

SCHOOL HEALTH SERVICE IN ENGLAND

KAZUO UCHIUMI*

Introduction

In Japan, the School Health Service (SHS) has been under the control of the Ministry of Education—Local Education Committee system. General practitioners check school children every year in periodic health inspections. However, a daily school health service has been carried out by the school health teacher, and every school has a post for them.

The current SHS in Japan has three main problems.

① The scope of SHS—What is its relationship with Public Health? What kind of activities should SHS do independently?

② What are the duties of the school health teacher?—The usual performer of SHS in Japan is the school health teacher. However, there has been some disputes about what the duties of the school health teacher are. This system of the school health teacher succeeded the pre WWII school nurse system. The origin of the school health teacher system dates back to 1905,¹ when there were two systems. One system was “one school nurse per school”, whilst the other was “one school nurse per several schools.” The latter had been introduced throughout England and USA. After WWII, the system of the school health teacher was adopted instead of the school nurse. Since then the school health teacher has had to unite two elements, nursing and teaching, as their essential duties. This school health teacher system is unique compared with ones of other countries.²

③ Is SHS education or welfare?—It is not easy to draw a line between them. However, if we stress the one aspect, it will guide to the different practices and results from the other aspect. So that we need to define our own SHS.

Experiences in some countries can provide lessons for other countries. English experiences are especially important for Japan, because it influenced Japan at the beginning of this century. Nevertheless, the systems of these two countries have developed independently and in a sense differently.

The author intends to look at the areas of health inspections, health guidance and health education (instruction), all within the jurisdiction of SHS. In this paper, he excludes an examination of health education because he has already dealt with that in a different paper.³

* Associate Professor (*Jokyōju*) of Health and Physical Education.

¹ Sugiura, Morikuni, *The History of the School Health Teacher*, Higashiyama-shobo, 1974, p. 20.

² The author has named her as “school health teacher” instead of school nurse.

³ Uchiumi, Kazuo, ‘Health Education in Schools in England,’ *Hitotsubashi Journal of Arts & Sciences*, Vol. 24, No. 1, December 1983.

I. History of SHS in England

Among the research on SHS in England, *The School Health Service* by V&S Leff⁴ is the most comprehensive. It describes realistically the health situation of children and the countermeasures for them historically with many materials.

Other publications, for example, *Children and Their Primary Schools*⁵ (Plowden Report), *The School Health Service: 1908-1972*⁶ (DES) are written from the historical aspect of children's health.

The images and meaning of SHS are still vague. Therefore it is necessary to investigate them.

The Author divides the history of SHS in England into three periods:

- 1 the origin and foundation of SHS (from 1907 to 1944)
- 2 the development of SHS (from 1944 to 1974)
- 3 from education area to medical area (from 1974).

1. The Origin and Foundation of SHS (from 1907 to 1944)

(1) The Education (Administrative Provisions) Act, 1907

The origin of SHS as an official system depended on this Act. In the item 13-(1)-(b),

"The powers and duties of a local education authority under Part III of the Education Act 1902, shall include—(b) the duty to provide for the medical inspection of children immediately before, or at the time of, or as soon as possible after, their admission to a public elementary school, and on such other occasions as the Board of Education direct, and the power to make such arrangements as may be sanctioned by the Board of Education for attending to the health and physical condition of the children educated in public elementary schools."⁷

By this Act, the Medical Branch⁸ was formed by the Board of Education and George Newman was appointed as the first Chief Medical Officer. This Act was enforced from the 1st of January in 1908, and the details of enforcement were described in some circulars. In circular 576 the aims of the School Medical Service (in 1944 it was renamed SHS) were described;

"... the work of medical inspection should be carried out in intimate conjunction with the Public Health Authorities and under the direct supervision of the Medical Officer of Health. . . . One of the objects of the new legislation is to stimulate a sense of duty in matters affecting health in the homes of the people, . . ."

⁴ Leff, V. & S, *The School Health Service*, H. K. Lewis & Co. Ltd., 1959.

⁵ A Report of the Central Advisory Council for Education (England), *Children and Their Primary Schools*, (Plowden Report). Vol. 2, HMSO, 1967.

⁶ DES, *The School Health Service: 1908-1972*, HMSO, 1975.

⁷ An Act to make provision for the better administration by the Central and Local Authorities in England and Wales of the enactments relating to Education. This Act may be cited as the Education (Administrative Provisions) Act, 1907.

⁸ DES, op. cit., p. 6. It was renamed Special Service Branch in 1945 and Medical Services Branch in 1972.

Circular 582 comments on the actual management of school medical inspection and circular 596 intends the establishment of school clinics.⁹

(2) Background

To understand the characteristics of the Act it is necessary to know first the birth process of this act.

Medical background—As a precondition we need to view the medical background and health situation of children in those days.

The industrial revolution brought slums in cities, crowded workplaces, depressed bodies and minds in workers and children. These conditions caused many disastrous diseases which became the hotbed for the spread of several communicable diseases. To counter these diseases, the Public Health Act was enacted in 1848. Since then, environmental health has been stressed. Around the beginning of this century preventive medicine prevailed, and personal hygiene was stressed.¹⁰

Under these circumstances, school doctors were appointed first in London in 1890, then in Bradford in 1893, and in 85 Local Education Authorities by 1905. School medical inspections had been performed in 48 authorities. School nurses were appointed in London in 1901. The Education Act 1907 provided for school clinics to be opened in every authority. The first one opened in Bradford in 1908. That was on the ground floor of the city hall and very well situated with 10 consulting, waiting room and washrooms. The number of school clinics in England were 30 by 1910, 35 by 1914, 692 by 1919 and 2853 by 1972.

Educational background—Although compulsory education started in 1880, child employment did not disappear and this caused many health problems in school children. For example about half of the children had decayed teeth and almost all of them had malnutrition. Other statistics of the period are: 2.5 million lice heads; 0.6 million near-sighted; 0.3 million hearing defects; 0.48 million physically maladjusted and 1.5 million anemia. This situation was worsened by the Boer War (1899–1902), economic depression and much unemployment. Therefore many LEAs had to investigate health situation of their children. The provision of school lunches was an urgent necessity because the central and most serious health problem of children was malnutrition.

There were, however, two stands concerning the school lunch fees. One was represented by the Conservative Party (then government) which opposed free school lunches and the other was represented by the newly formed Labour Party (formed in 1900) which insisted on free school lunches. At the general election in January 1906, the Liberal Party, supported by the newly formed Labour Party, won. Consequently, some policies of the latter were realized. For example, providing school lunch (and some workers laws), namely an Act to make provision for Meals for Children attending Public Elementary Schools in England and Wales, 1906, cited as the Education (Provision of Meals) Act, 1906.

According to the Act, school lunches were not perfectly free but it performed the pilot-like role for the following policies because it was the first social assistance in public education.¹¹ Eighty five LEAs started school lunch under the Act by 1908–9 and more than a hundred by

⁹ *Ibid.*, Circulars 576, 582 and 596, The Board of Education, HMSO, 1907.

¹⁰ Hashimoto, Masami, *Community Health Practices—From the View Point of Public Health and Administration*, Igaku-shoin, 1968, p. 30.

¹¹ Miyoshi, Nobuhiro, *The History of the Labor Party's Education Policies in Britain*, Aki-shobo, 1974, p. 144.

1910-1.¹²

Military background—Around the beginning of this century, some developed countries competed each other to get more colonies through the world. Then, they were on the road to WWI (1914-8, the first redivision of colonies among developed countries). At the time of the Boer War about half of the seven hundred thousand candidates for recruitment were rejected because of their bad physiques. For instance, in Manchester in 1899, eight thousand of eleven thousand candidates were omitted immediately because of their bad physiques and finally only twelve hundred were recruited, nearly ten percent.¹³

Such a situation made the Conservative Government and Military Office nervous. They made two interdepartmental committees in order to implement countermeasures in 1902 and 1903, and they reported respectively in 1904 and 1905.¹⁴

In the former report there were many recommendations. For example, some of them called for systematic health inspections in schools and the provision of school lunches. These reports influenced the enactment of the Education (Provision of Meals) Act, 1906 and furthermore the birth of physical education and health education.

With regards to physical education, the first syllabus was published in 1904, which was the revised from *Model Course* (1902). *Model Course* was based on the War Office's *Infantry Training*.¹⁵ *Syllabus of Hygiene for Teachers Training* was the first book published on health education in 1907 for teachers' training. It was then adopted for primary and secondary schools and influenced current health education.¹⁶

With relation to some policies concerning physical problems mentioned above, the School Medical Service especially introduced medical inspection in 1907 as one of the comprehensive countermeasures for children's health problems.

(3) Foundation

By the Education Act 1907, the LEAs were obligated to found school clinics and to employ school nurses. In 1912, medical treatment also was permitted. By the Education Act 1918, immediately after the WWI, medical inspection was only given to secondary schools and medical treatment to primary schools.¹⁷

The Act of the Ministry of Health was established in 1919, by which the whole powers and obligations of the Board of Education for medical inspection and treatment were transferred to the Ministry of Health, but with a condition. It was that the Board of Education implemented those powers and obligations for school children instead of the Ministry of

¹² Simon, Brian, *Education and the Labour Movement 1870-1920*, Lawrence & Wishart 1965.

¹³ McIntosh, P.C., *Physical Education in England Since 1800*, Bell & Hyman, London, 1952, revised & enlarged in 1968, p. 148.

¹⁴ Report of the Interdepartmental committee on Physical Deterioration (1904), HMSO, London. Report on the Interdepartmental Committee on Medical Inspection and Feeding of Children Attending Public Elementary Schools (1950), HMSO, London.

¹⁵ Uchiyumi, Kazuo, 'Study on the Aims and Objectives of Physical Education in England', *Hitotsubashi Journal of Arts and Sciences*, Vol. 24, No. 1, December, 1981. McIntosh, op. cit., chapter 9.

¹⁶ Uchiyumi, Kazuo, op. cit., (3).

¹⁷ In the subsection 18-(1) of the Education Act, 1918, medical inspection and *treatment* of children attending *secondary* schools are the responsibility of LEAs. However, in some references, for example (4) (5), only inspection is described. This will be the problem of further study.

Health.¹⁸ Therefore few changes occurred in everyday school medical services. And the Chief Medical Officer of the Ministry of Health held one position on the Board of Education as well.

Despite WWI and the economic depression around 1930 the School Medical Service developed with local medical services.

2. Development of SHS (From 1944 to 1974)

(1) National Health Services Act, 1946

As McIntosh said, the Boer War, WWI and WWII performed the introductory role of some educational policies including health policies.¹⁹ Although the severe battle between 1939–45 resulted in the retardation of SHS in England, two acts, the Education Act 1944 intended to reform post war education and the Act of NHS 1946, developed the SHS. It became free for children of primary and secondary schools to receive medical inspection and treatment by the Education Act, and for every English national by the latter act.

The Education Act 1944 obligated LEAs to perform (1) provision of school meals and milk, (2) free medical and dental inspections and treatments. The Act also obligated parents to make their children take those services outlined in (2).

A regulation of SHS in 1945 asked LEAs to appoint school dentists as well as school doctors who were already appointed. Also, the regulation raise the level of school nurses by requiring them to have the certificate of health visitor. Tables 1–3 give statistics on child diseases, school doctors and school nurses.

Table 1 is on the recorded incidence per 100 children examined of certain diseases and

Table 1. Recorded Incidence per 100 Children Examined of Certain Diseases and Defects Found at Periodic Medical Inspections to Require Treatment, 1915–1963

Condition	1915†	1931	1963
Malnutrition	13.3	1.2	0.5
Unclean heads	14.2	14.0	1.7
Unclean bodies	6.2		
Skin disease	1.8	1.2	1.4
Cardiac defect	3.6	0.2	0.2
Lung disease	3.6	Not available	0.5
Disease of nose and throat	20.7	7.0	1.5
Middle ear infection	2.5	0.5	0.3
Defective hearing	11.1	0.4	0.6
Defective speech	1.3	[Not available] [1.9 in 1932]	0.5
Defective vision (including squint)	17.3*	9.6*	7.8
Dental disease	69.1	68.0	62.0

* Excluding entrants to school. † Among pupils in 90 areas only.
Source: Plowden Report, Vol. 2, p. 51.

¹⁸ An Act to establish a Ministry of Health to exercise in England and Wales powers with respect to Health and Local Government, and confer upon the Chief Secretary certain powers there with (3rd June, 1919). This Act may be cited as the Ministry of Health Act, 1919.

¹⁹ McIntosh, op. cit., p. 143.

defects found at periodic medical inspection to require treatment, 1915–1963. From this we can appreciate the decrease in malnutrition, unclean heads and bodies, disease of nose and throat, middle ear infection and defective hearing.

Table 2 shows the number of school nurses between 1931 to 1963, and the rate of nurses against students has been stable recently.

Table 3 shows the rate of doctors against students.

Table 2. Number of School Nurses, 1931–1963

	Number of nursing staff	Number of nursing staff who were trained health visitors	Resultant equivalent number of whole-time school nurses	Ratio: nurse to pupils
1931	3,230	—	2,235	1:2,300
1938	3,313	—	2,398	1:2,000
1947	3,857	—	2,297	1:2,200
1955	6,276	4,561	2,548	1:2,600
1963	7,449	5,749	2,667	1:2,600

Source: Ibid., p. 81.

Table 3. Number of Doctors in the School Health Service, 1931–1963

YEAR	Whole-time in school health service	Whole-time school health and local health authority services		General Practitioners and married women doctors		TOTAL		Ratio: Full-time school Doctor to pupils
No.	No.	No.	Equiv. number working whole-time in school health service	No.	Equiv. number working whole-time in school health service	No.	Equiv. number working whole-time in school health service	
1931	277	676	—	386	—	—	662	1:7,500
1938	266	903	—	349	—	—	728	1:6,220
1947	276	1,332	—	—	—	—	832	1:6,000
1955	198	1,477	654	578	95	2,253	947	1:7,040
1963	146	1,752	733	623	103	2,521	982	1:7,250

Source: Ibid., p. 80.

3. From Education Area to Medical Area (From 1974)

(1) Reorganization of NHS

The National Health Service Reorganization Act enacted in 1973 transferred SHS on the date of April 1, 1974 from LEA to the Local Health Authority by sub-section 3-(1) of the Act:

“it shall be the duty of the Secretary of State to make provision for the medical and dental inspection at appropriate intervals of pupils in attendance at schools maintained by local education authorities and for the medical and dental treatment of such pupils”.

According to the Act every national can access necessary medicine with free charge. As the background elements for reorganization, economical depression, social instability. . . . On the other hand, inner reasons of NHS as such were that the respective services in NHS had been served separately, therefore the united and comprehensive services by an authority could not work smoothly. There were two reasons.²⁰ First, the inter relations between hospital services were not close enough in NHS. Secondly, some medical services, SHS by LEA, environmental health services by local authorities and industrial health services by the Ministry of Employment etc., were not parts of NHS.

(2) Some Opinions About the Transference of SHS into NHS

Some criticisms were raised on this transference. For example, some LEAs demanded the retention of their powers and obligations on SHS.²¹ Local Authorities Association (LAA) and National Union of Teachers (NUT) urged around 1971 that SHS should not be transferred into NHS and that it should stay under the supervision of LEA.²²

At this stage, May 1971, the Secretary of the Department of Social Services issued *NHS Reorganization* and started working groups to arrange and to establish new relationships between local authorities and new medical authorities.

Three working parties were organized. The first one was to arrange services in the Inner London City and was led by the Secretary of the Department of Health and Social Security. The second one made a report entitled *Management Arrangements for the Reorganized National Health Service*.²³

The third party wrote *A Report from the Working Party on Collaboration between the NHS and Local Government on its Activities to the End of 1972*.²⁴ Staff of this working party were from local authorities, NHS, Central Government and DHSS. At the first meeting of this party on August 3, 1971, three sub committees were established; personal social services, environmental health services and SHS.

The main purposes of those three sub committees were the establishment of the Joint Consultative Committee in the newly established health authorities and especially on the arrangement between various medical workers in the sub committees of environment and SHS. The School Health Service Group of the Society of Medical Officers of Health presented a document *The work of the School Health Service* to the sub committee of SHS with opinions on the actual situation of SHS and the functions of school doctors.²⁵

One year later, August 1972, these sub committees published their own reports for hearing from concerned organizations. After gathering the results which emanated from the hearings, both Secretaries from the Departments of Social Services and Education and Sciences recognized the committee opinions and decided to reorganize the NHS.

At the Annual Dinner of the Society of Medical Officers of Health in 1957, after being asked "whether with the Nation Health Scheme, a special service for school children is still

²⁰ Hino, Shuitsui, *Community Health and Life in England*, Jichitaimondai-kenkyusho, 1981, p. 75.

²¹ The Report of the Committee on Child Health Service, *Fit for the Future*, DHSS & DES, HMSO, 1976, p. 77.

²² 'Cinders No Longer', *Public Health*, Vol. 85, No. 3, March 1971.

²³ *Management Arrangements for the Reorganized National Health Service*, HMSO, 1972.

²⁴ *A Report from the Working Party on Collaboration between the NHS and Local Government on its Activities to the End of 1972*, HMSO, 1973.

²⁵ 'The Future of the School Health Service', *Public Health*, London, Vol. 86, No. 3, March 1972.

necessary," Sir Edward Boyle, Parliamentary Secretary to the Ministry of Education thought the answer was clearly "yes."²⁶

At the reorganization of NHS seventeen years later of 1957, the supervision of SHS was transferred, however the demand for SHS as such have increased.

In the next chapter the objectives and function of SHS and in the chapter III the system of SHS will be discussed.

II. *Objectives and Functions of SHS*

After the Education Act (1907) had been enacted circular 576 (1907) of the Board of Education described the aims of school medical inspections as follows:

"medical examination and supervision not only of children known, or suspected, to be weakly or ailing, but of all children in the elementary schools, with a view to adapting and modifying the system of education to the needs and capacities of the child, securing the early detection of unsuspected defects, checking incipient maladies at their onset, and furnishing the facts which will guide education authorities in relation to physical and medical development during school life."²⁷

Immediately after the WWII, the Central Council for Education raised the following seven items as aims of a comprehensive SHS,²⁸

- ① more comprehensive supervision of children in school;
- ② more and better facilities for treatment in hospitals and clinics;
- ③ complete child health records kept continuously and generally;
- ④ the early years of employment covered by health supervision on similar lines;
- ⑤ sound, effective health education in all schools;
- ⑥ suitable provision for handicapped children and
- ⑦ teachers well informed so that they can co-operate satisfactorily with the school health service.

In the Plowden Report (a report designed to reform the primary school system), the contents of SHS were disclosed in five items;

- ① the medical examination of children in school;
- ② the detection, assessment and medical supervision of handicapped pupils in school;
- ③ the advising of teachers and counselling of parents;
- ④ health education;
- ⑤ the control of infectious diseases in school.

There was another proposal on the objectives and functions of SHS, however, it did not exceed the ones mentioned above.

Here, there are some common features among them. For example, first, medical inspection was stressed. Secondly, on medical treatment and facilities what was stressed had changed. In 1907 the circular had no description on medical treatment as around then medical treatment was not an obligation of the local authorities, but around 1947, the situation had changed.

²⁶ Leff, op. cit., p. 290.

²⁷ Cited from Plowden Report, op. cit., (4), pp. 75-6.

²⁸ The Ministry of Education, *School Health and Life*, HMSO, 1947, cited from Leff, op. cit., p. 293.

Under NHS the main point of SHS was on the preventive, screening aspects more than on the treatment. Furthermore consideration was placed on school health staff and the arrangement of documents.

If any of the screened children had problems, they were sent to local health centres or hospitals for more complex treatment.

There is an important difference in where emphasis is placed in SHS between England and Japan. In the former the objectives and functions of SHS are discussed only from the medical aspect, but in the latter the educational aspect is also emphasized.

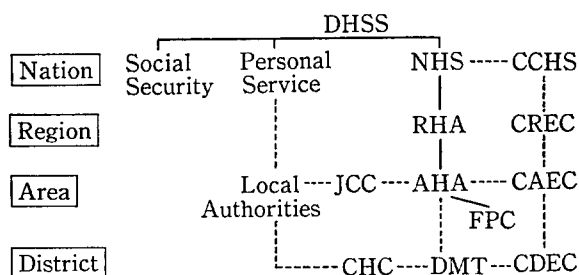
III. *System of School Health Service*

I. Area Medical Services (AMS) System

SHS became a component of the area medical service in NHS, so we should look at AMS in England first.

The population of England is 49 million and it is divided into 14 regions with their respective regional health authorities. Under those regions 90 areas have area health authorities (AHA) and 205 medical districts (see Figure I).

Figure 1. Structure of Social Security in England



Regional Health Authority (RHA) organizes health projects in the region and manages the distribution of health resources to AHAs and supervises their activities. AHA has responsibilities in meeting health demands of the area, to plan and administrate health services in the area. Although meetings are held once or a few times a month in the regional and area health authorities, regional and area teams of officers work to routine.

The management and administration at the level of health district is carried out by the District Management Team (DMT).

One Community Health council (CHC) is generally established in every medical district, totally 207 in England. The members of CHC are around 18–36, and although more than half of them are appointed by local authorities, one-third are from voluntary bodies concerning NHS and the rest are appointed by health authorities. The chairperson is elected among the members. The role of CHC is to recommend and advise AHA on health needs and give opinions about health services in the area, district.

The Joint Consultative Committee (JCC) was established to promote mutual coopera-

tion between social services, education and NHS in the area. Therefore SHS will be discussed here.

Local health practices consist of the following functions.

- ① The system of enrolled doctors—General practitioners in England are not civil servants but independents. They rent health centres (public facility) and patients are enrolled to any doctor.
- ② Health visiting—For the population of England 49 million, there are 10,300 health visitors, 15,000 district nurses.
- ③ Volunteers—They help people whom local authorities do not see enough.
- ④ Residents participation—CHC guarantees that intention, originated by the NHS reorganization in 1974. Voluntary organizations delegate some members to CHC.

These four functions are integrated in the health centre which is just a centre for primary care. Health centres were also transferred from the local authorities to AHA of NHS in 1974. In the ordinary health centre there are several doctors and they form groups with district nurses, health visitors and midwives. . . . The number of health centres has increased as follows: 28 (1948–67); 241 (1968–71); 309 (1972–76) and to more than 850 in 1977.

2. Community Health Practices

The author could not get recent materials of medical experts in SHS since the NHS reorganization in 1974. Therefore he uses those of 1973. (See Table 4). Health visitors with a certificate form the largest group, because they are usually engaged in SHS. Recently, health inspections by doctors in schools have been held when students confer and at one other

Table 4. *Staff of the School Health Service as at 31 December 1973*

	Medical Officers				Ophthalmic Specialists	Other Consultants and Specialists	Nurses and Health Visitors			Speech Therapists			Audiometricians	Chiropractists	Orthoptists	Physiotherapists	Others (excluding clerical staff)
	Solely School Health Service	Part-time School Health Service/rest of time on Local Health Service	Part-time School Health Service/rest of time as General Practitioner	Part-time School Health Service/rest of time on other medical work			With Health Visitors' Certificate	Without Health Visitors' Certificate	Nurses' Assistants	Senior Speech Therapists	Speech Therapists	Assistant Speech Therapists					
NUMBER																	
England																	
Full-time	110	1,114	—	—	4	—	4,058	1,377	275	125	314	11	81	57	15	153	146
Part-time	73	727	837	437	319	240	2,404	1,604	435	26	482	13	78	202	44	294	112
Wales																	
Full-time	3	117	—	—	—	—	421	164	13	8	7	—	3	16	—	3	8
Part-time	2	50	26	22	14	10	82	162	10	2	20	1	24	2	4	6	—
Total																	
Full-time	113	1,231	—	—	4	—	4,479	1,541	288	133	321	11	84	73	15	156	154
Part-time	75	777	863	459	333	250	2,486	1,766	445	28	502	14	102	204	48	300	112
WHOLE-TIME EQUIVALENT:																	
England	132.5	767.0	93.3	68.4	64.6	22.4	1,636.1	1,604.4	355.0	136.1	484.1	14.6	119.2	55.6	26.8	245.7	192.4
Wales	3.7	63.2	4.2	7.8	1.7	0.8	109.0	110.5	13.8	7.5	14.8	0.8	5.9	1.1	1.4	4.6	8.0
Total	136.2	830.2	97.5	76.2	66.3	23.2	1,745.1	1,714.9	368.8	143.6	498.9	15.4	125.1	56.7	28.2	250.3	200.4

Source: DES, *School Health Service: 1908–1974*, p. 49.

time. However, the usual functions of SHS are performed by health visitors. In this case, they are called "School Nurses".

(1) Primary Health Team

The reorganization of NHS changed also the system of local health practices; a district system was cancelled and a primary health team system was introduced.

Health visitors once had responsibilities for a district, but now they are responsible for people who are enrolled to a doctor with whom they work with in a same team.

Doctors in England do most of their work in counselling room and don't treat patients so much as in Japan. They advise and prescribe medicine. Patients with serious diseases are sent to regional hospitals. Everyday medical guidance and treatment at home are very important, and they are the task of health visitors and district nurses.

(2) Community Health Visiting

It is said that community health visiting in England has two characteristics,²⁹ health visiting and home nursing. The following staff are involved in community health visiting.

Health visitor—People who have graduated from a three year course in nursing school and a one year course in health visiting can be certificated as a health visitor. Their practice includes health education, health counselling, care and aftercare for tuberculosis, disabled people and aged people. . . .

District nurse—They nurse patients in the patients' home by making the bed, bathing, bandaging, giving injections and having medicine. . . .

Midwife—Recently child-births in hospital have increased, but usually the mothers only stay in hospital for two days. For ten days after leaving hospital they are under the supervision of a midwife and then they come under the supervision of a health visitor in the same primary health team.

The distinction between health visitor and district nurse is a result of a discrimination between health guidance, education and nursing. However, in some rural areas, staff are lacking and there are occasionally some triple duty nurses.³⁰

(3) School Nurse

"The 1945 School Health Regulation recommended that all school nurses should be qualified health visitors", however, "for reasons not entirely clear, but possibly connected with the 1959 School Health Regulations, which accepted nurses without health visiting qualifications as school nurses". Therefore, the belief that school nurses were only capable of examining heads for lice ("Nitty Nora") extended to many teachers as well as pupils and had given, little scope for school nurses to fully use their skills.³² Recently the situation has been improved.

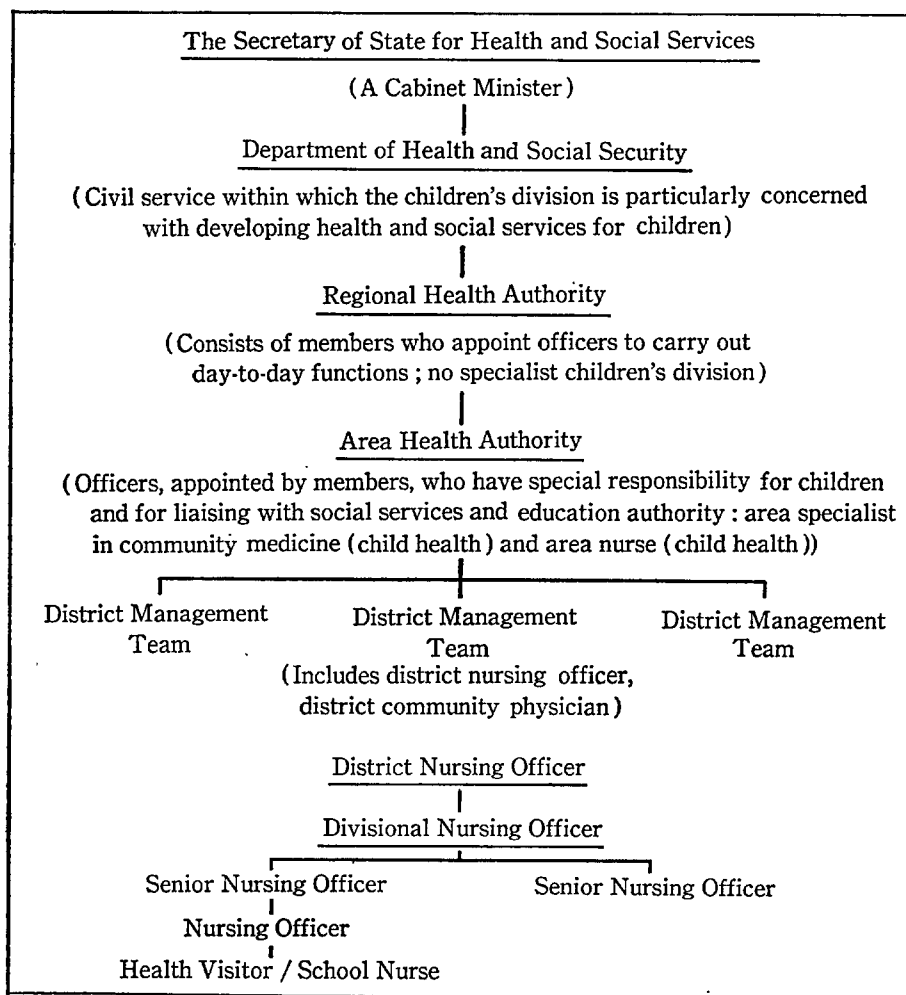
²⁹ Matsuno, Kaoru, 'Community Nursing Practices in England', *Kango (Nursing)*, Vol. 21, No. 12, December 1969.

³⁰ Kanekawa, Katsuko, 'Study on the system of community nursing practices in England (I)', *Bulletin of the Junior College of Medical Techniques at Kanazawa University*, Vol. 3, No. 1, 1979.

³¹ Slock, P.A., *School Nursing, A basic introduction to nursing in primary and secondary education*, BAILLÉRE TINDALL, 1978, p. 18.

³² *Ibid.*, p. 16.

Figure 2. *The Position of School Nursing in the Structure of the NHS*



Source: Stock, P. A., *School Nursing*, p. 18.

Table 5 shows the total hours and percentage of time spent on all work activities by health visitors doing normal duties, surveyed in an English county in October 1973.³³

Their average working hours a week was 35.03. They spent 12.1 hours (34.55%) in home visits, 8.63 hours (26.62%) in clerical and administration duties and 4.16 hours (11.88%) in travelling, and 3.36 hours (9.59%—42 minute a day) in school nursing. Within small schools nursing duties comprise of: medical inspections 37% of them, home visits-13.1%, hygiene inspection 12% and so on. One can see that medical and hygiene inspections occupy the central part of their duties.

³³ Thurmott, Priscilla, *Health and the School, An exploratory survey of the school nursing service in an English county*, Royal College of Nursing of the U.K., 1976.

Table 5. Total Hours and Percentage of Time Spent on all Work Activities by Health Visitors doing Normal Duties

	The survey week (hours)			The survey week (percentages)		
	School nursing	All other work	Total	School nursing	All other work	Total
Travelling	19.28	222.2	241.48	0.95	10.93	11.88
Home visits	25.58	676.42	702	1.26	33.29	34.55
Clerical and administration	21.25	479	500.25	1.05	23.57	26.62
Clinic sessions	0.5	103	103.5	0.02	5.07	5.09
Health education	17.42	13.5	30.92	0.86	0.66	1.52
Developmental testing and screening	0.67	60	60.67	0.03	2.96	2.99
Hygiene inspections	23.17		23.17	1.14		1.14
Vision testing	7.5		7.5	0.37		0.37
Pre-medical inspections	0.5		0.5	0.02		0.02
Medical inspections	72.25		72.25	3.55		3.55
Meetings		63.42	63.42		3.12	3.12
Child health sessions		163.5	163.5		8.05	8.05
Home nursing and midwifery		—	—		—	—
Other	6.92	55.83	62.75	0.34	2.75	3.09
Total	195.04	1,836.87	2,031.95	19.59	90.41	100%

Source: Thurmott, P., *Health and the School*, p. 48.

Table 6. Availability of Medical Rooms in Schools Which Health Visitors Served

	Schools where medical room was			Totals	No answer
	Available with exclusive use	Available but not with exclusive use	Not available		
(a) <i>Primary schools:</i>					
Number of health visitors	12	38	37	57	2
Number of schools	15	66	85	171	5
(b) <i>Secondary schools:</i>					
Number of health visitors	17	14	6	36	2
Number of schools	17	15	6	40	2
(c) <i>Special schools:</i>					
Number of health visitors	1	1	—	2	
Number of schools	1	1	—	2	0

All health visitors-58 All schools-213.

Source: *Ibid.*, p. 29.

(4) Medical Inspection Room

By *Standards for School Premises Regulations, 1959*, the availability of a room designed for the use of the health visitor/school nurse and known to be so used may be more important than the availability of a medical room. Table 6 shows the availability of medical rooms in schools where health visitors frequent.

In secondary schools, the availability of a medical room with exclusive use is in 17 schools (42.5%)—there is a medical room without exclusive use in 15 schools (37.5%)—. Together, a room can be seen to be provided in 32 schools (80%). However, in primary schools only about half of them have medical rooms. In all primary, secondary and special schools 54% have medical rooms.

Conclusion

There are both similarities and differences in the functions of SHS between England and Japan. A deeper comparative study of the two systems would produce mutual benefits for both countries.