The Labour Party
Outline Policy:

HEALTH
SOCIAL WELFARE

As adopted by the Labour Party Annual Conference, January 1969

HEALTH POLICY

1 INTRODUCTION

1.1. The Labour Party believes that the community has the responsibility of providing a free medical health service for all citizens without distinction. Its aim is to provide a health service which permits no discrimination between patients and which encourages the maximum involvement of the doctor with his patient. At present the health service is administered through a patchwork of legislation and regulations and is based on the concept of different medicines for different income groups.

1,2, The conservative government now in power proposes to introduce free choice of doctor without fee for some 30% of the population. It does not accept responsibility for providing the middle income group with similar facilities.

1.3. The medical profession is organised on outdated class lines. Hospitals are subject to no uniform system of control or administration. The cost of drugs is prohibitive to many sections of the communtiy. There are many areas where improvements are not merely desirable but also necessary.

1.4. A socialist policy on health is based on the acceptance of equality and of the right of every citizen to medical treatment without cost.

1.5. The aim of the Labour Party is the provision of a free comprehensive health service incorporating a general medical, hospital and specialist service, dental, aural and opthalmic services, free medicines to be provided on doctor's prescription. The dispensary system in its present form will be abolished and all persons will have a free choice of doctor. The present charges for hospital treatment will be dropped.

1.6. The underlying theme of this policy is a community approach to health care. The medical services will be organised on a community basis.

SECTION TWO : RECOMMENDATIONS

2.1. The Community has the responsibility of providing a free medical health service for all citizens without distinction or discrimination.

2.2. Where practicable, the Health Services will be organised on a community basis. Health centres will replace the present dispensary system and will provide the entire local community with a wide range of general and specialist medical services.

2.3. Special provision will be made for rural areas by ensuring quick access to the services of a family physician.

2.4. Hospitals will be organised as an integral part of a regional health service, the function of a hospital being to provide its region with a full range of specialist services.

2.5. Each Regional Hospital will develop one or more speciality thus keeping the speciality concerned in constant contact with living community medicine.

2.6. The other County Hospitals will be used as rural Health Centres serviced by family physicians and supporting staff.

2.7. A national ambulance service will be established to include a full complement of different types of ambulance, with particular emphasis on properly equipped road accident emergency service.

2.8. Hospital visiting hours will be rearranged to suit the patients, the community and the staff. Free transport will be provided for immediate relatives to visit patients hospitalised considerable distances from home.

2.9. All Hospitals in the State will be placed under the auspices of a National Health Authority which will take over voluntary hospitals. Each hospital will be run by a Board of representatives from the medical, nursing and other workers, the National and Local Health Authorities and the local Community.

2.10. Medicines and appliances will be supplied free on doctor's prescription. The pharmaceutical industry will be brought under community control and integrated into the health service.

2.11. The care of the aged will be viewed as a distinct problem which can only be solved by a comprehensive service specifically directed towards old age. The state will provide adequate staff, particularly geriatricians, and hospital and domiciliary nurses, to provide for them. The aim will be to reduce hospitalisation to a minimum.

2.12. The present system for treating the mentally ill will be replaced by developing psychiatric services centred on the community. The emphasis will be on community care and less hospitalisations.

2.13. Child psychiatry will be run on the same lines.

2.14.a Specialised teaching, medical and nursing services will be provided for the mentally handicapped. A Government Department of Psychiatry will be set up because of the abnormally high incidence of psychiatric admissions in our hospitals.

2.14. The physically handicapped will receive specialised training with a view to making them as self-supporting as possible.

2.15 Special programmes will be developed for dealing with Alcoholism and Drug Addiction.

2.16. The family physician will be a highly trained doctor, having equal status with the specialist, and receiving special training in social medicine, public health, psychiatry, personality factors and social processes.

2.17. A National College of Nursing will be established as an integral part of the University system, with free access to the profession.

2.18. A corps of assistant nurses will be trained to work as nurses' aides.

2.19. Extensive facilities will be made available for medical research. Chairs of Medical Sociology will be founded.

2.20. A National Health Authority will be established and made responsible for administering the Health Service in conjunction with Local Health Authorities.

2.21. Capital expenditure will be funded out of the State capital budget at low interest rates. Current expenditure will be met from the Social Fund, as described in the Party's Social Welfare Policy.

SECTION THREE : COMMUNITY HEALTH CARE

3.1. The Department of Social Medicine in UCD and the College of General Practicioners in Dublin have stated that 'Greater knowledge, greater specialisation has fragmented health care, raised new boundaries between disciplines and between levels of medical practice. Medicine has grown away from the patient and away from the community while professing the need to cater for both more closely. In particular the hospital has grown increasingly apart from the family doctor who, for so long, has been medicine's bridge to the society it serves. The Department went on to point out the need for the rationalisation and co-ordination of health services in an approach which would place the patient at the centre and might involve the concerted action of welfare, health and educational services.

3.2. Labour will organise the Health Services where practicable on a community basis. Medicine must relate to communal needs and health services should be an integral part of a community.

3.3. The basis of Labour's Health Service will be the Health Centres established at local level and which will replace the present dispensary system. These centres will be spaciously appointed buildings. Medical, nursing and social services, such as ambulances, will be available. The medical facilities at the centres will incorporate the following:

a) Social Service Department, with a social information centre.

b) Weekly or bi-weekly specialist clinics such as anti-natal and gynaecological; ophthalmology, surgical, medical, paediatric, including child psychology and psychiatric and phychological service to schools; dentistry; ear, nose and throat.

c) Routine pathology and bio-chemistry.

d) Chiropody.

e) Physiotherapy.

f) X-ray.

g) Child Welfare, school medical service and other public health activities.

h) Geriatric services, assessment, day care and welfare homes.

3.4. These specialists and services will operate as a background to the general work going on each day. Patients who are thought to require further specialist treatment will be brought back on the day of the specialist's visits to the clinic, who may refer them back for further investigation or treatment to the family physician. In this way the patient will be admitted to the hospital only when a definite course of treatment is found to be required or for very special investigation which may need hospitalisation. The patient will only be retained in hospital for the shortest time possible and will return to his home or health centre for after-care or follow-up. In this way unnecessary admissions to hospital will be avoided and length of hospitalisation drastically cut. Since health is only one of the care-giving forces in any community, links will be established with other agencies through a social information centre so that at whatever point a problem should enter, the appropriate forces are brought into play. An individual patient may require the concerted action of welfare, health or educational services and these must be available on call as required.

3.5. The Health Centre will be open from 9.00 a.m. to 6.00 p.m. There will be a free choice of doctor for normal surgery calls. During this period domiciliary calls may be arranged with the doctor of choice at the Health Centre. There will be a covering night surgery in large population areas to provide for emergency visits. Domiciliary calls after hours will be taken by the doctors on a rota basis. By this method no loss of continuity will occur in the attendance by a doctor of a patient, except in emergency. The doctor/patient relationship will be maintained. This system of organising the family physician service has the added advantage of reducing their exhausting burden of round-the-clock availability and will make a five-day week possible for them.

3.6. Each Health Centre will provide, as mentioned in paragraph 3.3., services for maternity and child care. The aim will be one hundred per cent hospital confinement for deliveries. The family physician may deliver, except in teaching hospitals at present. Discharge will normally take place forty-eight hours after birth. This will involve the establishment of a home-help service to aid the mother in the immediate post-natal period. The service will operate from the Health Centres.

3.7. All babies will be examined for congenital defects within twenty-four hours and again at the Centre by a paediatrician after six weeks.

3.8. At present there does not exist a comprehensive system for checking on the incidence of maternal mortality. The Centres will give special attention to this problem. The education of the mother in hygiene, child care and family spacing will be a continuing part of the Centres' programme. To assist in this programme a special corps of home health visitors will be established. Nursing centres and creches will be set up in conjunction with the Health Centres, particularly in thickly populated areas.

3.9. The pattern of the Health Centre network will be determined by the populations of different communities. Obviously a family living in a city or large town will be nearer to a Centre than a family living in a rural community. Special provision will therefore be made for rural areas by continuing the present local family physician system. The difference, as far as the patients are concerned, will be that the service will be free.

SECTION FOUR: THE HOSPITAL SERVICE

4.1. Under the Health Centre scheme outlined in the previous section, the hospital takes its appropriate place as an integral part of regional health service. Its function will be to provide a full range of special services to the region — as it has been pointed out, much of the clinical and social investigation will already have been carried out in the health centres, so that the number of patients requiring admission will be drastically reduced and hospital care will be reserved for those requiring truly specialist care or investigation. Under this system the out-patient department of the hospital will change its character drastically. No longer will patients pour in casually with a hurried note from their G.P. to be assessed from scratch. On the contrary, all the preliminary work will already have been done at the Health Centre and as a result the out-patient's department will no longer be thronged with rows of patients waiting hours to be seen by a hurried specialist. While the patient is in hospital the general supervision of his care will be carried out by the specialist in close consultation with the family physician who will, if necessary, visit him and maintain contact with him while he is in hospital.

4.2. It is envisaged that while providing the full range of medical, surgical and other specialities, that each regional hospital will develop one or more speciality in a particular degree up to national level such as, for instance, neuro-surgery or cardiology. In a small country such as Ireland there is only the need for one highly-specialised unit, thereby raising the academic standard of each hospital and, at the same time, keeping the super-speciality concerned alive by maintaining its contact with living community medicine.

4.3. The theme outlined will require modification in rural areas to allow for a more extended line of communication; while the exact form which the rural regional health service should take will depend on local conditions, it would seem logical that when one of the County Hospitals in a region has been selected as the most suitable regional hospital, the others will be used as the rural equivalent to the Urban Health Centre. From these centres the family physicians and their supporting staff will operate.

4.4. The operation of an efficient ambulance service is an essential if the reorganised hospital service is to work. The ambulance service as it currently stands will be augmented by a national ambulance service designed specifically to act as links between the specialists hospitals, the major population centres and the local hospital. The Department of Defence helicopter service would be an integral part of the system.

4.5. A proper ambulance service requires a full complement of different types of ambulances, such as bus, stretcher, emergency and a maternity flying squad. There is great need for a properly equipped road-accident emergency service with a doctor on board. The development of a national ambulance service will be a priority in Labour's policy.

4.6. In terms of general hospital organisation it will be a basic principle that hospitals exist for the patient and not the other way around. Visiting hours will be made conform to the social and economic pattern of the local community and will be liberalised where required. In the case of children requiring hospitalisation every facility will be made available for mothers who wish to stay overnight in the hospital with their child. Free transport will be provided for immediate relatives to visit patients who are hospitalised considerable distances from home.

4.7. All hospitals in the State will be placed under the auspices of a National Health Authority. The development of the hospital service will be the responsibility of the Authority. Voluntary hospitals will be taken over by the Authority. Where religious communities are in charge of administration they will continue in their administrative capacity but will be responsible to the Authority.

4.8. Each hospital will be run by a Board representing the doctors, nurses, (including those below the level of matron), administrative and other workers, representatives of the Health Authorities at National and Local level and representatives of the local community.

SECTION FIVE: MEDICINES AND APPLIANCES

5.1. Medicines and appliances will be supplied free on doctor's prescriptions. In the case of medicines the doctors in the Health Centres will prescribe for their patients in the normal way and prescriptions will be filled free of charge by the pharmacy trade or the Centre's own pharmacy.

5.2. Pharmacists will continue to provide a dispensary service to the community through the network of existing chemist shops. Each shop will stock two pharmacies, one for the normal transactions carried out by the shop and the other for filling the health service prescriptions.

5.3. There is a growing shortage of qualified pharmacists due to the low financial reward attached to the profession. If the community is to be properly serviced by an efficient and qualified profession then the pharmacists must be assured of incomes commensurate with their qualifications and role in the society. Pharmacists will secure proper incomes under Labour's service by receiving a standard fee for each prescription, plus a retainer for providing a community service.

5.4. The health service will have a list of drugs and medicines from which doctors will prescribe. The list will be established and kept up-to-date by the National Health Authority. The cost of drugs could be a crippling factor in the operation of the service unless the greatest care is exercised in preventing the abuse of State funds by unscrupulous elements.

5.5. It has happened that drugs of similar medical value vary widely in price. Furthermore, the pharmaceutial industry will be tendering to and supplying to the State. It will in these circumstances, be essential to ensure that clinical and commercial values correspond and that there is no profiteering by any section in the prescription and supply of drugs and medicines. Most of the drugs and medicines will be imported and their cost could, as in the case of the United Kingdom, be twice as great as the cost of the doctors administering the scheme. In the case of imported drugs, it will be necessary to ensure that the National Health Authority tests the product's clinical claims and establishes that the economic price is being charged.

5.6. It would be to the advantage of the medical service if the pharmaceutical industry in Ireland were brought under community control and integrated into the entire system. It could, for example, by virtue of the research capabiliy which it would have to maintain, substantially add to the resources of medical science in the country.

SECTION SIX : GERIATRICS

6.1. The present piecemeal approach to the geriatric problem fails to hide the abject neglect of our aged. The findings of the Chief Phychiatrist and his assistants in the Dublin Health Authority are that 'In neglecting this problem, not only are we disgracing ourselves from a viewpoint of Christian charity, in selfishly condemning this large and helpless section of our population to substandard facilities, but in addition we are allowing a monstrous tidal wave of problems to grow which will lead to a total breakdown of our national medical services. This problem is on the brink of an economic and national emergency.'

6.2. In 1966 the number of people over 65 was 332,000. It is estimated that by 1981 it will be 372.000. These facts suggest that the care of the aged must be viewed as a distinct problem which can only be solved by a comprehensive service specifically directed towards old age. For the very reason that the maintenance of an old person in society may require, at any given time, the involvement of various services, such as social agencies, medical, surgical, psychiatric, physiotherapy etc. Geriatric care must be thought of in terms of a comprehensive service which co-ordinates and embraces all these services. Moreover, geriatric care cannot be identified with hospital alone or simply with community care, but involves the continuance of services embracing every aspect of the problem.

6.3. Under the present regime the care of the aged does not seem to be the responsibility of any one section of our fragmented health services. While many of our voluntary hospitals treat them for acute illnesses, none has yet appointed a geriatrician. Indeed, it is doubtful that outside of Dublin the public sector has the services of such. A sizeable percentage

of our old people find refuge in private homes as long as their finances permit. These homes are not open to inspection by a Health Authority.

6.4. The bulk of our aged, therefore, are catered for very inadequately by the public sector, that is by Local Government. We find them in overcrowded, understafted wards, condemned to lie in beds until death releases them. Very many of these patients could be up and about even in hospital if the necessary trained personnel were in adequate supply. Very many of them need not be hospitalised at all if the services of community care already dealt with were part of the national health scheme. The services of a family physician, domicilary nurses, trained social workers, chiropodists, geriatric visitors, meals on wheels, etc. could all combine to keep hundreds of our aged living within the home community and would ease the pressure on hospital beds. The most pathetic feature of the present is the separation within the same institution of the aged husband and wife, who are deprived of any contact or communication with each other. From the moral standpoint this is wrong, from the humane it is cruel and in the revolution of community and hospital care for the aged, the separation of husband and wife must not be allowed to continue.

6.5. Care for the aged will be taken over by the public sector of health which will employ adequate numbers of geriatricians and their assistants, a wide network of social workers, an adequate supply of hospital and domicilary nurses and an adequate number of physiotherapists in all regional areas. To meet this latter demand the closed shop training centre in Dublin for physiotherapists must be broken. Such training centres must be established in each Unviersity City where the necessary teaching hospitals will also be available. Above all the teaching of medical and nursing undergraduates will include geriatrics in their respective curricula. It will be Labour's aim to maintain the dignity of the individual. This will be paramount in the case of the aged and the geriatric services will be designed and geared to support the responsibility of the person.

SECTION SEVEN : MENTAL HEALTH

7.1. In their proposals for a programme of research in mental health, the Department of Psychiatry in UCD states that the emphasis in the past in the treatment of the mentally ill was on hospitals while the community services remained relatively undeveloped. The emphasis on hospitalisation resulted in serious overcrowding of buildings which were in the main antiquated with inadequate utility services, resulting in turn in therapeutic inactivity, a low state of morale and an atmosphere not generally conducive to recovery. It is, therefore, necessary to make a break in this situation by developing psychiatric services centred on the community and related to the area being served and to make a fundamental break with the concept of hospitalisation with its allocation of doctors and nurses rigidly in relation to the number of patients.

7.2. The community and domicilary services will be integrated with the hospital. Continuity, whether in hospital or in the community will be provided by the psychiatric team serving a given area.

7.3. The following are the steps that will be taken to reduce overcrowding in mental hospitals:

7.3.1. An active discharge programme combined with an effective screening of admissions so as to ensure that only those requiring inpatient treatment will be admitted to hospital.

7.3.2. The building up of an active domicilary and community service and the establishment of effective liaison with medical practicioners.

7.3.3. The development of recreational, occupational and industrial therapy leading to an active programme of rehabilitation involving the establishment of hostels and retraining of patients.

7.3.4. Abandonment of the former divisions into isolated male and female hospitals with the gradual provision for integrated male and female units in each section.

7.4. The community help programme will provide a unique opportunity for a new and necessary approach to the understanding of mental health and will provide an indispensible dimension for a mental health research programme; for example psychiatric studies would include:

7.4.1. Early diagnosis and the effects of early treatment.

7.4.2. The defining of limits and degrees of competence as between the family physician and the psychiatrist in dealing with socio-psychiatric problems.

7.4.3. The exploration of the value of community nurses and social workers in this field of primary prevention.

7.4.4. The provision for genuine and continuing follow up in the community of patients who have required psychiatric tratment.

7.4.5. The exploration of the potential of the community based psychiatric service which can only develop adequately in close collaboration with the medical service.

7.5. As in the other medical services, the foregoing will very much reduce admissions to mental hospitals and long hospitalisations.

7.6. Child psychiatry will run on parallel lines to the foregoing, the emphasis being on community service. Assessment will relate to socio-economic factors, family background and patterns, this to relate in particular to autistic children, abolition of children's courts and industrial schools as a prerequisite to reforming delinquent children, assessment of admissions to rehabilitation centres with follow-up as in the case of discharged mentally ill adults, special schools to be provided for sub-normal children.

SECTION EIGHT: THE MENTALLY RETARDED AND PHYSICALLY HANDICAPPED

8.1. It will be the duty of the State to provide training facilities with specialised teaching, medical and nursing services, for the mentally handicapped The requirements of such measures will be placed under the guidance of a Government Department of Psychiatry in consultation with the Department of Health. It will be the object of a Labour Government to integrate the handicapped into society in so far as is possible and legislation will be introduced to ensure that they will have adequate employment opportunities.

8.2. The Department of Psychiatry in UCD in their research programme called for a separate Government Department of Psychiatry. The community need for such is proven by the fact that per capita, we have the highest number of psychiatric beds in the world — 7.3 per 1,000 of the population. It will be Labour's aim to establish such a Department.

8.3. The physically handicapped will be provided for by specialised training in whichever field their potential and capabilities direct. Every effort will be made to absorb them into society's workforce so that they can lead a full life, rather than as heretofore, through no fault of their own, being part of society's burden.

SECTION NINE: ALCOHOLISM AND DRUG ADDICTION

9.1. The incidence of alcoholism and drug addiction in the community is not fully known. Research indicates that the prevalance of alcoholism is high. Experience elsewhere indicate that drug addiction can become a real threat to community health. Labour will develop specialist programmes under the new Department of Psychiatry to tackle these particular health areas.

SECTION TEN: THE MEDICAL PROFESSION

10.1. Health services operated on a regional basis will require a family physician who will share in the same administrative organisation, training facilities, and staffing arrangements as the specialist physician. The family physician will have to be an expert in social medicine and public health and understand personality factors and social processes. In any area of regional health services there will be a number of doctors at senior level, some of whom will be specialists, while others will be family physicians as already defined. Regional hospitals will be in regional health areas to meet the health and social needs of the community. Each health centre will have its own contingent of community nurses and each nurse will have responsibility for a small number of families and will be the main channel through which all aspects of health impinge on the family. These family nurses will work directly under the supervision of the several family physicians.

10.2. The teaching advantages in regard to community medicine are obvious. It is envisaged that the family physician will be trained in the area health services as houseman, registrar and family physician. It would be advisable too that just as the family physician would undergo some exposure to various specialities, the trainee specialist should also gain some experience

working in community medicine. Medical students and student nurses could also be attached to the health centre for a portion of their undergraduate training.

10.3. There is a great need to modernise medical education. In particular phychiatry must become a major subject for study. Community health care, as has been mentioned will require doctors with highly developed psychiatric skills. Accordingly they will require a good grounding at undergraduate level in the psychiatric field. Post-graduate courses in specialist subjects will be made available with special financial assistance for attendance.

10.4. At present there are no training facilities for industrial medicine. This is a field that demands special training and it will be incorporated in post-graduate courses. It is particularly important in the agricultural industry that doctors should be available with these skills in view of the growing complexity of the agro-chemicals now commonly in use.

10.5. A National College of Nursing will be established as an integral part of the University system. Access to the profession will be free and all trainee nurses will undergo full-time study at the National College with practical sessions at training hospitals. The current practice of forcing nurses to work while studying will be abandoned. The general training course will be extended to include a course in psychiatric care. The time of extension will be decided by the Department of Health in conjunction with An Bord Altranais.

10.6. Liberalisation of training will call for the abolition of nurses' homes within the training hospitals. Student nurses will live out as do students of other professions. Apart from the advantages of a student nurse living as part of the general community, it will eliminate the present archaic situation where the number of trainees accepted at a given period is governed by the measure of accommodation for them in the institution.

10.7. A shortage of nurses exists in many areas due to the low salaries, long working hours and unsatisfactory conditions of work. The status and rewards of nursing must be raised and Labour will insist on immediate betterment of salaries and conditions generally.

10.8 Promotion to administrative and supervisory grades will be by qualification and competitive ability so as to rule out the traditional disadvantage of nurses in the secular section. Representation to hospital boards will be by vote of nursing staff rather than by appointment.

10.9. Labour will set up a scheme for training assistant nurses. Entry to this section will not call for the same standard of education as that of the general trained nurse. The time of training will be two years and successful trainees will be registered as assistant nurses. This force, which is working very successfully in England, will take the place of the untrained personnel at present employed as nurses aides. The advantage will be better service, with no waste of working time, as is experienced in untrained people coming in contact with hospital patients.

10.10. It will be the duty of the Department of Health to organise post-graduate courses for all branches of the profession, so that nurses will be kept up-to-date as medical science advances.

10.11 Discrimination against nurses who marry will be ruled out. As in the medical and teaching professions any nurse wishing to carry on after marrying will have the opportunity to do so, not at the end of the scale at present, but at a level commensurate with her qualifications and ability. The married nurse will be afforded the same opportunities to go on to the higher grades of the profession as her colleagues in the single section of the profession. This will in no way encroach on the avenues of advance open to the single women and to the religious. Indeed at present many hospitals could not carry on without the help of married nurses and with qualified competition as the basis for advancement, the best in the profession will only get to the top, resulting in better service to the hospitals and to the community at large.

10.12. Facilities proposed for general trained nurses will apply to psychiatric nurses. Psychiatric nurses will be required to specialise in the care of the mentally retarded and, like the general trained nurse, their training period will include experience in community centres.

SECTION ELEVEN : RESEARCH

11.1. Community health care will be linked with a medical social research board which will enable the necessary comparative study of other existing types of services to be undertaken, with reference not only to the quality of the services provided, but also with reference to efficiency and cost.

11.2. In the field of general medicine Labour will finance and make available facilities for advanced medical research. It will make available similar facilities for post-graduate medical education in accordance with the 1947 Health Act. Provision for the comprehensive study of preventive medicine to extend from ante-natal, through infancy, through school, right up and into all sections of industry, will be made. The advantages of such will be better health and the financial economy of prevention instead of treatment. In the field of industry it will decrease the man-hours lost and it will decrease the demand for hospitalisation and the possible easing of the present geriatric problems.

11.3. The special skills of the Sociologist will be required to investigate environment factors such as the relationship of work, housing, income, family size and social amenities to health problems and sociological studies of attitudes, fears and anxieties of illnesses in relation to services provided.

11.4. Departments of Medical Sociology will be established in the Universities to analyse and interpret society in relation to its medical needs and the services being provided.

SECTION TWELVE : ADMINISTRATION OF THE SERVICE

12.1. A National Health Authority will be established and made responsible for administering the Service. It will be composed of representatives from the medical professions, the Departments of Health and Psychiatry, hospital boards and local authorities. It will draw up the regulations governing the operation of the service and will make agreements with the professional medical and other organisations involved.

12.2. In each local government region there will be a Local Health Authority, composed of the medical and other workers concerned, hospital boards and local authorities. It will be responsible for the local administrative machinery in the operation of the service.

12.3. The Departments of Health and Psychiatry will be more involved in the policy and research fields than in duplicating the administrative systems of the National and Local Health Authorities.

12.4. The rationalisation and co-ordination of all aspects of health will, of necessity, absorb the private sectors into the public services, and thereby eliminate the two-tier system at present prevailing.

SECTION THIRTEEN : FINANCE

13.1. Capital expenditure will be funded out of the State capital budget in accordance with requirements established by the National Health Authority and Government Departments. As outlined in the Party's Banking and Financial Policy this investment capital will be advanced at very low rates of interest.

13.2. Current expenditure will be met from the Social Fund, as outlined in the Party's Socal Welfare Policy. Labour is opposed to flat insurance based schemes because these have no redistributive effects amongst the different classes of the community and because contributions are levied irrespective of the contributor's family income and responsibility.

13.3. By co-ordinated planning as outlined in Community Care, current costs would be drastically cut by:

13.3.1. No over-lapping of services.

13.3.2. The advantages of preventative medicine.

13.3.3. Drastic cut-backs in hospital admissions and length of hospitalisations.

13.3.4. Rapid diagnosis and top level care to all sections of the community which will drastically cut annual working days lost.

13.3.5. National control of medicines, thereby eliminaitng the present commercialisation, waste and over-prescription.

13.3.6. Encouraging, as far as possible, the mentally and physically handicapped to become self-supporting.

SOCIAL WELFARE

SECTION ONE : INTRODUCTION

1.1. The role of the Social Services is central to any democratic socialist programme. Not only do they act as a means for redistributing wealth and help to eliminate economic inequalities but they create the basic pre-conditions which allow man to contribute to the society in which he lives, to avail of the opportunities for personal development which are opened up to him by a socialist society and to participate in the government of the forces which shape his destiny. It is nonsense in present circumstances to talk of industrial democracy and the greater democratisation of our institutions. A man whose energies are directed primarily towards day-to-day problems of making a living in the face of rising prices, possible redundancy, ill-health and all the other unforeseeable calamities which he must face, is unlikely to be able or willing to devote much attention to the wider problems of his community and the nation at large.

1.2. The whole social service field must be seen as a complex of inter-related systems complementing one another. It is unrealistic, for instance, to talk of comprehensive health services without at the same time striving for an improvement in housing standards and cash sickness benefits. Similarly, it is ridiculous to expect the materially under-privileged to benefit from improved educational opportunities.

1.3. It will be the primary concern of a Labour Government to shape the Social Services so that they intelligently relate to the immediate and long-term needs of the community.

1.4. Irish social welfare policy at present is based on the Victorian 'plimsol-line' concept of assistance barely sufficient for survival. A harrowing example of this is the present rate of old age pensions. Those dependant on social welfare are given barely enough on which to survive and are regarded as being in some way at the bottom of a competitive ladder in the community, a permanent definition of failure to motivate the rest of society and a measure of success for the more fortunate.

1.5. But it is no longer realistic to regard poverty as being measurable in terms of money incomes alone. As J. K. Galbraith pointed out in "The Affluent Society," in 1958:
"People are poverty stricken when their income, even if adequate for survival falls markedly behind that of the community. Then they cannot

have what the larger community regards as the minimum necessary for decency; and they cannot wholly escape, therefore, the judgement of the larger community that they are in some way indecent.'

1.6. Yet even in terms of 'real' (as opposed to 'relative') poverty the situation in Ireland is serious. Based on figures supplied in response to Dail questions, Brendan Corish TD estimated that there were a half-million men, women and children in this country living on or below the poverty line. These were the people who appeared in statistics. Many of the Irish poor do not appear simply because our present social welfare system chooses to ignore them. A good example is the case of unmarried mothers and their children.

1.7. The inability of the present system to deal with poverty is acknowledged by the very existence of the Home Assistance grants scheme operated through the local authorities. Based on the discretion of the local authority, with no statutorily defined criteria, save that it is only used to rescue known destitute, the scheme represents the very worst type of welfare programme.

1.8. Labour's aim is to set down for the first time a comprehensive social policy based on a coherent political ideology which recognises the inherent dignity of each individual and the responsibility of society to preserve it.

SECTION TWO : RECOMMENDATIONS

2.1. Social Welfare must be based on a coherent political ideology which recognises the inherent dignity of each individual and the responsibility of society to preserve it.

2.2. The objective of this social welfare policy is to secure for each person a basic standard of living in terms of income and services, thereby eliminating poverty from society.

2.3. A Department of Social Development responsible for the co-ordination of all the social services will compute the basic standard in terms of income.

2.4. A Social Fund will be established which will incorporate all the functions currently carried out by the various pension schemes, and illness, redundancy and unemployment benefits.

2.5. Contributions will be obligatory on all earning members of the community based on a percentage of income with diminishing contributions as income falls. At similar income levels individuals will make the same contribution irrespective of the sector in which they are employed.

2.6. Contributors and their widows will be entitled to an income related to previous earnings from the fund in all circumstances where they have ceased to earn through illness, incapacity, unemployment or old age. All others who are unable to earn a living will be covered, by general taxation. Incomes will be related to the cost of living and wage movements.

2.7. The Social Fund will operate as a State Corporation, will administer the services, invest the funds, engage in social and economic research and advise the department of Social Development on modifications or the establishment of new services.

2.8. Retirement pensions will be a percentage of average income over the years immediately prior to retirement and will be between a half and three quarters of the average earnings. The full benefit will only accrue to those who have contributed for a standard working life and will be scaled down proportionately for all others. Facilities will be provided for retiring during a retirement period and for contributing at a higher level than the standard rate in order to receive a correspondingly higher pension.

2.9. Widows pensions will be related to their husbands' salaries, the age of the recipient, the number and age of the children and the period of the husband's contribution. The pension will be taken into account in determining the taxable income of working widows.

2.10. The unemployed will receive an income related to their immediately previous level of earnings and family commitments, the aim being to maintain the welfare of the individual and his family at their general level.

2.11. Those who become incapacitated during their working lives will receive a pension from the Fund.

2.12. In the event of illness an income will be paid after the first three days related to the full average income. The employer will pay for the first three days.

2.13. Children's Allowances will be paid from general taxation and will take into account the age of the child and the family size. The allowances will be regarded as taxable income for the parents.

2.14. The mentally and physically incapacitated, who have never worked, will receive an income, payable to the parents during childhood and to themselves as adults. In addition a wide range of medical and social services will be available to them.

2.15. Maternity incomes will be paid up to three months after the birth.

2.16. Abandoned wives and Unmarried Mothers will receive incomes.

2.17. The service will be administered on a community basis by a corps of trained social workers working from the Health Centres, in conjunction with the medical services.

2.18. A Social Information Bureau will be established in each centre.

SECTION THREE : BASIC STANDARD OF LIVING

3.1. The objective of Labour's social welfare policy is to secure for each person a basic standard of living in terms of income and services. The factors to be taken into account in computing the basic living standard will include food, accommodation, heat, light, clothing, transport and recreation. These will be translated into money incomes for adults, allowances for children and specialist services where necessary.

3.2. The computation of the basic standard in terms of income will be the responsibility of a Department of Social Development which will co-ordinate the activities of the various social services, such as health, education, housing and social welfare.

3.3. The resources of society must be devoted to the elimination and prevention of poverty. In our current private enterprise dominated economy, poverty, suffering and degradation are accepted as inevitable and exist side by side with wealth and affluence. Many live below the standards acceptable for a decent and dignified living. By computing and maintaining a basic standard of living below which no person will be permitted to fall, Labour will ensure that poverty is finally banished from our society.

SECTION FOUR : THE SOCIAL FUND

4.1. The creation of a Social Fund is central to Labour's Social Welfare policy. The fund will incorporate all the functions currently carried out by the contributory and non-contributory public and private pension systems, unemployment, redundancy, illness and disablement benefits and widows' pensions.

4.2. Contributions to the Fund will be obligatory for all earning members of the community and will include all those engaged in industry and commerce, in farming, in self employment and in public administration. Contributions will be based on a percentage of earnings which will increase with the level of income. Public and private concerns will contribute proportionately.

4.3. At similar income levels individuals will make the same contribution, irrespective of the sector in which they are employed.

4.4. In accordance with the philosophy outlined in the introduction the Social Fund will in effect redistribute income within the community by operating a system of diminishing contribution rates as income falls.

4.5. Contributors and their widows will be entitled to an income from the Fund in all circumstances where they have ceased to earn through illness, incapacity, unemployment or old age. All others who are unable to earn a living, such as those physically or mentally disabled, unmarried mothers and children at school, will be covered by general taxation.

4.6. The income received from the Social Fund will be related to the income earned in employment but in no case will it fall below that necessary to maintain the basic living standard.

4.7. All incomes from the Social Fund will be related to the cost of living and to wage movements in the community and will be adjusted accordingly.

4.8. The Social Fund will operate as a State Corporation and will be responsible for establishing the contribution rates on an actuarial basis, administration of the services and investment of the funds, paticularly the pension sector. In itself it will become a very important investment agency with a significant role to play in the determination of social and economic development. For example, its funds could be invested in housing and industry and, in this respect, it will co-operate with the Department of Economic Development.

4.9. It will furthermore involve in sociological and economic research so as to keep itself up to date in answering and anticipating the social and economic needs of the community. In the light of this research it will make recommendations to the Department of Social Development for the modification of existing services and the provision of new ones.

SECTION FIVE : SOCIAL FUND INCOMES

5.1. **Pensions :**

5.1.1. The Social Fund will absorb the present privately run superannuation schemes since it will enact all pension requirements in the community. Retirement pensions will be operative at any time within a retirement period which will permit flexibility in the retirement age.

5.1.2. The pension level will be a percentage of the average income over the period of years immediately prior to retirement. The objective will be to provide pensions within the range of a half to three quarters of this average income. In no case, however, will a pension be allowed to drop below the level necessary to maintain the basic living standard.

5.1.3. Any individual may opt to contribute above the standard rates laid down for his income in order to increase the level of his pension.

5.1.4. The full pension benefit will only accrue to those who have contributed over a standard working life, which could be in the region of thirty years. A person making contributions over a shorter working life will receive a proportionately scaled down portion of the full pension.

5.1.5. Widows' pensions will be related to the last full year of the husband's salary. The rate of pension will vary, depending upon the family circumstances of the widow, the number and age of the children and the period for which the husband was contributing to the fund. The Social Fund will also provide facilities for individuals to secure additional income for their dependents in the event of death.

5.1.6. The pension will be taken into account in determining the taxable earnings of working widows, who will, of course be contributors to the fund in their own right.

5.2. **Unemployment :**

5.2.1. There is no logical reason for the present three tier unemployment benefit system, i.e.

a Unemployment Benefit based on the social insurance system which terminates after the 'stamp' level has been exhausted.

b Unemployment Assistance which, in general, is given when unemployment benefit has been exhausted.

c Redundancy Payments which are made for the special case of unemployed because of economic or technological developments.

5.2.2. The unemployed will receive an income related to their immediately previous level of earnings and family commitments. The aim will be to maintain the unemployed and their families at their general level of welfare while other agencies within the social services operate, such as the retraining and redeployment services.

5.2.3. The unemployed include :

a those changing jobs

b those who are retraining

c the unemployable who have contributed

d the unemployable who have not contributed to the Fund, and

e those seeking their first job

The latter two categories will be provided for out of general taxation and will receive the necessary income to maintain the basic living standard. The unemployable include the physically and mentally handicapped from birth and these will be also eligible for specialist services appropriate in their condition. Those who have become incapacitated during their working life will in effect receive a pension taking into account previous income level, length of contribution period and family commitments.

5.3. **Illness :**

5.3.1. To complement the comprehensive health service it will be necessary to ensure that there is a system for maintaining the standard of living of the sick person and family concerned.

5.3.2. The aim of this system will be to provide for the payment of the full average income of the sick person after the first three days of sickness. The employer would be required to meet the income for those three days subject to reasonable safeguards.

5.3.3. These illness benefits will be provided for such time as it is apparant that the inability to work is temporary. In the event of the illness leading to permanent incapacity a pension will be paid as described in paragraph 5.2.3.

SECTION SIX : INCOMES FROM GENERAL TAXATION

6.1. **Children's Allowances:**

6.1.1. The main purpose of children's allowances will be to provide community support for the general level of family welfare. The level of the allowances will be such as to ensure that children can have equality of opportunity by providing a family environment conductive to their personal development.

6.1.2. The rate of the allowances for any particular child will take into account its age and the family size.

6.1.3. All Children's Allowances will be regarded as taxable income for the parents.

6.1.4. The allowance scheme will be designed to focus support where it is most urgently needed. Particular cases in point are the children of large low income families, fatherless children arising from the death or desertion of the father, the children of unmarried mothers, children of the unemployed or the incapacitated.

6.2. **The Incapacitated:**

6.2.1. Those whose mental or physical incapacity has prevented them from working will receive an income payable to the parents during childhood and personally during their adult life.

6.2.2. In addition a wide range of social and medical services will be available to deal with individual requirements and this is dealt with in the Party's Health Policy.

6.3. **Maternity:**

6.3.1. An income will be granted during the period of pregnancy to allow for extra dietetic requirements and during the post-natal period up to three months.

6.4. **Marriage:**

6.4.1. A cash grant will be payable to each married couple as an aid in meeting the heavy costs involved in setting up a home.

6.5. **Unmarried Mothers:**

6.5.1. The unmarried mother is often subject to severe emotional stress, possible strains and is unable to work in the immediate ante and post-natal periods. In addition to the medical services which will be available, an income will be provided to meet the financial demands of the mother and the child. Children's Allowances will be made as described in Section 6.1.

6.6. **Abandoned Wives:**

6.6.1. The abandonment of a wife often leaves a family in near destitution, particularly if the mother is unable to work, if the family is large or if the children are very young. The concept of family welfare and the policy aim of maintaining a basic living standard for all will ensure a family income for abandoned wives.

SECTION SEVEN : ADMINISTRATION

7.1. The best social welfare policy on paper can turn out to be the worst if its administration is bureaucratic, its personnel untrained and its attitude generally indifferent to human problems.

7.2. The service must serve the needs of people and not the other way around. A person or family confronted with a problem of illness, unemployment or death or such other, need not alone an adequate income but support and advice to assist them to overcome the problem and to adjust to the new situation. For this reason a corps of trained social workers is central to the success of this policy.

7.3. As outlined in the Health Policy, the health services will be designed on a community basis with the medical personnel operating out of health centres. The social workers will work from the Health Centres in co-operation with the medical teams, where necessary. A Social Information Bureau will be set up in each Health Centre, providing community information on the medical and social services available.

7.4. This community approach will minimise as far as possible centralisation of control over social workers while, at the same time, it will keep them constantly aware of the community's needs. Encouragment must be given to the workers to use their imagination and initiative in dealing with each individual case. Flexibility and adaptability are the prerequistes of good social work and not rigidity of procedure and manner.

7.5. The community organisations involved in the social welfare field will be encouraged and assisted in their work. The community basis of the service will make liaison and co-operation easy.

SECTION EIGHT : TRANSITION PHASE

8.1. The transition from the current system of social welfare to the system here proposed will require a period of between six to ten years. Special arrangements will have to be made for those who would be nearing their retirement period on the introduction of Labour's policy. Members of existing contributory or non-contributory pension schemes will be given the choice of staying with these schemes and of enjoying the rights to which they will be entitled or of joining the Social Fund.

8.2. The present recipients of Social Welfare payments must receive substantial increases. Although this expenditure will not be drawn from the new Fund, as they will not have been contributors, the present rates are disgracefully below the levels which justice would dictate. It will be necessary to devise a six to ten year plan to raise their benefits progressively in substantial amounts.

8.3. The financing of these increases will come from general taxation. The burden will be a diminishing one in terms of current expenditure as the population group involved will decrease over the years.

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