

opportunity for treatment. It is imperative that measures be taken to conserve the health of children. As shown in Section II, the Health Department, the Education Department, and Voluntary Aid Associations have already done much in this country to meet this prime indication.

*Medical Inspection of Schools.*—The medical inspection of schools is well organized and efficiently carried out. It is desirable that medical inspection be extended to the high schools as opportunity permits.

*Open-air Schools.*—Efforts are being made to establish open-air schools; but the modern schools of the Education Department appear to meet all requirements, and it were better that the energy expended for this purpose were directed into other channels and used where there is more pressing need.

*Health Camps.*—The health-camp system has given very satisfactory results. It is only in a small way at present, but it should be extended to all parts of New Zealand. It is not an expensive measure, yet funds are lacking. This scheme deserves strong support by voluntary-aid associations. Time and money would be saved if fixed health camps were established. At present a fresh start has to be made each year, and unnecessary difficulties are found in obtaining sites, in arranging for stores, and in organizing the camps.

*Open-air Home for Children.*—The open-air Home for Children at Cashmere is an interesting experiment, but it is expensive, and of limited application. The Committee are of opinion that measures applicable to a larger number of children have a prior claim, and this should be met before other open-air homes are established.

*Nutrition Classes.*—The nutrition classes for the malnourished that have made their appearance in a few schools might with advantage be extended to other schools.

*Convalescent Homes for Adults.*—There is a real need for convalescent homes for adult patients. The patient under treatment at home or who is discharged from hospital is often greatly benefited by a change in the country. Otago Central is, in the South, the happy—or, as at present, unhappy—hunting-ground for this class of patients. The hunt is often unsuccessful, for tuberculous patients are not well received, and often have to resort to deception to gain admission to the ordinary accommodation-houses. There are already convalescent homes for patients discharged from hospitals who suffer from other diseases, as at Warrington, but the great fear the public has of the infectivity of pulmonary tuberculosis bars these places to the tuberculous subject. A convalescent home constructed on open-air lines, and placed in some suitable locality, would meet an ever-present need, and would save many slightly affected patients from the cost of sanatorium treatment. Voluntary Aid Committees might well consider this suggestion.

## 2. (a) Notification.

We would recommend that the Health Department deal stringently with medical practitioners who neglect or decline to notify cases. The Health Officers are willing to forgo inspection if they have an assurance from the practitioner that all necessary precautions are being taken. The dread of inspection is the only reasonable ground for declining to notify. Inspection would in every case be less objectionable and always more helpful if it were done by a nurse. We recommend that local authorities employ a nurse for the purposes of inspection in these cases, or else pay the Health Department for the services of a specially trained departmental nurse. For work of this kind special post-graduate training is necessary, and we note with appreciation that a course of post-graduate training for nurses, which includes instruction in public-health work, has been initiated this year in Wellington.

## 2. (b) Domiciliary Supervision.

All representatives of the medical profession that have appeared before the Committee have stressed the fact that there are many advanced infectious cases in their homes who are under little or no supervision. Some of these are patients discharged from hospitals or who have left hospital against medical advice; some are cases who cannot enter general hospitals because they are barred by Hospital Board regulations, or chronic hospitals for the tuberculous because there is insufficient accommodation. The spread of infection from these cases could be lessened considerably were they supervised periodically by a visiting nurse. This domiciliary supervision is already being done in Dunedin and Christchurch, where there are well-organized tuberculosis dispensaries, but there is need that the system should be extended. It is a very important function of a tuberculosis dispensary, and wherever these exist a nurse detailed for this duty should be attached. In Wellington a tuberculosis dispensary has been opened, but a visiting nurse is not provided. If this dispensary is to do good service this provision must be made. The work of the dispensary nurse must co-ordinate with the inspecting-work done by the local authorities and by the Health Department. In country districts where there are no hospital facilities and distances are great this supervision can only be done by the local medical practitioners; but a financial difficulty at once arises. The patient discharged from hospital fails to report to the practitioner for economic reasons; the practitioner is disinclined to visit from fear of being charged with making a case. The solution of this difficulty is that the Hospital Board concerned should subsidize the practitioner where the patient is unable to pay.

## 2. (c) Institutional Treatment for Chronic Cases.

The chronic open case is the danger. Wherever practicable, these cases, especially indigent bed-ridden cases, should be admitted to hospital. As already indicated in Section III, there is inadequate accommodation in the country for these cases. This need should be supplied, and should have the first call on funds available for prosecuting the fight against tuberculosis.