aged 15-64 in one of the areas and a 1 in 2 sample in the other area, were interviewed.
- (24) Those with high ability were those who "had generally little difficulty in communicating with others, were able to look after their personal needs, were relatively independent, could make simple meals for themselves, help with most jobs around the house, able to tell time, select money, write own name and address, read street signs and follow simple directions" (ibid. p.13).
- (25) *ibid.* p.15.
- (26) The centre is directed by an occupational therapist and the staff includes a nurse, a driver and volunteers; in addition, a community physiotherapist is based there.
- (27) The country is divided into catchment areas associated with Diagnostic Assessment and Advisory Services (Table A5.5). Support services are good in urban areas and in those rural areas within easy access of clinics.
- (28) Medico-Social Research Board, Mental Handicap Section, Information from 1981 Census of Mentally Handicapped People.
- (29) Occasionally these 2 social workers may provide an emergency service outside of the EHB.
- (30) See Chapter 2, Section 2 (vi).

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

1. INTRODUCTION

The present framework of community care services stems from the 1970 Health Act and associated documents. The Community Care Programme covers a broad range of services including as it does three sub-programmes, Community Protection, Community Health Services and Community Welfare.

Community protection includes prevention of infectious diseases, child health examinations, immunisation, health education and other preventive services.

Community Health Services covers general practitioner services, drug supply and refund schemes, home nursing services, dental, ophthalmic and aural services.

Community Welfare covers personal social services and cash welfare payments. The former includes the work of social workers, child care workers and home helps.

2. SUMMARY

In this section key issues which were identified in the preceding chapters will be summarised under the following headings:

- Expenditure
- Employment
- Discretionary Services
- Services for Children
- Services for the Elderly
- Services for the Handicapped

Conclusions and recommendations are given in sections three and four respectively.

(i) Expenditure

There were nominal and real increases in expenditure on each of these sub-programmes between 1976 and 1985; however, non-capital expenditure on the Community Care Programme has increased less than average non-capital expenditure over the period. In particular, it has increased less than expenditure on the General Hospital Programme and the Programme for the Handicapped. Despite this, however, expenditure on some specific services increased more than the average between 1976 and 1985. Most of these services are part of the Community Welfare sub-programme (e.g. the Home Help Service) and of the Community Health Service sub-programme (e.g. Home Nursing Service).

In 1983 expenditure on the Community Care Programme decreased in real terms by 6%. This decrease was due almost exclusively to a 12.6% decrease in the General Medical Service and Drugs Schemes, mostly the drugs subsidy scheme on which expenditure decreased by almost 50%. Since then, total expenditure on Community Care has increased, although the 1985 figure is still marginally less in real terms than the figure for 1982.

(ii) Employment

Employment of all professional groups involved in the Community Care Programme has increased since its inception. Despite this some services are still grossly underdeveloped. This is especially true of speech-therapy, occupational therapy and physiotherapy. The latter service is almost non-existent within the Community Care Programme.

In a comparison of employment levels of all professional groups between Health Boards two facts are notable:

- (a) There is marked variation in the level of approved posts between Health Boards. This is only partly explained by the involvement of voluntary bodies in the provision of services. The evidence suggests that Health Boards differ in the level of service they regard as appropriate. This is not surprising in view of the absence for most services of national guidelines on the appropriate level of service as reflected in professional/population ratios, and the lack of nationally uniform eligibility criteria for certain services;
- (b) Some Health Boards consistently have large numbers of approved posts unfilled.

(iii) Discretionary Services

Some services provided as part of the Community Care Programme are discretionary. The most important of these services is the Home Help Service. This is discretionary in two senses. Firstly, there are no legally specified criteria for eligibility and secondly, it is in large part provided by voluntary community organisations whose funding is subject to the discretion of Health Boards. While expenditure on the home help service increased more than expenditure on any other service between 1976 and 1982, it started from a very low base and the increase occurred exclusively up to 1980. Expenditure in 1985 is equivalent in real terms to only 84% of the 1980 level.

(iv) Services for Children

Community care services for children include Child Health Services (covering Pre-School and School Health Services), and Personal Social Services for children and families. Variation between areas in availability of, and accessibility to, pre-school health services is marked as is evidenced by the fact that approximately 50% of children do not have access to developmental clinics. Similarly, there are marked variations between areas in the scope of the School Medical Service and the statistics available are limited in quantity and quality.

Personal Social Services for children and families include:

- (a) Social Work Services,
- (b) Services Supplementary to Family Care (domiciliary services, day care services and community projects)
- (c) Alternatives to Family Care (adoption, fostering and residential services).

The development of these services is uneven and no community care area has a comprehensive range of services. This is associated with a pattern of piecemeal development in response to immediate need, rather than a planned development based on the range of services needed in individual areas.

(v) Services for Elderly People

The Care of the Aged Report (1968) provided the framework within which the present structure of services for elderly people has developed. A review of services under four headings — Domiciliary, Day-Care Accommodation and Assessment Services — indicates that rigid divisions between Health Board programmes are not realistic and militate against the development of a comprehensive range of services. Day hospitals and geriatric assessment units, both of which are part of the General Hospital Programme, are essential elements of an effective range of services. Both services are grossly under-supplied in all areas and are non-existent in some. Welfare homes are part of the Community Care Programme in two areas and part of the General Hospital Programme in two others. The number of places available in these homes is at about one fifth the level recommended in the Care of the Aged Report. The inadequate level of provision coupled with limited availability of sheltered housing is reflected in pressure on long-stay accommodation despite the availability of double the recommended level of provision. This pressure is also due to inadequately developed assessment services and severely limited availability of rehabilitation personnel at the community level.

The major domiciliary services for elderly people are the public health nursing service and the home help service. It is not possible to establish the adequacy of either of these services due to the absence of the necessary statistics. There are some indications that the public health nursing service may be under considerable pressure due to increased curative nursing demands. The home help service is available to 2.8% of the population aged 65 and over, though there are marked variations between and within Health Board areas. The service is available almost exclusively to elderly people living alone.

Two key themes which emerge from a review of services for elderly people are:

- (a) the provision of responsibility for service provision and;
- (b) the failure to adopt a preventive orientation.

The division of responsibility arises not only between Health Board programmes but between Health Boards and voluntary bodies, and between Health Boards and local authorities. The present inadequate development of services reflects a failure to co-ordinate the action of these various sources. The failure to adopt a preventive orientation results in a focus on service development to meet needs once dependency has developed, rather than a focus on factors associated with the creation of dependency.

(vi) Services for Handicapped People

Community Services for handicapped people were reviewed with reference to the recommendations of the 1980 NESC Report, *Planning Services for Mentally and Physically Handicapped People* and the 1984 Green Paper on services for the Disabled People. It was illustrated that there have been few significant changes in Health Board services since 1980. Progress continues to be better with regard to services for mentally handicapped people relative to services for physically and sensorially handicapped people. This is reflected in:

- (a) the quality of information available at Health Board level;
- (b) the existence of structures both at Health Board and Department of Health

- (c) levels whereby attempts are made to co-ordinate and plan services; and the higher level of statutory financial support to voluntary bodies providing services for mentally handicapped people.

Two significant developments relating to family care were identified. These are a Care Attendant Scheme for physically handicapped people initiated by the Irish Wheelchair Association and an alternative family care scheme for mentally handicapped children. Both schemes have been evaluated and the indications are that they were successful in supporting the families studied and could have wider applicability. It was noted that while the Green Paper makes commitments to the development of a wide range of services, these commitments are not accompanied by commitments of additional resources, or plans to re-allocate resources.

3. CONCLUSIONS

Three sets of issues emerge from the review of the Community Care Programme undertaken in this report:

1. There is a remarkable level of agreement that community care is a desirable objective. This has been affirmed in policy documents and statements by politicians from the 1960s to the present. However, there is a marked contrast between the agreement on community care as a goal and:
 - (a) the commitment to specify the implications of this goal in terms of particular services necessary to make it a reality;
 - (b) the commitment of resources to support the development of this range of services.
2. The present level of information on community care services is grossly inadequate for evaluation and planning.
3. The development of services is hampered by organisational problems at a number of levels.

Each of these issues will be discussed in this section.

(i) Commitment to Community Care

The failure to identify the service and resource implications of community care as a policy goal is associated with a focus on the provision of formal services in the community, i.e. on the development of a limited range of services provided by paid workers. In particular, it is associated with a lesser development of services that are supportive of families than of those services which provide alternatives to family care. This pattern is based on the assumption that informal caring networks of friends and neighbours are the norm. It ignores the evidence that most social care in the community is provided solely by families. It arises from a public expenditure focus on community care as opposed to an opportunity cost focus. Community care is considered better partly because it is believed to be a 'cheaper' option than services provided on a residential basis. Such an interpretation ignores opportunity costs to carers, and the range of support services necessary to make community care a realistic option. Community Care Programme services are only one element of these support services. An enabling community care structure is dependent on a community care orientation in other health services and also on the wider social policy framework, particularly housing, transport and income maintenance policies. Discussions of community care rarely take these inter-relationships into account. As a consequence, factors associated with the creation of dependency are not identified and a preventive orientation is not adopted.

The service shortfalls identified throughout this report are due, not only to limited resources, but also the absence, for many services, of national guidelines on desirable levels of service and national statutory rules of eligibility for services. This results in significant variation between Health Boards in the aspired level of service provision as reflected by approved staff complements, number of planned places in day centres, geriatric assessment and rehabilitation centres and welfare homes. This means that people in objectively similar conditions have access to services in some parts of the country, but not in others. The national guidelines that are available are in some instances associated with an unequal distribution of services. A notable example is pre-school health services, Health Boards being obliged to provide developmental clinics only in those centres with a population of 5,000 or more. Furthermore, the level of adherence to national guidelines varies markedly between areas as is evidenced by the public health nurse/population ratios.

A major reason for the underdevelopment of services is the fact that the three policy streams — the resource and service policies and those relating to statutory/voluntary relations tend to be treated in isolation in discussions of community care policy. A commitment to service improvement is rarely accompanied by an analysis of the resource implications for other health services. In a situation of static or decreasing overall health resources such an analysis is essential since there are significant barriers to shifts in resources. If one considers the General Hospital Programme, which takes over 50% of gross non-capital health expenditure per annum, such barriers are clearly evident. Even without expansion of these services there is, because of rapid improvements in medical technology, an inbuilt pressure to increase resources. In addition, there is public and political pressure for maintenance of an array of hospitals which, according to expert opinion, is disproportionate to need. It is notable that the same public pressure that is mobilised for the preservation of small hospitals has never been evident with regard to community care services. A further factor that may militate against a shift in resources is the pressure of occupational groups within hospital services; while these may not be opposed to community care in principle, they are likely to resist any reduction in resources for their own sector. At present community care is not the primary care system within the health services, it is subordinate to hospital care, and perceived as such. The present rigid boundaries between programmes is conducive to this perception of community care. Until a community care perspective informs all health services irrespective of programme designation, this situation will continue.

(ii) Information

Significant problems were encountered in compiling this report because of the absence of information on many aspects of services and limitations associated with the information that is available. It was suggested in Chapter 1 that four elements are important in considering services, viz. levels of utilisation, impact on inequalities, risk reduction (reduction of risks of disability and prevention of admission to long term residential care) and efficiency. Apart from utilisation data, relating to which limitations have been identified, information concerning the other dimensions is limited. Development of indicators is not a straight-forward task.

With regard to inequalities across the life cycle, some information is available on take-up of services by age but information on socio-economic factors is almost non-existent.

The absence of information on take-up of services by socio-economic group and also by district-electoral division imposes severe limitations, both on epidemiological research and on decision-making on the deployment of resources within community care areas. In particular, it results in a failure to identify areas of marked disadvantage and factors associated with the creation of dependency and the resulting need for community care

services. This in turn militates against a preventive approach to community care. It is acknowledged that socio-economic indicators are difficult to collect on a consistent basis, however district electoral divisions can be used as the unit for socio-economic indicators, particularly in urban areas. This information could be supplemented by studies in a limited number of representative areas using more sharply focussed indicators.

A significant development with regard to information collection on community care services is the Community Care Information System (CCIS) developed in the North Western Health Board. This system provides "client" information to professional workers through a centralised "client record" accessible to authorised staff, service information to professional and administrative staff, and management information. It is notable that the information necessary for the development of this system is already routinely collected by health and social service professionals and administrators in all areas.

(iii) Organisational Issues

While the focus of this report has been on services, organisational issues emerged repeatedly as the basis for failure to develop an effective range of services.

These organisational problems arise at four levels:

- (a) Within the community care programme;
- (b) Between Health Board programmes;
- (c) Between Health Boards and local authorities;
- (d) Between Health Boards and voluntary bodies.

There have been, to date, considerable difficulties associated with the functioning of community care teams and in particular the role of non-medical and non-nursing personnel within these teams. The value of a multi-disciplinary approach to the delivery of services has been repeatedly emphasised in health and social services literature since the 1960s and is central to the McKinsey Report proposals. However, the resolution of the tensions inherent in the operation of a team whose members come from different professional backgrounds and work on the basis of different orientations to health and social services has received little attention in Ireland.

There are problems at the present time about the relationship to the community care team of dentists and, in some areas, of community welfare officers. While social workers participate in teams, those in some areas are highly critical of the present structures. The criticisms of all those professional groups are in part related to the objections to the dual role of the Director of Community Care/Medical Officer of Health. The proposals for change put forward by the different professional associations vary. The Irish Dental Association point out that the service provided by its members is a clinical one and has argued for a separate Dental Programme with a Chief Dental Officer who would have overall responsibility for community and institutional dental services. Similarly, the Irish Association of Speech Therapists has proposed a structure based on each programme but under the control of a Director of Speech Therapy.

The criticisms by social workers and community welfare officers relate more directly to the alleged medical bias in the present structure and the supplementary role to health services of personal social services and cash welfare services. This type of criticism is reflected in the Supplementary Report published with the final report on the Task Force on Child Care Services, where it is argued that the objectives of the Report cannot be achieved within the present administrative structure. That report proposed a fourth Health Board programme — Family and Child Care — with two Assistant Programme

Managers, one responsible for Child Care Authority functions and one responsible for Welfare Services. It is not suggested that this approach would be considered appropriate by all social workers or community welfare officers though this approach has been advocated by members of both groups particularly within the Eastern Health Board.

In contrast to these approaches it is argued by some personnel within the health services, and within the community care services in particular, that the reasons for the present difficulties arise from a failure to implement the structure proposed by the McKinsey Report. In this regard it is relevant to consider why multi-disciplinary teams are advocated and in particular why such a structure was advocated for the Community Care Programme. In theory, the purpose of collaboration between professional groups is to ensure a comprehensive service and to make access to appropriate services easier for individual applicants. The McKinsey Report states that the rationale for a multi-disciplinary organisation of services at local level is a "client-centred" approach as opposed to a fragmented approach. At this stage it is clear that this has not been achieved — health and welfare services have in most areas not been "forged into a single powerful force at local level". While co-operation between professionals at the day-to-day level is good in many areas, the less-than-effective functioning of the team is a serious problem, since it directly militates against evaluation and planning of services for particular target groups. At present the development of discrete services in response to needs is the dominant approach in most areas.

Inextricably linked with the internal team issues are problems related to the process of planning and budgetary control. In some Health Board areas, planning takes place with, at best limited, and at worst, no input from professional involved in the delivery of services. The present hierarchical structure is not conducive to such input. This has negative consequences, particularly on personal social services and rehabilitation services, which are relatively recently developed services and which started from low expenditure bases.

From a service point of view, it is suggested that two changes are essential if the present structure is to achieve the forging together of health and welfare services originally envisaged:

- (a) A stronger target group focus and;
- (b) Input at the planning and budgetary control level by senior members of professional groups identified as having primary responsibility for major service areas.

With regard to the first point, if the needs of particular target groups are to be the central concern of planning the focus must shift from a concern with professional boundaries to what each professional group has to contribute. This would necessitate the recognition of areas of primary responsibility varying according to the input of different professional groups. This is an essential first step in achieving effective participation of all professional groups. The second point is of importance particularly in a situation of static or decreasing resources. If expenditures have to be contained it is essential that economies are not distributed solely on the basis of least resistance from service beneficiaries, e.g. in discretionary services.

The problems identified in the previous paragraphs relate to the failure of the community care structure to achieve its potential. Organisational problems between programmes point to a more fundamental issue — whether or not the programme arrangement is the most appropriate structure for the achievement of a comprehensive range of services for all target groups. The problems associated with the present arrangements are most clearly illustrated in the case of services for elderly people. In

some Health Board areas all three programmes are involved in service provision. Apart from shortages of essential services, there is a gross mismatch between needs and available services with the result that many elderly people are inappropriately admitted on a permanent basis into long stay hospitals. This practice is reinforced by the fact that in most areas services are characterised by marked inflexibility between residential and community facilities.

The McKinsey Report acknowledged that the division of services by target groups might be the best arrangement for analytic purposes, but argued that this would be less efficient for management purposes than a programme arrangement. The evidence relating to services for elderly people indicates that there are serious deficiencies associated with the programme arrangement in many areas and that some mechanism is necessary to overcome that division of responsibility. In its recent consultative Document the Department of Health proposed that there should be a "much more active planning function at Community Care area level". In addition the Department suggested "that local health service management should move from a programme to a geographic basis". Two other options might be considered: Overall responsibility for planning the whole range of services, both residential and community, could be assigned to one programme. Alternatively there should be an official at the Health Board planning and budgetary control level who would co-ordinate the planning and development of services for elderly people (for example) across programmes. If the programme option is accepted and if a community orientation is accepted, then the Community Care Programme is the logical choice for this responsibility. To be effective such a change would have to include a commitment of resources, and some control over those resources, by the Community Care Programme.

Collaboration between Health Boards and local authorities is just as essential for some groups as is collaboration between health board programmes. In particular this is true for elderly people and handicapped people with special housing needs. The level of collaboration varies at present. The inadequate level of sheltered housing, (special housing with support services) which results in admission to long-stay centres for people with housing needs, is reflected in the fact that 20% of those admitted to long-stay geriatric units are admitted because of social reasons. The success of the recent initiative relating to housing repairs, involving both Health Boards and local authorities, illustrates the effectiveness of collaboration and in particular the importance of a commitment of funding from central sources for a specific purpose.

Problems between voluntary and statutory organisations relate to the absence of an agreed framework for the involvement of the voluntary sector either in consultation or planning, and in particular to the discretionary nature of their funding. The absence of such a framework is associated with the absence of agreement about, and only limited discussion of, whether voluntary organisations should be involved in the provision of services which are parallel with, or complementary to Health Boards and, if complementary, how complementarity is to be achieved.

In conclusion, the fulfillment of the official commitment to community care is dependent on a specification of the services and resources implied in the commitment, the establishment of an adequate information system at community care level, and action to overcome present organisational difficulties.

4. RECOMMENDATIONS

On the basis of the foregoing conclusions action is recommended at three levels:

Department of Health, Health Board and Community Care Team

The purpose of these recommendations is to emphasise the need for specification within each administrative area of the implications of the widely accepted commitment to community care. It is recognised that flexibility is essential so that the unique characteristics of particular community care areas can be taken into account. However, while identification of the needs of the three major target-groups (children, elderly and handicapped people) and a plan for services within each community care area is necessary, such plans must be formulated within broad guidelines agreed at Health Board and Department of Health levels.

On the basis of the existing pattern of development it is concluded that without guidelines on desired levels of service there is a distinct possibility that people in objectively similar circumstances, in terms of need for services, will have differential access to services purely because of geographical location. A further reason why agreement at Health Board and Department of Health levels is essential is that there is little leeway for shifts of resources within the Community Care Programme. Consequently a commitment to Community Care must be accompanied by an identification of the necessary resource shifts between programmes.

Thirteen recommendations are outlined under six headings as follows:

- General
- Personnel
- Services for Children
- Services for Elderly People
- Services for Handicapped People
- Statutory-voluntary relations

(i) General

The implications in terms of resources of the commitment to community care services which is evident in official policy documents and statements should be identified by the Department of Health. The magnitude of resource shifts between programmes necessary for the realisation of such a commitment in a situation of static or falling resources should be clearly identified.

A Community Care Information System, similar to that developed in the North Western Health Board, should be established in all areas.

(ii) Personnel

Professional/population ratios should be established. To this end:

- (a) The public health nurse/population ratios should be reviewed in the light of changing demands on the service. The issues of 24-hour nursing service, a twilight (6-11 p.m.) service, and a nursing attendant service should be included in this review. Attention should be given to the possible impact of increased curative nursing demands on the preventive side of the service.
- (b) Guidelines on the employment of social workers and community workers should be established — an exercise similar to the survey on the Workload of Public Health Nurses should be carried out in association with experts in the social work field.

- (c) Guidelines for the employment of rehabilitation personnel in community care should be established and the implications for training identified.

(iii) Services for Children

The Department of Health in agreement with Health Boards should establish guidelines with regard to services for children. The guidelines should be based on the perspective that if services are essential their availability should be guaranteed irrespective of geographical location.

In each community care area, pre school and school health services should be reviewed by community care teams in terms of needs, objectives, alternative means of meeting objectives, and outcomes.

A plan for the development of personal social services for children and families within each community care area should be developed. In formulating such a plan the whole range of services which have been identified in this report and in the Final Report of the Task Force and Child Care Services should be considered in terms of needs, objectives, and alternative means of meeting objectives.

The present arrangements for psychological assessment of school children should be reviewed in terms of take up and appropriateness to meeting need for referral in the first place. Statistical information on the service in terms of referral rates from particular areas, schools and population sub-groups should be collected with a view to assessment of needs.

(iv) Services for the Elderly

The Department of Health in agreement with Health Boards should establish guidelines on appropriate levels of service provision for elderly people. The guidelines should identify responsibility for the whole range of services irrespective of programme boundaries.

A review of the range of services for elderly people in each community care area should be undertaken by the Director of Community care in association with other Health Board programme representatives and those of voluntary organisations. Particular attention should be paid to the needs of isolated rural elderly people. A comprehensive plan for each area, identifying responsibilities and with clear time specifications, should be formulated.

A community based Geriatric Assessment Team should be established in each community care area. A key part of the service of this team should be liaison between hospital and community and mobilisation of necessary domiciliary supports. The members of the teams should include an area medical officer, full-time public health nurse, physiotherapist, occupational therapist. The team should have access to speech therapy services and home help services.

The initiative taken in the South Eastern Health board in establishing a Diagnostic Assessment and Rehabilitation Unit in association with a long-stay hospital should be reviewed for relevance to other areas. This is particularly important given the severe shortage of geriatric assessment units.

(v) Services for the Handicapped

The range of community services available for handicapped people of all disability groups within each community care area should be examined by the Community Care

Team in association with voluntary bodies with a view to identifying shortfalls, and planning for provision of the enabling structure necessary to make community care a realistic alternative to residential care. Among the key areas that should be covered are the following:

- Domiciliary Services, including twilight nursing and care attendant schemes.
- Workshop and Day Care Services
- Support Services
- Rehabilitation Services

Plans should specify responsibility — either by statutory authorities or voluntary organisations — for provision of particular elements of the agreed range of services.

(vi) Statutory/Voluntary Relations

A review of voluntary-statutory relations should be undertaken by the Department of Health in association with Health Boards and representatives of voluntary organisations in the provision of community care services. This review should consider issues related to co-ordination with statutory services, funding by statutory authorities and accountability for the quantity and quality of services provided.

TABLES

Table A2.1

**Percentage Share of Gross Non-Capital Health Expenditure by
Sub-Programmes 1976-1985**

Sub-Programmes	1976	1977	1978	1979	1980	1981	1982	1983	1984	1985
Community protection	2.1	2.1	2.2	2.2	1.8	1.8	1.6	1.6	1.5	1.6
Community health services	15.5	13.1	13.4	12.9	12.3	13.4	14.3	13.1	12.7	13.0
Community welfare	5.8	7.8	7.0	6.7	6.4	6.4	7.2	7.4	7.8	7.6
Community care programme - sub total	23.4	22.4	22.6	21.9	20.5	22.1	23.2	21.6	22.0	22.2
Psychiatric	13.5	13.1	13.0	11.4	12.8	12.3	12.0	12.3	12.0	11.8
Handicap	7.6	8.5	8.6	8.4	8.1	7.7	9.1	9.5	9.8	9.9
General hospital	48.0	48.7	49.7	49.7	53.8	53.4	50.8	51.1	51.3	51.2
General support	7.5	6.8	6.1	5.7	4.8	5.0	4.8	4.9	5.0	4.9
Total %	100	100	100	100	100	100	100	100	100	100
Gross non-capital total										
All programmes	£290.6	£355.6	£429.0	£537.5	£732.0	£858.0	£998.7	£1070.5	£1155.0	£1245.0
£million (current)										

Source: Department of Health.

Table A2.2

Estimated Non-Capital Health Expenditure by Sub-Programme, 1976-1985 (Current Prices)

Sub-Programmes	Estimated Non-Capital Expenditure										
	1976	1977	1978	1979	1980	1981	1982	1983	1984	1985	
Community protection	6.1	7.6	9.4	12.0	13.0	15.6	16.4	17.5	17.7	19.8	
Community health services	45.5	46.5	57.6	69.5	90.4	115.1	143.0	139.8	147.2	162.3	
Community welfare	16.8	27.6	30.0	36.2	46.8	54.8	72.0	79.7	89.7	95.2	
COMMUNITY CARE PROGRAMME	68.0	81.7	97.0	117.7	150.2	185.5	231.4	237.0	254.6	277.3	
Psychiatric	39.1	46.5	55.6	61.0	93.5	105.7	120.0	132.0	138.2	146.7	
Handicap	22.2	30.1	37.1	45.1	59.7	65.6	91.4	102.0	112.7	122.8	
General hospital	139.5	173.0	213.2	282.9	393.8	456.4	507.7	547.4	592.7	637.2	
General support	21.7	24.3	26.1	30.8	34.8	42.9	48.2	52.1	57.5	60.9	
Gross non-capital total	290.6	355.6	429.0	537.5	732.0	858.0	998.7	1070.5	1155.5	1245.0	
All Programmes	16.0	27.1	29.0	32.5	31.0	35.3	50.7	57.5	65.5	75.7	
Income	274.6	328.5	400.0	505.0	701.0	822.7	948.0	1013.0	1090.0	1169.3	

Source: Department of Health.

Table A2.3

Estimated Expenditure on Health Services by Sub-Programme 1976-1985 in Constant 1980 Prices, and Percentage Change 1976-1985

Sub-Programme	Estimated Non-Capital Expenditure											1985 % Change 1976-85
	1976	1977	1978	1979	1980	1981	1982	1983	1984	1985		
Community protection	10.9	12.1	13.4	14.6	13.0	12.9	12.1	11.8	11.1	11.9	9.1	
Community health services	80.5	73.8	82.3	84.8	90.4	95.1	105.1	94.5	92.6	97.2	20.7	
Community welfare	30.0	43.8	42.9	44.1	46.8	45.2	52.9	53.9	56.4	56.7	80.9	
COMMUNITY CARE	121.4	129.7	138.6	143.5	150.2	153.2	170.1	160.2	160.1	165.8	36.7	
Psychiatric	62.7	73.8	79.4	74.4	93.5	87.4	88.2	88.6	86.9	87.3	39.2	
Handicap	39.6	47.8	53.0	55.0	59.7	54.2	67.2	72.8	70.9	73.1	84.6	
General hospital	249.1	274.0	304.6	345.0	393.8	378.8	373.3	410.4	372.8	379.3	52.3	
General support	38.7	38.6	37.3	37.6	34.8	35.5	35.4	36.6	36.2	36.2	-6.5	
Gross non-capital total	511.5	563.9	612.9	655.5	732.0	709.1	734.2	768.6	726.9	741.7	45.0	

Source: Department of Health.

Table A2.4

Non-Capital Expenditure on the Community Welfare Sub-Programme by Service 1976-1985 (Current Prices)

Service	Non-Capital Expenditure £m										
	1976	1977	1978	1979	1980	1981	1982	1983	1984	1985	
Cash payments to disabled persons	11.136	16.711	18.310	20.800	25.750	30.116	40.229	44.035	49.6	53.0	
Home helps services	0.4	1.6	1.8	2.3	4.3	4.6	5.1	5.5	5.7	6.1	
Mobility allowances	---	---	---	---	0.150	0.428	0.535	0.580	0.3	0.3	
Cash payments to persons with certain infectious diseases	0.299	0.460	0.480	0.500	0.560	0.698	0.867	0.945	0.4	0.5	
Maternity cash grants	0.109	0.150	0.150	0.150	0.150	0.150	0.150	0.150	0.1	0.1	

Allowances for "constant care" of handicapped children	1.086	1.400	1.400	1.400	2.250	2.185	2.698	3.385	3.677	4.7	5.1
Meals-on wheels services	1.015	0.750	0.750	0.860	1.250	1.400	0.950	1.200	1.380	1.5	1.5
Grants to voluntary welfare agencies	0.181	2.220	2.220	2.420	2.800	3.800	4.400	6.100	7.200	9.0	9.4
Supply of free milk	0.530	0.600	0.600	0.660	0.800	0.800	0.650	0.750	0.850	0.9	0.9
Pre-school support services	---	---	---	---	---	---	---	0.400	0.440	0.5	0.5
Boarding out of children	0.400	0.400	0.400	0.450	0.700	0.750	1.130	1.650	1.900	2.4	2.5
Payment of children in approved schools	0.690	1.495	1.495	1.560	2.100	2.800	3.900	5.100	5.000	6.4	6.3
Welfare homes for the aged	0.678	1.423	1.423	1.500	2.100	3.600	4.300	5.600	6.150	6.8	7.4
Adoption	---	---	---	---	---	---	---	---	0.4	0.5	0.5
Total	16.8	27.6	30.0	36.2	46.8	54.8	72.0	83.4	89.7	95.2	

Source: Department of Health.

Table A2.5

Non-Capital Expenditure on the Community Welfare Sub-Programme by Service 1976-1985
in Constant 1980 Prices and Percentage Change 1976-1985

Service	Non-Capital Expenditure £m										% Change 1976-85
	1976	1977	1978	1979	1980	1981	1982	1983	1984	1985	
Cash payments to disabled persons	19.9	26.5	26.2	25.4	25.8	24.9	29.6	30.9	28.7	31.6	58.7
Mobility allowances	---	---	---	---	0.2	0.4	0.4	0.2	0.2	0.2	---
Cash payments to persons with certain infectious diseases	0.5	0.7	0.7	0.6	0.6	0.6	0.6	0.3	0.3	0.3	-10.0
Maternity cash grants	0.2	0.2	0.21	0.18	0.2	0.12	0.11	0.16	0.1	0.15	-50.0
Allowances for "constant care" of handicapped children	1.9	2.2	2.0	2.7	2.2	2.2	2.5	2.3	3.0	3.0	57.9
Cash payments to blind persons	0.6	0.6	0.6	0.6	0.6	0.6	0.7	0.6	0.6	0.6	---
Home help services	0.7	2.5	2.3	2.7	4.3	3.8	3.7	3.7	3.6	3.6	414.3
Meals-on wheels services	1.8	1.2	1.2	1.5	1.4	0.8	0.9	0.9	0.9	0.9	---
Grants to voluntary welfare agencies	0.32	3.5	3.5	3.4	3.8	3.6	4.5	5.8	5.7	5.6	1766.6
Supply of free milk	0.9	1.0	0.9	1.0	0.8	0.5	0.6	0.6	0.5	0.5	-45.0
Boarding out of children	0.7	0.6	0.6	0.9	0.8	0.9	1.5	2.2	2.1	2.1	200.0
Payments for children in approved schools	1.2	2.4	2.2	2.6	2.8	3.2	3.7	3.9	4.0	3.7	208.3
Welfare homes for the aged	1.2	2.3	2.1	2.6	3.6	3.6	4.1	4.4	4.3	4.5	275.0
Total	29.9	43.7	42.3	44.2	46.8	45.2	52.9	55.8	54.0	56.7	89.6

Source: Department of Health.

Note: Figures for pre-school support service and adoption services are insignificant and are included with boarding out of children. The former series commences in 1982 and the latter in 1983.

Table A2.6

Non-Capital Expenditure on the Community Protection Sub-Programme by Service 1976-1985, Current Prices

Service	Non-Capital Expenditure £m									
	1976	1977	1978	1979	1980	1981	1982	1983	1984	1985
Prevention of infectious diseases	1.9	2.1	2.5	2.8	3.2	3.3	3.6	4.0	4.4	5.2
Child health examinations	3.0	4.0	4.7	6.10	6.1	7.3	5.2	5.7	5.8	6.3
Food hygiene and standards	0.67	0.6	0.7	1.2	1.4	2.1	2.7	2.9	3.0	3.2
Drugs advisory board	---	0.1	0.2	0.2	0.2	0.4	0.5	0.5	0.6	0.5
Health education	0.4	0.4	1.0	1.3	1.5	1.8	1.8	1.6	1.7	2.2
Other preventive services	0.2	0.4	0.4	0.5	0.6	0.8	2.7	2.9	2.3	2.4
Total	6.1	7.6	9.4	12.0	13.0	15.6	16.4	17.5	17.7	19.8

Source: Department of Health.

Table A2.7

Expenditure on the Community Protection Sub-Programme by Service 1976-1985 in Constant 1980 Prices and Percentage Change 1976-1985

Service	Estimated Non-Capital Expenditure £m										% Change 1976-85
	1976	1977	1978	1979	1980	1981	1982	1983	1984	1985	
Prevention of infectious diseases	3.4	3.4	3.5	3.4	3.2	2.7	2.6	2.8	2.8	3.1	-8.8
Child health examinations	5.4	6.3	6.7	7.4	6.1	6.1	3.8	3.8	3.6	3.7	-31.5
Food hygiene and standards	1.2	1.0	1.0	1.5	1.4	1.7	1.9	1.9	1.9	1.9	58.3
Drugs advisory board	0.0	0.2	0.2	0.2	0.2	0.3	0.4	0.4	0.4	0.3	---
Health education	0.6	0.6	1.4	1.5	1.5	1.4	1.3	1.1	1.0	1.3	116.7
Other preventive services	0.4	0.6	0.6	0.6	0.6	0.6	2.0	1.5	1.4	1.4	250.0
Total	11.0	11.5	13.4	14.6	13.0	12.8	12.0	11.5	11.1	11.7	6.4

Source: Department of Health.

Note: Columns may not add exactly due to rounding errors.

Table A2.8

Non-Capital Expenditure on the Community Health Services Sub-Programme by Service 1976-1985 Current Prices

Service	Non-Capital Expenditure £m									
	1976	1977	1978	1979	1980	1981	1982	1983	1984	1985
General practitioner services (including prescribed drugs)	35.2	35.2	44.5	50.5	56.0	71.8	92.0	88.2	95.6	108.4
Subsidy for drugs purchased by persons ineligible under 21	1.5	1.7	1.9	3.9	6.5	10.8	12.5	8.0	6.3	6.6
Refund of cost of drugs for long-term illnesses including hardship cases	1.5	1.6	1.9	2.5	3.5	4.3	6.6	7.5	7.8	8.2
Home nursing services	2.0	2.5	3.1	3.6	12.0	14.8	16.1	17.5	19.3	20.1
Domiciliary maternity services	1.1	1.0	1.3	1.4	1.2	1.3	1.5	1.6	1.7	1.9
Family planning	----	----	----	----	----	0.1	0.1	0.1	0.1	0.1
Dental services	3.0	3.5	3.9	5.8	8.5	9.2	10.5	12.5	12.0	12.5
Ophthalmic services	0.6	0.7	0.8	1.5	2.4	2.7	3.4	3.6	3.6	3.8
Aural services	0.2	0.3	0.3	0.4	0.3	0.2	0.7	0.8	0.8	0.8
Total	45.1	46.5	57.6	69.5	90.4	115.1	143.0	139.2	147.2	162.3

Source: Department of Health

Note: Columns may not total exactly due to rounding errors.

Table A2.9

Expenditure on the Community Health Services Sub-Programme by Service 1976-1985 in Constant 1980 Prices and Percentage Change 1976-1985

Service	Non-Capital Expenditure £m										% Change 1976-85	
	1976	1977	1978	1979	1980	1981	1982	1983	1984	1985		
General practitioner services (including prescribed drugs)												
Subsidy for drugs purchased by persons ineligible under 21	68.2	61.1	69.0	69.4	66.0	66.0	89.2	70.7	68.9	73.3	4.0	
Refund of cost of drugs for long-term illnesses including hardship												
Home nursing services	3.6	4.0	4.4	4.4	12.0	12.2	11.8	11.8	12.1	11.9	230.5	
Domiciliary maternity services	2.0	1.6	1.8	1.6	1.2	1.2	1.2	1.2	1.2	1.2	-40.0	
Dental services	5.3	5.6	5.6	7.0	8.5	7.6	7.7	7.8	7.6	7.4	39.6	
Ophthalmic services	1.1	1.1	1.1	1.8	2.4	2.2	2.2	2.4	2.3	2.3	109.1	
Aural services	0.4	0.4	0.4	0.5	0.3	0.2	0.5	0.5	0.5	0.5	25.0	
Total	80.6	73.7	82.3	84.7	90.4	89.4	112.6	94.4	92.6	96.6	19.8	

Source: Department of Health.

Notes: (i) The very minute figures for Family Planning from 1981 onwards are included in Domiciliary Maternity Services. (ii) The totals may not add exactly due to rounding errors.

Table A2.10

Public Health Nurse Posts in Regional Health Boards, and Population Nurse Ratios, Various Years (Superintendent and senior phn's excluded)

Health Board	1978			1983		1985		Range of Population nurses ratios recommended in '75
	Posts approved	Posts approved nurse/population ratio	Posts approved	Population/ posts approved ratio	Posts approved	Population/ nurses ratio		
Eastern	294	3,957	354	3,375	356	3,459	3014 - 2458	
Midland	74	2,673	77(1)	2,625	79	2,631	2509 - 2419	
Mid-Western	101	2,977	107(2)	2,880	103	3,058	2823 - 2453	
North Eastern	104	2,700	108(3)	2,676	107	2,819	2743 - 2412	
North Western	96	2,125	96	2,169	99	2,146	2402 - 2315	
South Eastern	136	2,695	133	2,816	133	2,577	2619 - 2479	
Southern	142	3,634	136	3,862	128	4,191	2922 - 2460	
Western	144	2,331	143	2,387	148	2,349	2456 - 2335	
Total	1091	3,084	1154	2,933	1153	3,067	2616	

Source: Department of Health.

- (1) Includes 2 public health nurses who work as counselling nurses with the families of handicapped people.
- (2) Includes 5 members of a religious order who provide a nursing service.
- (3) Includes 3 public health nurses who work as counsellors for the handicapped.

Notes: The higher the ratio the lower is the provision of public health nurses relative to population.
The 1985 population/nurses ratio is based on the 1986 census results.

Table A2.11

Area Medical Officers by Regional Health Board, 1983 and 1987

	Posts filled		AMO: Population Ratio	
	1983	1987	1983	1987
Eastern	29	57	1 : 41,198	1 : 21,602
Midland	7	10	1 : 28,878	1 : 20,787
Mid Western	11	17	1 : 28,019	1 : 18,529
North Eastern	7	12	1 : 41,283	1 : 25,132
North Western	5	13	1 : 41,639	1 : 16,339
South Eastern	17	22	1 : 22,034	1 : 15,582
Southern	15	22	1 : 35,015	1 : 24,388
Western	16	22	1 : 21,327	1 : 15,807
Total	107	175	1 : 32,181	1 : 20,212

Source: Department of Health.

Notes: The Eastern Health Board figures include six substitutes, and part time and sessional workers on a whole time equivalent basis.

Seniors AMO's included in all figures; 1981 and 1986 censuses used to calculate 1983 and 1987 ratios respectively.

Table A2.12

Number of Social Workers Employed in Community Services by Regional Health Board, in 1981 and 1987

Health Board	Number of Social Workers 1981	Number of Social Workers 1987	Population/ Social Workers Ratio 1981	Population/ Social Workers Ratio 1987
Eastern	114	128	10,480	9,619
Midland	21	23	9,402	9,037
Mid Western	29	15	10,628	21,000
North Eastern	14	14	20,641	21,541
North Western	28	30	7,436	7,080
South Eastern	26	31	14,135	11,058
Southern	30	31	17,508	17,307
Western	35	37	9,752	9,398
Total	298	309	11,555	11,447

Source: Department of Health.

Notes: The higher the ratio, the lower is the provision of social workers relative to population.

The figures include a very small number of community workers and, senior social workers; the censuses of 1981 and 1986 were used for the 1981 and 1987 ratios respectively.

Table A2.13

Social Workers Employed in Agencies Other than Health Boards — Various Years

Agency	Numbers Employed
Department of Justice	163 probation and welfare officers
Local authorities	70 (34 social workers and 36 housing welfare staff)
Voluntary hospitals	84 (the vast majority in Dublin)
Family/child care voluntary agencies	26 (Barnardos, Women's Aid, Percy Place Hostel, Cherish, Ally, all mostly in Dublin, ISPCC in 4 locations)
Organisations for the handicapped	90 (50 in specialist voluntary organisations for the physically handicapped, 40 dealing with mental handicap)
Social Service Councils	56 (estimate)
Adoption Societies	25
Adoption Board	10
Industry	5

Notes/Sources: The probation and welfare figures include senior officers, but not the Assistant Principal and Principal grades, these figures are for 1987, and do not include probation staff on secondment to the Adoption Board; Local Authorities' figures are for end 1985 and include Housing Welfare Officers and Senior Housing Welfare Officers; Adoption Societies figures are approximate and are based on figures suggested by the FSUPC in relation to the registered adoption societies listed in the 1985 FSUPC Directory of Services; Social Service Councils data refer to 1983; Figures on Organisations for the Handicapped are taken from NESCC Report No. 50, Tables 5.9, page 155; Family/Child Care Agencies data supplied by ISPCC, refer to 1987, and include two management personnel in Dr. Barnardos; Voluntary Hospitals data are for January 1985.

Table A2.14

Social Workers Attached to Social Service Councils and Specialist Voluntary Agencies by Health Board, 1983

Health Board	Social Service Councils	ISPPC	Other specialist voluntary agencies
Eastern	13	3	21
Midland	4(1)	1(4)	—
Mid-Western	16	—	—
North Eastern	3	3	—
North Western	2	1(5)	—
South Eastern	15(3)	3	—
Southern	2	3	—
Western	1	—	—
Total	56	14	21

Notes: (1) Includes 3 seconded to Health Board from Athlone Social Service Council.

(2) Includes 8 from Clare Social Service Council who provide social work services in Clare on an agency basis for Mid-Western Health Board.

(3) Includes 12 employed by Kilkenny Social Service Council throughout Diocese of Ossory; 7 of these are members of religious orders working in a voluntary capacity. In addition, this organisation has 11 social work assistants — these are recent graduates working on a voluntary basis.

(4) Community worker/social worker.

(5) Teacher/social worker.

Table A2.15

Number of Community Welfare Officers Employed by Health Boards, and Population/Posts Ratio, 1981 and 1986

Health Board	Posts		Population/posts ratio	
	1981	1986	1981	1986
Eastern	76	138	15,720	8,922
Midland	20	24	10,107	8,661
Mid-Western	35	38	8,806	8,289
North-Eastern	18	30	16,054	10,052
North Western	37	28	5,627	7,586
South Eastern	27	40	13,873	8,570
Southern	60	55	8,754	9,755
Western	43	43	7,938	8,087
Total	310	396	11,108	8,932

Source: Department of Social Welfare.

Notes: Figures do not include Superintendents — 39 S.C.W.O.S. in 1986; 1981 and 1986 censuses used to calculate ratio for respective years.

Table A2.16

Number of Home Helps Employed (F/T = Full-Time, P/T = Part-Time)

Health Board Region	1974		1975		1976		1977		1978		1979		1980	
	F/T	P/T	F/T	P/T	F/T	P/T	F/T	P/T	F/T	P/T	F/T	P/T	F/T	P/T
Eastern	17	1,130	17	1,220	12	1,114	29	1,464	43	1,678	47	1,890	45	1,848
Midland	9	341	—	329	—	297	—	330	9	280	14	300	24	308
Mid-Western	35	187	20	207	16	240	6	278	7	258	4	339	2	387
North Eastern	—	216	—	286	19	269	—	280	14	362	15	493	16	594
North Western	26	196	26	251	27	451	30	461	42	553	46	791	41	835
South Eastern	8	378	9	347	11	327	11	446	12	489	21	320	16	710
Southern	—	493	—	627	3	631	2	663	3	795	6	823	7	952
Western	2	1,697	—	1,503	—	563	32	642	50	624	58	674	61	722
Total (full-time)	9	72	72	88	88	110	110	180	211	211	211	212	212	212
Total (part-time)	4,637	4,770	4,770	3,892	4,554	5,039	5,630	6,356	6,356	6,356	6,356	6,356	6,356	6,356

Sources: National Council for the Aged (1983), Report No. 3, *Community Services for the Elderly*; Department of Health.

Notes: The statistics given above include home helps employed directly by the relevant Health Boards and those employed by voluntary agencies which receive grants from Health Boards to provide a home help service. The figures represent the position as at 31 December of each year.

Table A2.17

Beneficiaries of Home Help Service (1)
(a) = Total Number of Beneficiaries (b) = Aged Beneficiaries

Health Board Region	1974		1975		1976		1977		1978		1979		1980		1981		Percentage of recipients who were elderly 1981
	(a)	(b)	(a)	(b)	(a)	(b)	(a)	(b)	(a)	(b)	(a)	(b)	(a)	(b)	(a)	(b)	
Eastern	1,570	1,678	1,576	1,180	2,120	2,443	2,536	2,545	3,020	76.3%							
Midland	1,169	1,259	1,180	n/a	1,804	1,843	1,914	2,194	2,545	76.3%							
Mid-Western	375	336	305	350	322	508	637	780	88.3%								
North-Eastern	322	301	259	n/a	297	481	572	689	88.3%								
North-Western	347	298	317	309	523	379	407	1,046	84.3%								
South Eastern	264	231	270	n/a	332	321	359	882	84.3%								
Southern	215	330	327	320	328	548	658	493	86.4%								
Western	197	293	293	n/a	312	503	609	426	86.4%								
Totals	5,23	649	815	856	873	1,027	1,144	1,367	91.6%								
	457	568	794	n/a	812	933	1,036	1,252	91.6%								
	332	296	370	491	528	623	779	953	86.1%								
	252	231	308	n/a	462	545	654	821	86.1%								
	493	662	824	669	750	936	1,054	1,179	87.8%								
	455	546	698	n/a	672	843	925	1,033	87.8%								
	1,708	1,541	563	906	n/a	1,214	1,410	1,404	86.7%								
	1,559	1,470	484	n/a	n/a	980	1,166	1,217	86.7%								
	5,563	5,810	5,097	6,021	n/a	7,771	8,634	10,242	83.0%								
	4,675	4,919	4,241	n/a	n/a	6,449	7,235	8,514	83.0%								

Sources: National Council for the Aged (1983) Report No. 3, *Community Services for the Elderly*; Department of Health, North Western Health Board.

Notes: The statistics given above include beneficiaries of home help services provided by the relevant health boards and those provided by voluntary organisations funded by Health Boards; the figures for 1974-1979 represent the position at 10 December of each year; the total number of beneficiaries in any year would be higher. The 1980 and 1981

Table A2.18

Speech Therapists Employed by Health Boards 1981 and 1987

	Posts		Posts per 100,000 population	
	1981	1987	1981	1987
Eastern	21	25	2	2
Midland	7	9	3	3
Mid Western	3	9	1	1
North Eastern	4	7	1	2
North Western	7	15	3	7
South Eastern	12	15	3	4
Southern	4	9	1	1
Western	12	17	4	5
Total	70	106	2	3

Source: Department of Health.

Notes: The population ratios for 1981 and 1987 were calculated on the basis of 1981 and 1986 censuses respectively; the figures are whole-time equivalents; the ratios are rounded to the nearest whole number; posts refer to posts filled.

Table A2.19

Occupational Therapists Employed by Health Boards 1981 and 1987

	Posts		Posts per 100,000 population	
	1981	1987	1981	1987
Eastern	29	23	2	2
Midland	3	7	1	3
Mid Western	2	6	1	2
North Eastern	11	13	4	4
North Western	25	38	12	18
South Eastern	3	7	1	2
Southern	15	21	3	2
Western	9	12	3	3
Total	97	127	3	4

Source: Department of Health.

Notes: The population ratios for 1981 and 1987 were calculated using the 1981 and 1986 censuses respectively; the figures include part-time and sessional staff and are rounded to whole-time equivalents; the posts refer to posts filled.

Table A2.20

Physiotherapists Employed by Health Boards and Voluntary Hospitals 1981 and 1987

	Posts		Posts per 100,000 population	
	1981	1987	1981	1987
Eastern	24	23	2	2
Midland	16	20	8	10
Mid-Western	10	21	3	7
North-Eastern	17	20	6	7
North-Western	23	37	11	11
South-Eastern	26	38	7	11
Southern	37	47	7	9
Western	33	34	10	10
Total	186	240	5	7

Source: Department of Health.

Notes: The 1981 and 1986 censuses are used to calculate the 1981 and 1987 population ratios respectively; the posts refer to posts filled; the figures are whole full-time equivalents and are rounded to whole numbers.

Table A2.21

Whole-time Dentists Employed by Health Boards; Number of Posts, Number Practising and Rates by Health Board Area, 1984

Health Board	Chief or senior dental surgeons		Established whole-time dental surgeon posts		Total number (whole-time) practising all grades		Ratio of population to dentists
	1981	1984	1981	1984	1981	1984	
Eastern	9	11	63	95	66	106	18,102
Midland	2	4	16	17	11	21	18,376
Mid-Western	3	4	22	40	18	44	17,122
North-Eastern	3	5	19	20	16	25	18,061
North-Western	2	3	13	18	11	21	18,927
South-Eastern	4	6	26	21	22	27	17,026
Southern	6	7	37	39	43	46	12,215
Western	3	3	26	36	27	39	12,641
Total	32	46	222	286	214	329	16,090
							10,751

Source: *Statistical Information Relevant to the Health Services, 1985*, Department of Health, 1982, 1985.

Notes: The 1981 and 1984 ratios are based on 1981, 1986 census figures respectively; the higher the ratio the lower is the number of dentists relative to population.

Table A2.22

Dental Services 1983 — Total Treatments Provided by Regional Health Board,
Distribution of Treatment between Adults and Children, and Treatments per 1,000 population

Health Board																		
	Eastern		Midland		Mid-Western		North-Eastern		North-Western		South-Eastern		Southern		Western		Total	
	%	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%	Number
Children	80.0		72.7		82.2		72.1		66.0		72.1		84.1		79.4		77.4	
Adults	20.0		27.3		17.8		27.9		34.0		27.9		15.9		21.6		22.6	
Total	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
Total Treatments	256,759	61,108	12,053	76,172	76,598	112,242	149,378	111,668	966,577									
Treatments per 1,000 population	215	302	393	264	368	300	284	327	281									

Source: Department of Health.

Note: 1981 census figures are used for the population calculations.

Table A3.1

Pre-School Child Health Services: Number Examined at 6 Months Paediatric Examination

Health Board	1982			1983			1984		
	Number	As % of eligible children	As % of eligible children	Number	As % of eligible children	As % of eligible children	Number	As % of eligible children	As % of eligible children
Eastern	15,523	78	74	16,444	74	70	13,324	70	70
Midland	845	81	72	869	72	55	408	55	55
Mid-Western	3,373	65	78	3,817	78	54	2,594	54	54
North Eastern	2,147	59	71	2,742	71	89	3,237	89	89
North Western	662	92	85	749	85	80	561	80	80
South Eastern	5,038	77	69	4,464	69	75	5,123	75	75
Southern	3,930	66	76	4,080	76	45	3,533	45	45
Western	3,776	96	88	4,137	88	74	4,273	74	74
Total	35,294	75	75	37,302	75	67	33,053	67	67
Percentage of all births	50%	—	—	56%	—	—	51%	—	—

Source: Statistical Information Relevant to Health Services, 1985, Department of Health.

Table A3.2

Children Examined at Scheduled examinations 1982-1984
Number and Percentage who Needed Further Attention

	Examination					
	6 month		12 month		24 month	
	Number	% of No. examined	Number	% of No. examined	Number	% of No. examined
1982	8,610	24	2,404	24	1,305	24
1983	9,291	25	2,454	24	1,265	31
1984	8,217	25	2,562	22	1,367	24

Source: Statistical Information Relevant to Health Services, 1985, Department of Health.

Table A3.3

Pre-School Child Health Services: Action Taken for Children Requiring Further Attention, 1984

	6 month Examination %	12 month Examination %	24 month Examination %
(1) Total number examined	33,053	11,612	5,599
(2) Numbers requiring further attention	8,217	2,562	1,367
(3) 2 as % of 1	25%	22%	24%
(4) Action Taken	%	%	%
Referred to specialist	31	37	54
Referred to family doctor	11	10	12
Retained under observation	68	61	38
Total	100	100	100
n	8,217	2,562	1,367

Source: Statistical Information Relevant to the Health Services, 1985, Department of Health.

Table A3.4

**Pre-School Child Health Services:
Clinics Other than Child Development Clinics 1984**

	No. of Clinics	No. of Children Attending
Eastern	1,689	15,211
Midland	—	—
Mid-Western	906	5,911
North Eastern	117	1,144
North Western	111	596
South Western	642	11,206
Southern	496	4,076
Western	57	338
Total	4,018	38,482

Source: Statistical Information Relevant to the Health Services, 1985, Department of Health.

Table A3.5

School Health Examinations: Number and Percentage of Schools visited 1980-1984

	Schools visited 1980-1984			
	No. of schools visited		Percentage of schools visited	
	Under 50 pupils	Over 50 pupils	Total	
1980	292	1,034	1,326	
1981	283	1,049	1,332	
1982	275	1,150	1,425	
1983	269	1,233	1,502	
1984	255	1,150	1,405	
		Under 50 pupils	Over 50 pupils	Total
		39	40	40
		43	40	40
		43	46	45
		42	48	47
		38	44	42

Source: Department of Health.

Table A3.6

**School Medical Inspections:
Percentage of Children Examined by Health Board area 1983-1984**

Health Board	1983	1984
Eastern	18	17
Midland	17	18
Mid-Western	32	29
North Eastern	27	24
North Western	20	19
South Eastern	26	30
Southern	24	23
Western	26	21
All	23	21

Source: Department of Health.

Table A3.7

School Medical Inspections: Number of Children Examined at Various Examinations 1984

	Number	% of all examined
New entrants examined	54,766	45
Selective examination	35,261	29
Other examination	31,074	26
Total	121,101	100
Overall % of school population examined	21%	

Source: Department of Health.

Table A3.8

School Medical Inspection 1984 — New Entrant's Examination
Number and Percentage of Total Examined Needing Further Attention

Health Board	Number	Percentage
Eastern	4,738	30
Midland	728	33
Mid-Western	2,211	45
North Eastern	2217	33
North Western	799	25
South Eastern	2,561	33
Southern	3,383	37
Western	2,711	50
Total	19,348	35

Source: Department of Health.

Table A3.9

School Medical Inspections: Action Taken for Children Requiring Further Attention, 1984

	New entrants	Selective examination	Other examination
(1) Total number examined	54,766	35,261	31,074
(2) Number requiring further attention	19,348	12,239	6,603
(3) 1 as % of 2	35%	35%	21%
<i>Action Taken</i>			
Referral to specialist	51.0	51.0	56.5
Referral to family doctor	11.3	8.6	9.4
Retained under observation	49.9	51.9	37.6
Total	110.2	112.9	103.5
n	19,348	12,239	6,603

Source: Statistical Information Relevant to the Health Services, 1985, Department of Health.

Note: The columns add to more than 100% as action taken can fall into more than one of the three categories.

Table A3.10

Adoption Orders and Placements 1976-1985

	1976	1977	1978	1979	1980	1981	1982	1983	1984	1985
Number of applications received	1,277	1,296	1,228	1,234	1,354	1,189	1,254	1,115	959	883
Number of adoption orders made	1,104	1,127	1,223	988	1,115	1,191	1,191	1,184	1,195	882
Number of orders made in respect of children placed by:										
— adoption societies	905 82.0%	938 83.2%	1,064 87.0%	845 85.5%	928 83.2%	951 79.9%	879 73.8%	921 77.8%	793 66.3%	588 66.7%
— health boards	91 8.2%	79 7.1%	52 4.2%	42 4.3%	77 6.9%	80 6.7%	80 6.7%	75 6.3%	85 7.1%	54 6.1%
— the natural mother	9 0.8%	6 0.5%	12 1.0%	7 0.7%	5 0.5%	13 1.1%	11 0.9%	15 1.3%	20 1.7%	28 3.2%
Number of orders made in respect of family adoptions	99 9.0%	104 9.2%	95 7.8%	94 9.5%	105 9.4%	147 12.3%	221 18.6%	173 14.6%	297 24.9%	212 24.0%

Source: Annual Report of An Bord Úchtlála (Adoption Board), 1985, page 18.

Table A3.11

Distribution of Adoptions, 1985

	Number	%
<i>Adoption orders made in respect of children placed by:</i>		
— registered adoption societies	588	66.7
— health boards	54	6.1
— the natural mother	28	3.2
Sub-total	670	76.0
<i>Family adoptions</i>		
Natural mother and husband	156	17.7
Natural mothers alone (including 2 widows)	6	0.7
Natural father and his wife	1	0.1
Natural father alone	1	0.1
Grandparents (including 3 widows)	29	3.3
Other relatives (including 1 widow)	19	2.2
Sub-total	212	24.1
Total	882	100

Source: Annual Report, An Bord Úchtlála (Adoption Board), 1985, page 6.

Table A3.12

Nature of Care Provided for Children taken into Care or Notified to Health Boards, 1983

Type of care	Health Boards										Total	%
	Eastern	Midland	Mid-Western	North Eastern	North Western	South Eastern	Southern	Western	Total	%		
	%	%	%	%	%	%	%	%	%	%		
Foster-care-short term	13.5	23.8	25.6	2.3	22.6	9.8	17.5	27.6	16.4			
Foster-care-long term	20.3	50.1	43.8	51.8	38.4	39.1	36.4	41.4	33.7			
Foster-care — Private	6.3	—	—	—	—	—	—	1.3	2.7			
Residential care	59.3	25.5	30.6	44.8	39.0	51.0	45.0	29.7	47.2			
Supervision at home	0.7	—	—	—	—	—	—	—	—			
Total %	100	100	100	100	100	100	100	100	100			
N	1,412	235	464	241	159	427	418	239	3,595			

Notes: Statistics based on episodes of care, not number of children; information based on returns from social workers to Department of Health.

Source: Children in Care, 1983, Department of Health, Tables 3H, 3D.

Table A3.13

Children in Care 1980, 1981, and 1984

Type of Care	1980	1981	1984
Foster care through Health Boards	45.4	49.7	50.0
Foster care — private	7.7	7.0	3.3
Residential homes	46.9	43.3	42.9
Total	2,456	2,552	2,534

Source: Department of Health.

Table A4.1

Population Aged 65 and Over by Health Board — Numbers and Percentage of Total Population, 1981

	Eastern	Midland	Mid-Western	North Eastern	North Western	South Eastern	Southern	Western	Total
Population 65 and over	101,570	21,906	34,261	30,134	30,247	40,787	67,714	48,335	368,954
Region's share of elderly population	27.5	5.9	9.3	8.2	8.2	11.1	16.7	13.1	100
Percentage of total population 65-74	5.5	6.9	7.2	6.8	9.2	6.9	7.6	9.0	6.9
Percentage of total population 75 and over	3.0	4.0	3.9	3.7	5.3	4.0	4.1	5.3	3.8
Percentage of total population 65 and over	8.5	10.9	11.1	10.5	14.5	10.9	11.7	14.3	10.7

Source: Statistical information relevant to the Health Services, 1985, Table A2.

Table A4.2

Percentage of Population Aged 65 and Over by County, County Borough, and Region, 1981

Health Board	County or County Borough	Region
Eastern	Dublin Co. Borough	11.1
	Dublin	4.7
	Dun Laoghaire	13.8
	Kildare	6.9
	Wicklow	9.6
	Laois	10.9
	Longford	11.0
Midland	Offaly	10.2
	Westmeath	10.4
	Clare	12.5
	Clare	9.1
Mid-Western	Limerick Co. Borough	10.7
	Limerick	10.7
	Limerick	11.1
	Tipperary N.R.	11.9
North-Eastern	Cavan	13.8
	Monaghan	12.3
	Louth	9.2
	Meath	8.7
	Sligo	14.2
	Leitrim	17.6
	Donegal	14.0
	Tipperary S.R.	11.3
	Waterford Co. Borough	9.0
	Waterford	11.5
North-Western	Wexford	11.3
	Kilkenny	0.9
	Carlow	9.8
	Kerry	13.9
South-Eastern	Cork Co. Borough	9.7
	Cork Co.	11.8
	Galway	12.5
South	Mayo	15.9
	Roscommon	15.6
Western	Galway	12.5
	Mayo	15.9
Total	Roscommon	15.6
	Total	10.7

Source: Census of Population, 1981, volume 2.

Table A4.3

Percentage of Population, Males and Females, Aged 65+ Living Alone
by County and County Borough, 1981

Health Board	County or County Borough	Males %	Females %	All %	
Eastern	Dublin Co. Borough	13.8	28.1	22.9	
	Dublin	8.6	19.6	15.1	
	Dun Laoghaire	12.5	29.3	23.6	
	Kildare	12.5	20.0	16.5	
	Wicklow	14.5	23.4	19.5	
	Midland	Laois	15.1	19.7	17.5
		Longford	19.4	19.0	19.2
		Offaly	14.8	19.5	17.1
		Westmeath	15.7	20.7	18.3
	Mid-Western	Clare	15.8	17.8	16.8
Limerick Co. Borough		17.5	25.0	19.8	
Limerick		14.9	18.6	16.9	
Tipperary N.R.		19.4	13.9	16.8	
North-Eastern	Cavan	19.4	19.9	19.6	
	Monaghan	17.7	21.5	19.6	
	Louth	13.4	25.8	20.5	
	Meath	13.9	21.1	17.8	
	North-Western	Sligo	18.4	19.5	19.0
		Leitrim	22.3	19.4	20.9
		Donegal	17.0	19.1	18.1
	South-Eastern	Tipperary S.R.	15.1	21.9	18.8
		Waterford Co. Borough	12.6	23.5	19.3
		Waterford	15.9	23.2	19.8
Wexford		14.1	20.0	17.2	
Kilkenny		15.0	20.2	17.7	
Carlow		14.4	20.1	17.6	
South	Kerry	14.9	18.1	16.5	
	Cork Co. Borough	12.7	27.0	21.8	
Western	Cork	13.5	19.1	16.5	
	Galway	12.8	13.7	13.3	
All	Mayo	15.6	16.7	16.1	
	Roscommon	18.0	17.5	17.7	
		14.6	21.6	18.4	

Source: Census of Population 1981 Volume III, Table 16.
Note: The denominator for the data is the total population which includes the population not living in private households.

Table A4.4

Population Density By County and County Boroughs
and Percentage of Population in Towns, 1981

Health Board	County or County Borough	Persons per square kilometre	Percentage of population in towns with legally defined boundaries %
Eastern	Dublin County and County Borough	1,089	100
	Kildare	61	59.2
	Wicklow	43	66.5
	Laois	30	41.1
Midland	Longford	30	33.9
	Offaly	29	49.0
	Westmeath	35	51.6
Mid-Western	Clare	27	46.0
	Limerick	60	59.3
	Tipperary N.R.	30	43.0
North-Eastern	Cavan	28	29.5
	Monaghan	40	35.9
	Louth	108	70.0
	Meath	41	34.0
North-Western	Sligo	31	44.6
	Leitrim	18	23.2
	Donegal	26	35.9
	Tipperary S.R.	34	45.9
South-Eastern	Waterford	48	65.6
	Wexford	42	40.6
	Kilkenny	34	43.7
	Carlow	44	52.0
	Kerry	26	37.5
South	Cork County and County Borough	54	63.2
	Galway	29	40.2
	Mayo	21	29.4
	Roscommon	22	23.0

Source: Census of Population 1981, Volume 1, Table 11.

Table A4.5

Percentage of Patients Resident in Long-Stay Geriatric Units on 31 December, 1983 by Medico/Social Status

Patients	Category of Unit	Health Board geriatric hospitals/homes %	Health Board welfare homes %	Voluntary approved nursing homes %	Other private nursing homes %	Total %
Social		15.8	65.2	13.9	24.7	21.9
Acute illness		4.8	0.7	3.6	3.5	3.9
Chronic sick		64.0	20.4	40.4	31.3	49.1
Terminal		3.5	1.6	3.6	2.6	3.2
Mental handicap		3.7	1.7	1.5	2.4	2.8
Chronic psychiatric		5.5	8.5	7.5	4.1	6.0
Other		2.7	1.9	13.1	31.4	9.6
Not stated		0.1		16.5		3.5
Total — Per cent		100	100	100	100	100
— Number		7,063	1,389	2,838	2,266	13,556

Source: Statistical information relevant to the Health Services, 1985, page 75.

Table A4.6

Percentage of Population Aged 65 and Over in Receipt of Home Help Services — 1981

Health Board	Percentage of population aged 65 and over
Eastern	2.2
Midland	3.2
Mid-West	2.6
North-East	1.5
North-West	4.2
South-East	2.0
Southern	1.7
Western	2.6
Total	2.8

Source: Department of Health

Table A4.7

Costs to Department of Health of Geriatric Hospital and Welfare Home Care — August 1985 (1)

	£ per week per patient
Geriatric Hospital	229.72
Welfare Home	118.00

Source: (1) Department of Health data for 1983, increased by change in the public expenditure deflator from 1983 to 1985.

Table A4.8

Dietary Deficiency of Dublin (Central City) Sample of Elderly People

Component	Percentage deficient	Component	Percentage deficient
Energy	32.8	Vitamin C	56.7
Protein	11.9	Iron and Vitamin C	31.3
Iron	47.8	Calcium	17.9

Source: National Prices Commission, *Monthly Report*, No. 58, January, 1977

Table A4.9

Number of Chiroprodists Available and Required by Health Board

Health Board	Estimated minimum number of chiroprodists required	Number of whole-time equivalent qualified chiroprodists available (1987)
Eastern	43	3
Midland	9	2
Mid-West	14	3
North-East	13	1
North-West	11	2
South-East	16	4
Southern	24	3
West	18	5
Totals	148	23

Source: Department of Health.

Notes: The data in the right hand column are rounded to whole numbers and are based on the whole-time equivalents of part-time and sessional personnel.

Table A4.10

Bed Provision for the Elderly in Health Board Regions: Long Stay, Welfare Home Beds and Assessment Places (Actual and Recommended), 1984

Health Board	Category				Total
	Type of accommodation	Long-stay	Welfare	Assessment	
Eastern Health Board Private/Voluntary	1,053 939	438 1,911	246 0	1,737 2,850	
Midland Health Board Private/Voluntary	1,992	2,349	246	4,587	
Mid-Western Health Board Private/Voluntary	851 222	156	0 0	1,007 222	
North-Eastern Health Board Private/Voluntary	1,037	156	0	1,229	
North-Western Health Board Private/Voluntary	1,316 594	310 70	0 0	1,626 664	
South-Eastern Health Board Private/Voluntary	1,910	380	0	2,290	
South-Western Health Board Private/Voluntary	1,112 148	140 36	0 0	1,252 184	
Total	1,260	176	0	1,436	
North-Western Health Board Private/Voluntary	631 260	259 0	10 0	900 260	
South-Eastern Health Board Private/Voluntary	891	259	10	1,160	
Southern Health Board Private/Voluntary	1,447 641	198 36	25 0	1,670 677	
Western Health Board Private/Voluntary	2,088	234	25	2,347	
North-Western Health Board Private/Voluntary	1,116 293	248 685	110 0	1,474 978	
South-Eastern Health Board Private/Voluntary	1,409	933	110	2,452	
Western Health Board Private/Voluntary	1,106 352	418 10	0 0	1,524 362	
Total	1,458	428	0	1,886	
North-Western Health Board Private/Voluntary	8,632 3,449	2,167 2,748	391 0	11,190 6,197	

Source: National Council for the Aged, Institutional Care of the Elderly in Ireland, Dublin 1985, page 118.
 Notes: The column 'recommended' refers to the Care of the Aged Committee recommendations; 1981 Census used. Total does not include the column 'recommended'.

Table A4.11

Special Housing for the Elderly

Year	A		B	
	Total number of housing units provided by local authorities	Number of units provided for elderly persons	B as a % of A	Housing units provided by voluntary organisations
1970	3,767	375	9.8	123
1971	4,789	475	9.9	182
1972	5,902	590	10.0	118
1973	6,072	600	9.9	125
1974	6,745	670	9.9	50
1975	8,794	875	10.0	55
1976	7,263	763	10.5	33
1977	6,333	893	14.1	44
1978	6,073	925	15.2	11
1979	6,214	681	11.0	17
1980	6,008	625	10.4	45
1981	5,681	631	11.1	39
1982	5,686	550	9.7	842

Source: Department of the Environment.

Notes: Some of the Voluntary Organisations' units include caretaker accommodation.

Table A5.1

**Care Attendant Scheme
Frequency and Duration of Visits to Families Receiving a Regular Service**

	Total families	1 hr	2 hrs	3 hrs	4 hrs	5 hrs	Total hours
Once weekly	14	1	5	4	3	2	44
Twice weekly	8		6	1			16
Three times weekly	3		3				6
Once every two weeks	1					1	5
Total	26						

Source: Faughnan, P. *Home Care Attendant Scheme*, I.W.A. 1983.

Table A5.2

Care Attendant Scheme
Type of Occasional Emergency Care Attendant Service

	No.
Emergency intervention for one week duration	2
Week-end or Holiday Break for Relative	2
Emergency Day/Overnight	2
Service made available as and when requested	9
Total	15

Source: Faughnan, P. *Home Care Attendant Scheme, I.W.A. 1983.*

Table A5.3

Care Attendant Scheme
Cost of Operation of Pilot Scheme — February to July 1983

Co-ordinator's input — half-time (Assessment and Selection of Families; Liaison; support to Care Attendants; Follow-up with Families, Awareness Programme, etc.)	£ 5,500
Secretarial back-up (including phone, postage, etc.)	2,000
Payments to Home Care Attendants for hours worked from February to July inclusive	3,452
Total	10,952

Source: Faughnan, P. *Home Care Attendant Scheme, I.W.A., 1983.*

Table A5.4

**Eastern Health Board Area Community Care Programme
Day Activation Centres for Physically Handicapped People**

<u>OPERATING</u>		Managed (in association with EHB) by:
(November 1983)	Location:	
	Park House, Stillorgan, Co. Dublin	The Polio Fellowship of Ireland Mount Street Club Committee Order of Malta
	15/16 Fenian Street, Dublin 2	
	St. Agnes's Road, Crumlin, Dublin 12	
<u>BEING DEVELOPED:</u>		
	Blackheath Drive, Clontarf, Dublin 3	Irish Wheelchair Association Central Remedial Clinic
	Health Centre, Cromcastle Road, Coolock Dublin 5	
	Athy, Co. Kildare	Irish Wheelchair Association Open Door
	Fatima House, Bray, Co. Wicklow	

Table A5.5

Diagnostic Assessment and Advisory Service 1983

Health Board	Community Care Areas	Organisations
Eastern	Dublin City and County. The 8 Community Care areas are divided into 4 catchment areas for the purpose of Diagnostic Assessment and Advisory Services. Kildare Wicklow	Child Study Centre (St. Vincent's, Navan Road), Hospitaller Order of St. John of God, (St. Augustine's, Blackrock) St. Michael's House (Goatstown and Ballymun) Stewarts Hospital (Palmerstown). Moore Abbey (Monasterevan) Hospitaller Order of St. John of God (Blackrock).
Midland	Laois and Offaly	Moore Abbey (Monasterevan).
Southern	Longford and Westmeath	Centres in Tullamore and Mullingar
	Cork City and County (5 Community Care Areas)	Cork Polio and After Care Association, Brothers of Charity (Lota)
Mid-Western Western	Kerry	Brothers of Charity (Lota)
	Limerick, Clare, Tipperary N.R.	Brothers of Charity (Bawnmore, Limerick)
North-Eastern	Galway, Mayo and Roscommon	Brothers of Charity (Renmore, Galway)
	Louth, Monaghan and Cavan	Hospitaller Order of St. John of God (Drumcar, Co. Louth)
South-Eastern	Meath	Child Study Centre (St. Vincent's, Dublin)
	Kilkenny, Waterford and Wexford	Brothers of Charity (Belmont Park, Waterford)
	Tipperary S.R. Carlow	Brothers of Charity (Lota, Cork) Moore Abbey (Monasterevan)

Table A5.6

Examples of Specialised Social Work Services, 1983

Disability	Agency	No. and Area	Supports
Blind	National Council for the Blind	Employs 8 Social Workers throughout the country.	Health Boards pay from 40% - 50% of the salary. Variations between Health Boards.
Deaf	National Association for the deaf.	Two social workers based in Eastern area.	80% subvention from Eastern Health Board.
Spina Bifida	Spina Bifida	One social worker providing a national service.	Employed by the NRB.
Wheelchair-bound	Irish Wheelchair Association.	Six Social Workers serving regional Health Board areas.	Extensive variations in levels of overall support from different Health Boards — generally no direct supervision to social workers.
Mental Handicap	Diagnostic, Assessment and Advisory Services Residential Centres.	Sixty-five social workers. The majority operate jointly as members of Diagnostic Assessment and Advisory teams and in the provision of a community-based service. The remainder are attached solely to special residential centres and day services.	Salaries paid from general funding services by Department of Health. Sessional arrangements with Health Boards in the case of some Diagnostic Assessment and Advisory Services.

APPENDIX I

Background to Community Care in Ireland

The Commission of Inquiry on Mental Handicap which reported in 1965 stated:

It is accepted as a general principle, that community care (i.e. care provided outside residential centres) is therapeutically better for a handicapped person, permits of a fuller development of his personality and avoids the difficulty of adjustment to normal life which is frequently experienced after prolonged care in a residential centre. It is desirable, therefore, that community care should be provided so that, where possible, the mentally handicapped can be retained in their own homes or in suitable family care (1).

Much of the discussion on community services during the 1960s related to service for elderly people; in 1966 the White Paper on *The Health Services and their Further Development*, which was the blue-print for the 1970 Health Act and thus the present structure of health services, stated that:

The government's general aim is to encourage old people to stay at home and to endeavour to ensure that assistance will be available where needed to enable them to do so without causing hardship to the aged or too heavy a burden on their relatives. Primarily, this assistance will form part of the ordinary pattern of health services..... and this should adequately meet the medical and allied needs of most old people (2).

It was stated that in addition improved geriatric services would be developed by the health boards.

The Inter-Departmental Committee on Care of Aged reported in 1968 and the emphasis of the Report was unequivocally on the need for community facilities to avoid institutional care:

The Committee's recommendations, regarding the services which should be provided, are based on the belief that it is better, and probably much cheaper, to help the aged to live in the community than to provide for them in hospitals or other institutions (3).

Based on this belief the Committee considered a wide range of services: income maintenance, housing, home nursing, medical, ophthalmic, dental, and aural services, physiotherapy, chiropody, provision of aids, boarding out, day-hospitals, day centre, clubs, laundry service, meals service, social work services and home help services.

A second emphasis in these reports was on the role of voluntary bodies. This emphasis was evident in official reports as early as 1949. In the Report of the Inter-departmental Committee on County Home, issued in that year, it was recommended that co-operation between local authorities and voluntary organisations whose members visit the aged should be fostered and that local authorities should assist these organisations.

This theme was echoed in the White Paper on the health services (1966), in which it was stated that,

Voluntary organisations can often provide the most effective home aid. It is important that their efforts should be supported by encouragement and assistance

from public authorities and if all the services are to be provided effectively then there should be close co-ordination between those working voluntarily and the appropriate public officials.

The Report on the Care of the Aged recommended that "Local authorities should take an active role in encouraging voluntary bodies providing services for the aged and should support them financially". Further, it recommended the establishment of social service councils, concerned with achieving the co-ordination of all local activities, public and voluntary with the dissemination of information in regard to all the services available and with the fostering of community services.

This emphasis on voluntary bodies was reflected in the McKinsey Report which recommended that one of the functions of the Programme Manager for Community Care would be;

to communicate the nature of the target for Community Care Programmes and to agree with the heads of voluntary agencies on the funds they are to receive to ensure that there is an agreement about the specific contribution the voluntary agencies will make to reach these targets and to encourage the effective operation and co-ordination of these organisations (4).

FOOTNOTES

APPENDIX 1

- (1) *Report of the Commission of Inquiry on Mental Handicap*, Government Publications, Stationery Office, Dublin, 1985.
- (2) *The Health Services and Their Future Development*, Government Publications, Stationery Office, 1966.
- (3) *The Care of the Aged*, Report of an Inter Departmental Committee, Government Publications, Stationery Office, 1968.
- (4) *Towards Better Health Care*, McKinsey and Co, 1970/1.

APPENDIX 2

Expenditure Changes on Sub-Programmes and Services

Expenditure on the Community Protection Sub-programme increased in real terms up to 1979 and since then has decreased. (Table A2.7). This trend is significantly determined by the trend in the child health item. This is the largest single service within this sub-programme — over 30% of the total expenditure is on this service; expenditure on this service grew until 1979 and then sharply declined; the real 1985 figure is 50% of the figure of 1979. It is notable that despite these expenditure trends, the coverage of developmental clinics and school medical inspections did not diminish, as the data in Tables A3.1 — A3.6 clearly show. There are two possible explanations — either increased efficiency in the organisation and delivery of these services, and/or inaccurate returns on school medical and child developmental clinics. In addition to the decrease in expenditure on Child Health services, expenditure on services directed specifically towards the prevention of infectious diseases (one quarter of the sub-programme) also decreased between 1976 and 1985 (8.8% decrease). Expenditure on all other services under the Community Protection heading increased by considerably more than the average health expenditure increase over the period, though from very small bases.

The major items of expenditure in the Community Health Services Sub-programme are general practitioner services and drug subsidies and refunds (85% and 76% of the total in 1976 and 1985 respectively). Between 1976 and 1985, expenditure on these services increased (Appendix Tables A2.8 and A2.9). In 1983 the expenditure on these services fell significantly — due mostly to a decrease in the drugs subsidy scheme. Apart from the GMS and Drugs Schemes the other major items of expenditure are the Home Nursing services and the Dental Service. Expenditure on the Home Nursing service has increased dramatically in real, as well as in nominal terms. This increase coincided with the public service job creation programme and the implementation of the recommendations of the 1975 Working Party Report on the Public Health Nursing Service. Taking the period from 1976 to 1985 there was a real increase in expenditure on this service of 230% (Table A2.9). Most of the other items in the sub-programme all display the same trends, namely significant growth over the period, expenditure which is still small in amount, and constant real expenditure since 1981.

The largest item of expenditure in the Community Welfare Sub-programme is cash welfare allowances, which comprised 66% of the total Community Welfare Budget in 1976 and 56% in 1985. The growth of 58.7% in cash payments in real terms is attributable to a combination of rising numbers of beneficiaries and of real growth in rates of payment.

Apart from cash welfare payments, the main items of expenditure in the Community Welfare Programme (Tables A2.4 and A2.5) are the Home Help Service, Grants to Voluntary Organisations, Payment for Children in Approved Schools and Welfare Homes for the Aged. Measured in constant prices, Home Help Service expenditure increased by over 400% between 1976 and 1985. In 1981 and 1982 expenditure on this service decreased in real terms, and the 1985 level of real expenditure is still below the 1981 figure. It is notable that the Home Help Service is discretionary; as a consequence it is probably easier to make cut backs in this area than in areas where there are statutory obligations to provide a minimum level of service and/or where permanent staff are employed. Expenditure on the Meals-on-Wheels Service has not maintained its real value from 1976; this may in part reflect an accounting change since some of the expenditure on this service may be included under Grants to Voluntary Welfare Agencies. The latter item grew from a very low level, at a very rapid rate from 1976 to

1983: since then real expenditure has remain constant.

Between 1976 and 1985 real expenditure on payments for Children in Approved Schools increased fairly consistently; the increase over the whole period was 208%. Expenditure on Fostering is still very modest — £2.5 million in 1985; however, this reflects an increase of 200% since 1976.

Expenditure on welfare homes for the aged has increased continually since 1976; it is notable that expenditure on these homes is included as part of community care expenditure in only 4 of the Health Boards — the North West, the North East, the East and the Midlands. It is part of the Special Hospitals Programme in the South Eastern, Mid-Western and Western Health Board areas and part of the General Hospital Programme in the Southern Health Board.

APPENDIX 3

Note on Non Health Board Social Work Employment

The 1980 Directory of Social Service Organisations(1) indicates that there were 56 social workers providing services on behalf of social service councils (Table A2.14); eleven of these were formally linked to community care teams. Information is not available on what percentage of the remainder are professionally qualified social workers or are employed — at least some are likely to be members of religious orders and working in a voluntary capacity.

Most of the work of other voluntary organisations is focussed on particular target groups (Table A2.13). For example, there are about 90 social workers employed by various organisations providing services to handicapped people; these are not evenly distributed throughout the country (2). The other major category of employer is Voluntary Hospitals who employ 95 social workers most of these are based in Dublin. It is not clear to what extent these social workers adopt a community focus. In their submission to the National Manpower Planning Committee, the voluntary hospitals considered that there was considerable pressure on social workers because of the high number of patients presenting social problems which come to light for the first time following admission to hospital. They pointed out that because of staffing levels follow-up after discharge, which was considered essential, was impossible.

The specialist voluntary agencies are of interest in that they provide a community based service to specific groups, for example Barnardos provide:

- (a) services to single mothers;
- (b) services to families using their pre-school services and neighbourhood resource centres;
- (c) a day-fostering service on an agency basis for the Eastern Health Board in one community care area in Dublin.

Barnardos' services are confined to the Dublin area. The ISPCC, too, is involved in community services but again its services are focussed on communities and families associated with its specialist projects, pre-school services and family centres.

Most of the voluntary social work activity is confined to the Eastern, Mid-Western and South Eastern Health Board areas. Within these Health Boards it is not evenly distributed, being confined to particular community care areas.

APPENDIX 3

Footnotes and References

- (1) National Social Service Council (1980): *Directory of Social Service Organisations*, Dublin, 1980.
- (2) Included are social workers employed by the National Council for the Blind, The National Association of the Deaf, The NRB (for services to Spina Bifida sufferers), The Irish Wheelchair Association and Mental Handicap Services.

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