STATISTICAL AND SOCIAL INQUIRY SOCIETY OF IRELAND.

EXAMINATION OF THE SICKNESS EXPERIENCE FOR THE YEAR 1935 OF PERSONS INSURED UNDER THE NATIONAL HEALTH INSURANCE ACTS.

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There are approximately 500,000 persons in the State engaged in gainful occupation either as manual workers or as clerical workers with a rate of remuneration not exceeding £250 per annum. This bulk may be taken as a representative group and is the only particularised group in the nation in which it is possible to measure from existing data the incidence of sickness and disease in the working population.

This is the first time that any figures of the incidence of sickness of those insured under the National Health Insurance Acts have been made available. It would probably be advisable at the outset to explain the source of the information, the type of member dealt with and other similar details. Who are these 500,000 and whence comes this particular information?

The National Health Insurance Acts provide that all clerical workers earning not more than £250 per annum and all manual workers shall be insured against loss of work through illness. These were formerly members of insurance societies organised on widely varying bases, and those societies had neither the opportunity nor the incentive to investigate of themselves the incidence of the illness experience of each separate group nor the machinery to co-operate collectively. Since December, 1934, when the unification of the former Insurance Societies was completed, Cumann an Arachais Naisiunta ar Shlainte (The National Health Insurance Society) is the only Society in Ireland entitled to transact National Health Insurance business. The year 1935 reviewed in this paper was the first full year of administration of the Unified Society. All the information, tables and graphs, in this paper have been compiled by the Society and are reproduced with the permission and approval of the Committee of Management.

The benefits provided statutorily are four in number: sickness benefit, disablement benefit, maternity benefit and, for women only, marriage benefit. As it is intended to deal with the first two of these only, no explanation of the terms and conditions for marriage and maternity benefit need be given.

Sickness Benefit consists of payments during illness of 15s. a week for men and 12s. a week for women, after 104 weeks from entry into insurance and payment of 104 contributions; 9s. a week for men and 7s. 6d. a week for women after 26 weeks from entry into insurance and payment of 26 contributions. These rates are applicable until the higher rates first mentioned become payable. The benefit com-

mences on the fourth day of incapacity and is given for a period or periods not exceeding 26 weeks.

Disablement Benefit consists of payments during illness after 26 weeks' " sickness benefit " has been received:—7s. 6d. a week if 104 weeks have elapsed from entry into insurance and 104 weekly contributions have been paid.

The relation between sickness and disablement benefit is that an insured person is first entitled to sickness benefit for a period of 26 weeks. Unless there is a clear break of 12 months between the termination of one period of illness and the commencement of the next, all periods of illness are linked up to ascertain when the 26 weeks' sickness benefit are completed. When an insured person has received 26 weeks' sickness benefit either in one long illness or in a number of short " linked up " periods, the disablement benefit rate is paid thereafter—and this benefit endures, if illness continues, until age 70 years. To requalify for a further period of 26 weeks' sickness benefit, the claimant must recover and not claim for a full period of 12 months. It will be seen, therefore, that there is no difference between the type of illness or degree of incapacity which is required in claiming either of these types of benefit. In the figures that follow both types have been added together and treated as one.

In order to be entitled to benefit, a member must be " incapable of work by reason of some specific disease or bodily or mental disablement." Where the incapacity is due to a disease or accident in respect of which the member is entitled to compensation under the Workmen's Compensation Acts or the Employers' Liability Act, or to damages at Common Law, no benefit is payable and such incapacity has not been included in this survey.

The usual evidence of incapacity required by the Society is a medical certificate and arrangements have been made with practically every general practitioner in the country to supply these certificates to insured persons who have fallen ill—the cost of certification being borne by the National Health Insurance Fund. It should be borne in mind that the only arrangement made is for the supply of certificates when a member is ill and deemed incapable of work. The National Health Insurance scheme in Ireland is unique in the fact that it does not provide any medical attendance for the insured persons. It has been pointed out, particularly by members of the medical profession, that in consequence of this absence, the examination of claimants for benefit is not by any means, generally speaking, sufficiently thorough to enable an accurate description of the illness to be given—that the doctors mainly concern themselves with the fact of incapacity for work. In so far as this is true, the classification of the claimants according to illness is unreliable. There is no doubt that such illnesses as tuberculosis, venereal disease and cancer are not always correctly certified because of the passive or active objection of those incapacitated.

The other information as to claimants which is given, i.e., age, duration of illness, county of residence, etc., may be relied upon as being substantially accurate. Any divergences will be commented upon as they arise.

To come to a consideration of the actual figures themselves: the figures taken are the claims for sickness and disablement benefit for the year 1935, the actual period covered being from 7th January,

1935, to 4th January, 1936. The claims have been analysed under the following headings and classifications—sex, marital status (of women), illness, county of residence, age, and occupation, the number of claims and the duration of incapacity in weeks being given for each classification. Where an insured person claims for more than one period in the year each of the periods is counted as a claim. It has not been found possible for technical reasons to give the number of claimants under each heading.

In Appendix Table I a general view of the insured persons is given. This table brings to light (1) the very large proportion of the entire population of the country which is represented by the insured persons; (2) the ratio of the number of men insured to the number of women; (3) the small proportion of insured women who are married; (4) the closeness of the figures for the average duration per claim in the case of men and single women and the large difference between these two and the average for married women; (5) the considerable difference between all three classes in the number of claims and the total duration per 100 persons insured.

It will be noticed that the total number insured given is that as at 31st December, 1934, the year immediately prior to that under discussion. This figure, which is that used throughout the paper, is taken, as it is considered that it provides the best basis to work on, as a member must be at least six months in the Society before becoming entitled to benefit. Owing to the great latitude given to insured persons in the matter of surrender of contributions—they are given six months in which to surrender contributions for the previous six months—and in the termination of their insurance—they are given a year of free insurance after they have ceased to contribute—it is very difficult to give the absolute figure of the number of people open to risk at any given time. An approximation sufficiently accurate to discharge the purpose of critical examination can be made and the figures given here, though subject to subsequent rather slight variation, serve as a good indicator and a useful basis of comparison for the sexes.

Before going into more detail concerning the incidence of illness, it is advisable to complete the picture of the structure of the insured population by pointing out that the average ages are as follows:—

Men	36.25 years
Single Women	28.06 years
Married Women	42.68 years
Both sexes	34.18 years

The great disparity in ages explains to some extent the higher rate of incapacity for married women as shown in the above Table I, but it accentuates the rate for single women whose lower average age should imply a lower rate of incapacity.

Illness Classification.

The illnesses from which claimants are certified to be suffering have been classified under 18 main heads and the total number of claims and the total duration of illness under each head ascertained. In Appendix Table II these figures are given, together with the figures showing the average duration per claimant and the percentage distribution, that is, the total number of claims and the total duration

for each illness shown as a percentage of the total for all types of illness.

In the total duration rheumatism is the principal cause of incapacity, being well in front of all other types of illness, for all three classes of member—the predominance being more marked in the men and married women than in the single women. Second place, for men, is taken by respiratory disorders, consisting principally of bronchitis, pneumonia, and other similar illnesses, excluding tuberculosis and the common cold. For both the single and the married women, blood diseases, consisting principally of anæmia, take second place.

This table illustrates the need for a greater concentration, by way of remedial measures, on some of the commoner illnesses, showing as it does, the higher proportion of illness that arises from them. The low position in the scale of metabolic and endocrine diseases—illness of the type of goitre or diabetes—and of the tumour group—principally consisting of cancer—is noteworthy, but absence of a large number of cases of the latter illness may be attributable to two causes, firstly, the difficulty of certification previously mentioned and, secondly, the low average age of the insured persons relative to the age of greatest incidence for this disease.

These percentages show the relative burden of incapacity amongst the whole insured population, but do not show what were the causes of incapacity which caused the longest period of illness to the individual. These causes are shown under the heading "Average Duration per Claim." The figures under this heading were obtained by dividing the total duration of each illness by the total number of claims for that illness. The result gives a classification very different from that shown on the percentage table. The first and second places for each of the three classes are held by the same two illnesses, tuberculosis and cardiac disease. Corresponding to the higher sickness rate for married women, there is a higher all-round average duration for each illness. For the single women and for the men, the average for tuberculosis, cardiac disease, and the endocrine group (goitre and diabetes) is over 20 weeks or over 4½ months. In fact, the average duration per claim for all illnesses is remarkably high at 14 weeks or over 3 months, while for married women it is over 4½ months.

Cancer and other malignant tumours which occupy, as certified, a very small proportion of the total incapacity of insured persons, have a prominent place amongst the illnesses causing extended incapacity to the individual. The prominent place taken by cancer and by tuberculosis in average duration is not entirely unexpected, but it is probable that, in a large number of cases, the certifiers only certify people to be suffering from either of these two illnesses who have reached the chronic stage and so have little objection to the publication of their malady. There are practically no certificates received in respect of the third of present-day scourges—venereal disease. The consequential obscurity as to the real incidence of these three groups of disease is deepened by a similar obscurity, arising from similar causes, in the statistics of the Registrar-General. A very difficult problem of lack of adequate information is, therefore, posed, not only to the statistician, but, more important still, to those whom he serves —the medical and social research workers.

Two solutions may be offered: (1) that certificates be forwarded direct by the certifiers—to the local registrar in the case of death and

to the National Health Insurance Society in the case of incapacity, or (2) that a code of illnesses be used which would be available only to the certifiers and the central authorities whereby the real illness would be designated a code number.

The examination of the age classification of those incapacitated is the next step to be undertaken The total number of insured persons has been classified according to the number in each five-year age group, the total number of weeks' benefit and total number of claims received being similarly classified. This has enabled the calculation of the actual incidence of sickness for each type of illness at the various ages per 100 members The resulting table (Table III Appendix) is capable of treatment in two very different ways. Reading horizontally gives a comparison of the effect which age has upon the course of any particular illness, while a vertical reading shows the effect which each illness has upon persons in any particular age group. It is proposed to deal firstly with the horizontal reading

Duration per 100 Members per Age Group.

For all illnesses taken together there is a steady rise from the first age group unchecked to the last group. For men up to the group 56-60 years the rise is in a remarkably steady fashion and thereafter it mounts very suddenly. For single women the rate also moves in a very steady manner, but the rise is much greater throughout and the severe rise commences at the 46-50 years group. The married women do not follow the same even trend: the rise is even more than that of the other two classes, while the severe rise again commences at the 46-50 years group.

There is a great difference between illnesses taken separately and the total figures. In each illness the men show a fairly steady rise, while the women, both single and married, are subject to considerable variation.

Tuberculosis: The rate of incapacity rises for the earlier age groups and then either evens out or, as in the case of women, falls. The point at which this fall occurs is very significant. The peak point for women (leaving out the 60-70 years group) is the age group 26-30 years. The Registrar-General's Return (1937) shows the death rate for females in 1935 for the age group 25-34 years to be the second highest. The peak point for men, again omitting the two highest age groups, is the group 41-45 years. The Registrar-General's Return (1937) shows the death rate for men for 1935 for the 35-44 years group to be the second highest. The highest death rate for men and women, in 1935, was in the 20-24 years age group, an age at which it is probable that insurance might not have commenced. The indication is, therefore, that the drop in the middle ages is due to weeding out of the worst cases by death.

Rheumatism: As rheumatism represents over 20 per cent. of the certified incapacity, it is natural that the form of the rheumatism experience should be very similar to that of the total of all incapacities. The tremendous rise in the rate of incapacity after the 56-60 years group is reflected in the illnesses of the respiratory system and of the circulatory system.

Other illnesses: The marked fall in the rate of increase in the duration of married women's incapacity for the 56-60 years group which is found in all of the illnesses except rheumatism deserves attention and

would appear to be due mainly to a more than average experience for the preceding ten years.

The subdivision into illnesses and again into age groups makes the figures on which the married women's experience is based very small and consequently subject to fluctuation with small changes in the totals.

Illnesses of Greatest Duration in Each Age Group.

An examination of the table vertically provides a very instructive index of the risks to which each age group is subject, as revealed by the statistics.

MEN.

Microbic Fevers: consisting principally of colds and influenza hold pride of place in the 16-20 years group. Respiratory disorders and tuberculosis come next in order, while nervous and mental disorders bring up the rear.

In the next group *Tuberculosis* has taken the premier place and it remains the primary cause of incapacity for men up to the age of 40 years.

The *Nervous and Mental group* moves up from last place to third last in the second age group, and thereafter takes second place to tuberculosis from the age 26 years to 40 years, after which it replaces tuberculosis as the main cause of incapacity for men. It continues to hold the first place from age 40 years to 50 years.

The *Microbic Fevers group* drops to second place in the 21-25 years group, and thereafter to the sixth place.

Rheumatism occupies a middle position for the earlier age groups and does not make itself felt until the 46-50 group, when it assumes a strong position. After 50 years it dwarfs the other illnesses.

Cardiac Disease: This does not, relatively speaking, affect those under 40 years, but thereafter its importance as a source of incapacity increases until for those over 60 years it is second in importance.

The peculiar position of the respiratory disorders group should be noted. For no age group is it the primary cause of incapacity, yet in each age group it is amongst the three premier causes. This may in part be due to the fact that each age has its own peculiar respiratory illness, or to the utility of such terms as bronchitis, pneumonia, etc., as descriptive epithets for causes of genuine incapacity, the real names of which may not be acceptable to the patients.

SINGLE WOMEN.

The first point that draws attention in the study of the figures for women is the high place occupied by *blood diseases* for every age up to 60 years. Does anæmia (which is practically the only blood disease certified) exist to such a notorious extent in a country so rich in food? Or is it that the domestic servants, who comprise over 50 per cent. of the employed insurable single women, are so badly fed that they cannot work? Or is anæmia a cloak for tuberculosis, cancer and venereal disease? There are a number of questions that might be asked—but where are we to look for an answer?

With the exception of this intrusion of certified anæmia, the incidence of illness for each age group follows a trend very similar to that of the men, with the notable exception that tuberculosis and

nervous and mental disorders each hold sway for a much shorter period, and rheumatism comes forward at an earlier age, as the main source of incapacity. Heart disease also comes to the fore at an earlier age, while respiratory diseases do not take a prominent position until the middle ages.

MARRIED WOMEN.

As has already been pointed out, the small number of married women insured means that extensive sub-division results in such a small number in each group that the statistics, at least in the sparser age groups, are not too reliable. But two important points deserve mention, firstly, the incapacity arising from pregnancy and the diseases of women does not include the four weeks after confinement. The framers of the National Health Insurance Scheme some 25 years ago considered that the £4 paid to an employed married woman on confinement should be ample not only for the costs of maternity but also for the maintenance of her family until she again becomes capable of work four weeks later. The incapacity shown under this heading does not, therefore, include the four weeks, but refers to incapacity prior to confinement or else subsequent to the four weeks after confinement.

The second point of interest is that at no age do *nervous and mental disorders* assume a position of primary importance. With a view to checking the evidence of the rate of insanity of married persons, reference has been made to the reports of the Registrar-General and of the Inspector of Mental Hospitals, and it is very surprising to find that there are no statistics given in either publication relating to married people as distinct from single. The theories have been put forward that marriage is conducive to longevity and it certainly seems to be favourable to sanity. Would not both theories repay extra attention by compilers of official statistics in a country of few marriages and many mental patients?

County Distribution of Illness.

The regional incidence of illness next claims attention. Here the difficulty of sub-division of small numbers again arises. By leaving out of account the experience of the women—both single and married—two ends are served: the inaccuracy due to small numbers arising from sub-division of the relatively small number of women is avoided and the figures for the counties as given by the men's figures present a more accurate figure—as employment of men is more likely to be evenly distributed through a county than that of women, whose employment is chiefly in urban districts.

There are three main divisions of the figures for each county: (1) the average duration in weeks per claim; (2) the average number of claims per 1,000 insured men; (3) the average duration in weeks per 1,000 insured men.

It is possible to approach the examination from either of two viewpoints—each county may be taken separately and the experience of the various illnesses compared, or each illness may be taken separately and the experience in the different counties examined. As time does not allow a detailed examination from either of these two aspects, a brief review is given and the full tables of figures are reproduced for the benefit of all who require further particulars (Tables IV and V appended).

In Table IV a summary is given of the experience for men under all three heads—average duration per claim, average number of claims per 1,000 insured men, average number of weeks' illness per 1,000 insured men. Figures are also given showing the death rate for all persons in the same areas for the year 1936, the nearest year to 1935 for which rates fully corrected for population are available. The table is divided into two—the counties and principal towns where the duration per 1,000 insured men is over the national average, and those in which the duration per 1,000 insured men is below the national average.

Examination of the table reveals that in the following areas all *four* figures are below the national rates:—The counties of Dublin, Limerick, Sligo and Galway, and the towns of Galway, Dundalk, Sligo, Waterford and Kilkenny. *Three* of the figures are below the national average in the counties of Kildare, Kerry, Clare, Mayo, Leitrim, Donegal and Cavan, and in the cities of Dublin and Limerick.

On the other hand, the *four* figures are above the national rates in the counties of Laoighis, Carlow, Wexford, Wicklow, Westmeath, Monaghan and Longford. *Three* of the figures are above the national rate, for the counties of Louth, Meath, Offaly, Tipperary, Kilkenny and Waterford, for the City of Cork and for Clonmel town.

Whilst it is admitted that the figures for the death rates being for the entire population, both men and women, are not strictly comparable with those of the insured men, the grouping of the counties suggests a degree of correlation. The counties with a favourable experience are the counties of Dublin and Kildare and the coastal counties from Donegal to Kerry. Those with an unfavourable experience are the eastern and midland counties. The ascertainment of the causes, if any, that lie behind the grouping would probably provide sufficient material in itself for a paper of considerable scope.

The extraordinary range of the figures for insured persons in this table deserves attention. The lowest rates are for the town of Galway with 103 claims per 1,000 insured and an average duration of 961 weeks per 1,000 insured. At the other end of the scale there is the County of Wexford with 272 claims per 1,000 insured and an average duration of 4,128 weeks per 1,000 insured. It is difficult to understand how one area could have a sickness rate four times that of another, but the predominance of Wexford is not new to social statisticians. Nor is Wexford unique, for the neighbouring counties of Wicklow, Carlow and Laoighis do not lag far behind. The rates for the town of Galway are unusually low, but they can hardly be said to be unique in so far as the rates for the contingent areas of Galway County, County Clare and County Mayo are also fairly low. The contrasts which are thus revealed might be said to be attributable to a difference in the age grouping of the population in these counties. It is not possible to include a survey of the relative ages of insured men in the various counties, but a comparison can be made of the incidence of the illnesses.

Diseases in each County.

In Table V (Appendix) the average duration of each illness per 1,000 insured men in each county and in the principal towns is shown.

It will be remembered that, in dealing with the incidence of illness at the various ages, the earlier ages were seen to be subject to microbic fevers and tuberculosis; the middle ages to nervous and mental dis-

orders; and the later ages to rheumatism and heart disease. This table undoubtedly shows a very high incidence of rheumatism and heart disease in Wexford and the neighbouring counties, but the incidence of microbic fevers is also well marked. Tuberculosis and mental diseases are above the national average though not in the marked fashion of the other illnesses. For Galway and its neighbours the incidence is well below that for the entire country for all types of illness. There are two notable exceptions. Incidence of tuberculosis in the town of Galway is slightly above the national rate, and the incidence of microbic fevers in Clare considerably higher than the national rate. Even when account is taken of these latter, it can hardly be argued that there is sufficient evidence for claiming the vastly different dispersal in age groups that would be required to explain away the difference in sickness rates.

The other counties also disclose a number of prominent features. Tuberculosis and mental diseases are below the national rate in rural areas and above in the urban areas, while the contrary is true of rheumatism. Microbic illnesses are well above the national average in nearly all the Leinster and Munster rural areas, while they are below in the Connaught and Ulster rural areas. Generally speaking, microbic illnesses are lower in the urban areas than in the rural areas. Digestive disorders are prominent in a few areas which are, generally speaking, below the average for most other illnesses—the rural areas of Donegal, Leitrim, Cavan, Kildare, Cork and in the City of Waterford.

Before leaving the survey of the counties, it is opportune to refer to the question of the correlation of the death rate and the sickness rate, which may be raised as a result of the comparison between the figures that has been made. The theory has been advanced that the increased expectation of life which medical science now offers has resulted in the preservation of life for longer periods, but not for longer periods of working capacity. It is argued that the saving of life has resulted in a greater degree of incapacity, particularly in the later age groups. At first sight it would therefore appear that the sickness and death rates for each county should be in inverse ratio and that a high death rate should correspond to a low sickness rate. This is not a true view of the theory, for it refers not to a static rate per annum, but to the change in the rates over a period of years and postulates that where there has been a substantial fall in the death rate there should be a substantial rise in the sickness rate. It is not possible adequately to verify the theory from the present figures, as there are no Irish figures giving the sickness rate prior to those given here for 1935, and as, therefore, the rise and fall in the sickness rate cannot be compared with the rise and fall of the death rate, the theory has yet to be proved for Ireland.

OCCUPATIONAL INCIDENCE.

The final classification of illness and incapacity is based on the occupation of the claimants. When members are making a claim for benefit, they are asked to state both the name of their employer and their occupation. The code used to extract the resultant information is a modification of the occupational code used in the 1926 census. No classification according to industries has yet been made. It is not possible to give these figures per 100 insured persons in each occupation, as the total number of insured in each occupation is not

known. When the full 1936 census figures become available it will be possible to estimate the number fairly accurately.

In spite of this absence of full information, it is possible to get a broad idea of the relative risks involved in different types of occupation. As in the county classification, the figures for men only are given. The occupational classification of incapacity amongst women has many interesting features, but it is not possible within the limits of this paper to deal with them. The figures are available should they be required at any future date.

In Table VI (Appendix) the total duration of incapacity experienced is classified according to the occupation of the claimants. It will be seen that general labourers are responsible for 68 per cent. of the total. Without knowing whether this class represents the major portion of the insured persons, it is impossible to judge whether or not this percentage is proportionate to membership or not. The table is given as an indication of the figures on which the following comparison has been based. Seven of the occupations have been taken and the probability of sick persons in any of these occupations being incapacitated from any of the seven main types of illness has been calculated (Table VII Appendix). The fact that there are a large number of claims in some occupations as against others does not affect the table as the figures have been calculated independently for each. It is important to remember that the table does not show the probability that a member belonging to any of the various occupations will fall ill. Given the hypothesis that a man is ill and that his occupation is known, the table shows the type of disease from which he is most likely to be suffering.

Agricultural Workers are more liable to rheumatism and heart disease.

Railway Workers are shown to be more liable to microbic illnesses than any other type of worker and are remarkably free from tuberculosis.

Road Transport Workers (not including railway workers) appear to be more subject to digestive disorders than other classes of workers. Representations have recently been made to the London Passenger Transport Board that drivers of motor vehicles are subject to stomach trouble. This would also appear to be suggested by this table and the theory would merit further attention.

Other Transport Workers. These workers show a relatively high incidence of tuberculosis and a low rate for heart disease.

Commercial Workers—principally shop workers—are prone to mental diseases and to tuberculosis, but are relatively free from heart disease and rheumatism.

Clerical Workers are still less exposed to the risk of rheumatism or heart disease, but are more liable to mental diseases, tuberculosis and digestive disorders.

Labourers are open to rheumatism, heart disease and tuberculosis.

This brings us to the end of such of the figures as it is intended to survey in this paper. A number of the tables given are condensed from more detailed tabular statements and it would be possible to give greater detail in nearly every instance. To do so would result not in a paper of modest proportions, but in a book of considerable length. The principal aim has been to show the possibilities of investigation that are presented and the opportunities offered of

measuring our medical requirements both regionally and industrially. The problems of prevention and cure of sickness are urgent and demand a reform based not only on scientific modern theory but also on present-day facts. Age has its shallows, counties their reefs and industries their currents—but the skilful mariner will navigate the charted seas—somewhat fatigued, perhaps, but safe. As yet the years, the areas and the occupations are not satisfactorily charted, marked and buoyed—and the navigators have still much to learn. Is an effort being made either to cure or prevent the million and a half weeks of sickness with which this paper deals? Is an adequate return obtained for money spent on social services? Are the nation's health services planned on a national basis? Is rehabilitation of the sick workman, whether illness be due to ordinary illness or occupational risk, the object of present policy? Is the present system of publicising patent medicines beneficial? These and many other questions arise naturally from the subject matter and are posed as problems requiring discussion and decision.

Before concluding I wish to offer my sincerest thanks to Mr. R. Henderson, the Secretary of the National Health Insurance Society, who has given both assistance and encouragement with great generosity, and also to my assistant in the Statistical Section of the Society's staff—Miss M. Connolly—who, with her staff, has been responsible for the heavy work of compiling, tabulating and graphing the statistics. Finally, I wish to convey my thanks to Dr. Rowlette, who kindly arranged this lecture, and to you, the Statistical and Social Inquiry Society, and especially to Dr. R. C. Geary, whose enthusiasm for the subject matter has been both inspiration and incentive.

APPENDIX.

TABLE 1

	Men	Women		Both Sexes
		Single	Married	
Membership—31/12/'34 ...	335,409	137,084	13,440	485,933
Total No of Claims ...	59,623	31,322	5,945	96,890
Total Duration in weeks ...	866,787	443,525	123,172	1,433,484
Average Duration per claim in weeks	14 55	14·16	20·71	14·81
No of Claims per 100 members	17·78	22 85	44·23	19·94
Duration in weeks per 100 members	258 43	323·54	916·46	295·00

TABLE II.—SICKNESS EXPERIENCE IN 1935 OF (1) MEN, (2) WOMEN (SPINSTERS AND WIDOWS), AND (3) WOMEN (MARRIED)

Code No.	Illness	Total Number of Claims			Total Duration (in weeks)			Average Duration (in weeks)			No. of Claims as % of Total for all Incapacities			Duration as % of Total for all Incapacities		
		Men	Women		Men	Women		Men	Women		Men	Women		Men	Women	
			S. & W.	M.		S & W.	M		S. & W.	M.		S & W	M		S & W	M.
1	Tuberculosis	2,697	1,382	193	83,375	40,275	6,879	30·9	29·1	35·5	4·5	4 4	3·2	9·6	9 1	5·6
2	Rheumatism	11,186	4,007	1,006	194,134	74,764	26,756	17·4	18·7	26·6	18·8	12 8	16·9	22·4	16·9	21·7
3	Nervous and Mental	3,690	2,148	341	95,484	44,470	8,348	25·9	20·7	24·5	6·2	6·9	5·7	11·0	10·0	6·8
4	Accidents	204	40	14	3,032	459	219	14·9	11·5	15·6	·3	·1	·2	·3	·1	·2
5	Skin	4,864	2,055	234	38,539	18,260	4,690	7·9	8·9	20·0	8·2	6·6	3·9	4·4	4·1	3·8
6	Digestive	5,981	3,108	439	62,755	36,819	7,843	10·5	11·9	17·9	10·0	9·9	7 4	7·2	8·3	6·4
7	Respiratory	8,002	2,581	504	112,317	39,357	11,296	14·1	15·3	24·4	13·4	8·2	8 5	13·0	8·9	9·2
8	Kidney	1,466	446	142	22,606	7,130	3,031	15·4	16·0	21·3	2·5	1·4	2·4	2·6	1·6	2·5
9	Microbic Fevers	9,216	3,742	392	38,698	20,517	3,235	4·2	5·5	8·3	15 5	11·9	6 6	4·5	4·6	2 6
10	Pregnancy and Diseases of Women	—	724	908	—	7,410	9,587	—	10·2	10·6	—	2·3	15·3	—	1 7	7·8
11	Cardiac	3,276	1,553	416	91,757	40,919	13,542	28·0	26·4	32·6	5·5	5·0	7 0	10·6	9·2	11·0
12	Tumours	391	103	16	6,557	2,108	368	16·8	20·5	23·0	·7	·3	·3	·8	·5	·3
13	Metabolic and Endocrine	486	407	85	11,517	8,315	2,602	23·7	20·4	30·6	·8	1·3	1·4	1·3	1·9	2·1
14	Blood	708	4,386	691	10,314	52,304	13,733	14·6	11·9	19 9	1·2	14 0	11·6	1·2	11·8	11 1
15	Metallic and other Non-bacterial Poisons	6	3	—	81	21	—	13·5	6 9	—	·01	·01	—	01	·01	—
16	Miscellaneous	2,654	1,968	371	44,487	26,645	7,658	16·8	13·5	20 6	4·5	6·3	6·2	5·1	6·0	6·2
17	Eye, Ear and Throat	3,157	2,221	131	36,856	19,171	2,503	11·7	8·6	19·1	5 3	7·1	2 2	4 3	4·3	2·0
18	Fractures, Ruptures, etc	1,639	448	62	14,277	4,580	881	8 7	10 2	14 2	2 7	1·4	1·0	1·6	1·0	·7
	All Incapacities	59,623	31,322	5,945	866,786	443,524	123,171	14·5	14·2	20·7	100·11	99·91	99·8	100·—	100 —	100·—

TABLE III.—SICKNESS EXPERIENCE 1935.

{NOTE:—S.W. = Single Women M.W. = Married Women}

AVERAGE DURATION (IN WEEKS) PER 100 INSURED PERSONS, FOR EACH SPECIFIED ILLNESS, IN FIVE-YEAR AGE-GROUPS.

ILLNESS		AGE-GROUP											TOTAL
		16–20	21–25	26–30	31–35	36–40	41–45	46–50	51–55	56–60	61–65	66–70	
Tuberculosis	Men	4·9	17·8	23·9	24·5	28·0	35·2	34·8	33·8	28·3	38·0	44·3	24·9
	S & W.	7·6	27·0	46·8	46·2	43·3	46·8	47·1	36·7	31·0	29·5	60·6	29 4
	M W	—	24·3	66·4	61·0	53·6	50·8	50·6	45·4	26·2	68·8	71·8	51·2
Rheumatism	Men	4·1	7·8	10·0	12·9	19·1	24·9	40·9	69·5	139·7	346·3	922·2	57·9
	S & W	6·8	17·2	22·2	33·4	37·6	87·7	120·4	225·6	301·4	599·4	1,160·2	54 5
	M W	3·1	7·6	27·7	37·2	53·7	84·8	166·3	303·0	450·0	786·0	1,441·9	199·1
Nervous and Mental	Men	1·5	5·5	14·0	17·0	27·5	38·8	42·6	53·2	57·7	86·7	157·6	28·5
	S & W	3·7	13·2	27·3	47·3	65·6	68·0	77·8	106·1	136·0	162·4	240·6	32·4
	M W	—	12·2	12·4	19·0	27·8	53·2	74·7	110·3	93·0	167·1	264·6	62·1
Digestive	Men	3·9	9·8	9·8	13·0	11·8	15·8	22·4	30·2	34·4	69·3	117 7	18·7
	S & W	9·9	23·0	25·7	26·7	29·1	36·1	59·0	52·9	89·6	110·5	150·5	26·9
	M W.	5·4	23·1	17·0	32·6	39·0	48·0	61·8	75·3	121·6	130·3	184·4	58·4
Respiratory	Men	6·2	10·7	12·0	13·2	19·9	26·9	41·1	54·0	71·7	147·4	298 6	33 5
	S & W	7·0	16·5	24·6	32·2	28·0	37·0	53·6	93·1	145·4	164·2	304·4	28 7
	M W.	43·3	9·2	28·7	29·4	45·1	61·5	78·9	133·6	155·0	250·0	360·5	84·0
Microbic Fevers	Men	6·4	10·8	9·0	11·2	11·4	13·1	11·5	13·9	13 3	19·6	31·3	11·5
	S & W	9·9	15·9	17·1	15·3	13·7	14·6	16·7	21·9	26·2	29·2	27·8	15 0
	M W.	1·1	8·8	13·7	22·1	26·7	33 0	23·1	25·2	30·2	22·2	38·6	24 1
Cardiac	Men	1·7	3·3	6·6	7·2	9·1	16·7	23·9	43·3	71·1	151·9	352·3	27·4
	S. & W	2·1	7·4	15·9	23·2	35·8	52·3	72·6	125·7	173·6	291·9	533·2	29·8
	M W.	3·1	3·4	33·2	19·7	38·7	51·7	83·2	195·2	193·9	359·3	517·2	100·8
Blood	Men	1·2	1·7	1·0	1·6	2·0	2·3	3·4	6·4	7 0	12·6	12·6	3·1
	S & W	12·9	31·6	41·5	46·7	54·2	63·7	82·6	73·6	82·2	112·4	167·1	38·2
	M W.	42·8	42·6	82·5	92·4	124·6	84·8	90·4	137·5	115·8	118·9	176·8	102·2
TOTAL (Including Illnesses not specified)	Men	41·0	90·2	111·5	130·9	164 5	216 9	275 6	376·6	536·6	1,080·1	2,374·6	258·4
	S. & W.	81·9	201·5	275·0	347·0	390 6	521·2	649·9	909·5	1,247·8	1,823·4	3,244·3	323·5
	M.W.	193·9	297·3	521·5	543·0	574 0	659·2	814 6	1,231·2	1,504·6	2,349·4	3,706·4	916·5

TABLE IV

COMPARISON OF COUNTY SICKNESS RATES (MEN) FOR 1935 AND DEATH RATES (ALL PERSONS) 1936

Counties and Principal Towns	(1) Death Rate per 1,000 1936	(2) Average Duration per Claim (in weeks)	(3) Claims per 1,000 Members	(4) Duration per 1,000 Members (in weeks)	Number of Figures in Four Previous Columns	
					(*a*) Above National Average	(*b*) Below National Average
TOTAL	14·37	14·55	178	2,584	—	—
(A) Counties and Towns with Duration per 1,000 Insured (Men) above National Average						
Leinster						
Laoighis ..	15·21	16·18	249	4,031	4	—
Carlow ...	14·59	15·67	227	3,557	4	—
Wexford ...	15·42	15·17	272	4,129	4	—
Wicklow ...	14·59	15·67	205	3,213	4	—
Meath ...	15·28	14·24	211	3,001	3	1
Offaly ...	14·44	12·73	224	2,853	3	1
Kilkenny ..	14·64	13·24	220	2,919	3	1
Longford ...	14·99	16·22	198	3,217	4	—
Louth ...	14 01	15·05	186	2,801	3	1
Westmeath ...	14 71	16·66	198	3,298	4	—
Munster :						
Tipperary ...	14·95	13 52	199	2,696	3	1
Waterford ...	14·71	14·35	197	2,825	3	1
Cork ...	13 55	15·69	170	2,670	2	2
Ulster :						
Monaghan ...	15·50	15·57	182	2,834	4	—
Principal Towns						
Cork ...	14·77	17·82	175	3,111	3	1
Drogheda ...	10·97	19·60	166	3,246	2	2
Tralee ...	12·45	16·61	160	2,652	2	2
Clonmel ...	15·69	17·66	148	2,620	3	1
(B) Counties and Towns with Duration per 1,000 Insured (Men) below National Average.						
Leinster .						
Dublin . .	12·71	14·35	167	2,394	—	4
Kildare ...	14·19	13·41	181	2,427	1	3
Munster						
Limerick ...	13·96	14 05	172	2,417	—	4
Clare ...	14·53	14·30	139	1,992	1	3
Kerry ...	13·04	17·37	129	2,243	1	3
Connaught						
Galway . .	13·71	11·67	108	1,263	—	4
Mayo ...	13·15	16·44	123	2,017	1	3
Sligo ...	13·86	14·34	134	1,922	—	4
Leitrim ...	16 04	13·28	175	2,320	1	3
Roscommon	14·65	15·40	115	1,763	2	2
Ulster						
Donegal ..	14·61	13 99	163	2,282	1	3
Cavan . .	15 62	15·23	155	2,355	2	2
Principal Towns						
Dublin and Dun Laoghaire	14·76	14·46	168	2,431	1	3
Limerick ...	14·91	14·39	172	2,470	1	3
Galway . .	12·63	9·32	103	961	—	4
Dundalk ...	13·28	13·07	156	2,033	—	4
Sligo .	11·12	14·18	143	2,023	—	4
Wexford ...	14·89	15·75	152	2,393	2	2
Waterford ...	14·16	13·70	165	2,257	—	4
Kilkenny ...	13·99	13·79	159	2,196	—	4

TABLE V.—AVERAGE DURATION, IN WEEKS, PER 1,000 INSURED MEN, IN EACH COUNTY AND PRINCIPAL URBAN AREA IN 1935, CLASSIFIED BY SEVEN MAIN CAUSES OF INCAPACITY (MEN ONLY)

Counties and Principal Towns	Illness							
	Tuberculosis	Rheumatism	Nervous and Mental	Digestive	Respiratory	Microbic	Cardiac	* Total
Dublin (City and County)	353	401	353	135	367	90	211	2,394
Dun Laoghaire Borough and Dublin City	354	407	367	137	379	88	213	2,431
Remainder of County	342	334	201	105	237	116	191	1,990
Offaly	219	732	192	169	357	148	394	2,853
Westmeath	210	1,005	396	266	252	133	289	3,298
Carlow	167	856	282	321	435	272	474	3,557
Kildare	237	567	201	233	209	166	333	2,427
Louth (Urban and Rural)	188	731	306	202	262	161	295	2,801
Drogheda	175	892	336	274	372	91	286	3,246
Dundalk	187	441	264	153	181	112	166	2,033
Remainder of County	204	1 018	339	201	269	317	512	3,542
Cavan	190	733	182	200	225	81	174	2,355
Monaghan	255	609	203	261	424	95	360	2,834
Donegal	151	610	187	248	272	96	225	2,282
Sligo (Urban and Rural)	191	463	177	164	286	71	147	1,922
Sligo Town	218	374	287	166	376	37	108	2,023
Remainder of County	164	552	68	161	196	106	186	1,821
Leitrim	88	614	206	189	318	95	332	2,320
Longford	137	1,029	241	232	266	129	463	3,217
Roscommon	104	431	152	145	257	79	197	1,763
Mayo	178	593	138	144	294	101	145	2,017
Galway (Urban and Rural)	157	238	94	101	168	72	121	1,263
Galway City	258	112	19	103	159	53	33	961
Remainder of County	119	285	121	100	172	79	154	1,376
Laoighis	345	1,066	274	270	476	277	426	4,032
Kilkenny (Urban & Rural)	179	850	271	217	236	195	327	2,919
Kilkenny City	332	427	108	268	134	134	223	2,196
Remainder of County	138	966	316	203	264	212	355	3,117
Tipperary (Urban & Rural)	232	664	241	203	295	150	244	2,696
Clonmel	226	520	225	249	360	69	434	2,620
Remainder of County	233	685	244	196	285	162	215	2,708
Limerick (Urban & Rural)	163	485	305	186	374	82	251	2,417
Limerick City	155	414	377	200	487	58	270	2,470
Remainder of County	170	547	243	173	274	102	235	2,370
Clare	226	447	238	136	339	84	176	1,992
Waterford (Urban & Rural)	216	665	285	165	375	98	315	2,825
Waterford City	210	403	258	121	261	77	291	2,257
Remainder of County	223	941	318	211	495	119	341	3,422
Kerry (Urban and Rural)	234	442	230	176	305	67	233	2,243
Tralee	486	340	314	166	308	40	217	2,652
Remainder of County	173	466	210	178	304	74	236	2,145
Cork (Urban and Rural)	231	510	338	224	352	95	352	2,670
Cork City	372	450	505	205	429	70	409	3,111
Remainder of County	149	544	242	234	307	110	320	2,415
Meath	178	810	330	203	284	153	379	3,001
Wicklow	276	859	300	217	380	168	294	3,213
Wexford (Urban & Rural)	292	1,176	295	373	503	222	479	4,129
Wexford Town	250	389	250	257	189	133	359	2,393
Remainder of County	302	1,366	306	401	579	243	508	4.547
GRAND TOTAL	249	579	285	187	335	115	274	2,584

* Including illnesses not specified

TABLE VI

PARTICULARS FOR ALL ILLNESSES IN PRINCIPAL OCCUPATIONS

(MEN ONLY)

OCCUPATION	Total Number of Claims (a)	Total Duration (in Weeks) (b)	Average Duration per Claim (in weeks) (c)	Percentage of Total for all Occupations	
				Claims (d)	Duration (e)
Agricultural Workers . .	1,788	25,802	14·4	3·00	2·97
Workers in Wood and Furniture	1,262	15,137	11·9	2·12	1·75
Metal Workers	1,524	14,571	9·6	2·57	1·68
Transport Workers —					
(i) Railway	2,291	30,743	13 4	3·84	3·54
(ii) Road	2,701	30,112	11·1	4·53	3·47
(iii) Other Transport and Communications (excluding water)	1,437	16,113	11·2	2·41	1·86
Commercial Insurance, etc	2,072	23,578	11·4	3·48	2·72
Clerical Workers ...	1,483	14,292	9·6	2·49	1·65
General Labourers ...	37,361	592,059	15·8	62·66	68·25
Total nine highest Occupational Groups ...	51,919	762,407	14·7	87·08	87·89
Total all Occupations ...	59,623	866,787	14·5	100·00	100·00

TABLE VII.

CLAIMS DIVIDED ACCORDING TO OCCUPATION OF CLAIMANT, SHOWING NUMBER OF CLAIMS IN RESPECT OF MAIN ILLNESSES AS A PERCENTAGE OF TOTAL FOR EACH OCCUPATION (MEN ONLY)

Occupation	Illness								
	Tuberculosis	Rheumatism	Nervous and Mental	Digestive	Respiratory	Microbic	Cardiac	Seven Highest Illnesses	All Illnesses
Agricultural	3·13	22·71	6·26	10·46	11·58	14·77	6·88	75·79	100·0
Transport —									
(1) Railway	2·27	20·08	6·02	8·90	11·17	22·52	5·59	76·55	100·0
(ii) Road	4·22	13·70	5 15	11·74	14·70	19·10	3 67	72·28	100·0
(iii) Other Communications (excluding water)	6 05	12·25	6·19	10·09	13·01	19·62	3·48	70·69	100·0
Commercial, Insurance, etc	6·90	8·74	8·16	10·38	12·84	16·84	4·44	68·30	100·0
Clerical	7 96	5·66	8·56	11·19	12·95	18·48	2·70	67·50	100·0
General Labourers	4·09	21·46	5·79	9·96	13·30	14·72	5·84	75·16	100·0
Total Occupations	4·52	18·76	6·19	10·03	13·42	15·46	5·50	73·88	100·0

DISCUSSION ON MR. Ó BROLCHÁIN'S PAPER.

SENATOR ROWLETTE, proposing a vote of thanks to Mr. Ó Brolcháin, said that it was to enable the member to obtain the benefit that the certificate was furnished, and not for any scientific or statistical purpose. The medical attendant who was asked to give a certificate could not refuse it merely because he was not satisfied of the nature of the illness. To alter the diagnosis subsequently because of further knowledge might disturb the patient's equanimity—and the equanimity of the officials of the Society. At that period of an illness there may be one symptom more marked than another, and the medical certifier might put down that as the description of the incapacity—anæmia, debility, or so forth. Anæmia might be put down as covering a whole host of diseases, and it might be the only true statement that the medical certifier was able to make. There was a tendency to continue the same diagnosis all through. Medical attendants usually gave an accurate certificate of the cause of death, whereas the certificate Mr. Ó Brolcháin had to rely on was a certificate based on a purely preliminary diagnosis. Mr. Ó Brolcháin drew attention to the fact that the names of certain diseases were avoided on certificates and that was true to some extent of certificates of the cause of death as well as of certificates of incapacity. It was true of such diseases as tuberculosis, cancer, and venereal disease. He was not sure that Mr. Ó Brolcháin was right in his statement that venereal disease was the third of the present day scourges.

Dealing with the solutions offered by the lecturer: (1) that certificates be forwarded direct by the certifiers—to the Local Registry in the case of death and to the National Health Insurance Society in the case of incapacity, or (2) that a code of illnesses be used which would be available only to the certifiers and the Central Authorities whereby the real illness would be designated a code number, Dr. Rowlette said it would require statutory authority before these suggestions could be carried out. A medical man who gave information to an outside party with regard to the health of his patient would be open to an action for damages and could be mulcted in heavy damages. The certificate he gave is not a certificate given to the Government or to the Insurance Society, but a certificate given to the patient himself, and if the patient gave it to the Society that was his own affair.

He went on to say that he thought all medical men in practice would be surprised on hearing Mr. Ó Brolcháin's lecture to be told that there was such a very large number of women incapable by reason of anæmia. Primary anæmia had become a very rare disease. When he (speaker) was a student thirty years ago or more a large number of women lived over shops, were badly fed, had long hours, and practically no open air, exercise or light, and as a result anæmia was then a fairly common disease.

Mr. Ó Brolcháin had raised an enormous number of questions which deserved the most serious consideration; and it was hoped that the Medical Research Society would be able to devote some money towards investigating some of the questions raised.

DR. FRANK KANE, in seconding the vote of thanks, said that here in Ireland with a population of three millions they had an insurable population of five hundred thousand. Comparing that with the figures in England the difference was very marked. They had only

half the people insured here that they would expect. Why should that be? He did not think they could avoid the view that the Insurance Scheme itself must be fundamentally unattractive, and a large number, corresponding to two and a half millions in England, did not come in here. They get first of all a small allowance of 15/- a week; which they did not get that at once. It involved a fee to the doctor to get the first certificate unless the patient went to a dispensary and stood a long time in a queue. The fee given for the certificate was very small and the practitioner could not afford to give the patient anything more than a cursory glance. The sum of £51,000 was spent yearly on certificates and he thought that could be much more usefully expended. For instance one could get, say, the services of a hundred medical men for that sum—enthusiastic services. Then to explain this small percentage of population insured they must consider the fact that the considerable number of small farmers in Ireland interfered with the growth of the number of insured though, if the scheme were worth while small farmers would insure their sons and daughters as had been the experience in England.

It was found as was to be expected that the exposed labourer suffered from rheumatism. Tuberculosis was the dominant trouble with the enclosed worker—well clothed but not living sufficiently hygienically. Then in motor drivers they had nervous strain. They had two classes of motor driver—one very rich and the other very poor—and both suffered from stomach complaint. The 'bus driver consequently figured in the statistics. Of course these conditions were modified by fashion. Anæmia was once a fashionable disease. Women were predisposed to it, and a number of them rather liked to be told they suffered from it.

MR. C J. MCSWEENEY said he would like to stress the importance of this new line of investigation. It was particularly so at the present time when the future development of their public health services and of their hospitals was in the melting pot. It was not for him to comment on the statistical side of the paper, but one noticed how one disease seemed to be prominent throughout, and that disease is rheumatism. Professor Rowlette pointed out that rheumatism is a very vague term. As he said, there are two broad types of rheumatism, one formerly called acute or juvenile, the other now called chronic or adult rheumatism. In the field of social services these diseases are of great importance. The first was the main promoter of heart trouble. It was estimated that 50 per cent. of all deaths from heart disease were due to rheumatism contracted during school life. In a great number of cases the heart condition developed early and, if appropriately treated, was curable. It may be of interest to the audience to know that some years ago a movement was started in Dublin under the National Health Women's Association to deal with this question of juvenile rheumatism and attack at the source this cause of rheumatic deaths. They now had clinics established in three hospitals in Dublin, and they meet weekly. They had twenty beds in Linden Convalescent Home for early cases of rheumatic heart disease referred from thte clinics. They had been favoured also by the Medical Research Council to the extent that the Council is paying the salary of a Medical Research scholar who is now being trained in England so that he can undertake a survey of this problem of Juvenile rheumatism in Dublin when he comes back. The problem of adult or chronic rheumatism was also very

important and Doctor O'Reilly would deal with it. It was hoped soon that advance would be made in dealing with that problem in Dublin.

Dr. T. J. O'Reilly, in associating himself with the vote of thanks, said he was indebted to the lecturer for figures supplied to him about a year ago when he delivered a lecture in this country on the subject of chronic rheumatism. It was a saying in his profession that you can prove anything from statistics, by which was meant statistics ill applied. The application of figures to clinical conceptions, the turning of diseases and their results into numbers, is a difficult art. The material for the statistician to work on must be most carefully collected.

Diseases when viewed from the social aspect fall into two large groups:

(1) The acute conditions such as pneumonia, influenza, etc., characterised by a short course and a rapid outcome in death or complete recovery.

(2) The chronic diseases tuberculosis, rheumatism, the cardio-vascular degenerations and the mental diseases whose duration is measured in months and years, whose course is a slow one, usually downwards, whose natural recovery rate is small, and whose result is more commonly a cripple rather than a corpse. Those are to-day the socially important diseases and the diseases whose burden falls on the family, the Insurance Societies and the State. In all countries in which an accurate survey has been made chronic rheumatism has proved the most menacing of all. Figures which attempt to give the real incidence of the chronic rheumatic diseases are difficult to get. Mortality figures are of little help, for these diseases do not kill, death coming from some intercurrent cause.

Advances in therapeutic measures during the past ten years have altered completely the outlook in these diseases. To-day, if taken in time, a cure can be promised in 80 per cent. of the cases, and this figure continues to improve yearly. In the civilised countries of the world clinics and special hospitals for the treatment of chronic rheumatism are in existence or being started. The National Committee for rheumatism in Ireland has devised a scheme for a clinic for the treatment of chronic rheumatism in Dublin along the lines which have proved successful in other countries in Europe, and it was hoped that a start would be made with this clinic in the near future.

Dr. Geary said that these were the most important statistics that had come before the society for a long time and their potentialities were great.

He was stimulated by Mr. Ó Brolcháin's paper to take out some figures from the Scottish National Health Insurance statistics, and he would ask the lecturer to what extent the figures for Ireland and Scotland were comparable, because the contrasts were so unfavourable to this country as to be almost sensational. According to Mr. Ó Brolcháin the figures for duration in sickness in days per member in this country was 18 for men compared with 11 in Scotland, for single women, 23 in this country and 11 in Scotland, for married women 64 to 21, and for both sexes combined 21 to 11½. When analysed by age groups it was found that the number of days of incapacity per year for men is very similar up to the age group 36-40. At ages 41-45 the Irish rate rose to 15 as against 10 in Scotland. In subsequent groups the contrasts were 19 to 11; 26 to

12; 38 to 15½, becoming more marked with increasing age. There must be some explanation for these vast differences.

As regards type of illness, tuberculosis was the cause of 9 per cent. of incapacity in this country compared with 6 per cent. in Scotland. The percentage for rheumatism was 21 in this country and 12 in Scotland.

As to the quantity of sickness and disablement per person, the amount of sickness in weeks per person averaged 1·7 in England and Wales, 1·8 in Scotland, 1·9 in Northern Ireland and 2·3 here.

Disablement as a percentage of both sickness and disablement was far higher in this country than in the other three. It was 51 per cent. in England and Wales; 54 per cent in Scotland; 62 per cent. in Northern Ireland, and 72 per cent here.

Referring to Table VI, he found it hard to credit that non-agricultural labourers could account for anything like two-thirds of total claims for men, as shown.

THE PRESIDENT, in conveying the vote of thanks said they would all agree that what they had heard was a very valuable contribution to the records of the Society; and they had also been favoured by a discussion by people recognised as authorities in their profession. Dr. Geary had dealt with the paper from the statistical point of view, whereas the other speakers were looking more to the future to see what value could arise to the community from the attention which Mr. Ó Brolcháin had drawn to this very important aspect of the social condition of the country. He was sorry Mr. Ó Brolcháin did not make a distinction between sickness benefit and disablement benefit because there was a distinction in the published figures. Perhaps they should also have some information about the frequency of the claims—how many had first claims and how many had second claims. The certification of diseases was one of the matters dealt with, and Senator Rowlette certainly had enlightened them on the difficulties that were inherent in this subject on account of the risk of hurting the feelings of the subject himself or his relatives if a detailed description of the malady had to be given. He put it to the meeting that the best thanks of the members was due to Mr. Ó Brolcháin for his paper that evening.

MR. Ó BROLCHÁIN expressed his appreciation of the vote of thanks and of the criticisms of his paper, and said if they could awaken interest in these social problems they would have done their part. Dealing with Dr. Rowlette's criticisms about certification, he said the person receiving the certificate would not know from the technical language used what he was suffering from. An important point was raised by the President—the question of sickness and disablement. There was a great difference between the two. The average duration for disablement claims was up to 40 weeks. For a sickness claim it was only 7 weeks.