IRISH MEDICAL ORGANISATION
Ceardchumann Dochtúirí na hÉireann

Advocating for Change

IMO Position Papers 2005-2010

April 2011

Irish Medical Organisation
10 Fitzwilliam Place
Dublin 2
tel (01) 676 72 73
fax (01) 661 27 58
email imo@imo.ie
website www.imo.ie

Mission Statement

The role of the IMO is to **represent** doctors

in Ireland and to **provide** them with all relevant services.

It is committed to the **development** of a caring,

efficient and effective Health Service.

Advocating for Change

IMO Position Papers 2005-2010

Contents

IRISH MEDICAL ORGANISATION
Ceardchumann Dochtúirí na hÉireann

Introduction

As the leading representative body for the medical profession, the Irish Medical Organisation (IMO) is strongly committed to the development of a caring, efficient and effective Health Service. In this context, advocacy is a key activity of the IMO and the Research and Policy Unit conducts research and develops policy on a wide range of Health Service and Societal issues with the aim of influencing Public Policy in a constructive and practical way.

Doctors have a unique knowledge and experience and are best placed to advocate for better health services on behalf of their patients. The IMO harnesses that unique knowledge and over the years, has developed numerous influential policy papers based on general motions passed at the AGM and in consultation with its members.

This document is designed to act as a reference guide to IMO policy. It provides a brief summary of each policy paper from 2005 to 2010 followed by the IMO Recommendations. All Policy Papers are available to download on the IMO website at www.imo.ie/policypapers

For further information contact:
Vanessa Hetherington
Research and Policy Unit
Irish Medical Organisation
10 Fitzwilliam Place
Dublin 2
Tel: (01) 6767 273
Fax: (01) 6612 758
Email: vhetherington@imo.ie

Mental Health Services – Nov 2010

In 2010, the IMO surveyed GP and Consultant Psychiatrist members to find out the major issues affecting the treatment of patients with mental health illness. The IMO Position Paper on Mental Health Services are based on the result of that survey and on issues raised at Annual General Meetings of the IMO in recent years. Doctors are frustrated that patients continue to be treated in antiquated institutions inappropriate to their needs and that community mental health teams are inadequately staffed for the provision of holistic multidisciplinary care. For more than a decade the IMO has been calling for adequate Mental Health Services and since the publication of the Mental Health Strategy – *A Vision for Change* members have deplored its slow progress. The IMO have called on the Minister for Health and Children to replace rhetoric with action and implement Mental Health Policy.

Specifically the IMO recommends:

Funding

- The budget allocated to Mental Health Services should be transparent, based on need and represent value for money;
- Capital funding for the implementation of *A Vision for Change* must be ring-fenced. Funds from the sale of psychiatric lands must be immediately released and diverted funds must be returned;

Leadership and Planning

- In keeping with the recommendations of *A Vision for Change* the HSE should set up a specific Mental Health Directorate to oversee implementation of Mental Health Policy;
- The HSE implementation plan 2009-2013 should be published showing clear links between outcomes, timeframe and resources;

Mental Health in Primary Care

- Resources and adequate support must be provided for the treatment of mental health patients in Primary Care including:
  - direct access to publicly funded counselling and psychotherapy services;
  - improved communication links between General Practice and Mental Health Services to support GPs in the treatment of patients and with appropriate referral and follow-up care;
  - a consistent nation-wide position on the provision of free medication to patients with psychiatric disorders.

Mental Health Act 2001

- The IMO calls on the Mental Health Commission to review with regard to cost and the effects on the treatment of patients:
- the operation of Mental Health Tribunals;
- involuntary admissions procedures.

Multi Disciplinary Community Mental Health Teams

- The moratorium on recruitment in the HSE must be lifted immediately to allow the urgent recruitment of full multi-disciplinary Community Mental Health Teams;
- Services should be of equal high standard across regions and Mental Health and Primary Care catchment areas should be co-terminus;

- Evidence based intervention programmes including home-based services, crisis intervention and assertive outreach services must be provided to respond to the needs of people with acute illness on a 24/7 basis;
- Crisis intervention requires joint collaboration between Mental Health Services and the Garda Síochána;
- Funding should be provided to roll out the early intervention in psychosis pilot programme on a national basis;

Services for people with Severe and Enduring Mental Illness

- Rehabilitation and recovery teams must be established and secure alternative accommodation provided beforehand to facilitate the closure of the remaining 15 psychiatric institutions and the transfer of patients into the community setting;
- A cross-departmental approach is required to ensure that the housing, employment, education and social welfare needs of vulnerable patients are met;
- Recovery is a cornerstone of the Mental Health Strategy and all staff should be trained in recovery-oriented competencies;

Child and Adolescent Mental Health Services (CAMHS)

- Urgent attention must be given to the completion of 100 Child and Adolescent in-patient units in order to reach the deadline of December 2011when no child under 18 years is to be admitted to an adult unit;
- Full multi-disciplinary CAMH teams must also be established to guarantee timely assessment and treatment of young people with mental illness;

Mental Health Services for Older People

- Dedicated old age psychiatry services must be rolled out throughout the country with a focus on treatment within the home and family contexts;
- Service provision must be based on actual numbers of elderly people;
- Where acute hospitalisation is required, patients should be accommodated in specialised units with staff trained in dealing with old age problems;
- Access to appropriate public residential care for elderly people who are mentally ill must be provided on an equal basis;

Specialist Mental Health Teams

- Full specialist Mental Health Services must be developed including services for patients (both adults and children) with intellectual disability, liaison services, forensic services and patients with dual diagnosis of addiction and mental health disorder and patients with eating disorders;

Mental Health Awareness

- Continued investment in mental health awareness and suicide prevention is needed. The recommendations detailed in *Reach Out: The National Strategy for Action on Suicide Prevention 2005-2014* and the report of the Joint Oireachtas Sub-Committee on the *High Level of Suicide in Irish Society* must be implemented in full;
- The media should recognise its role in reducing stigma and national media guidelines should be developed in respect of reporting on individual's mental health issues;
- Adequate psychological and financial support should be provided for carers.

Universal Health Coverage – Apr 2010

Mounting pressure on the health care budget and the fear of lack of services has pushed debate on universal health insurance firmly onto the public agenda. The IMO is committed to a universal healthcare system that aims to secure access to adequate quality healthcare for all when they need it and at an affordable cost. The IMO also insists that whatever changes are introduced to health coverage in Ireland, the process by which change is brought in must include:

- Informed public debate;
- Consultation with all relevant stakeholders, including patients and doctors;
- Detail of the proposed model including funding sources;
- Analysis of current and future manpower resources needed for implementation;
- A realistic time table for implementation.

The IMO Position Paper on Universal Health Coverage examines the current issues and challenges facing the Irish healthcare system – access to services, inequity and sustainability and outlines the rationale for health funding reform.

The IMO recommends that the following principles should form the basis of a universal health care system regardless of the model of financing:

IMO Principles of Universal Healthcare

Universality – access to adequate healthcare for all

All residents in Ireland should have access to appropriate 'promotive, preventive, curative and rehabilitative healthcare'[1]. This means that all residents should be entitled to medically necessary care including hospital and GP services as well as services such as public health services and long-term care services which are ill-catered for under traditional social health insurance models.

Health services that are free at the point of access

All residents in Ireland, not just medical card holders, should be entitled to medically necessary healthcare that is free at the point of access.

Equity of access

Access to services must be based on medical need only and not on ability to pay or any other criteria including place of residence or age.

Solidarity

A universal health system requires a degree of social solidarity where healthy people subsidise the sick and the rich subsidise the poor. The funding system must be progressive – that is based on ability to pay. The State must provide a safety net so that healthcare is affordable for low-income groups and individuals with higher medical needs.

1. WHO Achieving Universal Health Coverage: Developing the Health Financing System Technical Briefs for Policy-Makers No. 1 2005

Transparency

The public should be able to see clearly what they are paying towards healthcare and what they are receiving in return, thus allowing people to make a better judgement on whether they are receiving value for money or not. The health services that patients are entitled to should be clearly defined. Decisions concerning public funding should be made in an open and transparent manner.

Quality of care and value for money

Quality and value for money must continue to be the core of health service provision in Ireland regardless of whether providers are public, voluntary not-for-profit or private. Standards of care must be based on evidence and international best-practice and must be adequately communicated as well as independently monitored.

Choice and Mobility

The doctor-patient relationship must be respected. Patients must be allowed to choose their physician.

Clinical Autonomy

Clinical autonomy must be guaranteed. Physicians must be free to diagnose and treat patients without political interference or interference from third party insurers. Conflicting political and commercial interests must not impact on a doctor's professional duty to act in the best interest of the patient. Doctors must be free to advocate for services on behalf of their patients.

Efficiency

The flow of funds, from collection and pooling to purchasing, must be carried out efficiently. In the purchasing or provision of services money must follow the patient.

Affordability

The health care system must be affordable. Measures to contain costs must be evidence-based.

Sustainability

The health financing system must be flexible enough to cope with: the needs of an ageing population; future trends in health care provision; increasing public expectations and rapidly changing technology.

Lifestyle and Chronic Disease – Sep 2008

Chronic diseases such as cancer, cardiovascular disease, diabetes, mental health problems and asthma are a major cause of death and ill-health in Ireland and worldwide. Certain lifestyle factors such as obesity, poor diet, physical inactivity and tobacco, alcohol and drug consumption are known to increase the risk of chronic disease. At least 80% of heart disease, stroke and type 2 diabetes as well as 40% of cancer could be prevented if certain major risk factors were eliminated.

Despite this, trends in obesity and alcohol and drug consumption continue to rise, though smoking rates have stabilised. Chronic diseases and associated mortality are unevenly distributed across social groups, as are the underlying lifestyle factors that contribute to them.47 38% of those at risk of poverty and 47% of those living in consistent poverty report having a chronic illness compared to 23% of the general population. Mortality rates from chronic diseases are three times higher in the lowest occupational classes than in the highest. Rates of obesity, tobacco, alcohol and drug consumption are all higher amongst lower income groups. Lifestyle choices are established in childhood and adolescence. In Ireland, high rates among young people for all risk factors prevail.

Members of the IMO are calling for the elaboration and implementation of an over-riding lifestyle policy for the prevention of chronic disease which facilitates and promotes healthy lifestyle choices among the general population.

IMO Recommendations

Structural

- An intersectoral committee should be created to develop and prioritise schemes that promote healthy living across all Government departments.
- Because different diseases have common risk factors, prevention strategies should be integrated in an overriding healthy lifestyle promotion policy.
- Strategies should be integrated across settings, such as health centres, schools, workplaces and communities.
- A population-wide approach is needed to take the focus away from the individual and should include legislation, tax and price intervention, information and awareness campaigns and proven screening procedures.
- Because risk factors are established in childhood and adolescence and rates are higher in lower socio-economic groups campaigns should also be tailored toward young people and lower income groups.

Funding

- Taxes such as levies on tobacco and alcohol should be ear-marked for health initiatives.
- Funding for lifestyle health promotion should be clearly defined in the annual budget and protected.

Planning and Investment

- Planning and investment should be long-term with return measured in terms of expected health gains.

Health Services Organisation and Delivery

- Health services organisation and delivery should be reoriented away from reactive acute health care towards clinical prevention and control.

- Resources should be provided for the expansion of primary health care services with particular emphasis on lifestyle and chronic disease issues.
- Clinical interventions designed to reduce both the onset of disease and the development of complications should be based on overall risk.
- Chronic disease registries should be established for patient management, to identify people at risk of second chronic diseases and for monitoring the effectiveness of health promotion and disease prevention programmes.
- Evidence based treatment guidelines should be elaborated and implemented across the health service. Treatment guidelines should be based on best research data available and established in conjunction with healthcare workers.
- All health care workers especially doctors must be encouraged and supported to initiate discussion of lifestyle issues and risks with patients. Suitable training must be provided for doctors in both prevention and treatment and materials used should be universal and standardised.

Patient Involvement

- Services should be provided to support patients in behaviour change.
- Patient self-management should be strengthened by providing basic information about risk factors and the skills to those at lower risk to manage their own conditions with some support from health care workers.

Suicide Prevention – Sep 2008

Suicide prevention is a major public health challenge both in Ireland and worldwide. The IMO Position paper on Suicide prevention looks at suicide rates in Ireland and explores the complex relationships between depression and suicide, alcohol abuse and suicide and young males and suicide.

The Position Paper then looks at Suicide Prevention Strategies including treatment approaches, follow-up care after suicide attempts, awareness and education campaigns societal and community based interventions. While there are few evidence based interventions that have any impact on suicide rates, there are however promising initiatives that impact on mental health in other ways that need to be researched, implemented and evaluated further.

IMO Recommendations

- The IMO calls for the full implementation of the recommendations outlined in *Reach Out: The National Strategy for Action on Suicide Prevention 2005-2014* and the recommendations detailed in the report of the Joint Oireachtas Sub-Committee on the *High Level of Suicide in Irish Society.*

At each level of action proposed the IMO further recommends:

General Population Approach

- Focus on known interventions that encourage early diagnosis and treatment of at-risk individuals for example training and awareness programmes for primary care physicians, hospital staff and mental health services staff and gatekeeper education for school teachers and staff of community organisations.
- Continue to fund and evaluate public education campaigns that improve recognition of mental health problems, reduce stigma and encourage help-seeking.
- Research, fund and evaluate school-based multi-faceted projects which promote self-esteem and improve problem solving amongst young people.

Targeted Approach

- Again focus on known interventions that improve follow-up care after suicide attempts, for example suicide intervention services in hospital Accident and Emergency departments.
- Address the inequalities in mental health care provision for adults and the under provision of appropriate psychiatric and mental health services for children and adolescents[2] by implementing the recommendations in the report of Joint Oireachtas Sub-Committee on the *High Level of Suicide in Irish Society.*
- Given the relationship between alcohol abuse and suicide the IMO calls for the full implementation of the recommendations of the National Strategic Task Force on Alcohol.
- Continue to fund and evaluate community-based initiatives such as suicide prevention centres, and initiatives that attempt to reduce social isolation.

Responding to Suicide

- Fund and support services for the bereaved including voluntary bereavement support groups.

---

2. Since 2003 the IMO has called for the adequate resourcing of inpatient psychiatric services for children and adolescents.

Information and Research

- Further research is needed into the cause of suicide including:
  - better data collection on suicide and social indicators, divorce, migration, increased alcohol consumption rates etc.
  - the relationship between alcohol, depression and suicide particularly amongst young men
  - media influence on suicide and young people
- Monitor those programmes that improve mental health and protective factors for their long-term impact on suicide rates
- Research and evaluate other interventions for their possible effect on suicide rates or mental health problems

Protecting the Vulnerable – A Modern Forensic Medical Service – Mar 2008

The IMO position paper *Protecting the Vulnerable – A Modern Forensic Medical Service* examines the current state of Forensic Medical Services which relies on the good will of both the Gardaí and of local practitioners, who may have little or no training in forensic medicine or be aware of the rights of victims or detainees.

The IMO Proposal

The Forensic Medical Practitioner's Role

The practitioner must be available to the police and trained to an agreed standard. The police have to be able to rely on a uniform standard of training and expertise being available to them. Among the many sensitive problems which forensic medical practitioners have to treat are allegations of abuse and assault, the examination of detainees, the collection of physical evidence, often of an intimate nature, the provision of professional and expert testimony and medical reports. Practitioners must also treat and support Garda officers injured in the line of duty. They must obtain evidence of the standard required for presentation in court, attend courts and advise the police on the development of appropriate accommodations for sexual assault suites and medical examination rooms.

Expertise Required

Practitioners will require an ability to treat and diagnose a wide variety of conditions. While it would be expected that doctors working in the field will have training and experience of illness and injury related to and caused by psychotropic drugs or the illness and injuries caused by excessive consumption of alcohol, forensic medical practitioners will require a much broader range of skills. These will include the management of chronic illness such as asthma, cardiac disease, epilepsy and diabetes. Doctors will also need some expertise about mental health conditions and the skills to assess psychological problems relating to suicide and attempted suicide. The management of people infected with contagious and infectious diseases such as Tuberculosis, HIV and Hepatitis must be acquired by forensic medical practitioners. They must also have expertise in handling the medical aspects of cases involving physical and sexual abuse.

While most doctors would expect specific extra training in the medical aspects of their role, they would also need sufficient legal knowledge to understand the legal significance of their actions in cases which require either expert medical testimony or the collection of physical evidence. They would also need to be clearly aware of their legal responsibilities arising from their attendance at scenes of crimes or disturbance.

Skills and Training

Forensic Medical Practitioners need properly structured training so that they can fulfill their role competently. This training can be offered through a week's full-time training, delivered annually to participating practitioners. Practitioners should be encouraged to increase their expertise through Master's degree level programmes and regular Continuing Medical Education.

Role of the Garda and the Department of Justice

In order to optimise the Forensic Medical Service for the patient, victim or detainee, the Garda Síochána and the Department of Justice must co-operate to establish, in each appropriate Garda setting, properly designed custody suites and examination rooms with all the appropriate equipment.

Garda personnel will require training in the management of sick or incapacitated people whether in custody or at the scene of incidents. The creation of a trained corps of forensic medical practitioners will also require the development of defined service level agreements and protocols.

Service Structure

The needs of the Garda Síochána to provide an optimal service to the public must be the leading driver for the structure of the service. The police service understands the requirements to treat victims of physical crime, victims of domestic abuse and detainees with care and consideration. The service must be structured to offer an optimal service across the country. It must take account of social, demographic and geographical constraints so that a service of uniform quality will be offered to the public and the police.

In total, ten full-time practitioners would serve with twenty-six part-time colleagues. The service would be led by a Medical Director from the complement of full-time practitioners who would liaise with the Department of Justice and the police.

Remuneration should be handled by another agency of the State to demonstrate the complete impartiality of the Forensic Medical Service and to avoid any imputations of collusion between the police and the doctors employed.

Disability Ages 0-18 years – Nov 2007

The focus of this policy paper is the issue of provision of a seamless service to disabled children between the ages of 0 and 18 years. The IMO sees the provision of appropriate health and education services to those whom competent professionals define as in need of these services, and who would benefit from them, as the basis on which to proceed. Services, where possible, should be designed to fit around the child rather than the other way around.

Concerns are also raised that the HSE framework for provisions of services to disabled children is aspirational as no specific resources or timeframes have been determined. Nor is there clear national leadership on the roll out of the Disability Act 2004.

IMO Recommendations

- All planning in this area must be focused on the needs of the child. Services must in all cases be tailored to suit the child. Therefore, the model outlined by the IMO should be adopted for immediate implementation of the HSE framework;
- A National Implementation process is required to ensure that implementation of the recommendations of the Disability Act 2004 and the EPSEN Act 2004 are introduced in a nationally standardised way and that a forum for feedback from parents and professionals is provided;
- The HSE framework should be costed and the Department of Health and Children should clearly allocate the multi-annual, ring-fenced budget for disability with associated timeframes against the framework developed by the HSE;
- A comprehensive service, free at the point of access, should be provided for both the mentally and physically disabled of this country regardless of parents' income;
- Gaps and inadequacies in diagnostic and treatment services must be addressed so that all children are seen and have access to treatment as early as possible;
- Immediate provision of extended care facilities for young chronically disabled patients should be funded and provided;
- The inadequacy of care assistance and tax relief provided by the State for the disabled and the mentally handicapped should be urgently addressed.

IRISH MEDICAL ORGANISATION
Ceardchumann Dochtúirí na hÉireann

Co-Location and Acute Hospital Beds – increasing capacity, preventing inequity – Jul 2007

In July 2007 the IMO produced a Position Paper entitled *Co-Location and Acute Hospital Beds – increasing capacity, preventing inequity* detailing the IMO's concerns about the Government's plan to expand acute hospital bed capacity through the co-location of private hospitals on public hospital sites. Of particularly concern is that the project will create greater inequity between public and private patients as well as the ability to adequately plan the delivery of healthcare as more and more care is delivered by the private sector in an ad hoc basis.

IMO Recommendations for a New Model of Care

- The IMO propose that the State should acquire part ownership (equity) of any hospitals developed on sites owned by the State and where the State funds a significant part of the infrastructure (through tax concessions).
- The not-for-profit model (like the voluntary hospital tradition in Ireland or the endowed charitable trusts in the US) should be adopted unless there is convincing and conclusive evidence that this model will not work.
- If a for profit model is adopted, then the profits should be capped and the money raised re-invested by the State in healthcare
- Any additional capacity created in this way should be made available to all patients equally on the basis of need rather than the ability of the patient, the insurer or the State to pay.
- This capacity should be focussed on providing protected space for elective care (surgery, orthopaedics, ENT, gastroenterology, cardiology, etc.) and the planned management of chronic disease.
- There should be a single waiting list for public and private patients (regardless of whether the State or insurance companies are paying) with patients prioritised on the basis of need.
- Clinical governance standards should apply equally to any new clinical facilities, as should appropriate public access to information (FOI), independent monitoring of standards (HIQA) and the remit of the Ombudsman.
- These developments must be accompanied by an assurance that there will be appropriate ongoing investment, allocation of resources and expansion of facilities in the public hospitals where the majority of patients (both public and private) will be treated.
- There must be a guarantee by Government that it will provide the funding shortfall in public hospitals (approximately £700M) that will be created by removing private patients.

Role of the Doctor – Apr 2007

The Role of the Doctor was published in 2007 following extensive consultation with the membership. A detailed survey was carried out including questions on the attitudes of doctors to their role and the necessary attributes; the importance of communication with various groups and the variety and importance of different skills. The response from the membership was excellent.

The report identifies the doctor's fundamental functions as diagnostician; continuous scholar; advocate; communicator; student, teacher and mentor; additional tasks and activities and core values.

Conclusion

The work life of doctors is dominated by their prime concern of care for their patients. Much sacrifice and many years of study and work were required to qualify as doctors. Medicine innovates constantly and so the practice of each individual doctor must change constantly.

In order to keep pace with developments in the practice of medicine, doctors are required to undertake a continuous regimen of scholarship and, in order to ensure that the general standard of care for patients is maintained, doctors are committed to teaching and mentoring their successors.

Dedicated as they are to the care of their patients, doctors advocate on behalf of individual patients, on behalf of patients in their community and on behalf of the health and well being of citizens in the nation as a whole.

One of the most important attributes of doctors is their willingness and ability to communicate in a meaningful, cogent and understandable way with patients, with other members of the professional team caring for their patients and with a wider audience on behalf of patients.

Both as a group and individually, doctors enjoy generally a high reputation for their professionalism and expertise inspiring trust and confidence in their abilities among patients. This benefits not only doctors but also patients who gain through their satisfaction with the diagnosis and treatment from their doctors.

Increasingly, due to extraneous circumstances, there are obstacles which doctors are required to surmount. Everyone working in society today faces the dilemma of work/life balance. No less than anyone else, doctors fall prey to the vicissitudes of modern life. However, pressures on and within the health service generally exacerbate the imbalance in doctors' lives.

To optimise the contribution of doctors to the health of patients and, in particular, to accommodate the particular challenges presented to female doctors, assistance with work/life balance issues is urgently needed.

The administrative workload required of all doctors, whether they work in hospitals, in the public health service or as general practitioners, deflects them from their primary focus of caring for patients and intensifies the demand on a very scarce resource, time – doctors' professional time and also their private or personal time.

Many doctors view with dismay the attempt to restrict their role as advocates for patients, both individually and as a group, as well as their role as advocates for an improved health service. Attempts to prevent "whistle blowing" are contrary to the vocation, training and professional commitment of doctors.

Doctors, living in the real world, recognise that budgetary constraints must be taken into account in the management and operation of the nation's health services but they reserve to themselves decisions as to the appropriate treatments for patients.

The real worth of the health service can only be reckoned by the quality of the many thousands of dedicated people at all levels who work in it for the patients in their care. Doctors throughout the country in hospitals, and elsewhere, are qualified, experienced and dedicated professionals who deserve the consideration of suitable arrangements for their working and personal lives as well as for their inclusion in decision making that affects patients in their care.

Medical Schools – Aug 2006

The IMO identifies four factors that are currently causing significant difficulties for the Medical School system and for the profession as a whole:

1) Insufficient funding for medical education and training both at undergraduate and postgraduate level in Ireland.
2) The absolute number of student places is too low in relation to the current and future personnel requirements of the sector.
3) The arbitrary 'cap' on the number of places for Irish/EU students at 305 remains in place and restricts intake to approximately 315 i.e. there are too few places being funded for Irish/EU candidates.
4) The lack of a clearly defined medical career structure and body such as central training authority within which to situate undergraduate medical education and postgraduate training and its effect on retention of graduates.

These factors are of primary importance in order to improve the quality of the educational experience and professional training at third level and meet the demands of a rapidly changing health care service.

IMO Recommendations

1. The IMO recommends the following improvements to the undergraduate medical education system;

a) An increase in the overall number of medical school places at undergraduate level open to Irish / EU citizens.
b) An increase the proportion of the overall number of places allocated to students coming from within the Irish education system. The IMO recommends the removal of the 'cap' on Irish /EU student places.
c) Funding for medical student places comparable to international standards.
d) Comprehensive lifelong career planning for the medical profession in order to prevent loss of human capital from the healthcare system.
e) Proper remuneration for Consultant trainers and protected time for training for both Consultants and NCHDs.

2. The IMO rejects any proposal to introduce a graduate-only entry system to the medical profession for the following reasons;

a) Within the context of the European Union, undergraduate medical entry is the norm (Ref: Bologna Declaration).
b) International experience demonstrates that graduate entry does not significantly increase diversity of intake.
c) Undergraduate entry to medical school is not the cause of the points' race or any adverse affects on second level students; the cause of these problems lies in the inadequate supply of state-funded third level places in medicine for Irish / EU students.
d) The issues regarding lack of diversity of intake should be addressed by reform of the second level education curriculum.
e) Female participation in the medical workforce will be adversely affected by a graduate only entry system.

3. Ireland needs to increase the number of fully funded places open to Irish/EU entrants substantially.

4. Ireland needs a properly funded world class medical education system, open to talent which will enhance the standards of patient care.

Obesity – Apr 2006

The universal message from the literature tells us that to reduce the risk of obesity and related illnesses, people must adopt a healthy balance of food intake and physical exercise. Increases in physical activity and small reductions in calorie intake lead to weight reduction. It is also clear from the research that modest weight loss improves health, prevents type 2 diabetes and reduces risk of cardiovascular disease. An integrated service approach across all sectors is needed, that encourages healthy living with a view to combating the obesogenic environment. Where diet and exercise regimes have repeatedly failed for a number of morbidly obese patients, medication and/or weight reduction surgery can be effective.

IMO Recommendations

Medical Practice

- The IMO believes that General Practitioners, Public Health and Community Health Doctors have a key role to play in the management of overweight and obesity. They must be encouraged and supported to initiate discussion of weight with patients.
- Treating obesity is a priority. Multi-disciplinary specialist centres with resources to perform weight reduction surgery need to be established nation-wide to address the degree of obesity in Ireland.

Whole-Society Action

- A strategy to tackle the problem of overweight and obesity should focus on the population as a whole in order to take the focus away from the individual and reduce some of the social blame that has tended to be levelled at overweight or obese people and should include programs to treat or prevent obesity in culturally, ethnically, and socio-economically diverse populations.
- Facilitating a whole-community approach to the problem is important. There are a number of key settings in which policy needs to be developed. These include:
  - Child Care settings
  - Schools – Primary and Secondary
  - Primary Care Services
  - Family and Community Care Services
  - Maternal and Infant Health
  - Neighbourhoods and Community Organisations
  - Workplaces
  - Food Supply
  - Media and Marketing
- It is important to establish public health initiatives that would complement a strategy on obesity and enhance its implementation, for example, the development of a Strategy on Diabetes or the Strategy on Alcohol. Community Health doctors and Public Health doctors have a major role in this field.
- All relevant Government departments – Education and Transport – need to work in a coordinated way on the problem of overweight and obesity.
- There is a need to establish and publicise a set of national guidelines for physical activity to clarify appropriate types and amounts of physical activity needed for the general population to maintain or reduce weight.

- There is a need to recognise and acknowledge the multicultural nature of Irish society and the potential cultural differences in relation to attitudes to foods, eating, body shape and size. It is important to ensure that all dietary guidelines and the food guide pyramid include ethnic food staples and multicultural symbols depicting serving size. Recommendations on recommended daily amounts (RDAs) would also facilitate doctors and others to communicate the importance of a health diet to all persons.

Focus on Children and Young People

- Children and adolescents are an important target group for prevention. However, there is a need to be aware that adolescents may misinterpret messages about weight and concern for eating disorders needs to be considered. It is recommended that the focus for children in a strategic plan should be to encourage them to:
  - Be physically active
  - Enjoy a wide range of physical activities
  - Continue to be physically active as they get older
  - Consume a healthy diet
  - Develop skills that will enable them to select and consume a healthy diet as they get older.
- Restrictions should be placed on advertising which targets young children including pre-school children to consume inappropriate foods and carbonated drinks.
- The IMO calls on the Department of Education & Science to review the primary school curriculum so it promotes physical education as a means of tackling the problem of obesity in childhood.

Evaluation

- It is important to assess the effectiveness of obesity prevention and treatment programmes. Monitoring and evaluation are vital to establish the success of any strategy and are crucial for determining the success of future strategies and policies by providing valuable information to policy makers at the stage of policy design and review. A strategy to prevent overweight and obesity therefore should be monitored and evaluated at regular intervals with the appropriate data identified and any data deficiencies addressed to ensure that evaluation is meaningful.

Prevention

- **The IMO believes that good medical practice in the treatment of obesity requires emphasis on prevention. Obesity prevention programmes / strategies combined with early treatment will reap the greatest dividends.**

IRISH MEDICAL ORGANISATION
Ceardchumann Dochtúirí na hÉireann

Care of the Elderly – January 2006

In 2006, the IMO felt compelled to publish this position paper because it believed that the following problems needed to be tackled immediately:

- The effects of the A&E Service Crisis on the Elderly
- The inadequate provision of public nursing home beds
- The difficulties involved in relying on private nursing home beds
- The failure of the Health Service to respond to demographic shifts
- The poor co-ordination of primary, secondary and community services
- The correct use of Public – Private Initiatives to fund nursing home provision.

In 2009 the problems continued. Recommendations were updated in the IMO Submission to the Department of Health and Children on the New Positive Ageing Strategy

Summary of recommendations

Healthy Lifestyle Promotion

- Healthy lifestyle should be promoted to all ages from childhood and adolescence and continued through adulthood to old age;
- Evidence-based programmes should be introduced to:
  - promote healthy diet and physical activity in old age
  - warn of the dangers and deter smoking and alcohol abuse
  - prevent falls and disability
  - promote appropriate pharmaceutical use;

Mental Health Promotion

- Education campaigns aimed at the elderly and their carers and at healthcare professionals are needed to ensure mental health problems are detected and treated at an early stage;
- Programmes are required that prepare older people for major changes in their life such as retirement, bereavement or declining health;
- The development of social networks supporting older people are also proving to have a significant effect on mental and physical well being, and should be encouraged;
- Policies are also required to address the wider determinants that impact on mental health such as diet and physical activity, age discrimination, barriers to participation in meaningful activity, social isolation and poverty.

Access to Adequate Health Care

- Ageist attitudes in health policy and healthcare should be tackled;
- Improved integration and communication between services is required for a person-centred approach to care and the seamless transition of patients between healthcare settings;
- Chronic disease management requires continuity of care and is therefore best suited to the General Practitioner under contract;

- Current and future demand for community and long-term care must be adequately assessed and provided for;
- Standards of community and long-term care should be rigorously implemented and exceeded;
- Training in geriatrics or gerontology and exposure to old people should be mandatory for all healthcare staff that deal with the elderly;
- Older people must be given adequate information to enable them to make informed choices about their care;
- The issue of medical manpower must be addressed with a full assessment of undergraduate and graduate training needs:
- The recruitment and retention of skilled motivated healthcare staff are required to meet the needs of an elderly population;
- The contribution made by carers must be recognised and supported;
- A fair instrument for the funding of long-term care must be found.

IRISH MEDICAL ORGANISATION
Ceardchumann Dochtúirí na hÉireann

Health Service Funding – Mar 2005

The IMO recognises Health Service Funding as the single most important political issue for Irish men and women and in this position paper the IMO seeks to dispel a number of myths about the funding of healthcare in Ireland:

- **Myth No. 1: Health Accounting Systems** – Ireland has no national system of accounts.
- **Myth No. 2: Private Health Spending** – Estimated at 25% of the total health budget, there is no accurate figure for the amount spent on private healthcare.
- **Myth No. 3: Capital Spending** – While per capita spending was above EU average from 1997 to 2002 it is unreasonable to think that recent rapid increases are sufficient to remedy the decades of stunted services.
- **Myth No. 4: Current Spending-** Figures are misleading as approximately 20% of healthcare expenditure is spent on social programmes.

The recommendations were updated in the IMO Submission to the Expert Group on Resource Allocation and Financing in the Health Sector:

Transparency of public health accounts

The IMO recommends the adoption of the OECD System of Health Accounts (SHA) and the publication of annual health accounts prepared with the OECD SHA. The SHA classifies health care by sources of funding, by service provider industries and by function, and therefore addresses three basic questions of where does the money come from?; where does the money go to?; and what kind of services and goods are purchased?[3]

Long-term planning

The health services are complex and require detailed long-term planning to run efficiently and to best serve the needs of patients. Service planning must be based on a realistic assessment of the likely number of patients who will need treatment and budgets must be then allocated accordingly, rather than rationing the services to fit the budget. A long-term approach is required with ring-fenced, multi-annual funding for health services in order to deliver real value.

Capital investment

To increase quality of care and value for money, substantial capital investment is needed across the health system including the upgrading of acute care facilities, investment in modern diagnostic and treatment technologies and facilities, investment in primary care and long-term care as well as a national system of electronic health records.

Acute Hospital Capacity

The IMO is opposed to the co-location of for-profit private hospitals on public sites. Because hospital capacity issues concern essentially elective treatment for public patients and complex treatments for patients with chronic disease the IMO has called on the Minister for Health and Children to change the proposal for co-located hospitals to units for elective patients and patients with chronic illness. This recommendation

3. OECD 2000, A System of Health Accounts

would not only save millions on duplicated infrastructure and services, but additional savings could be made from the planning and the monitoring of the co-located hospitals.

Primary Care Teams

Adequate investment in facilities and resources to support primary care teams is needed for their success. Without adequate funding, it is likely that the transfer of services from secondary to primary care and the development of Primary Care Teams will fail. Primary teams must be established and evaluated before services are withdrawn from acute care.

Manpower

The issue of medical manpower must be addressed with an assessment of undergraduate and post-graduate training needs, which consolidates recommendations from previous reports including the Buttimer, Hanley and Fortrell reports.

Services for Older People

The IMO supports the Home Care Package initiative as a viable alternative to residential care for Ireland's older citizens, however the demand for Home Care Packages must be properly assessed and funding provided to adequately meet that demand.

Better community and rehabilitation services are vital, but they are complementary to, and will never eliminate the need for, an adequate range of public nursing home beds, appropriately resourced and geographically distributed to ensure equity. It has been estimated that Ireland could require an additional 10,021 long term care beds by 2021.[4] This highlights the urgency of addressing long-term and home cares services for the elderly.

Chronic Disease Management

Chronic disease management (CDM) requires continuity of care and is therefore best suited to the General Practitioner under contract. CDM will also require strengthening communication between services with the development of a secure system of electronic health records so that all clinical staff can access data relating to a patient and organisational systems for the efficient transfer of patients between services.

Public Health and Chronic Disease Prevention

The proportion of healthcare expenditure allocated to public health and chronic disease prevention must increase. Ireland has among the highest rates of obesity and alcohol abuse in Europe, as well as high levels of tobacco consumption and drug abuse. These risk factors are common to different diseases and economies can be made by integrating strategies into an overall lifestyle policy for the prevention of chronic disease.

Recognition should be given to the valuable role played by community medicine in screening and surveillance of children and adolescents and in mass vaccination. Services are provide free, are on a statutory footing and play a valuable part in early detection of child health and development problems.

4. PA Consulting 2007, HSE Acute Hospital Bed Capacity Review…p

Road Safety – Mar 2005

The IMO position paper on Road Safety highlights the alarming figures in relation to persons killed or injured on Irish roads. In 2002, 376 people were fatally injured in 346 separate accidents. According to the National Roads Authority, of those killed 200 were car users, 86 were pedestrians, 44 were motorcyclists, 18 were bicyclists and 28 were classified as other road users. The number of persons seriously injured was 9,206 in a total of 6,279 accidents. The paper then explores important developments of Road Safety Policy and legislation in Ireland.

IMO 20-point plan to improve the performance of road safety in Ireland:

1. Increase funding for the effective implementation and enforcement of the Penalty Points Systems introduced under the Road Traffic Act in 2002.
2. Ensure that the Penalty Points System is implemented.
3. Ensure that sufficient resources are provided for the national road safety awareness campaigns.
4. Research showing a direct positive relationship between speed levels and accident rates reveals a need to introduce more effective enforcement of speed limits in Ireland.
5. Speed limits need to be changed where appropriate. Specifically, the IMO recommends that a maximum speed limit of 20 mph (32 kph) be introduced in built up areas and housing estates.
6. Pedestrians represent 20% of all road deaths with the elderly one of the most vulnerable in this regard. Policies need to be designed and implemented to improve the risks for example, by adjusting pedestrian crossings to suit their needs.
7. Another vulnerable group in this regard are cyclists. The IMO believes that one way of improving the risks here is to make all cyclists wear protective headgear.
8. Another recommendation which would improve the safety of pedestrians and other vulnerable road users is the banning of 'Bull Bars' from all vehicles on the public highways.
9. The IMO recommends that a comprehensive set of Guidelines on Medical Fitness to Drive are developed and regularly updated.
10. The IMO believes that it is important to continue with public awareness campaigns on the dangers of driving under the influence of alcohol.
11. The IMO believes that there is a need to increase the rate of enforcement for drink driving offences in order to improve the safety of all road users.
12. Blood alcohol levels in Ireland need to be reduced in line with the EU standard i.e. from 80 mgs% to 50 mgs%.
13. Legislative powers to increase evidential breath-testing are important and need to be strengthened in an effort to combat drink-driving.
14. A new area of investigation in terms of regulation and enforcement is the issues of driving under the influence of other drugs and substances. The IMO believes that more funding is required for epidemiological investigation regarding the impact of drugs.
15. The IMO feels that in order to improve detection in this area the government should support drug-testing technology. The IMO recommends that random testing of drivers for mood altering drugs and substances is introduced as soon as possible.

16. The IMO also believes that the Gardaí need to be resourced in the training of drug-related impairment recognition.
17. The IMO recommends increased enforcement of seat belt use and the necessary resources to enable the law enforcement agencies to do so.
18. The IMO also recommend that legislation be introduced to ensure that seat belts are fitted and work in buses, including minibuses.
19. Continued policy developments are required to make the roads on which we travel safer. Road construction is an essential component of any good road safety strategy. In this regard, the IMO believes that the situation would improve if good quality roads were built between all the major towns and cities.
20. Non dual-carriageway roads should have passing lanes at regular intervals of five miles.

Medical Card Eligibility – Mar 2005

The positive relationship between poverty and ill-health is well-documented. Available evidence suggests that those on low incomes or in poverty have relatively high mortality rates, higher levels of ill-health and fewer resources to adopt healthier lifestyles. One vital link for people into the primary health care system, particularly for those least able to afford it, is that provided by the free medical services available under the General Medical Services scheme. Persons who are unable, without undue hardship, to arrange General Practitioner medical and surgical services (plus dental and optometric services) for themselves and their dependants are provided with a medical card under this scheme entitling them to free services.

The IMO looks at the trends in medical card cover and makes the following recommendations to government concerning eligibility for free health care services;

Recommendations

- Increase income thresholds for medical card eligibility based on the national minimum wage. Thresholds for all other categories of recipients, including single persons living with family, married couples and children should be increased proportionately.
- The IMO calls for the development of clear eligibility criteria based on the minimum wage and the application of an annual rating mechanism reflecting changes in living standards.

In response to the Report of the Special Group on Public Service Numbers and Expenditure Programmes 2009, the IMO updated recommendations on Medical Card Eligibility as follows:

- The income guidelines and allowances for eligibility for a medical card should under no circumstances be lowered.
- Thresholds should be increased to minimum wage in order to encompass all those living in or at risk of poverty.
- Introducing cost-sharing for prescriptions under the GMS and LTI Schemes will discourage the use of essential medicines particularly for people on low incomes, the elderly and those suffering from long-term disease and should not be implemented.

Accident & Emergency – Mar 2005

The process of health reform, which has been under way since 2002, is founded on changes in the structures, funding, and delivery of health services in Ireland. Accident and Emergency Services form one of the most visible parts of the Health Service. Despite the reform processes, the experience of the patient at A&E has not improved. The IMO Position paper looks at International Experience in Reforming Emergency Care, Alcohol Policy to reduce demand on A&E services and the development of Acute Medical Units.

IMO Recommendations:

Demand Reduction

- Implementation of the Primary Care Strategy as the first step to reduce demand on A&E services.
- Direct access for GPs to diagnostic services.
- Provision of more out-of-hours GP services.
- Increase home care packages for older people.
- Transfer elderly patients from inappropriate acute beds to long stay nursing accommodation.

Alcohol Policy

- Measures to reduce the problem of alcohol related illness presenting to A&E services.
- Ban on advertising.
- Reduce overall consumption,
- Employ Liaison Staff in A&E departments.

Accident & Emergency

- Implementation of the recommendations of the Report of the Committee on Accident and Emergency Services and Acute Medical Units to accelerate the expansion of appropriately staffed consultant physician led AMUs and additional A&E consultants.
- Increasing the effectiveness of Triage.
- Implementation of clear patient-driven protocols for access and discharge from AMUs.
- Dedicated cleaning and security services for A&E.
- Effective communication between A&E, AMUs, and Primary Care.

Hospital Service Changes

- Increasing the numbers of Acute Beds in Hospitals.
- Improving access to inpatient beds.
- Negotiations to expand access to pathology and radiology services.
- Increasing the number of High Dependency Unit beds.

Resources

- Ring-fenced resources including manpower and funding.
- Develop and implement a long-term funding plan.

IRISH MEDICAL ORGANISATION
Ceardchumann Dochtúirí na hÉireann

Acute Hospital Bed Capacity – Mar 2005

The IMO recognises that a vital element to the success of the health reform plans is investment in the much needed reform. One vital area in need of improvement in the public health system is acute hospital bed capacity. The position paper analyses the findings of The National Review of Acute Hospital Bed Capacity 2002 and identifies issues in relation to private hospital bed capacity, wasted capacity, elderly bed capacity and medical staffing.

IMO Recommendations

- The productive and efficient public hospital service must be given priority in funding.
- The Hospital Service needs at least 15,000 public acute hospital beds.
- Private facilities must not be given undue favour with tax breaks.
- Private facilities do not represent best value for taxpayers' money.
- The true figures for acute hospital beds should be published regularly. The measure should be of beds available not mere bed figures which include closed wards and those wards yet to be opened.
- The privatisation of eldercare has had the effect of imposing huge costs on patients and their families; this process must be reversed by the provision of adequate numbers of public nursing home beds.
- Acute beds must not be used as a substitute for affordable, public, nursing home beds.

Manpower – Mar 2005

The IMO believes that it is important to acknowledge that recruitment and retention problems exist in all branches of medicine and stress that the current position whereby the rapidly increasing demands of the health service fall on a static pool of doctors is unsustainable. To address the problem a strategic approach to the manpower problem must be employed; it is necessary to expand the number of places in medical schools, improve training opportunities and develop structured career pathways for all doctors.

In summary, implementation of health reforms will create the need for a greatly increased number of doctors in the Irish health system. This will have consequences for the entire continuum of medical education, training, and practice from undergraduate to consultant level. The importance of putting the appropriate changes and structures in place in order to recruit and retain medical staff to reflect current and future service requirements cannot be underestimated and should not be overlooked.

IMO Recommendations

Undergraduate Education

- An increase in the overall number of medical school places at undergraduate level. At the moment of the 850 places in medical school in Ireland, 350 are available to Irish or EU applicants.
- An increase in the proportion of the overall number of places allocated to Irish or EU applicants. The IMO recommends the removal of the 'cap' on Irish or EU student places.
- Per capita funding for medical students must be sufficient to ensure an adequate long-term supply of doctors.
- Comprehensive lifelong career planning for the medical profession in order to minimize loss of human capital from the healthcare system.

Postgraduate Training

- The number of accredited training posts should be tailored to the likely number of consultant posts.
- The changes in the ratio of consultant to training posts will require greater and more effective use of paramedical and non-medical staff in hospitals.
- The out-of-hours workload must be included in the calculation when determining the manpower levels required.

Increasing the Number of General Practitioners

- Given the 'lead in' time, the number of training places in this speciality needs to be increased.
- Special consideration needs to be given to ensuring an appropriate and adequate geographical distribution of GPs.
- New out-of-hours arrangements via co-operative service schemes need to be prioritised and adequately funded, particularly in rural areas in order to make practice attractive to young graduates (particularly women) while enabling doctors approaching retirement to reduce their night work on an equitable basis.

- In rural areas, the unavailability of locums makes it difficult to take annual leave and special arrangements must be put in place to provide a reliable supply of locums. For these doctors, study leave is largely inaccessible so therefore new models of distance learning and residential courses need to be developed and funded for rural GPs. With respect to the particular conditions and circumstances under which rural doctors must work, the IMO/ICGP recommend that a preferential package of income and other benefits in essential for rural doctors.
- The IMO and IGCP also recommend that the retirement age for all contracts should be 65 with optional retirement from age 60.

Joint Papers from The Irish Medical Organisation and the British Medical Association Northern Ireland

Obesity in Europe – Jun 2010

The Irish Medical Organisation (IMO) and the British Medical Association Northern Ireland (BMA(NI))

recognise that obesity levels are increasing throughout the European Union (EU). Both organisations urge their respective governments, the leaders of the EU and other Member States to continue to work together to reduce obesity levels and address the long-term implications of obesity through the formulation and implementation of coordinated policies and strategies.

Cross-border measures

Both organisations have joined forces and together are calling for a range of measures to tackle obesity North and South of the border:

Education to increase understanding of the problem of obesity and what constitutes a balanced diet and healthy lifestyle

- The implementation of a North-South parental education campaign;
- Dedicated classroom time spent teaching children about nutrition and healthy lifestyles both sides of the border;
- More extensive use of the media, including children's programming, to promote healthy lifestyle messages;

Measures to improve nutrition and encourage physical exercise in schools

- The introduction of common standards in both jurisdictions relating to nutrition, hydration and physical exercise in all school and pre-school facilities;
- The removal of vending machines selling unhealthy snacks and drinks in schools North and South of the border;
- Adequate and safe sporting facilities should be provided for children in all schools;

A halt to advertising unhealthy foodstuffs targeted at children

- A ban on advertising of unhealthy foods to children including TV advertising of processed foods before 9pm.

EU Opportunities

Coordinated public health measures are essential to effect change to reduce and indeed prevent obesity, thus lessening the impact on healthcare systems.

The EU is already leading the way to encourage joined-up approaches through, for example, the EU Platform on Diet, Physical Activity and Health. This Platform has secured commitments for action from stakeholders at European, national and local level. It recognises that the momentum of activities now needs to be sustained.

The IMO and BMA(NI) would urge policy makers and stakeholders in the United Kingdom and Ireland to recognise the work of the Platform and encourage them to play a leading role in the long-term activities of the Platform.

Care of Older People on the Island of Ireland – Oct 2008

The demographic challenges facing healthcare providers may be summarised thus:

"The ageing of populations is assuming increasing importance in healthcare planning and delivery. An increasing proportion of the Irish population now lives well into old age….Strategies are required to decrease ill-health and disability and to maximise quality of life in what will be an increasing proportion of the population in Irish society in the future." [5]

The BMA(NI) and the IMO believe that the older population on the island of Ireland, should have access to care which is: of high quality; evidence based; well resourced; equitable and available to all on the basis of need; delivered with due regard to the dignity of patients.

Underpinning all of the recommendations below is the need for equity of access to healthcare; and for service users and carers to be treated with dignity and respect.

Summary of Joint Recommendations

1. Cross-border initiatives that improve healthcare for older people should be developed and implemented
2. Full integration and coordination of healthcare services is essential to achieve person-centred care
3. The recruitment and retention of skilled healthcare staff must be made a priority for all agencies involved in delivering healthcare
4. Person-centred care must be a key element of older people's healthcare
5. Communication in the delivery of healthcare must be improved
6. Models of care should be tailored to an individual's need
7. Carers must be supported, and their contribution recognised
8. The social inclusion of older people in our society must be at the forefront of all policy
9. Standards of care in all healthcare settings must not only be rigorously implemented, but exceeded
10. Nutritional care should be made a priority
11. Positive mental health must be promoted

5. Brenner & Shelley 1998, cited in One Island-Two Systems A comparison of health status and health and social service use by community-dwelling older people in the Republic of Ireland and Northern Ireland by Healthy Ageing Research Programme published by the Institute of Public Health in Ireland, 2005

Road Safety – Jan 2007

There is evidence that the impact of road accidents is often worse in border areas between European states. A recent European-funded survey by CAWT (Co-operation and Working Together) has illustrated this in the border counties in Ireland.

The IMO and the BMA (NI) have policies on various aspects of road safety which we have been discussion with our respective governments for some years. This briefing paper highlights just three of our joint top priorities and recommendations. We are requesting that the European Parliament adopts these recommendations and takes them forward on an international basis.

Joint Priorities and Recommendations

1. To lower the permitted blood alcohol level when driving, in both the UK and Ireland from 80mg/100ml to 50mg; this now widely accepted as the EU standard given the number of countries that have adopted it. This should also be accompanied by improved legislative powers to increase evidential breath testing; an increase in the rate of enforcement for drink-driving offences; plus public awareness campaigns, such as those which currently happen on a cross-border basis in Ireland.

   Only the UK, Ireland, Luxembourg and Malta have an 80mg/100ml limit.

2. The IMO and BMA (NI) are concerned at the influence of drugs (both illegal and prescribed) on driving skills and recommend that:
   - Governments should raise the awareness of this issue with the public and educate them as to the potential impact of drugs on driving ability.
   - The public needs to be made more aware that the side effects of certain prescribed drugs can affect ability to drive.
   - Governments should ensure speedier and more specific and coordinated research in order to establish appropriate drug testing devices.

3. The BMA and the IMO believe that another recommendation which would improve the safety of pedestrians and other vulnerable road users is the banning of “bull bars” from all vehicles.

   Modern road vehicles are much safer than their predecessors, both for drivers and passengers. However, much of this safety improvement is negated by the fixing of external bumpers. They are not only potentially lethal to small children and damaging to adults when involved in a collision with such vehicles but often reduce the safety affect for drivers and passengers.

   Apart from agricultural vehicles, there is no requirement for these additions to road vehicles. Our two organisations want to see bull bars banned as fittings on vehicles and until such time as this happens, we believe the EU should bring pressure to beat on motor insurance companies to either increase premiums or refuse to cover vehicles which have non-factory fitted bull bars added.

Position Papers published by the Irish Medical Organisation are available on www.imo.ie

Mental Health Services	Nov 2010
Universal Health Coverage	April 2010
Suicide Prevention	Sep 2008
Lifestyle and Chronic Disease	Sep 2008
Protecting the vulnerable –	
A Modern Forensic Medical Service	Mar 2008
Disability, Ages (0-18 years)	Nov 2007
Co-Location and Acute Hospital Beds	July 2007
Role of the Doctor	Apr 2007
Medical Schools	Aug 2006
Obesity	Apr 2006
Care of the Elderly	Jan 2006
Health Service Funding	Mar 2005
Acute Hospital Bed Capacity	Mar 2005
Medical Card Eligibility	Mar 2005
Road Safety	Mar 2005
Accident & Emergency	Mar 2005
Manpower	Mar 2005

Joint Papers from The Irish Medical Organisation and the British Medical Association Northern Ireland

Obesity in Europe	Jun 2010
Care of Older People on the Island of Ireland	Oct 2008
Road Safety	Jan 2007