Health Services: A Critical Appraisal

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In presenting some reflections on health services to the Statistical and Social Inquiry Society of Ireland I would like to make it quite clear that I suffer from certain handicaps. The designing of a health service involves exercises in economics and administration as well as in medicine and the relation between all three is so intimate that the best results can only be obtained if the planners have experience of each aspect. I have no training or experience in economics or large-scale administration and the sources of information on these subjects do not ordinarily come my way. I am a doctor, not even a doctor in practice but an academic doctor, so what I have to say will be said from this point of view. If the economists find my ideas uneconomic and the administrators find them unwieldy or impractical, I can only crave their indulgence.

One other point should be cleared up at this stage. I must plead guilty to being prejudiced in favour of doctors. Furthermore, such clinical associations as I have, and they are associations that I value, are with the consultant branches of the profession—that supposedly intransigent group which has been so often a thorn in the flesh of those planning health services.

In view of all these advantages, I must tread warily. Since our present health service is the result of government planning and any modifications can only come into operation in the same way, I will begin by a brief historical outline of the relation of governments to health matters. I will then deal with a few examples of health services in other countries, and in the historical and geographical perspective that I hope thus to create, I will approach the situation in this country at present.

Health, man’s most precious possession, has been the subject of interest and controversy from the earliest times. A few enlightened communities, of which it is believed the ancient Chinese were an example, stressed the importance of maintaining health, that is, preventing disease rather than merely curing it, but in the vast majority interest was not really aroused till illness had actually supervened. Attempts to cure were only surpassed in their quaintness by the theories put forward to explain the disease process.
It was soon realised that the public might sometimes need protection against unscrupulous and unskilled doctors. At first this responsibility was discharged by the government and we know of penalties that were laid down for certain types of professional incompetence. But even in these early times it must have been apparent that the regulation of the practice of medicine presented difficulties which governments were not always the best authorities to handle and when the doctors suggested that they should be authorised to do this themselves they were not discouraged. In England, Henry VIII gave royal charters to the Royal College of Physicians and the Royal College of Surgeons, an important function of each of the new bodies being the regulation of practice, particularly in London and the surrounding area. The principle of giving the profession a controlling voice in safeguarding the standard of practice is embodied today in the constitution of the General Medical Council.

After the foundation of the Royal Colleges nearly two centuries were to pass before the government, again in England, began once more to show an interest in matters which, if not directly medical, would find recognition in most well-planned health services. The dissolution of the monasteries had left the poor, including the sick poor, without any institution in which they could seek shelter and comfort and perhaps even receive treatment. At the very end of the reign of Queen Elizabeth I an Act of Parliament empowered parishes to levy taxes on the rich, the proceeds to be applied to the relief of poverty and suffering. From this and two or three similar acts passed during the next 30 years sprang subsequently the lunatic asylums and the workhouses.

Progress continued to be slow and it was not till the end of the eighteenth and the first half of the nineteenth centuries that a further series of measures dealing with public health matters were enacted. The government, either through lack of interest or lack of courage, still avoided any direct concern for the individual case of illness and these and many similar subsequent acts dealt mainly with environmental hygiene. The provision of medical care for paupers in workhouses was the only indication that the government accepted any responsibility for the treatment of disease. The incarceration of the mentally ill in lunatic asylums when there was no provision for either investigation or treatment was intended to protect the community rather than to relieve suffering. The isolation of those suffering from infectious diseases in fever hospitals had a similar protective purpose. Such provision as was made for the treatment of the sick who happened to be above the pauper level was the result of voluntary effort and was centred on the voluntary hospitals, which were founded in considerable numbers during the eighteenth and nineteenth centuries.
While the structure of the public health service, as we now know it, had been defined by the middle of the nineteenth century, it was not till Lloyd George's National Health Insurance Act, 1911, that the British Government first produced legislation of substantial significance dealing with personal illness. The provision in this act for making available medical care to individual members was financed from contributions made by employed persons and their employers, for the government seemed to be concerned primarily with maintaining the health of the labour force. The same concern, expressed in the Beveridge report, for the maintenance of a steady level of full employment led to the series of enactments that introduced the conception of the welfare state into Great Britain after the Second World War. The focus of the system then introduced was the National Health Service Act, 1946.

The introduction of the Health Acts, 1947 to 1954 into Dáil Éireann was undoubtedly stimulated, at least in part, by the change that had been made in Great Britain.

In approaching the theme of the Future of the Health Services in Ireland, I have felt it advisable to give this brief sketch of the historical background of this and similar attempts to improve the health of the people by legislation. All such attempts that have been made in these countries have been strenuously resisted by the majority of the medical profession and the same sort of resistance is automatically demonstrated by the professionally organised American Medical Association when any suggestion is made of a change in the direction of a national health service in the United States of America. If we agree that it is desirable that those introducing a new system or improving an old one should get the co-operation of those who will be operating the proposed arrangement then the reasons for this resistance are obviously of interest and if the experiences of the past give us any indication of them they are worth considering.

The British National Health Service

The National Insurance, National Assistance and National Health Service Acts, with other related measures passed by the Westminster parliament between 1944 and 1948, were designed primarily, not for the purpose of establishing a welfare system under which the state would assume responsibility for dealing with all difficult and unpleasant situations like illness, unemployment and old age, but in order to ensure the maximum productive efficiency of the community. Unexpected episodes of ill-health were seen as a threat to output, which it would be in the interests of the State as an employer to remove.

Consequently, the National Health Service is the first example of a comprehensive service where medical care is available to all without direct payment to the doctor. Members of the community when ill
may be seen by the doctor of their choice in his office or in their own homes, or they may be treated in hospital, they may have advice at maternity and infant welfare centres and they may be provided with domestic help in their own homes, or an ambulance to take them to hospital

Except for certain items for which small charges are made, the direct cost of these services is borne by the State and by the local authority. From April 1, 1958, to March 31, 1959, the total cost of the National Health Service in England and Wales was £632,500,000, of which 78 per cent was borne by the Exchequer, 4 per cent by the Local Authority from the rates, 17 per cent by contributions from the community, and less than 1 per cent by sums recovered from patients. The total cost was about 3 ½ per cent of the total national resources for the same period and was about four to five times the amount foreshadowed when the Bill was going through Parliament.

Doctors are paid for their services on a per caput basis, in the case of general practitioners, and on a sessional or salary basis in the case of those working in hospitals or in the public health service.

Only a few per cent of the doctors in the country are not members of the service and devote themselves exclusively to private practice outside it, though many doctors who are members only give part of their time to the service and see private patients in the remainder. Conversely, the majority of the community receive their medical care through the service, but there is nothing to prevent a patient from changing from a service to a private doctor or even from consulting both for the same illness. Only a small minority of people insist on being treated privately for all their illnesses.

In addition to the services dealing directly with matters of personal health, special aspects of the whole structure deal with the health of school children, children in institutions and factory workers, with national assistance and with food hygiene. The administrative arrangements of this complicated system are summarised in Diagram 1.

When the service was being introduced, many fears were expressed about its outcome. Doctors would be victimised and their initiative would be stifled. The doctor-patient relationship would be destroyed. Patients would be seriously restricted in their choice of doctor. The scheme would be abused and would be wasteful. In the event it is now generally agreed that most of these fears have proved groundless. The Medical Services Review Committee, under the chairmanship of Sir Arthur Porritt, has recently issued its valuable and comprehensive report to which many further references will be made. Evidence was sought on matters regarding which fears had been expressed and it was concluded that there was no indication that doctors had lost status or
that the number of dissatisfied patients was significant. During the five
years 1956 to 1961 the number of complaints for which some foundation
had been found varied from 70 to 86 each year in the whole service
dealing with 48 million people. The standard of practice is believed to
be high and original contributions are being made constantly by all
branches of the profession. Patients have free choice of doctor within
the service and the doctor-patient relationship appears to remain
satisfactory, though the cynic might point to the increasing amount of
litigation. There are undoubtedly instances of irresponsible waste,
but the steadily rising cost of the service is to be attributed largely to
the falling value of money and to the introduction of new and more
expensive treatments.

Nevertheless, the Porritt Committee and others who have given the
matter some thought have come to the conclusion that certain aspects
of the service should be modified considerably. The most important
basic fault lies in the number of controlling bodies. No fewer than six
Ministries are involved, with a multiplicity of intermediate boards and
committees. In many aspects of the service responsibility is shared
between a Ministry and the local health authority and in some, like the
school health service, the local authority has to work with two Ministries.

The deepest divisions in the service as a whole are between domiciliary
care, hospital care and the public health service. These three aspects
developed independently and with different emphasis. The oldest,
domiciliary care, springs from man's interest in disease and from his
attempts to apply his learning and his skill to understanding and curing
it. Hospitals were established largely to shelter the sick poor and many
centuries elapsed before they became the centres for investigation and
treatment that we know today. Mental hospitals were established to
protect the public from dangerous lunatics and fever hospitals to prevent
the spread of infectious disease in the community. In neither case was
effective treatment available for any single condition before the beginning
of this century. The public health service developed from the efforts of
a few reformers during the first half of last century and its purpose was
to reduce the risk of outbreaks of infectious diseases such as those which
had scourged the country during the previous centuries. With the
rapid increase in population the results of such outbreaks would have
been serious indeed.

The background of the separate development of domiciliary, hospital
and public health services is thus clear enough but it is not an adequate
reason for their continued isolation when all these have been incorporated
in a single service. And what is true of the service as a whole is also true
of various sections of it. The hospital service can be taken as an example.
It is true that the transfer of a large number of independent voluntary
hospitals, many of which were small, to the state broke down many barriers, but others remained. In particular, the mental hospital service remained separate from the rest and there is still a fairly clear-cut division between acute and chronic hospitals. A variety of specialist hospitals also continue their work, sometimes in relative isolation.

The existence of these divisions renders the service cumbersome in operation and introduces delays. They are also the source of wasteful overlapping within the service and therefore restrict its efficiency both from the point of view of the doctor and the economist. A few examples of this will suffice.

1 Variety of medical care required in a single hospital

Taking each of the three main types of hospital, acute (including hospitals for infectious diseases), chronic and mental, each type of hospital will usually have patients who would more properly belong to one of the other types and not infrequently will patients of all three types be found in a single hospital. Thus the elderly patient admitted to an acute hospital with an acute medical condition frequently remains there for a very long time after his condition has improved as much as can be expected in view of his age. Patients in mental hospitals are, of course, subject to all types of acute illness. Transfer of patients from one type of hospital to another is rendered administratively more complicated by the fact that each type is in a separate section of the service. It is, of course, made even more difficult by the geographical isolation of some hospitals, particularly those for mental illness. Several different levels of care must, therefore, be provided in each type of hospital. This means that the elderly chronic sick patient in an acute hospital is a source of waste for he does not need the elaborate and expensive services provided there. On the other hand, the acutely ill patient in a mental hospital must have the appropriate type of skilled attention specially provided for him.

2 Problems in nursing

Mental and chronic hospitals have much greater difficulty in recruiting nurses than do acute hospitals. The present administrative separation aggravated frequently by geographical isolation makes it difficult to operate schemes for interchange of nurses.

3 Lack of flexibility

The pattern of disease in a population is liable to change. Within the last 20 years the need for hospitals for tuberculosis and infectious diseases generally has been greatly reduced and some hospitals built for these purposes are now nearly empty. The same administrative and geographic factors militate against their ready utilisation for other types of illness.
The relation of a hospital to the community which it serves

While there are many diseases, particularly those requiring surgical intervention, that can only be treated in hospital the increased effectiveness of the newer drugs often makes it possible for the patient to go home at a much earlier stage of treatment than formerly. A most striking development in this direction is encountered in psychiatry. When the hospital doctor has discovered what is wrong and decided on an effective remedy he can transfer the patient to his family doctor. This is good, for it releases hospital space and reduces the expense to the patient. However, if the patient is to benefit fully from it, there must be a close liaison between the hospital doctor and the family practitioner and between both and the authorities which deploy community services for domiciliary care. When the hospital doctor, the family doctor and the various community services are responsible to and paid by different authorities difficulties often arise in the smooth working of this liaison.

The closure of many small hospitals in which general practitioners formerly worked part-time has removed one of the easiest and most direct contacts between the hospital system and the community.

The relation of preventive to curative services

At present these are separate services. The doctor who decides that a child should have more milk to ensure normal growth and prevent illness and the centre to which the mother takes the child for the milk belong to different services. The doctor in a manufacturing town whose practice consists largely of patients with chronic bronchitis aggravated, as he knows, by atmospheric pollution, can do nothing to speed a smoke abatement order. An elaborate system of notification was instituted long ago to deal at once with such crises as an outbreak of smallpox but the much commoner, day-to-day inter-communication may be far less efficient. Preventive and curative medicine are under separate local administrations and are practised by different doctors and nurses. Furthermore, the trend is to keep them apart.

Some consideration has been given to these problems and some attempts have been made to deal with them. As has been said before, the fact that all hospitals are in the service is in itself a very great help. A system of health centres in which certain services were to be centralised was envisaged under the Act, but only a few such centres ever came into being. More recently, a ten-year plan has been proposed to bring groups of hospitals into closer association with each other so that general hospitals could deal with short-stay psychiatric and geriatric cases, the more chronically ill patients being treated in special hospitals. But this is far from being an adequate solution. Two interesting proposals of a much more far-reaching nature have been made. The first is that of Dr. T. McKeown, Professor of Social Medicine in
Birmingham University He suggests that future hospital planning and new development should be in terms of hospital communities rather than individual hospitals. The hospital community would consist of a group of hospitals on one site providing for the acutely ill and the chronic sick, for paediatric, geriatric and psychiatric patients, for midwifery, infectious diseases and all other branches of hospital care. The whole spectrum of medical skills would be available on the site, and while each doctor would primarily have responsibility for his own unit or speciality, his services could be readily given to patients whose principal ailment was in a different speciality. Such a centre would also serve as the base for community services and would provide a link between family practitioners and their hospital colleagues.

Obviously, such a development would need radical changes in the present administrative arrangements. The Porritt Report, without referring to the hospital community plan of Professor McKeown, has put forward a recommendation that "in future one administrative unit should become the focal point for all the medical services of an appropriate area, and that doctors and other personnel should be under contract with this one authority." They suggest that this authority should be called "The Area Health Board" and that the present boundaries which are often different for the different authorities operating in the same area should be replaced by the boundary of the new Board.

The Porritt Committee's conception of the administrative basis of this new proposal for co-ordinating medical and ancillary services in an area is summarised in Diagram 2, taken from the report.

It seems, therefore, that the medical and related needs in Great Britain are being satisfactorily met by the present comprehensive service and that many fears expressed on its inauguration have proved groundless, but that the difficulties arising from multipartite control are seriously hampering smooth and economic operation and that this problem requires attention.

Health services in Finland

The health services in the Scandinavian countries show many points of similarity. I have chosen to discuss the Finnish system because there are a number of features in which Finland resembles this country.

The total area of Finland is about four times that of Ireland but about 40 per cent of its surface is taken up by the very sparsely populated Lapland and by the 60,000 lakes that are a feature of the country. The remaining area, which is about 2.5 times that of Ireland, has about 4.5 million people, of whom about 40 per cent are engaged in agriculture. There is only one large city, the capital, Helsinki, which has
a population of about 550,000, and only two other cities with populations over 100,000

For over seven centuries Finland had been a possession, first of Sweden (1155-1809) and then of Russia. She declared her independence in 1917 but she is still influenced considerably by both her powerful neighbours. Educational standards, particularly in higher education, have been largely those of Sweden. The Swedish language is recognised and is used in certain areas of Southern Finland. The Swedish National Party has 14 of the 200 seats in the Finnish parliament.

Finland has an emigration problem, less pressing, perhaps, than that of Ireland, for its population continues to increase steadily if slowly. The emigrant's most popular target is Sweden, though the U.S. and Canada also attract substantial numbers.

The pattern of health and social services is conditioned by the nature of the country and its population. Distances are great and communications are rendered difficult by the lakes and by the long and severe winter. Health services must, therefore, be decentralised as far as possible and control of local conditions placed in the hands of local groups. The population is economically more homogeneous than that of most other countries. There are very few rich people and very few poor. In 1952 less than 1 per 1,000 possessed property of more than £10,000 in value, and only about 2 per cent had possessions valued less than £1,000. Standards of living have improved during the last 10 years but it is unlikely that these figures have changed substantially.

For the purposes of general administration Finland is divided into 12 provinces and 552 rural and urban communes. The urban communes are spread over 35 cities, the average population of a commune being about 20,000. Rural communes vary widely in size and population, the average population being about 6,000.

The administrative structure of the health services is summarised in Diagram 3. Ultimate responsibility is shared between the Ministry of the Interior and the Ministry for Social Affairs, but they are not concerned directly with the administration of the services. This is the function of the State Medical Board, with its Director-General and deputy Director-General. The "chain of command" extends outwards through the provincial medical officers to the Commune Public Health Boards and the Commune physicians.

Because of the nature of the country, there is an advanced degree of decentralisation of the health services. The commune public health board has considerable autonomy, with duties defined by law. These duties include control of environmental sanitation and foods, control of epidemics, maternal, child and school health services, tuberculosis and venereal diseases services, mental health services, local medical
care and hospital policy. Commune physicians, public health nurses and midwives are employed to carry out these duties.

General practitioner services in the rural communes are largely based on the commune hospital, the commune physician being often the only doctor in the district. Even in urban areas most of the lower income sections of the population receive their medical attention through the commune and its hospital. The hospital system, therefore, assumes even greater importance than usual, so it has been planned with corresponding care. There are four grades of general hospital—commune, district or regional, central and university. The commune hospitals are small and often without any specialist services. Where provision is made for a specialist service it is usually shared between two or more communes. District hospitals are larger and usually have two or three specialist services. The range of specialist services is distributed over adjacent district hospitals so as to avoid duplication. Central hospitals usually have a full range of specialities, except for radiotherapy and neurosurgery. These and the other specialities, together with facilities for research, are centred in the university hospital, which is staffed on a better scale than the central or district hospitals.

This carefully planned arrangement seems to avoid effectively that wasteful duplication of specialist services with which we are familiar in this country. Hospitals for mental diseases and tuberculosis were distributed in approximately the same way as the central hospitals. Because these services developed independently of the general hospitals and of each other, the boundaries of the relevant districts are often different and this may complicate the transfer of a patient from one service to another. Legislation is being planned to deal with this situation.

A feature of the organisation is the high degree of efficiency of the maternity and child welfare service. At least 96 per cent of the expectant mothers register at the health centres for ante-natal care and in nearly 75 per cent of these the women attend as early as the fourth month of pregnancy. The communes have small maternity hospitals, with as few as 10 beds in some cases. About 90 per cent of all deliveries take place in hospital. Almost 100 per cent of children under 1 year are registered at health centres.

The standard of these services is reflected in the remarkably low figures for maternal and infant mortality.

Finances

All except the small proportion of medically indigent patients make some contribution towards the cost of their medical care, but this does not usually amount to more than 20 per cent. The remainder of the
cost incurred in running the health services is borne partly by the municipal budget of the commune and partly by the central government. This applies both to hospital and general practitioner attention.

Conversely, the commune is expected to contribute to the cost of maintaining wards for specialist care in regional, central and even in university hospitals.

The gross national product of Finland in 1955 was about £1,190,000,000, and of this 3.8 per cent, or about £45,000,000, was spent by the central and commune governments on health services.

**Health services in Ireland**

The general pattern of the health service in this country is familiar to most of us, but a brief review will be given for the sake of completeness. For the purposes of the health services the population is divided into lower, middle, and higher income groups. The lower income group are those who cannot by their own industry or other lawful means provide any medical attention for themselves or their families. Those whose incomes are judged sufficient to provide general practitioner services for themselves and their families but not sufficient to provide hospital and specialist services are said to be in the middle income group and those who have an income which is judged adequate to provide all the medical services they may require are placed in the upper income group.

With the exception of certain items for which small charges are made, all medical services are provided free for those in the lower income group. Those in the middle income group must pay for general practitioner attention themselves. They may also be asked to pay a modest maintenance charge in hospital and small charges are made for certain items of medical care, but they make no direct payment for the main hospital and specialist services including those elaborate services that make a serious illness so costly. As those in the higher income group are, by definition, supposed to be able to provide all the medical services they may require from their own resources, no provision is made for them, with the exception of hospital and sanatorium care for infectious diseases, child welfare services for children under six years and school medical services for children attending national schools. The parents may have to pay for hospital and specialist services arising out of child welfare clinic examinations but similar services for conditions discovered at school medical inspections are free.

**Definition of Groups**

The decision as to which group an individual or family should belong is made by the Health Authority. Persons seeking free general practitioner
services must apply to be admitted to the General Medical Services Register, furnishing particulars of their income and the incomes of any members of their families who may be in employment, with details of fixed charges on the family income and any other circumstances that might be in favour of their application. The income levels below which persons are, on the average, admitted to the Register vary from one health authority to another and in general they are higher in urban than in rural districts. In view of the many factors usually taken into consideration the dividing line between lower and middle income groups is far from definite, but in general for an average family none of whom is employed it would fall at about £8-£10 per week in Dublin and at a somewhat lower figure in rural areas. The Register is reviewed at least once a year. The regulations provide for emergency admission to the register in case of sudden illness but if the district medical officer reports that he believes the patient is not entitled to a free general practitioner service, the patient’s position is reviewed and his name may be removed from the Register. The proportion of the population on the General Medical Services Register in 1962 varied from 14.4 per cent in Dublin to 35 per cent in Waterford County Borough.

The middle income group consists of those persons whose income is above the level for inclusion in the lower income group but who (a) are insured under the Social Welfare Acts, (b) have an income of less than £800 per annum, or (c) are farmers whose farms have a valuation of £50 or less.

About 28 per cent of the population are in the lower, 57 per cent in the middle and 15 per cent in the upper income groups.

**The Services Provided**

**General medical services**

For the purpose of providing general practitioner services for those in the lower income group the country is divided into 644 dispensary districts in which some 670 district medical officers (dispensary doctors) work. In addition to dealing with cases of illness in the lower income group of his district, the district medical officer has important duties relating to the general health of his district. These include informing himself respecting influences that may affect public health adversely and making reports to the medical officer of health, reporting outbreaks of infectious diseases, making returns of any type of disease that may be required of him. His appointment is part-time, so he may engage in private practice if his other duties permit.
**Hospital and specialist services**

Each health authority is required to make hospital and specialist services available for persons in the lower and middle income groups. Specialist services do not include ophthalmic or aural services. These services may be provided in an institution of the health authority concerned or of some other health authority, or in a voluntary hospital, by arrangement and with the Minister's approval. If the authority provides certain facilities in a hospital of its own, permission to avail of similar facilities in a voluntary hospital is not easy to obtain. Otherwise, a patient may choose the hospital in which he wishes to be treated but he has not a right to choose the doctor by whom he will be treated, though he may be allowed such choice if it does not give rise to any problems in the hospital.

The health authority determines the specialist services provided in its own institutions and each voluntary hospital similarly determines which specialist services will be provided by it. In the latter case, however, the specialist in charge of the service will only be paid by the health authority if the clinics concerned have been approved.

**Mental treatment service**

Mental treatment is provided in mental hospitals throughout the country. Patients may be admitted or treated in the out-patient clinics and admissions include voluntary and temporary patients, as well as those whose illness is of a more serious and prolonged nature.

**Maternity and infant care service**

All medical requirements for women in respect of motherhood and for the children up to the age of six weeks are provided free for those in the lower and middle income groups. Medical attention in respect of motherhood is provided either in maternity hospitals or at home and the patient is free to decide which type of attention she prefers. In the former case, the health authority arranges with the hospital in the same way as for any other hospital service. To provide for patients who do not wish to place themselves under the care of a hospital, the local authority arranges with practitioners to undertake the care of such patients during pregnancy and confinement for a specified fee. Any practitioner, including a district medical officer, may enter into an agreement with the health authority to provide this care and the patient is free to choose her doctor from amongst those who have agreed. The hospital or the practitioner, as the case may be, will also be responsible for the care of the baby up to the age of six weeks.

A woman who wishes to be confined at home is entitled to have all the requisite medical and surgical appliances and materials provided free. She may also avail herself of the services of a midwife.
doctor is expected to examine her three times at least during pregnancy. Her delivery may be conducted by the midwife, but if any difficulty arises, the midwife must call the doctor.

**Child welfare service**

The health authority is required to provide clinics at which mothers may receive advice about children under the age of six years and may have their children examined. The purpose is to discover defects at an early stage, to secure treatment for any defects noted and to raise the standard of health to the highest level possible. Treatment is not provided at the clinic, the child is referred to a hospital or to his own doctor. This service is available to all income groups. Health authorities are expected to provide a clinic in each town of 3,000 or more inhabitants. There are at present 88 clinics in the country, conducted by whole-time medical officers of the health authority.

**School health service**

The health authority is required to provide a health service for pupils of all income groups attending national schools and other primary schools at which a satisfactory service is not available. The emphasis is on assessing the general standard of health and discovering defects. For treatment, the pupils are referred to their general practitioner or to hospital. Only those in the lower income group get general practitioner treatment free, but all pupils may receive hospital or specialist attention free for conditions discovered during the school medical examination. The service is conducted by whole-time medical officers of the health authority and each child should have at least three examinations during his school life.

**Dental, ophthalmic and aural services**

Health authorities are required to provide these services for pupils of national schools, if the defects were discovered at school medical examinations, for children under six years attending child welfare clinics if the defects were discovered at the clinic, and for the lower income group generally. The dental service is provided partly by whole-time and partly by part-time dentists employed by the local authority. As there are only 80 whole-time and 52 part-time dentists and the school population alone is about 500,000 it is hardly necessary to suggest that the service is far from comprehensive. Thirty-five part-time ophthalmologists are employed for examining and treating eye defects and prescribing glasses. There are long waiting lists for ophthalmic examination in some areas.
Treatment of ear defects is available for the lower income group but up to the present hearing aids have only been available for children for whose education they were necessary and adults who could not otherwise earn their living.

**Infectious diseases service**

The fever hospitals are the oldest provision made for infectious diseases. They are still in operation under the health authorities and patients with infectious diseases are treated in them free, regardless of the income group to which they may belong. The incidence and importance of fevers have diminished very sharply during the last two decades and the fever hospital accommodation is not at present fully utilised. The only infectious disease which has increased in incidence during this period is poliomyelitis and one of the most important purposes being served by certain of our fever hospitals is the treatment of cases of paralytic polio. With the increasing success of vaccination against this disease the need for its treatment will also diminish.

Tuberculosis, though an infectious disease, is not treated in fever hospitals but in sanatoria. Two of these are voluntary institutions and the remainder are controlled by health authorities, which also use the two voluntary sanatoria by agreement with their governing bodies. Surgical and drug treatment are provided for all income groups. To encourage patients to take full advantage of the sanatorium and fever hospital facilities for the treatment of infectious diseases cash allowances may be paid to those whose circumstances make this necessary.

An important part of the infectious diseases service is prevention. This includes BCG vaccination and mass radiography in the case of tuberculosis, and vaccination against poliomyelitis, smallpox, diphtheria and whooping cough.

**Public health services**

The services so far described are usually classified as personal health services. For the purpose of safeguarding the health of the public in general a system of public health services was instituted long before any state subsidised service was available for personal illness. This deals with the control of epidemics, the provision of a satisfactory water supply, the disposal of sewage, housing standards, and other matters that may affect health generally rather than the health of a particular person. The official of the health authority responsible for this system is the chief medical officer (otherwise called the medical officer of health) and he and his medical assistants have the support of non-medically qualified personnel in several fields, such as health, sanitation, social work. The chief medical officer of the health authority is also, of course, directly concerned with almost every other aspect of the health services.
mentioned above, but many of these are duties which have come within his province relatively recently.

Diagram 4 summarises the administrative structure of the Irish health services, from which it will appear that while the "chain of command" may not be as direct as that of Finland it is much simpler and more direct than that of the British National Health Service.

Finance

The cost of the health services is met from three separate sources, the State, the local authorities and the Hospitals Trust Fund. The liability of the last of these is limited to the hospitals, in which regard the fund is responsible for capital expenditure and for the annual operational deficits. The latter item now amounts to about £2,000,000 per annum.

Apart from this figure the estimated cost of the service for the current year is about £20,500,000. This expense is incurred almost entirely by the health authorities but the State reimburses each authority to the extent of half of its outlay. It may be said, therefore, that half the cost of the health services is defrayed by the health authorities from the rates and half by the department of finance from direct and indirect taxation. The total expenditure represents about 2.7 per cent of the gross national product.

Voluntary health insurance

When the structure of the health services was being discussed in the period 1947–1953 it seemed clear that a comprehensive service of the type operating in the United Kingdom was not acceptable to a substantial section of the people and that, in any case, it was likely to be much too costly. The present system was accepted as a reasonable compromise between the old poor-law dispensary approach and the comprehensive service type. The only persons who might still find themselves in serious difficulties would be members of the upper income group who might be stricken with serious illness for which they had failed to make adequate provision. To meet such cases the Voluntary Health Insurance Board was established which, for moderate premiums, enables the insured person to contribute quite substantially towards the cost of illness. Although the benefit of this scheme is restricted by the exclusion of pregnancy and illness occurring in the elderly, it places a satisfactory safeguard within the reach of members of the upper income group whose incomes are still in the lower brackets in this category and who have young growing families.

We have now reached the stage at which we may look critically at our health service. Let me say at once that the general basis of the service has my approval. Modern methods for the investigation and treatment of disease and the elaborate research that leads up to them are so costly.
that only a relatively small fraction of the population of any country can afford a serious illness. The average business man in America regards a serious illness in his family as a much worse blow to his financial stability than a bad trading crisis. It was obvious twenty years ago that something would have to be done here, and it was clearly not feasible for us to adopt the British type of comprehensive health service. And so, even at the risk of appearing unenterprising, I am going to confine myself for the remainder of this paper to seeing what improvements might be made in our health service as it is organised at present rather than to suggesting radical changes in that organisation.

The points that I propose to consider are:

1. Type of central control
2. Methods of deciding eligibility for the different grades of medical service
3. Organisation of hospital and specialist services
4. Relation of the service to teaching and research
5. Arrangements for review

1. Type of central control

In this country and in Great Britain the central control of the service is the responsibility of one or more departments of the government and is directly political. While there are no drastic changes of personnel such as may take place in the U.S., the possible results of a change of government can range from relatively minor changes of emphasis to alterations of a major character, and even conceivably to a new type of service. In the Scandinavian countries the non-political state medical boards give greater stability. They also make it possible to concentrate all aspects of the service in one central organisation instead of spreading various aspects over several ministries. On the other hand, members of Scandinavian services often mention the disadvantage of not having a political incentive. Where there is no minister for health the health services are likely to get a smaller proportion of the funds that the exchequer has to distribute than they might hope for if there was a special minister with an undivided allegiance to make the case for them. From experience here one wonders whether it makes any substantial difference, for health seems to be a relatively low priority when the national income is being apportioned. I feel, however, that the concentration of all aspects of the health services in a single board or council might have certain advantages and I do not think that such a board need be denied direct political contact if such a contact were thought to be important. The advantages would include, for example, the bringing together under this authority of those aspects of food inspection that are at present under the Department of Agriculture and the safeguarding
of industrial health, which is at present the responsibility of the Department of Industry and Commerce. Social welfare and public assistance administration, which have such important implications for health, should also be brought in. Representatives of interests such as education, agriculture, industry and social welfare could be included on the board much more easily than they can on the staff of a full scale ministerial department and direct contact between the board and the workers in these areas would be easier in consequence.

An example of the way in which political contact might be maintained is provided by the USA. The Federal Government of the USA includes a Department of Health, Education and Welfare, the head of which is a member of the President's cabinet. Can we not also visualise a minister with a broadly based responsibility? His province would include everything concerned with health and for the discharge of his functions he would have the assistance of a national health board, representative of all the interests involved. The small size of this country is a disadvantage in many respects but there are also respects in which it is an advantage and one of these is the opportunity it offers for concentrating administration.

2 Method of deciding eligibility for the different grades of medical service

The method of deciding whether any given citizen should be placed in the lower or middle income group is basically the same from one health authority to another, but there must be considerable variations in the manner in which the basic plan is operated. Otherwise it is difficult to see how such widely differing proportions of the populations of the County Boroughs are admitted to the General Medical Services Register. The proportions on December 31, 1962, were, Dublin 14.4%, Cork 23.6%, Limerick 26.0% and Waterford 35.0%. A study of the manner in which the method is applied in one health authority has convinced me that it is fair and reasonable. If the officer's decision is considered harsh the unsuccessful applicant can always raise the matter with a member of the authority who has the right to ask for particulars of the case concerned and of other cases admitted and rejected about the same time, so that justice may be seen to have been done. But there does not appear to be any machinery for extending this review procedure to include a number of health authorities or, perhaps, all the health authorities in the country. While undoubtedly there are wide variations in population pattern between health authorities the figures suggest that some degree of standardisation of the criteria for admission to the Register might result in considerable saving.

3 Organisation of hospital and specialist services

Hospital and specialist services are provided by health authorities, either in health authority institutions or in voluntary hospitals.
considerable part of this work is done in the Dublin voluntary hospitals in which there are not less than 300 clinics each week. Before the introduction of the present health services the voluntary hospital doctors received no fees in respect of patients whom they saw at outpatient clinics or whom they attended in the public wards. Their income was derived to a very large extent from private practice outside the hospital. Some of the patients seen by them in their consulting rooms or treated in semi-private wards were in the upper ranges of the middle income group and consequently the new service meant a loss of income for the doctor at least in respect of the hospital care of these patients. It was therefore necessary to devise some means of paying the doctor for his work in hospital. This was done by allowing a fee for each session (three hours) which he spent seeing patients in the lower and middle income groups in out-patient clinics and a fee for every such patient he treated in the hospital. The number of out-patient clinics and hospital beds recognised for this purpose was the number for which the doctor was responsible immediately before the introduction of the service. Some out-patient clinics have been started since then and there has been some increase in the number of beds, but in both cases the increase has been small.

This introduces an undesirable element of rigidity into the system. As knowledge advances and new specialities are developed, further clinics are needed to cater for them, but quite frequently these are not recognised for payment of the doctor, who must work in them for nothing unless a doctor holding an existing clinic waves his right to be paid for it. Similarly, whereas it was formerly the practice for hospitals to recruit a young graduate by appointing him to an assistantship, members of the senior staff allowing him to take over a small number of beds, this does not now take place for each bed that a hospital doctor relinquishes represents a reduction in his income. Both these circumstances militate against the recruitment of young staff. In Great Britain the doctor is paid on a sessional basis for in-patient as well as for outpatient work so that at least there is greater freedom in the allocation of beds. The difficulty in Ireland arises from the urgent desire of the health authority to limit as far as possible the costs of these services, an understandable objective if we remember that the cost of the service as a whole has increased 3·6 times in 15 years.

4 Relation of the service to teaching and research

Perhaps the most important defect of our health services is the absence of any provision for training young men and women for the profession of medicine. This statement may appear to some to go too far but as a teacher I would be less than frank if I did not make it. No business or profession can flourish that does not take an active interest in recruitment.
and training Medicine is probably the most formidable complex of disciplines that faces the student. The medical course is long and costly both for the student and for the teaching bodies. The efficiency of the medical services depends on the competence of the doctor more than on any other single factor. Yet those who control the service for which the prospective doctor is being trained disclaim any responsibility for that training and make no contribution to it, financial or otherwise. The government policy is that all aspects of education are the responsibility of the department of education. This does not create any difficulty as far as the departments entirely inside the medical school are concerned, but when we come to those departments, like pathology and bacteriology, whose functions extend into the clinical sphere, and to the clinical departments themselves, a most unsatisfactory situation arises. The conditions under which the Hospitals Trust Fund is administered prevent the use of the fund for any educational purpose, so that the provision of accommodation and equipment for teaching medical students in the hospitals must also be undertaken by the teaching body. But the teaching body has no rights in the property of the hospital and consequently may not be anxious to spend considerable sums in providing the lecture rooms and laboratories required for teaching. The direct result of all this is that the Irish voluntary teaching hospitals, as a group, are less well equipped to carry out their essential function of teaching than any other teaching hospitals in these islands.

Research fares somewhat better. The Medical Research Council, which receives an annual grant from the Hospitals Trust Fund, subsidises research in hospitals, but frequently accommodation is not available and the Council is then in the same position as the teaching bodies—it has little money to spend on building and is reluctant to provide accommodation over which it cannot have any continuing right of ownership.

The countries whose services we have considered afford no help in the solution of this problem, for their hospitals are the property of the State and State funds can properly be spent on them, whether these funds come through the channel of health or education. It can only be urged that the present situation in this country is so ludicrous, if not indeed dangerous, that it demands the joint attention of the two departments concerned.

5 Arrangements for review

One of the disadvantages of having a strong political element in the control of the health services is that planning tends to be on a short-term basis. The first serious review of our health services, which have now been in operation nearly ten years, was commenced a few months ago by a select committee of Dail Éireann. Its report is unlikely to be ready.
before the end of the year and if a general election should take place in the meantime the proceedings of the committee would come to an abrupt end. The health services are costing the country over twenty millions each year yet there is little evidence of thoughtful long-term planning. No business of this magnitude would neglect this obligation. There are many examples of discrepancies which should have been removed long ago. The differences between the proportion of the populations of different health authorities on the General Medical Services Register have been mentioned. We are also aware of the statement commonly made that Ireland has a greater number of hospital beds per 1,000 people than almost any other country in the world. Yet, in Dublin many of the teaching hospitals have to supplement their normal bed capacity constantly by putting down stretchers. Figures for bed occupancy of 96 per cent and average patient stay of under two weeks speak for themselves, and their voice is fortified by the fact that the Bed Bureau has constant difficulty in finding vacancies for cases urgently needing admission to hospital.

We do not know the types of patients in our hospitals. We do not know the extent of the elderly and chronic sick problem. We do not know if the figures for the proportion of paediatric beds to population quoted for other countries apply here. The possibility of rendering the hospital service more efficient by the greater use of convalescent homes has never been systematically explored.

It is surely unnecessary to labour the point further.

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Diagram 1

HEALTH AND WELFARE SERVICES IN GREAT BRITAIN

Minister of Health
Central Health Services Council
Advisory Committees
Medical Practices Committee

Minister of Education

Home Office

Minister of National Insurance
National Assistance Board

Minister for Labour

Minister for Agriculture

Regional Boards
Regional Hospitals

Hospital and Specialist Services

Boards of Teaching Hospitals

Medical Practices Committee

Medical Officer of Health and Assistants

General Medical Services Executive Council

Ophthalmic Services Committee

Local Medical (etc.) Committees

Ambulance
Home midwifery
Home nursing
Home help

Care and aftercare
Health Visitor

Infant Welfare

Mental Welfare

Health Education
Sanitation

Education

Local Authority

School meals
School Medical Inspection
Medical care of School children

Local Authority

Welfare Department

Welfare Officer

Children's Department

Children's Officer

Children in Institutions
Boarded Children
Adoption

Juvenile Courts
Remand Homes

Assistance — Residence or Welfare service for Elderly and Handicapped

Insurance Benefits

Factory Health

Veterinary Services

Milk Cereals
Diagram 2
PORRITT COMMITTEE'S SUGGESTED ORGANIZATION FOR BRITISH N H S

Parliament
(Minister of Health of Cabinet rank)

Ministry of Health
(National Medical Advisory Committee)

Regional Planning Committee
(set up jointly by two or more Area Health Boards)

Area Health Board

General Medical,
Dental,
Pharmaceutical & Ophthalmic
Services Council

- General Practitioner Services
- Dental Services
- Pharmaceutical Services
- Supplementary Ophthalmic Services

Hospital Services Council
- Consultant Services
- Hospital Beds
- Domiciliary Consultant Service
- Blood Transfusion
- Ambulance

Preventive and Social Health Services Council
- Promotion of Health
- Prevention and Control of Disease
- Health Education
- Vaccination and Immunisation
- Maternity and Child Welfare
- School Health
- Deployment of Health Visitors, District Nurses and Social Workers

Occupational Health Services Council
- Environmental Health Services in Industry and Commerce

Statutory Professional Advisory Committee

Statutory Professional Advisory Committee

Statutory Area Professional Advisory Committee

Statutory Professional Advisory Committee
Diagram 4

HEALTH SERVICES IN IRELAND

Voluntary Health Insurance Board
Mass Radiography Association
Rehabilitation Organisation
Blood Transfusion Association
Cancer Association

Practitioner
Voluntary Hospitals
County and District Hospitals
Distress Medical Officer
Ambulance
Maternity Service
Child Welfare Service
Sanitary Service
School Medical Service
School Meals
Food Hygiene Inspectors
Health Education

Minister for Health
National Health Council
Hospitals Committee
Advisory Committee

Local Authority
Manager MOH Consult Health Committee

Mental Hospital Authority
Food Hygiene - Agricultural products
Minister for Agriculture

Mental Hospital Service
Inspectors

Occupational Health
Minister for Industry and Commerce

Health Inspectors
DISCUSSION

Dr B O'Regan when proposing a vote of thanks to Professor Jessop said When considering the Irish Health Acts one must realise that their application to Dublin and possibly Cork is entirely different to that in the rest of the country. It has made little change to the availability of medical services in rural Ireland where the standard of general practitioner and hospital care is high and available to anybody in need of it. Few cases are now sent to Dublin except to the specialised surgical departments or to the children's hospitals. Any change in the service would only be the possible extension of free medical care to a higher income group.

In Dublin, an opportunity arose some years ago to give free choice of doctor to the lower income group. This proposition must have been examined then but apparently it was rejected. It would be difficult to work it particularly as Dublin appears to be “over doctored”, but I am of the opinion that it would be a better system than the present one.

There are too many small hospitals in Dublin having as many specialist departments in them as will fit. This leads to extravagance in the purchase of specialised equipment and lack of maximum efficiency among medical staff, as in my opinion, two or more groups of surgeons in the same speciality will produce better work in the one centre where they are in constant contact with each other than when one is working in isolation in a separate hospital.

The Dublin hospitals including the local authorities, hospitals should be governed by one Hospital Board which would control and administer them, but as there are in effect four groups of hospitals, I cannot see this ideal ever being attained. The recent federation of several hospitals on the South side was a very welcome move towards this unity of control.

The Health Act is now due for review. It was planned by laymen, is being administered by laymen—I believe that the medical men have a very big contribution to make to its better working. They should not be omitted from whatever group will be charged to review it. It must also be remembered that the Health Authority which pays at least fifty per cent of the cost in Dublin must also get adequate representation and should be consulted in any future extension that will add to the cost of the scheme.

Dr O'Donnell, County Medical Officer, Kildare, expressed his appreciation of Professor Jessop's paper. In regard to the Irish Health Service, he felt that the present Service had many good points and some bad points but on the whole was a much better Service than the previous one which was based on the Public Assistance Act, 1939.
Good points in the present Service he enumerated as Maternity Services, Availability of Specialists Services and free or nearly free Hospital Services for lower and middle income groups.

Bad points in the present Service were lack of choice of doctor and inequality of distribution of Medical Cards in the different counties.

He was of opinion that the British National Health Service was the best Health Service in the world and this had been endorsed by the Porritt Report. The British Ministry of Health was doing a great deal of long term hospital planning and this planning embodied the eventual abolition of the large isolated Mental Hospital as we know it at present.

In conveying the vote of thanks to the lecturer the President said that in his view economic analysis had a most important contribution to make to the problems involved in the provision of better health services. Several speakers had praised the British Health Services but this view was not universally held. In fact recently Professor Jewkes had been advocating a return to conditions of free competition in a market economy for health services since he believed that the efficiency in the allocation of resources in the present system was so bad. We should take steps to ensure in organising future developments here that this reproach does not apply to us.

Administrators and doctors must continually answer questions in relation to development of health services, as to what services and facilities to provide, how to provide them and how much to provide. The public share of the expenditure was of continually growing importance and the resources were scarce so that it was a typical field for the application of economic analysis. Thinking about these problems in terms of “need” or “best possible care” is liable to be misleading. In selecting a method of care for a particular patient or in choosing a preventive or organisational programme for the community one cannot always opt for doing all that can possibly have some useful effects. There are not enough doctors, nurses, hospital beds or money to go around. The decision to give more doctor hours, more nursing, more drugs to one patient or one programme than another is equally a decision to give less to another patient or another programme. Similarly, to spend more money on health is correspondingly a decision to spend less on education, on housing, on social assistance etc. It therefore follows that to select a particular method of health care is not justified merely because it is a “necessary” or “good” use of resources but because it is a better use than any other use to which the resources can be put.

The problem, therefore, is one of the optimal use of resources, a typical problem in economics and operation research. To tackle it adequately the problems must be quantified and, for maximum usefulness, the questions must be adequately and properly formulated.
It is obvious that the estimates made will not be accurate, but to think in terms of optimal allocations rather than in terms of meeting needs will produce better decisions. He felt that people's attention should be directed in this country to the work which the Nuffield Trust was doing in Britain and we should certainly take heed of the conclusion of Forsyth and Logan recently when they concluded that doctors automatically adjust the demand for in-patient beds to available supply. This is probably also true of the number of beds in mental hospitals.

The approach must, in his view, be a statistical and economic one. It was not sufficient merely to say that the statistical problems were difficult or the quantification imprecise. It is true that in this field there is considerable variability but it is because of this variability that the statistical approach was essential. Creative economic analysis and competent statistical research could help doctors and administrators to choose among alternative programmes of prevention or diagnosis, among different methods of treatment, to balance in-patient and outpatient care and to solve similar problems in designing a health service.