THE ECONOMIC AND SOCIAL RESEARCH INSTITUTE

Memorandum Series No. 125

State Aid to the Handicapped 1960-1977

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State Aid to the Handicapped 1960-1977

At the outset, might I express my appreciation of the kindness of the Union of Voluntary Organisations for the handicapped in asking me to open their 1977 session with a review of the evolution of state aid to the handicapped. The task of putting together the material opened for me new vistas of the extent of the dedication of you and others of my fellow citizens which were truly inspiring. In my heedless way I had given so little thought to the plight of the handicapped that this paper would not have been possible without the unstinting help of many people, both in state and voluntary organisations. Even so I realised I could not do it justice in the time at my disposal. This paper, therefore, contains some first impressions of State involvement from one whose main work has been hitherto in the area of regional development.

In this paper I look first at the broad trends in government expenditure since 1960. Then I consider some measures of performance in particular areas and finally I outline some policy options for the future in relation to available governmental resources.

THE TREND OF EXPENDITURE SINCE 1960

The Council of Europe report on social rehabilitation in 1972 recommended that as far as possible the handicapped should not be segregated from the rest of the community. One might, laughingly, say that nowhere has this precept been so admirably applied in Ireland as in the compilation of statistics. For example, the provision of free transport for school children has introduced a new dimension into the provision of schooling for many children suffering from physical handicaps. The total sum expended on these children cannot be readily disentangled

from that for other children though perhaps some estimates could be made, given more time. Similar considerations apply to many other items of expenditure, such as teachers' salaries. For this reason the data could not always be disentangled in time for this initial report. Instead some surrogates have had to be adopted in these cases.

In discussing government expenditure for the handicapped it is useful to consider first transfer payments made by the public authorities and then examine the direct provision of goods and services by these agencies. In total the former accounted for about 30% of all government expenditure in recent years and the latter about 50%. Transfer payments are moneys paid by the public authorities which were not on a quid pro quo basis. Some categories of transfer payments are paid exclusively to the handicapped or their providers. These would include disablement benefits and constant care allowances for handicapped children. Other transfers are made to a category of people, some of whom may be handicapped . School bussing mentioned already is one example, another would be unemployment benefits.

Table A1 in the Appendix sets out some of the transfer payments likely to include payments to the handicapped. Where it has not proved possible to disentangle the handicapped from the non-handicapped beneficiaries we will assume in our discussion of the trend over the years that the share of each of these items going to the handicapped has remained constant as well as the number of handicapped involved.

In making a comparison of payments over time two yardsticks can be applied. Has the level of payments kept up with inflation?

This would be the minimum to be expected. Table A1 gives the consumer price index for each year since 1960 and shows that the 1977 level of prices was almost four times higher than that obtaining in 1960.

A stronger measure would be whether the payments not only kept up with inflation but also enabled the recipients to share in the rising standard of living enjoyed by the nation as a whole. Table A1 also provides figures on the growth of GNP in real terms over the period. Living standards in 1977 were over 80% higher compared with 1960. Put differently payments would have to rise by fourfold to keep up with inflation but sevenfold if in addition they kept with general living standards.

Let us now see how the various payments measure up to these criteria. First, we shall examine those transfer payments to which the recipient is entitled as a consequence of previous insurance contributions and then those paid without reference to previous insurance. Both are set out in Table A1.

Transfer payments to insured persons

Disability Benefit is payable where a person is unfit for work due to illness or disablement. It not clear how much of the expenditure goes to either category but obviously our concern here is with the disabled. Persons insured for 156 weeks can obtain benefit up to age 69. Otherwise only a year's benefit is payable. Expenditure under this scheme has risen almost twice as fast as real living standards - from £44 in 1960 to at least £57.5 millions this year.

This does not tell the whole story. Over the study period the range of benefits increased. The first innovation was the payment of compensation for occupational injuries since 1967. These were paid to those suffering from accidents or diseases associated with their

employment. They included injury benefits, disablement benefits, constant care allowances and medical care. Injury benefits were paid for the first 26 weeks of a disability after which disability or disablement benefit took over. Disablement benefit was also payable where the claimant was capable of work. Expenditure under these four headings has risen rapidly from £0.5 million initially to over £10 millions ten years later.

Three years later invalidity pensions were introduced for those with prolonged incapacity at the same rate of disability benefits. Over 65 years of age these beneficiaries may obtain a retirement benefit or an incapacitated persons old age contributory pension if over 69 years. All of these are more clearly focussed on incapacitated members of the insured work force and their dependents. The levels of expenditure for these new categories were £1.4 millions in the first year. Since then outlay has grown rapidly. It will be over £35 millions this year i.e. over 60% of the total payments under Disability Benefit. It may be that these new schemes have weeded out the long term handicapped from the general expenditure under Disability Benefits. I cannot say at present.

All those who benefit from these schemes have a righ to treatment benefits introduced in 1967 for dental optical and hearing aids and also to pay-related benefits introduced in 1975. In this they are treated exactly like many other categories of insured workers. It is not possible to say at present how much of the rapidly growing amounts under these subheads finds its way to handicapped persons. Compared with 1960 when the only scheme was the Disability Benefit costing £4.4 millions the progress made up to the present has been impressive. Total expenditure on all these schemes is shown in Table A1 to have reached £126 millions or 29 times the 1960 level.

In other words expenditure grew four times faster than the standard of living. This is not, of course to imply that the payments to individuals are high or even adequate at present. An adult with a dependent spouse and 3 children would get £32.16 a week currently in disability benefit which might be supplemented by disablement benefit irrespective of income from other sources. On its own it would not provide an adequate income for these five people.

Allowances to uninsured persons

Unfortunately many handicapped people have never had the opportunity of being in insured employment. For them different provisions obtain. These usually involve a means test so that the greater the income from other sources the smaller the assistance.

In 1960 an important allowances was that paid for the maintenance of persons suffering from infectious diseases though the payments were not as high as they had been in the fifties when tuberculosis and polio were the major targets of the Health Act of 1947. As you know better than I do, it was the prospects of rehabilitating those suffering from these infectious diseases that spurred on the voluntary organisations that are now acknowledged for the major contribution they have made to the development of rehabilitation consciousness in the community at large since that time. The Rehabilitation Institute began with a concern for those inflicted with tuberculosis while the Central Remedial Clinic and such bodies as the Cork Polio and General Aftercare Association began their activities on behalf of the victims of poliomyelitis. By 1960 these infectious diseases were on the wane. The rehabilitation work started in connection with them resulted in the Department of Health setting up the National Organisation for Rehabilitation in 1957, which was the forerunner of the present National

Rehabilitation Board set up ten years later. The victory over TB led to a major medical advance when the Sisters of Mercy converted their tuberculosis hospital, with the help of the Department of Health, to make it the National Medical Rehabilitation Centre.

The declining importance of maintenance allowance to persons suffering from infectious disease is reflect in the fact that payments in 1974 were the same as in 1960 in spite of the falling value of money and rising affluence and 1974 was a considerable improvement on many intervening years. Budgeted expenditure this year is in excess of £0.4 million.

A more substantial item of expenditure in 1960 was that for allowances for the maintenance of disabled persons which was paid to chronically disabled persons over 16 years of age who are not living in institutions. In 1960 expenditure was less than three quarters of a million pounds. By 1975 expenditure had reached £10.7 millions and budgeted expenditure for 1977 is £14 millions. This would mean a 19 fold increase of a growth about three times faster than the combined effects of rising affluence and falling money values. Part of this change may reflect greater numbers living outside institutions.

I have included in the table payments for Home Assistance which could be added to the Disabled Persons Maintenance Allowances. This source of assistance has been revamped and is now called supplementary welfare allowances.

I might have included old age and blind non-contributory pensions in the table because these include blind people and other incapacitated persons. The total expenditure in 1960 was £11 millions compared with almost £60 millions in 1975. As such payments have more than kept pace not only with money values but also rising standards of living.

This does not imply of course that they were adequate but merely that the position of these categories was no worse relative to the rest of the community in 1975 and in 1960 as far as payments were concerned assuming the numbers of recipients were the same in both years. These groups were better off to the extent that they availed of the free travel, free electricity and free television licences introduced in 1968. The Budgetted expenditure on these pensions is estimated at £73.6 millions this year while the free services are reckoned to be worth a further £10.5 millions.

The progress in provisions for insured persons therefore has been more marked than that for uninsured people. To the extent that the majority of the handicapped were not employed this would mean that the redistribution effects of government expenditure have benefitted them to a lesser extent than the better off workers whose income and employment record have been more favourable. Nonetheless in some provisions considerable progress has been made. It would be useful if the handicapped and blind could be distinguished from the old in making an assessment of this progress.

A recent innovation in expenditure that can be unequivocally be allocated to the handicapped is the provision for constant care allowances for handicapped children between the ages of 2 and 16 years of age. The initial payments in 1974 were £784,000 and expected to be over 70% higher this year.

Table A1 also includes an item for payments under Section 65 of the Health Act 1953. This section permits health authorities some discretion in making payments and is frequently invoked for that reason. Part of the expenditure here relates to the training of handicapped. Of the £1.5 million spent in 1976 about a quarter was spent as follows.

Training grants	£117,000
Away from home allowances	£146,000
Workshop not entitled to disabled allowances capitalism grant	£ 91,000
Transport costs-commuter tickets	£ 16,000
Minibus costs	£ 17,000
	£387,000

At present I cannot report what fraction of the remainder was devoted to services for the handicapped or what the figures were for other years. Given the size of other expenditures these figures seem small to an uninitiated person like myself.

Table A1 also records the rise in expenditure on the free transport service for school children - from £2 million in 1968 to a budgetted £11.5 millions in 1976. Dublin school children do not normally benefit from this service. However handicapped children in the city and county do. I understand that the availability of this service has improved the lot of many of the physically and mentally handicapped children and enabled a switch to be made from residential care to the much more satisfactory arrangement of living at home. It would be valuable to document the impact of this service.

Free transport has not solved all problems. In many parts of the country the population as a whole is fairly sparse so that the incidence of handicap are very widely scattered. I was surprised to discover, for example that in the whole of Donegal there were only 3 profoundly deaf children. The parents of these children are anxious to have a local school rather than send them off to board for 5 days a week. In other counties the transporting of children to school could take more than the house each way

which educators regard as the upper limit. Some parents, however, still wish this maximum to be relaxed. An alternative to transporting small numbers of children is of course to pay a teacher to give them special assistance at home. This payment would not be deemed a transfer but rather as direct expenditure which I discuss in the next section. There have been difficulties in getting teachers with special qualifications for this task in some areas. Nevertheless the programme has been expanding and cost about £10,000 in the last year. The high marginal tax rates for existing teachers has been a problem in attracting qualified teachers where the amount of teaching would not warrant a special appointment.

Table A1 also gives some data on the growth in the provision of medicine to homes by pharmacists. In the four years since the scheme was introduced in 1972 payments quadrupled to over £16 millions. I do not have the most recent figures to hand. However, I am informed that included in this expenditure are outlays of £1.3 millions for drugs to sufferers with long term illnesses such as diabetics.

Provision of goods and services

Up to this the discussion has related to transfer payments in terms of actual allowances given to people or the imputed value of services such as transport. In 1975 about 30% of public expenditure took this form. In the same year almost 50% of public expenditure was incurred in the direct provision of goods and services such as primary education, health etc. It was not possible to segregate services to the handicapped from those to the rest of the community in the time at my disposal. However I have been provided with much interesting material on certain aspects of this expenditure which I believe provide a good indication of achievements in particular areas. Let me begin with education.

Education

Tables 2 gives the number of children in special classes for selected years since 1952 and also the teacher-pupil ratios for different types of handicap. Table 3 gives the number of remedial teachers in national schools since 1963. Both tables are self-explanatory. The numbers of children in special school has quadrupled since 1960. The biggest advances have been made in dealing with the moderately and mildly handicapped and the emotionally disturbed who were first catered for in that year. The advances in treating the mentally handicapped have been a consequence of the recommendations of the Governmental Commission on this matter in the mid sixties. A survey by Dr. Mulcahy of non-residential handicapped indicated that all but 175 were being catered for. Investigation of these cases indicated that the diagnosis by the district nurse was in many cases not sufficiently accurate and a reassessment has been undertaken by a specialist team. In general the level of care is believed to compare very favourably with the best international standards.

In recent times a start has been made with children suffering from multiple handicaps and from specific reading disabilities. The numbers of physically handicapped catered for in special schools has not grown. The 1976 figure was only three quarters of the 1960 level. This may reflect in part the emphasis on integrating the physically handicapped into the ordinary schools and also the growth in the number of home teaching schemes from 25 to 70 schemes in recent years. It will be noted that a new school run by the Spina Bifida Association has been launched in Tallaght.

In Table 2 some figures on teacher pupil ratios are provided. National schools in general have an overall ratio of 32.7 to 1, which is higher in urban areas and lower in rural. The highest ratio for the handi-

TABLE 2

No. of Children in Special Schools

Category of School and Pupil Teacher Ratio	1952	1956	1960	1964	1968	1970	1974	1976
Blind and Partially-Sighted 1:15 approx.	53	63	103	147	158	157	150	145
Deaf and Hard of Hearing 8 : 1 6 : 1 (profoundly Deaf)	155	379	422	485	613	694	740	774
Physically Handicapped (varies according to type of handicap)	513	807	985	865	830	737	700	744
Mildly Mentally Handicapped 1 : 16 (Schools and classes)	–	198	583	882	1550	2216	3700	4579
Moderately Mentally Handicapped 1 : 14	–	34	45	316	1260	1466	1750	1950
Specific Reading Disability	–	–	–	–	–	–	–	23
Emotionally Disturbed 1 : 12 (Severely Disturbed) 1 : 8	–	–	32	73	157	204	300	325
Multiply-handicapped	–	–	–	–	–	–	–	12
Total	721	1481	2170	2768	4568	5474	7340	8552

TABLE 3

This is a very approximate/estimated table of the numbers of full-time remedial teachers serving in National Schools at the end of each school year.

Year	Teachers	
1963/64	1	
1964/65	1	
1965/66	5	
1966/67	15	
1967/68	29	
1968/69	41	
1969/70	69	
1970/71	117	
1971/72	120	
1972/73	160	
1973/74	230	
1974/75	330	No new remedial teachers appointed as pupil/teacher ratio reduced considerably in ordinary classes.
1975/76	330	

Note: Until 1970 a national enrolment of 12 units was deducted for the remedial teacher when the staffing of the rest of the school was being calculated on the averages. As from 1970 there is no deduction.

capped is 16:1 so that per pupil State expenditure is at least twice that spent on other children and, in some cases, five times as great. It is not possible to provide a detailed account of all developments in special education. Instead I have appended a summary by the Department of some recent advances in this field which provides a wealth of information. One or two points worth noting here: To help overcome the difficulties of very small schools a minimum capitation grant of £250 per school per annum has been introduced from July 1976. Furthermore the allocation towards the provision of special course for teachers, about half of which relates to courses in special education was increased from £45,000 in 1976 to £80,000 in 1977. Expenditure on equipment for special education was budgetted to rise from £54,800 to £75,000 in the same period.

Frequently people active in promoting special education are interested in progress in other countries. The EEC commissioned the chief inspector of the Danish special education, Kurt Jorgensen, to report on the position in the schools of the European Community. His investigations are completed and it is expected that his findings will provide useful comparative material when they appear, hopefully next Spring.

Health

The Department of Health provides the main coordination within the Public Services of work for the handicapped. Like the expenditure of Department of Education the voted funds of the Department do not always reflect the volume of money being channelled towards the handicapped. Rather quickly I extracted some subheads from the Health Vote to give a broad impression of the orders of magnitude involved in Hospital expenditures. These figures are in Table 4 somewhat misleading for a number of reasons. They do not always contain supplementary estimates nor do they

TABLE 4

Voted Funds for Hospitals by Type of Hospital (£'000)

Financial Year	General	Voluntary Hospitals Deficit*	Tuberculosis	Psychiatric	Central Mental	Chronically sick and me tally handi- capped etc.
1962/3	6770		1100	4550	60	2020
1963/4	7120		980	4720	61	2240
1964/5	8950		870	5220	63	2470
1965/6	10770		870	6390	81	2800
1966/7	11350		925	6535	83	3170
1967/8	13120		970	7820	88	4000
1968/9	15065	1080	1014	8442	96	4320
1960/70	18310	2750	1060	9670	110	5200
1970/1	20340	3200	1120	11340	153	6030
1971/2	25400	9400	1140	13920	157	7340
1972/3	34230	9400	1340	16630		10310
1973/4	42200	12635	1530	21000		13000
1974 (9mths)	49274		1235	17620		12375
1975	85830		1895	28697		21805
1976	114920		2385	36350		28280

* Grant-in-Aid + Hospitals and homes catering for the chronically sick mentally handicapped etc.

New Categories of Expenditure 1977 (£'000s)

Health Boards		Voluntary Bodies	
General Hospitals	54,880	Hospitals	67,955
Psychiatric incl. mental handicap	49,250	Homes for mental handicap	11,210
Long stay hospital	18,350		79,165
Welfare homes	1,280		
Extern hospitals and homes	5,030		
	110,440		

Additional Data for Recent Years

Payments to Health Bodies other than Health Boards, i.e. Voluntary Hospitals and homes for the mentally handicapped, etc. and in recoupment of expenses of General Medical Services.

Year	£'000
1973/4	44,131
1974 (9 mths)	40,050
1975	80,693
1976	93,477

record the payments from the Hospitals Trust Fund which made good the deficits of the voluntary hospitals in the period prior to 1974.* They are budgetted amounts not actual expenditures.

Even with all these misgivings about the data it is clear that hospital services have expanded enormously since 1962. The accounts for 1977 are on a different basis but broadly speaking £190 millions is to be provided in Voted Funds this year compared with less than £15 millions in fifteen years ago. In 1968 the Hospitals Trust Fund had to be supplemented for current expenditure. In 1974 the grant-in-aid approach was abandoned in favour of a more direct method of payment.

Mental Handicap

In the nineteenth century mentally handicapped were often lodged in county homes or lunatic asylums, as were many geriatric cases. This legacy has persisted and may account for Ireland reputedly having the highest incidence of hospitalised mental illness in the world. It has been Department of Health policy to rectify this situation. The measure of their success is set out on Table 5 which show the rise in the number of places for mentally handicapped in special residential centres (all run by voluntary groups). From the level of 2,626 in 1961 there has been a steady rise to over 5 thousand in 1976. It is reckoned that about 3,000 more are still in geriatric and psychiatric hospitals. The increase in the numbers of those participating in various schemes run by voluntary bodies on a day basis has been much more dramatic: a tenfold rise from 600 in 1965. With these advances have gone a rapid rise in running costs from £2.6 million in the financial year 1971/2 to an estimated £21 millions this year.

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* Supplementary funds to the Hospitals Trust Fund are given however.

TABLE 5

Some data on voluntary bodies catering for the mentally handicapped.

Year	Places in Special Residential Centres	Running Costs £'000	Numbers attending school special classes, care units and workshops on a day basi
1960/1	2734		
1961/2	2626		
1862/3	2745		
1963/4	2925		n.a.
1964/5	3111		632
1965/6	3414		600
1966/7	3628		1030
1967/8	3760		1430
1968/9	3981		1861
1969/70	4050		2418
1970/1	4195	n.a.	3000
1971/2	4295	2623	3008
1972/3	4367	3367	3904
1973/4	4548	4516	4439
1974	4698	5950 (9 mths)	4796
1975	5000	14000	5299
1976	5000+	18000	5888
1977		21000	

Building Programme for day and residential centres

1950/60	£1,484,373
1960/70	£1,715,178
1970/75	£6,601,586

Rehabilitation

At the outset I outlined the transfers that are paid to handicapped people. In the last two decades the international climate of opinion has moved away from relying exclusively on a system of outright grants on the grounds that these do not permit the handicapped person to become completely integrated into society. It is now recognised that it is as important for the handicapped to have a feeling of personal dignity and selfworth as it is for any one else. Inactivity is as fatal for his or her physical and mental wellbeing. As society is organised at present, starting work or resuming work gives the best hope of integration by providing a purpose to life that was not there before that was lost.

The handicapped need to be brought out of the isolation that has been too frequently their lot. The task of integration requires that prejudice be combatted, that the community be alerted to their special needs and that the handicapped be made as independent as is practical.

This concept of rehabilitation is a fairly recent one. Internationally the progress of rehabilitation can be seen both from the number of beneficiaries and from the objectives set and the means of achieving them. An EEC study commented on this growth and claimed that a number of factors were inhibiting its development along modern lines. These were the dispersion of initiatives, the legacy of traditions of charitable work, the complexity of legislation which had developed on a piecemeal basis and the multiplicity of instances and institutions competent to intervene. An older Council of Europe study on the other hand noted that historic and political factors had led to the State assuming the major initiative in countries such as the Netherlands, Germany, Austria and the UK and the exclusive role in Scandinavia while France, Belgium and Italy favoured a marriage of the State and the voluntary organisations, which

enabled the community to benefit from the deciation initiative and flexibility of the latter and the overall coordination and organisation of the former. The existence of active voluntary bodies, it warned, should not be used to provide a pretext for the State to opt out. At the very least the State should lay down the principles and rules of rehabilitation, supervise and control as well as finance realistically recognised bodies within an overall plan of rehabilitation. Any gaps in the system were to be provided by the State.

The modern concept of rehabilitation evolved as a result of advances in techniques of care and vocational rehabilitation and as a result of the change in the climate of opinion concerning the disabled and of the place in society to which they are entitled. From a concept of assistance based on charity thinking has moved to that of insurance based on collective solidarity and mutual support. The idea has evolved "social risks" against which all must be compulsorily covered by collective responsibility guaranteeing repayment of medical costs and providing financial benefits as substitute incomes. Solidarity requires that the disinherited elements in the population should not be merely given a minimum to enable them to stay alive but all the population without distinction should have - the

- the greater measure of security for the future
- obtain a fair distribution of incomes

and achieve equality of opportunities in life that is as real as possible.

In the case of the disabled the emphasis has shifted toward social integration by means of medical and vocational rehabilitation. Two motives inspire this trend:

1. The disabled have a right to work and a policy of full employment should assist them to get it.

2. Others hold that the disabled must become productive and cease to be recipients of assistance. In this way the need for paying benefits is minimised and wealth is created. To achieve this status for the handicapped prejudiced opinions about their capabilities must be countered by demonstrations of their potential to share in national building and also by ensuring that architectural, bureaucratic and other barriers to the fulfilling their role be eliminated.

A measure of the success of Irish attempts at this type of rehabilitation would be to relate it to the many international standards published in this regard. The outline of a full programme of rehabilitation published by the World Health Organisation might be particularly apt. I have not had an opportunity to do so. However speaking as an ordinary citizen I would feel that the State role in combatting prejudice has not been too noticeable. Apart from a leaflet yesterday morning on the subject from the Irish Epilepsy Council I am not aware of much propaganda in this regard. The scope for employing handicapped people at my place of work has as far as I know not been publicised. The traditional role of blind telephonists seems to have been written off with the introduction of PABX systems and the many other opportunities neglected. This is surely an area where greater publicity would pay dividends.

In many countries a quota of new jobs created are reserved for special categories. Foley and Kennedy report that in France 3 per cent of jobs are reserved for various deprived categories by a low of 1964, later increased to 10 per cent but priority goes to workers with large families. In Germany 6 per cent of the jobs are in sheltered workshops for hard to employ categories. In Italy 15 per cent are reserved for war invalids,

refugees from former Italian colonies and the handicapped. The excellent record of the Netherlands is well known. Sheltered workshops and wage subsidies are used to provide employment for hard to place labour. In many countries the fact that handicap often arose through heroism in war-time has disposed the public to be more active in helping these unfortunate people. Up to how I have not come across any targets for employment in the Irish context. Clearly the size of the problem with the able bodies has weakened the sense of urgency in providing for the handicapped.

Access

Architecturally some progress has been made in catering for the special needs of certain types of handicapped in the new draft Building regulations which will apply not only to State buildings but to all places to which the public have access. These regulations cover the approaches, the access and the internal circulation. Regulations need to be implemented. As you are aware the Irish Wheelchair Association and the National Rehabilitation Board has began monitoring the situation in this regard.

Housing and Cars

Mrs Molloy, the wife of the former Minister for Local Government was committed to the cause of the handicapped and through her husband was influential in forming attitudes within that Department. I had hoped to obtain some idea of Departmental expenditure on the modification of buildings as well as the tax concessions and grants to disabled motorists. It would appear that housing many of the handicapped especially in the Dublin area is a cause for concern not least for the prejudice attempts as housing often uncover. I do not have at present any idea of the progress made in

the last two decades in providing suitable accommodation for the handicapped.

Training

As far as employment and training is concerned the National Rehabilitation Board estimates that at present there are approximately 2,600 places in industrial therapy units attached to psychiatric hospitals, about 1,500 places in centres for the mentally handicapped and a further 1,000 places in general workshops. This is about one third of the number of adults which the Robin's report estimated might benefit from preparation and training for work. Much of this development has occurred in recent years but clearly there is a long way to go yet.

The European Social Fund has been a major innovation on the scene since Ireland's accession to the EEC in 1973. The basic philosophy of the Common Market is market oriented and inclined to favour training and infra-structural developments in preference to industrial subsidies and other forms of employment promotion. As a result very considerable finances have flowed into AnCO, the national training authority. In 1975 the Authority trained 141 handicapped people on an integrated basis with the able bodied. These people had been rigorous screened by the National Rehabilitation Board as being suitable for open employment. AnCO spent 12.7 millions in 1976 on the training of 13,000 people* - almost £1,000 per trainee. Of this £5.85 millions was received from the European Social Fund. The European Social Fund does not favour the use of its funds for the training of the handicapped unless it can be shown that this is an economic proposition. The criterion they apply is whether the trainee has been placed in employment or not. This criterion is not applied to AnCO trainee - 81% of whom are placed within 6 months.

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* Including short courses for school leavers.

Bodies directly associated with training the handicapped received in 1973 £184,000 from EEC, in 1974 £396,000, and expect to get £495,000 for 1975. Applications for 1976, 1977 and 1978 are £1.7, £3.5 and £4.4 millions respectively. If the criterion of placement is rigorously defined and adhered to it is very unlikely that a large fraction of these applications will be successful. There is also the danger that the form of finance could distort the services provided by voluntary bodies for handicapped. The existence of these ESF moneys might enable the Irish government to refocus its own supports in a manner that complements the European sources of finances in an integrated way.

Criteria for measuring achievement

(a) How many handicapped?

This rather sketchy review leads us to ask the question whether the Irish situation is developing satisfactorily. No one would suggest that the ideal has been reached at present. One way to answer this question would be to relate it to the members of handicapped and their requirements. Here we find that an accurate assessment of the total situation is not available at present. Some estimates of the position have been prepared by the Robins report. Censes have been undertaken of some groups, such as that by Dr. Mulcahy on mental handicap, and the work of the National Association for the Deaf. I was struck in the latter case by the need for trained detectives. A survey of Kildare schools in 19 produced 120 reported cases of children with deaf symptoms in 28 of the 93 schools in the county. A call to these schools led to 340 being referred to further examination. This led to an investigation of the schools which had not reported any deaf children with the result that 1145 children or ten times the original number were finally referred for examination. I am not clear

how these children slipped through the school medical checkups.

The picture on handicaps will be very much improved next year when the National Rehabilitiation Board undertake a nationwide survey in conjunction with the Assistant Directors for Community Care in the Health Board areas.

(b) What does the individual receive?

Another way to evaluate the situation is to study the actual benefits and allowances paid to handicapped persons. The 1976 levels of some of these are tabulated in Table 6. Blind pensions for single uninsured persons were a maximum of £10.20 a week in line with the levels of non-contributory old age pensions. It is appropriate to assume that the handicapped person is single and uninsured, as Pauline Faughran's survey showed that 60% of the wheelchair bound were single and the same proportion without any work at all. A recent study by the National Prices Commission revealed that the diets of 73% of the old age pensioners they surveyed were unadequate in nutrition. Had they a knowledge of food values (in terms of price and nutrition) and had they been able and willing to shop around they could have obtained adequate diets for somewhat less outlay. However if they could have afforded a greater expenditure perhaps a lack of nutritional knowledge would have been less serious. It is likely that many of the handicapped suffer from the same problems and many, like the old, may therefore be seriously underfed. Certainly the levels of deprivation in housing, income employment and social life reported in the Irish Wheelchair survey make for very sobering reading.

Table 6: Details of some weekly payments to the handicapped and their dependents as in October 1977.
(Note: Average Weekly Male Industrial Wage = £ 80 approximately)

Scheme	Code	Age Limit Lower	Age Limit Upper	Personal Rate	Dependent Adult	Children (each) First 2	Children (each) Others	Means Test	Possible Supplements (see code at base of Table	On expiry payments made under other scheme (see code at side)
Insured Persons:		yrs		£	£	£	£			
Disability Benefit										
Under 18	AA	-	18	11.35	-	-	-	No	PQ	AB or BA
Over 18 (156 stamps)	AB	18	69	13.05	8.50	3.75	3.10	"	PQ	BA
" " (less than ")	AC	18		"	"	"	"	"	P	H
Invalidity Pension	BA	-	65	"	"	"	"	"	PQ	CB
	BB	-	66	"	"	"	"	"	PQ	D
Retirement Benefit	CA	80	-	15.50	9.30 (under 66)	-	-	"	RSTWX	-
	CB	65	80	14.60	11.00 (Over ")	-	-	"	RSTWX	CA
Old age contributory	D	66	-	"	"	-	-	"	RSTWX	-
Occupational Injuries										
Injury Benefit (for 26 weeks)	EA	-	18	Max: 14.30		"	"	"	UV	AA + EC/ED
" " "	EB	18		" 18.30	8.50	"	"	"	UV	AB + EC/ED
Disablement Benefit (100%)	EC	18		" 18.30	"	"	"	"	UV	
" " (20%)	ED			3.66*					UV	
Non Insured Persons										
Blind	F	21	80	Max 12.35	6.15 Max	3.30	2.50	Yes	KST	GB
Old age (non-contributory)	GA	66	80						RSTW	GB
" " "	GB	80	-	" 13.30	"	"	"	"	RSTW	-
Health Board Payments										
Disabled Person's Maintenance	H	16		11.90	none	none		"	LX	-
Infectious Diseases "	J			12.00	9.90	3.30		"		-
Blind Welfare "	K	21		4.30	4.30	0.95	0.85	"		-
Supplementary Welfare Allowance	L			10.30	7.60	3.30	2.50	"	T	-
Training grants for handicapped	MA			4.08				No		
Lodging of trainees " "	MB			10.00				"		
An Co Allowances	NA	35	-	30.50	6.25	1.25	1.25	"		
	NB	21	35	27.25	"	"	"	"		

Other Codes:

P = Pay related benefits
Q = Treatment benefit (not for dependents)
R = £1 a week living alone allowance (over 66 yrs)
S = Free travel, electricity, T.V.
T = Cheap fuel
U = Medical Benefit
V = Constant Care Allowance £3.45 - 13.80 per week
W = Incapacitated person over 69 years £6.90 per week
X = Free drugs

*Under 20% disablement a gratuity of £1020 is paid

(c) What is the international situation?

A third measure of performance would be to relate Irish achievement with those in other countries. No separate information is available to me at present on the specific areas of supports for the handicapped in other countries. An indication of the situation is provided by Brendan Broderick of the Central Statistics Office who prepared a set of social accounts for Ireland together with comparative figures for other EEC countries at a meeting of the Statistical and Social Enquiry Society of Ireland in 1975. He stressed that differences in social structures etc. made it highly risky to make such international comparisons. This is something I wish to take up in a moment. In Table 7 I have given figures for social benefits as a percentage of GDP at market prices which show that the Irish level is the lowest proportion by far of all EEC countries. As these figures are given as a proportion they overcome the difficulty that the general per capita level of GDP in Ireland was 51.3% below the average level of the EEC as a whole in 1975. In addition the figures give specific benefits as a percentage of GDP and as a percentage of all benefits in 1972.

Future Prospects

If the situation in Ireland is unsatisfactory what can be done about it? The new government proposes to undertake a complete reorganisation of the mental health service as well as a comprehensive programme for the mentally handicapped. In addition it has a number of other proposals in the health field which has a clear bearing on the handicapped which, no doubt, Professor O'Donoghue will develop tomorrow night.

I would be glad to know what you think are the priorities. My initial impression is that education and medical services are

Table 7 Expenditure on Social Benefits in 1972

	As a % of GDP Invalidity physical and mental disability	Employment Injury occupational disease	All benefits	As a % of all social benefits Invalidity etc.	Employment Injury etc.
Ireland*	1.4	0.1	13.1	10.4	0.5
UK	1.1	0.2	16.1	7.0	1.2
Denmark	2.7	0.3	20.3	13.5	1.4
France	0.4	0.8	18.1	2.4	4.6
Germany	1.0	1.1	21.1	4.7	5.1
Italy	2.9	0.7	19.6	14.7	3.8
Netherlands	3.9	-	22.4	17.4	-
Belgium	1.1	1.0	18.7	6.2	5.2
Luxembourg	n.a.	1.2	18.5	n.a.	6.3

* Not strictly comparable since Irish figures on private payments by firms and private schemes to sick persons are not available. This would not affect many of the handicapped.

not the problem. It is more the setting up of some training centres, the need for more employment opportunities and: in the case of those less suited for employment more day care centres and better accommodation particularly after the death of the handicapped person's parents. Greater employment opportunities could help overcome to some extent the low levels of income. Better allowance would also seem to be required for those who cannot work. In any event more funds will be needed. How can these be obtained? Time does not permit to give more than a brief outline to this question.

Sources of increased expenditure for the handicapped

Earlier in the paper some indication was provided of the magnitude of state expenditure on particular services. In 1975 £222 million was spent on education and £214 millions on health. Levels in recent years have been higher still. If more income is to be provided for the handicapped this could come about in several ways.

1. Government revenues could grow as a consequence of higher incomes deriving from economic growth without additional government interventions.
2. Revenues could also grow by a budgetary decision to divert a greater share of the annual output of goods and services to public rather than private use by taxation and borrowing.
3. Revenues received could be reallocated to services for the handicapped from other uses even if total revenue did not grow.
4. The total devoted to the handicapped might not grow but schemes introduced to use the funds more effectively. All of these possibilities are interrelated and several of them could take place simultaneously. Here let us examine them *seriatim*.

Higher growth

More funds could be available if the revenue of the

State rose as a result of economic growth. The present government hopes to achieve a 20% growth over the next three years. If they succeed government revenue might absorb about 8% of this growth. This extra money is already committed due to the need for Ireland to reduce its borrowing requirements substantially, due to the demands on schooling being made by the rapid rise in the number of births in the recent past and perhaps also due to the increased cost of salaries in the public sector.

A large share of GNP for the public sector

Government revenue could also increase if tax rates increased or if the tax net was spread more widely. It has been asserted that the country is at the limits of taxation. This has not been demonstrated. Ireland has levels of taxation well up with other European countries but there are many with higher levels. Scandanavian countries tax more and provide more services. As a proportion of the wages earned the levels of social security contributions in Ireland are the lowest in Europe and about a sixth of the level of the highest country, Italy, where the firm pays all the contribution. For those who pay taxes the interval between the bottom and the top of the scale is shorter in Ireland than in most European countries but large sections of the community pay no taxes, such as exporting industrialists and farmers. Sources of tax, such as rates and car taxation, have been given up. Irish society could pay more taxes.

A larger share of a fixed budget

Assuming that revenues do not increase and no change in taxes is contemplated money for the handicapped can only be obtained by increasing the allocation to this programme from that devoted to other programmes. Before discussing this it should be noted that a simple way to divert funds towards the handicapped is to ensure that public support

as far as possible is under a convenant.

In the competition for limited public funds the voluntary agencies must become ever more politically vocal. Dr. Patey, the Dean of Liverpool, has been quoted by Frank Cluskey as saying "Christians have often been much more ready to involve themselves in personal social services than to engage in political work. But ultimately the decisions which have to be made ... have to be made at the political level". The voluntary organisations in this union have been active politically already since without this involvement little of the progress that I have reviewed tonight would have occurred. Effective political involvement will benefit from a critical appraisal of the costs and achievements of public programmes and by an understanding that targets can be achieved in a variety of ways some of which make little demand on the Exchequer.

To take some examples. It might be argued that the economic state of the country requires that all resources be funnelled into productive rather than social investment and that the highest GNP which results will be better able to pay for socially desirable projects. This is like saying that the claims of justice must be deferred until the triumph of materialism is insured. I said "justice" because, as the recent pastoral on the Work of Justice states emphatically: "Before giving "charity" or alms we must give to others what is due to them. Justice involves giving another what is rightly his own. We have to give back what is not ours before we can give away what is ours"

The structures of society may be unjust to take an example at random the NESC report on health claims that the State provides £28,000 to train a physician whose chances of migrating are 50:50. Why not provide the same to integrate a handicapped person? Why not give the third level student a loan and use the funds released to provide more adequately for those whose post-training income is less likely to provide a source of repay-

ments? Again wealthy house purchasers get as much as £1,200 per annum from the State to buy expensive houses. This is not politically visible, being disguised as mortgage interest allowances. Finola Kennedy's study of Public Social Expenditure in Ireland illustrates some of the ways that social expenditure winds up increasing the income of groups in society - mainly middleclass - whose priority claim on this funds is difficult to establish. For example demands that state schemes should be universalist rather than selective often mean that the small funds available are totally inadequate when spread over the larger population but would have been significant if focussed more narrowly on the target population. Finola Kennedy estimated that instead of giving £50 to each child £235 could have been given to each poor child - and obviously more to each poor family. This need not mean the stigma of a mean's test. It only requires the continuation of the clawback system. In 1975 childrens allowances were £45.4 millions - or 120 times the expenditure on training allowances to the handicapped. Where they as socially justified?

The Third Programme for Economic and Social Development has argued convincingly that there need not be a stark conflict between economic and social objectives. Kieran Kennedy has shown that for many handicapped people the provision of suitable employment is not only justified on humanitarian grounds it makes sound economic good sense. In cases where the issue is less clearcut the solidarity of the community requires that no category of people be marginalised on the fringe of society. It is imperative that society decide that, if necessary, some economic growth will be sacrificed to ensure that all members of society can enjoy a feeling of welf-worth. It would be possible to show in a roundabout way that this also can make sound business sense. *

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* To take an example at random it would be interesting to evaluate the social benefits from £6.6 millions given to Snia Viscosa in Sligo against similar expenditure on jobs for the handicapped.

Better value from existing expenditure

Assuming that no further funds are available then it is necessary to achieve the objectives at less cost. The Donnison report on Social Policy illustrates the great variety of ways that the housing needs of poor people and the income requirements of small farmers can be met. Each method involves different levels of administration and other demands on public funds and differs in the success with which it achieves its objective. Let us take a few examples:

The State might legislate that all enterprises over a given size must employ a minimum number of handicapped. This would cost the State little. It need not always involve extra cost for the employer either, since Dutch experience has shown that the productivity among some types of handicapped can be even higher than average. Clear demonstration of this truth would help dispel prejudice, or perhaps it is only thoughtlessness? As I mentioned earlier many countries insist that the handicapped be employed - perhaps because much of this disability was the result of individual heroism in defending the State during wartime. Foley and Kennedy report that the figures are 3% in France, 6% in Germany and 15% (including refugees) in Italy.

The State might provide tax reliefs or remove disincentives on firms. Up till now a handicapped worker earning £15 a week would cost his employer almost £20 in labour costs but only take home £11.50. Dr. Robins has commented on the disincentive this low wage would be to the worker. Equally important, if not more so, is its impact on the employer. The latter is well aware that social security taxation at present penalises the use of low paid labour. The regressive nature of the tax is only now being appreciated by administrators and politicians.

The State might provide subsidies. Clearly this would be pointless if its taxation methods negatived these incentives. Subsidies need not prove expensive in terms of State funds since they would remove the need to provide allowances to the unemployed, would increase national wealth and return to the State to some extent in direct and indirect taxation.

The State might only buy goods from firms that meet the target level of employment or give priority to their tenders.

The State might employ the handicapped itself.

The State might insist that firms receiving large State subventions employ a minimum number of handicapped.

The State might pursue policies that result in all children receiving a wide range of vocational and academic qualifications that reduces the need for retraining at a later stage.

This list could be continued. Enough has been said to indicate the wide variety of options open to the State.

An awareness of these issues and their fruitful examination should help the voluntary bodies in this Union to campaign for a better deployment of State aid for the handicapped. With the backing of these supports they can plan with the State the more effective integration of the handicapped into society which we all desire.

Time is running out. Let me conclude as I began by thanking the Union for inviting me to examine this socially vital area of State aid to the handicapped.

Table 1: Expenditure on certain transfer payments 1960-1977 (For some years budgetted rather than actual expenditure are provided in some cases. These are given in parentheses.)

£'000

Transfers	1960	1961	1962	1963	1964	1965	1966	1967	1968	1969	1970	1971	1972	1973	1974	1975	1976	1977
Benefits to Insured Persons																		
Disability Benefit	4,369	4,965	5,345	6,776	7,419	8,025	9,613	10,198	11,658	14,353	16,486	16,809	18,784	23,697	30,130	41,500	52,000	57,500+
Invalidity Pensions											1,058	4,168	3,775	3,679	4,506	6,800	8,300	10,400
Retirement Pensions											365	1,497	3,819	8,090	10,506	15,980	20,500	25,100
Treatment Benefit								624	590		927	1,148	1,343	1,433	1,805	2,500	3,100	3,990
Pay related Benefit																9,300	14,300	18,000
Occupational Injuries Benefit								541	852	1,051	1,353	1,714	2,123	2,807	3,352	4,500	8,514	11,074
Non insured persons																		
Rehabilitation and Maintenance of Disabled Persons	728	794	846	969	1,218	1,609	1,918	2,273	2,642	3,254	3,895	4,566	5,037	5,655	7,681	9,919	11,469	14,000
Maintenance allowance to persons suffering from infectious diseases	281	246	229	207	197	202	192	198	199	213	231	230	233	230	280	300		410
Home Assistance	591	559	585	605	673	762	850	990	1,060	1,217	1,367	1,416	1,628	1,927	2,236	2,600		
Free Travel, electricity, radio, T.V.								244	681	1,200	1,424	2,323	2,732	3,801	4,889	7,200	8,538	10,452
Blind welfare allowances			(21)	(23)	(23)	(29)	(29)	(30)	(31)	(33)	(36)	(36)	(36)					(340)
Domiciliary care for handicapped childre															784	1,116	1,168	(1,350)
Payments under Section 65 of the Health Act 1953											n.a.	408	364	477	1,064	1,500		
Payment of medical goods to households													4,025	8,318	10,030	16,100		
Transport services for school children									2,145	2,422	2,919	3,715	4,634	5,077	6,598	8,200	(11,439)	(11,150)
Consumer Price Index 1960 = 100	100	103	106.8	110.7	114.3	122.9	125.6	130.5	136.5	145.7	154.2	169.6	185.4	204.0	231.5	286.7	332.7	388.1
Growth in real GNP 1960 = 100	100	104.9	107.7	111.5	117.8	120.1	121.3	127.3	135.8	140.6	144.9	150.1	158.5	164.5	167.0	166.7	170.9	181.7

Note figures for 1975 and 1976 are provisional in many cases while those for 1977 are estimates based on budgetary provisions.

APPENDIX B

SPECIAL EDUCATION

Special Education comprises special help for children with mental and physical handicaps and for children who are socially deprived or in conflict with the law.

A. Visually Impaired or Blind Children

(1) Integration experiment has commenced in Rosminian Secondary School, Drumcondra, and is proposed in St. Anne's Convent Secondary School, Milltown, for September, 1977. ("Integration" is educating visually handicapped children in ordinary schools.)

(2) Agreement reached to set up a new co-education complex in Merrion comprising educational, residential and assessment facilities. A Study Group consisting of representatives from the 2 schools, the N.R.B., Department of Health and Department of Education is now planning the project.

(3) Special Transport Scheme set up for country children in the Dublin residential schools for the blind to enable them to visit their homes more frequently.

(4) A Visiting Teacher Service will shortly be established on a pilot basis.

B. Hearing Impaired or Deaf Children

(1) Visiting Teacher Service for Hearing Impaired Children formally established with 15 teachers now serving in the field.

(2) Special Transport Scheme for regular visits home for children in residential schools set up in September 1974.

(3) Advisory Committee on the Education of the Deaf set up.

(4) Improved teacher/pupil ratio introduced as recommended in the Report of the Committee for the Deaf.

(5) New school for severely hard of hearing girls completed at St. Mary's, Cabra.

(6) Two classes for non-communicating, multiply-handicapped children established in Phibsboro, Dublin and Lota, Cork on trial basis - a similar class is being set up in the Marino Clinic, Bray, Co. Wicklow.

(7) Planning proceeding on a new complex for hearing impaired children in Cork; on new buildings for deaf and severely hard of hearing boys at St. Joseph's, Cabra and on new buildings for oral deaf and non-oral deaf children in St. Mary's, Cabra.

(8) The number of teachers seconded to the Diploma Course in U.C.D. for teachers of hearing impaired children rose from 5 in 1973 to 14 at present.

(9) Integration experiment in Douglas Community School, Cork (integration of hearing impaired children in ordinary classes) commenced in October, 1976.

C. Mentally Handicapped - Mild

(Mildly mentally handicapped pupils can be provided for either in special schools or special classes.)

(1) New schools opened in Kilcullen, Co. Kildare, Ballina, Co. Mayo, Ennis, Co. Clare, Tallaght, Co. Dublin and new schools are proposed for High Park, Dublin and Mullingar. New buildings to replace temporary premises or extensions to existing buildings were provided in Portlaoise, Carlow, Sligo, Cashel, Dungarvan and Navan. New school buildings are in course of planning for Glasnevin and High Park (Dublin)

and for Limerick, Letterkenny, Newbridge, Ennis and Mullingar. Extensions are planned for Dundalk and Drogheda.

(2) Experimental curriculum for senior pupils was introduced, in association with the National Rehabilitation Board, in Scoil Ghiarain, Glasnevin.

(3) Special classes were set up in Counties Cavan, Clare, Cork, Donegal, Limerick, Longford, Leitrim, Mayo, Roscommon, Kildare, Westmeath and Dublin.

A total of 4,579 pupils are being catered for in special schools and classes - only 500 short of the target of 5,000 set by the Commission on Mentally Handicapped.

D. Mentally Handicapped - Moderate

(1) New schools established in Longford, Charleville, Co. Cork, Navan, Co. Meath., Lixnaw, Co. Kerry. New buildings to replace temporary premises provided at Cootehill, Co. Cavan, Kilkenny, Athlone, Co. Westmeath, Newbridge, Co. Kildare and Drumcar, Co. Louth. New school buildings planned for Raheny, Islandbridge, Stewarts Hospital (Dublin) and for Castlebar, Roscrea and Charleville. New extensions planned for St. Martin's, Waterford, Lota (Cork) and Beaufort (Co. Kerry).

(2) Grants provided for teaching and equipment in new pilot vocational training centres in Cork, Galway, Celbridge, Ballymun and Stewarts Hospital (Dublin). These centres provide training for pupils leaving special schools and entering open and sheltered employment.

(3) A curriculum committee set up to produce a handbook as a guide for teachers.

A total of 1950 moderately mentally handicapped children are now being catered for. The target set by the Commission on mentally handicapped

has been exceeded because it has been possible to cater for a wider age range than anticipated.

E. Physically Handicapped

(1) The pilot scheme in Ballymun Comprehensive school was extended and similar schemes were introduced in Ballinteer Community School, Dublin and in Mayfield Community School, Cork. This scheme involves integration of the physically handicapped in ordinary schools at post-primary level.

(2) Additional accommodation being provided in the school at the Central Remedial Clinic, Clontarf.

(3) Home-teaching schemes for home-bound children and as remedial education for other physically handicapped children (i.e. spina bifida, haemophiliacs etc.) increased from approximately 25 to 70 schemes.

(4) Grants given to the Rehabilitation Institute for part-time teaching at their workshops in Lifford, Sligo, Galway, Longford, Naas, Waterford, Clonmel and at some of the Dublin Centres. These schemes are essentially for adult handicapped who have missed out on general education.

(5) New school proposed at Tallaght - to be run by Spina Bifida Association.

F. Emotionally Disturbed

New schools established in the Dublin area in Cabra and in Phoenix Park and also in Kilkenny. New school building provided at Beaumont (Dublin).

G. Children with Specific Reading Disabilities

New special school, the first of its kind in the country, set up on a trial basis in St. Oliver Plunkett School, Monkstown. A school is also

being established in association with the residential centre for disturbed children to be conducted by the Eastern Health Board at Warrenstown House, Co. Dublin.

H. Remedial Teaching Schemes for Children in ordinary schools who need extra help.

(1) Special Saturday morning remedial teaching schemes established in Counties Meath, Cork, Wicklow, Kildare, Clare, Cavan, Monaghan and Tipperary.

(2) Part-time remedial schemes sanctioned in Child Guidance Clinic, Harcourt Street Hospital and in Child Development Clinic, Ballymun.

(3) The number of full-time remedial teachers in primary schools increased from 160 to 330.

(4) The number of special classes in primary schools increased from 92 to 143.

(5) New in-service courses for primary school remedial teachers were set up in Limerick and Drumcondra and the number of teachers attending annually rose from 55 in April 1973 to 100 in December, 1976. A special Summer course was run in July, 1974 and July, 1975 for remedial teachers in primary schools outside the Dublin, Cork and Limerick areas. This course was run again in July, 1976 and is to be continued in July, 1977

J. Travelling Children

Additional special classes for travelling children were established in national schools in Limerick, Cork, Galway and Dublin. Special schemes to aid pre-school children were established in Dublin and Carlow and grants allowed for an evening voluntary scheme in Limerick. Special classes for children from travelling families have been established in national schools in Bunclody, Rathkeale, Taghmon and Portlaoise. Pre-school classes have been established in Dublin, Roscommon, Boyle and Carrick-on-Shannon.

Disadvantaged

The Research Report on the Rutland Street Project was published in 1975. Having considered the results of the project, the Government authorised its continuance as a resource service to Irish education. This will include the development of Rutland Street as a base for the training of teachers interested in the new techniques and curricula for teaching disadvantaged children. One such course has already been held. Special classes using the Rutland Street Curriculum have been set up in six other disadvantaged areas of Dublin and are being monitored with a view to further extension.

Child Care

The Department continued to implement the Kennedy Report progress being made in the following respects:-

(i) A new Child Care Adviser was appointed to the Department in February, 1976.

(ii) A modern special school for youngsters who have been in conflict with the law (Ard Mhuire, Oberstown, Co Dublin) in replacement of Daingean reformatory was opened in January, 1974.

(iii) The industrial school at Letterfrack was closed in June, 1974.

(iv) A new school for St. Joseph's Clonmel (similar to Oberstown) is being planned; in the meantime works are being carried out to keep the existing buildings serviceable.

(v) Twelve purpose built group homes for children in need of care and protection have been completed at Moate, Drogheda, Killarney, Cappoquin, Lakelands, Sandymount (Dublin), Fethard, Rathdrum and Limerick. Two further homes are in course of construction at Renmore, Galway.

(vi) Schemes of modernisation have been carried out at a number of existing

homes with the aid of grants from the Department. These include Sunday's Well (Cork), Drogheda, Kilkenny, Passage West, Tralee, Rushbrooke, Booterstown, (Dublin), Lenaboy (Galway) Waterford, Moate, Salthill, Wexford, Lakelands (Dublin), Cappoquin, Goldenbridge (Dublin), Clonmel, Whitehall (Dublin) St. George's and St. Vincent's, Limerick, Benada Abbey, Sligo.

(vii) Training facilities, already made available through the residential child-care course at Kilkenny, were augmented by the establishment of a new course at St. Mary's College, Cathal Brugha Street, Dublin.

(viii) The capitation grants to residential homes were increased from £11 per child per week on 1/4/73 to the current level of £18 per week. A study on the general financing and staffing of the homes was carried out and discussions on an inter-departmental basis are proceeding with conference of major Religious Superiors which it is anticipated with result in further improvements in the financial arrangements, for the homes and in the remuneration of the staffs employed.

(ix) A Task Force on child care, on which the Department of Education was represented, was set up in November, 1974 and has presented an interim report dealing with additional services regarded as urgently needed. Plans for implementing these proposals are in hands.

(x) As a result mainly of improved services in the community itself (e.g. probation and social work) the number of children in residential care has fallen from 1621 on 31st December, 1972 to 1320 on the 31st December, 1976.

SPECIAL EDUCATION INCREASE FROM 3/73 - 6/76

Type of School	3/73 No. of Schools	3/73 No. of Teachers	3/73 Total average enrol. for qtr. ended 31/3/73	6/76 No. of Schools	6/76 No. of Teachers	6/76 Total average enrol. for qtr. ended 30/6/76
Blind and Partially Sighted	2	16	150	2	20	145
2. Hearing Impaired						
(a) Schools	4	99	768	4	140	774
(b) Visiting Teachers Service	-	3	-	-	11	-
(c) Classes for dually/ multiply handi- capped	-	-	-	-	3	12
3. Mentally Handi- capped						
(a) Schools	26	182	2815	30	239	3260
(b) Classes catering almost exclusively for mild mental handicap	29	29	-	93	133	1319
4. Mentally Handicapped Moderate						
(a) Schools	24	125	1636	30	163	1856
(b) Units attached to other type schools	3	6	90	4	11	94
(c) Voluntary Schools	-	-	-	-	-	-
5. Physically Handi- capped						
(a) Hospitals	12	33	462	12	26	376
(b) Other	4	21	254	4	26	322
(c) Schemes in Com- prehensive/Com- munity Schools	1	1	20	3	3	46
6. Emotionally Dis- turbed	8	26	233	11	44	325
7. Specific Reading Disability	-	-	-	-	-	-
8. Deviant Boys	5	23	202	3	24	188
9. Itinerants	1	4	71	1	4	43
					850	8,783