IRISH MEDICAL ORGANISATION

Ceardchumann Dochtúirí na hÉireann

2012 annual report & accounts

IRISH MEDICAL ORGANISATION
Ceardchumann Dochtúirí na hÉireann

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.

IRISH MEDICAL ORGANISATION
Ceardchumann Dochtúirí na hÉireann

Annual Report & Accounts 2012

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IMO Organisational Structure

Annual General Meeting

Policy-making body of the Organisation.
Open to all members.

Council

Meets on a quarterly basis and is chaired by the President and has 25 members elected by the Specialty Groups. Council has the overall control over general policy implementation in accordance with the rules and policy formulated by the AGM.

Management Committee

Meets eight times a year and monitors the performance of the secretariat, receives monthly management accounts and ensures that policy is being implemented. It consists of the President, Vice President, Honorary Treasurer, Honorary Secretary, Chief Executive, Chairperson of each Specialty Group and immediate past President.

Specialty Groups

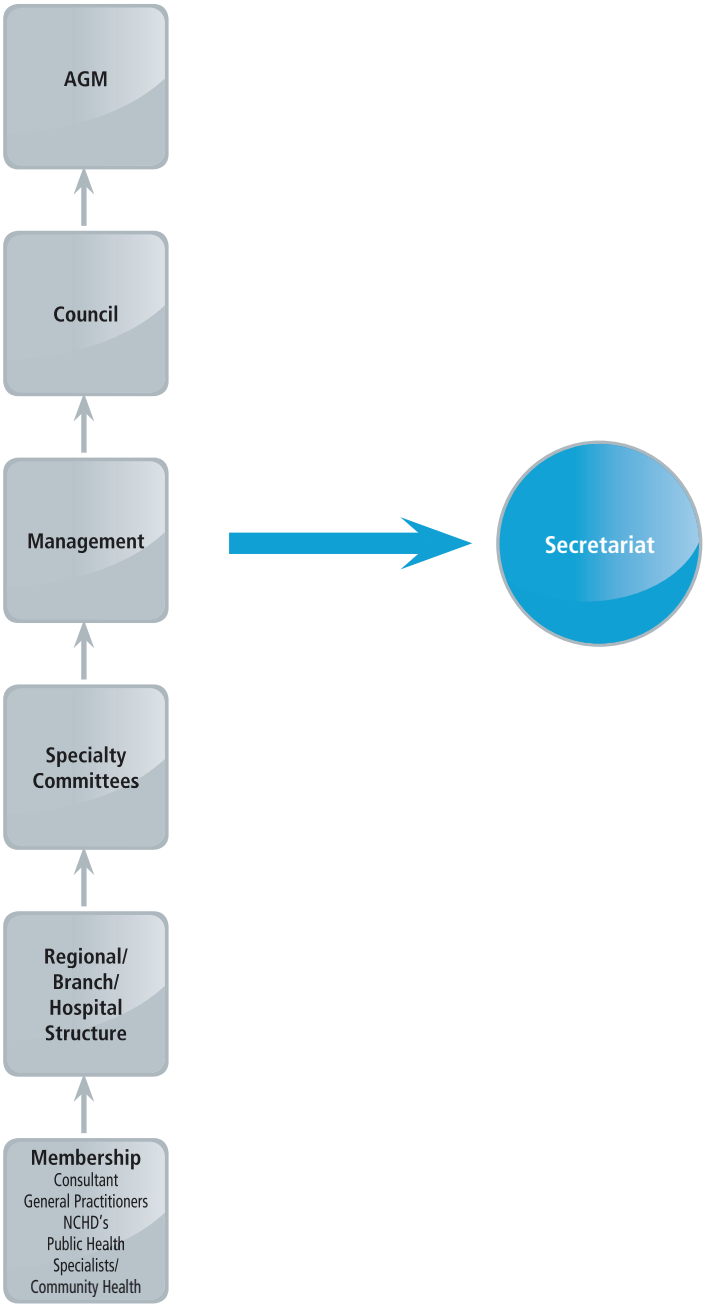
General Practitioners, Consultants, Public Health Doctors, and Non Consultant Hospital Doctors. The groups meet eight times per year and decide on action to be taken in relation to issues affecting the relevant groups. If issues arise which affect other specialty groups, those issues are referred to Management Committee for decision.
Each Specialty Group contains regional and specialty representatives.

Standing Committees

International Affairs.
Ethics.

Regional Structure

Each speciality group is sub-divided into Regional Divisions which correspond with the HSE Administrative Areas. Each Regional Division is divided into branches, where applicable, and each Branch is to have a Chairperson and Secretary.



IRISH MEDICAL ORGANISATION
Ceardchumann Dochtúirí na hÉireann

Honorary Officers

President Dr Paul McKeown

Vice-President Dr Matthew Sadlier

Honorary Treasurer Prof Sean Tierney

Honorary Secretary Dr Brett Lynham

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IMO Council 2012/2013

Dr Paul McKeown (President)
Dr Matthew Sadlier (Vice-President)
Dr Ronan Boland (Immediate Past President)
Dr Trevor Duffy (Chair Consultant Committee)
Dr Mark Murphy (Chair NCHD Committee)
Dr Mary Conlon (Chair PHD Committee)
Dr Ray Walley (Chair GP Committee)
Dr Seamus Healy
Dr Neil Brennan
Dr Peadar Gilligan
Dr Siobhan Barry
Prof Sean Tierney (Hon Treasurer)
Dr Niall Sheehy (resigned Feb 2013)
Dr Mary Gray
Dr Jim Keely
Dr Truls Christiansen
Dr Colm Loftus
Dr Padraig McGarry
Dr Dela Osthoff
Dr Muhammad Razi Shaikh
Dr Hwei Lin Chua
Dr Brett Lynam (Hon Secretary)
Prof Joe Barry

IMO Management Committee 2012/2013

Dr Paul McKeown (President)
Dr Matthew Sadlier (Vice President)
Prof Sean Tierney (Hon Treasurer)
Dr Brett Lynam (Hon Secretary)
Dr Trevor Duffy (Chair Consultant Committee)
Dr Ray Walley (Chair GP Committee)
Dr Mary Conlon (Chair PHD Committee)
Dr Mark Murphy (Chair NCHD Committee)
Dr Ronan Boland (Immediate Past President)

IRISH MEDICAL ORGANISATION
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Introduction from President

Dear Colleagues

As I write this message I am more conscious than ever of the crucial role the IMO plays in the health services and the absolute necessity for a strong and united trade union for doctors.

2012 was a difficult and challenging year for the health services, the profession and, it goes without saying, for our own Organisation. However, before dealing with our own internal issues, I want to highlight some of the extensive work the IMO has undertaken in the past year and which is covered in greater detail elsewhere in this Annual Report.

Industrial Relations is the core activity of the Organisation and through the past year we were very active in representing the interests of our members across all the specialty groups. While recognising the difficult financial position facing the country, it is our role to defend and protect the interests of our members and the wider health services. This task is becoming increasingly difficult in an era where priority seems to be given to short term economic measures which take no account of the long term problems to which they lead. The irony of the situation is that doctors, as a profession, want to do more for their patients, but are working in an environment where there are not opportunities for new initiatives and where obstacles are being placed which prevent us from delivering effective and affordable care.

For our GPs the dominating theme over recent years has been the brutal cuts in resources to general practice which will, as we have outlined, have a devastating impact on patients and will not save the State any money in the long term as more pressure will inevitably fall on our secondary care services. For consultants there were intensive negotiations on new Work Practices, which, while accepted by a ballot of our members, were not adhered to by the HSE. Another example of a clear breach by the HSE which we intend to vigorously pursue. For public and community health it is a constant struggle to get the Department and the HSE to provide the very basic resources required to deliver a good service, let alone a first class quality service to the population. The stark reality is that our young doctors are leaving the country in droves to pursue careers abroad where not only are the working conditions better but more importantly the training opportunities and career development options are far superior. This is a sad indictment of our health services today.

So never before has it been so important to belong to a strong organisation which seeks to deliver for doctors and the wider health services. Our policy and advocacy work is essential in this regard. Doctors on an individual basis are constantly advocating on behalf of patients whether it be for health or other social services. The IMO, as the profession's key representative body, can speak with authority on a wide range of health and societal issues. If we don't speak out who will?

So this Annual Report details the work of the Organisation across all the units but the basic objective of all the work we do is to fulfil the IMO 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.

On internal IMO matters, our attention was dominated through the latter part of 2012 and in the early months of this year by the controversy arising from the departure of the former Chief Executive.

While I want to acknowledge the overwhelming support of members around the country for myself and my colleagues on the IMO Executive Committee, we are all acutely aware of the hurt, anger and frustration which many members have felt that the organisation found itself in this situation in the first place. I share those feelings.

Our focus now is on reviewing carefully the circumstances which led to that situation arising but more importantly on engaging in a process of renewal for the organisation. My colleagues and I believe that through our response to this mess, the IMO can emerge as a stronger, more transparent, more democratic and more effective organisation working on behalf of all our members.

Openness and transparency will be key qualities in the IMO going forward. With that in mind, we insisted in the settlement negotiations with the former CEO that the IMO must be free to reveal the full details of the settlement with all of our members and those details are contained within the Financial Statements in the Treasurer's Report.

Significantly, even after taking account of all the elements of the settlement the IMO is financially stable and can continue to deliver services to members.

So, colleagues, we have and continue to go through difficult times but we are committed to a programme of Renewal, Action and Leadership and with your support I and my colleagues will keep working hard to deliver.

Thank you for your support.

Yours sincerely

Paul McKeown.

Dr Paul McKeown, President

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Industrial Relations Profession-wide Issues

HSE National Service Plan 2012

The Service Plan was published on 16 January and targeted a €750m reduction in budget for 2012 with a further reduction in staff of approximately 3000. In addition there were anticipated delays in colon cancer screening, 515 nursing home beds cut, 5000 home help hours cut, 17,600 fewer treatments and 23,000 day cases axed.

The Minister also accepted that the requirements under the European Working Time Directive (EWTD) would not be achieved for NCHDs. This was a serious admission and the IMO wrote to the EU Commission setting out concerns on the stance adopted by the Government and requested a meeting.

The HSE subsequently published an action plan to deliver the above savings. The Health Sector Action Plan represented a major challenge. It brought together a series of strands, each of which was a challenge on its own:

1. Impact on frontline service delivery;
2. The scale of funding reductions;
3. The scale of employee number reduction;
4. Acceleration of changes in delivery/care models and work practices;
5. Overall reform agenda.

What was stark was the lack of any substantive planning to deliver the majority of the plan. There was liberal reference to requirements, reviewing, flexibility, compliance and implementation; but very little detail on how any of these strands would be introduced and rolled out.

The plan reflected a series of aspirations as opposed to any substance on delivery.

Context

Financial and Human Resources

Budget reductions of €750 million for 2012, approximately 3,313 retirements, reduction in staff numbers and a continuation of the embargo of all but essential frontline vacancies were the headline statements. However, no detail whatsoever was provided on how any of this would be achieved while continuing to cope with population growth and the extra demands this placed on the service along side an ageing populace and an increase in disease incidence.

Primary Care

The government had previously placed an emphasis on the development of multi-disciplinary Primary Care Teams (PCTs) as being central to the health reform programme. However, this warranted four lines in the action plan and provided no detail except to state that "staff will co-operate with the change programme including moving from hospital to community settings and changes in rosters as appropriate." Funding of €20 million had been allocated in 2012 to "support" the development of the PCTs. No indication was provided on funding beyond this.

Acute Hospitals

The plan demonstrated clearly that a 'cart before the horse' approach was being adopted. It talked about changes being underway in regard to the organisation of acute hospitals and that arrangements were being made to establish hospital groups as quickly as possible this year.

A framework was being developed by the Minister that all hospitals, large and small, would have to adhere to. No detail, just aspirations. By the end of 2012 a plan had still not been provided by the Minister.

There was also an element of 'hand wringing' when it came to other changes:

- Flexibility of consultants – while not implementing all of the 2008 contract;
- NCHD retention – not even mentioned in the plan;
- Consultants to resolve EWTD non-compliance – something the HSE and government had resolutely failed to tackle for nearly 4 years;
- Public/private mix – while still referring to the flawed HIPE Measurement System.

As the year progressed the HSE did not take any substantive action to address the long working hours of NCHDs and the ongoing breach of the EWTD. Negotiations did commence on Consultant work practices and this is covered in the Consultant section of this report.

Level 1 Consultant Grade

The Minister indicated in May that a new Level 1 Consultant grade would be introduced by the end of the year. No detail was provided.

The IMO sought clarity on the purpose and value of the role, however, the Minister did not accept an invitation to meet. The decision at the time was seen by the IMO as a short term political expedient that did nothing for long term NCHD retention or career prospects. It also had the effect of devaluing the role of Consultants. It was self evident that no significant value would be provided to patient care. The Consultant and NCHD Committees worked together to challenge the introduction of the new grade.

This analysis proved correct as the Minister withdrew the plan and on 18 September announced a 30% reduction in salary for new Consultants. This unilateral imposition not only impacted 'new' Consultants but also existing permanent, temporary and locum Consultants. A campaign was launched to fight this draconian measure and further detail is provided in the NCHD section of this report.

Public Services Agreement (PSA) – Croke Park

The Public Service Agreement (PSA) [Croke Park] continued to operate throughout the year and regular meetings on its application were held. The IMO was represented on the Health Sector Implementation Body – the only union/ organisation representing doctors that is directly involved in the formal Croke Park negotiations.

The changes required in the public sector finances appeared to fall disproportionally on the Health Sector. Patient safety should be the first and last priority, which IMO members put in to practice on a daily basis; however,

Industrial Relations
Profession-wide Issues

the restrictive manner in which reform was approached by the HSE and government was a serious cause for concern.

A number of key areas where government – across the public service - and the HSE came to the fore during the year:

Sick Leave/Pay – through direct negotiation, and subsequently using the Labour Relations Commission (LRC) and the Labour Court, changes were made to sick leave and sick pay arrangements across the public service;

Allowances – all allowances and premium payments were suspended for new recipients in February. A review was conducted by the Department for Public Expenditure and Reform (DPER) and the outworking of this will continue into 2013. The IMO wrote to Minister Howlin and set out our concerns on allowances that directly impacted our members. Further detail is provided in the NCHD section of this report..

Consultant Work Practices – the HSE commenced negotiations on work practices; details can be found in the Consultant section of this report.

Towards the end of the year the Croke Park National Implementation Body met with the Taoiseach and it became clear that greater savings will be sought from employees across the Public Sector in 2013. The impact in Health was the most pronounced – with €1.9bn already taken out of the Department for Health budget and a further €721m reduction for 2013 alongside approximately 2,500 jobs.

A meeting took place on 28 November between the Public Service Committee of the ICTU and government representatives. Government set out the rationale for an 'extension' to the Croke Park agreement to take it up to 2016. Further meetings were scheduled for January 2013.

Moratorium of Recruitment

The moratorium continued, and is expected to do so into 2013. This presented problems for posts being filled, with many left unfilled and other members of staff expected to undertake the additional duties.

As a consequence the use of agency staff continued despite that fact that agency staff were being utilised to cover vacant posts that were essential for the service to operate. Paying fees to employ agency staff simply to ensure an arbitrary headcount ceiling is maintained was illogical.

The IMO continued to press for the moratorium to be lifted. In certain instances a request to lift the moratorium was accepted, e.g. Consultant/ NCHD ratio - particularly where members expressed the view that patient safety may be an issue. IMO continued to challenge other instances that arose.

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Dr Trevor Duffy, Chairperson

Consultants

Consultants Committee 2012/2013

Committee Members: April 2012 – April 2013

Regional Representatives

Dublin/Mid Leinster
Prof Sean Tierney

Dublin/North East
Dr Trevor Duffy
Dr Patrick Manning
Dr Peadar Gilligan

South
Dr Neil Brennan
Prof John Higgins

West
Mr Finbarr Condon
Dr Naishadh Patil
Dr Seamus Healy
Dr Christine O'Malley (Co-opted)

Speciality Representatives

General Medicine
Dr Bernard Walsh

Obstetrics/Gynaecology
Dr Michael O'Leary

Pathology
Dr Clive Kilgallen

Anaesthetics
Dr Tony Healy

Psychiatry
Dr Siobhan Barry

Radiology
Dr Niall Sheehy (resigned Feb 2013)

Consultants

Work Practices

In May the HSE met with the IMO to set out proposals for changes to Consultant work practices. This was conducted under the auspices of the Public Service Agreement (PSA) - Croke Park, although the IMO argued that some items fell outside the remit of the agreement.

The main areas of change sought by the HSE covered:

1. Historic Rest Days – the IMO argued that this proposal was outside the scope of the PSA and should be removed;
2. Rest Days Going forward – a reduction in rest days going forward was unacceptable and had the potential to impact on the health and safety of both patients and Consultants;.
3. Second Opinion payment – this impacted directly on the Mental Health Service and the ability to demonstrate that an independent second opinion was being sought;
4. Clinical Directors – a proposal to strengthen the role of Clinical Directors who would have the responsibility for a wider range of activities;
5. Removal of any outstanding entitlements from the 2008 contract. This was eventually removed from the proposals;
6. Support for the introduction of the proposed new Consultant grade – as there was no detail on what this would look like the IMO argued that it should be changed to reflect the commitment already provided to the Minister for Health in May, i.e. agreement to enter into negotiations, with a view to reaching agreement, on the proposed new grade. During the negotiations at the LRC in September this disappeared from the proposals and was replaced by an intention to "substantially reduce the salary" for new Consultants. This is unacceptable to the IMO and not within the scope of the PSA. The HSE removed the reference but after the talks concluded the Minister made the announcement that a 30% reduction would be imposed. More on this later in this report;
7. 5/7 and 24/7 Roster patterns – this was a requirement under the PSA;
8. Pre-2008 contracts and 2008 contracts – the requirement for 5/7 and 24/7 rosters, as stated above, emanated from the PSA and, although not specified in any Consultant contract, the IMO was committed to enter negotiations.

Following a period of direct negotiation – where the HSE were intent on referring matters to the LRC and Labour Court – no progress was made. Subsequent LRC and Labour Court intervention concluded in the final version being subject to a ballot of Consultant members and was accepted when the ballot concluded on 21 November.

The LRC Agreement and binding Labour Court decisions were circulated to members and posted on the IMO website.

As we approached the end of 2012 it became obvious that the HSE was not adhering to its commitments set out in the agreement. This breach of both the binding Labour Court decision and the PSA will be vigorously pursued by the IMO.

Historic Rest Days

It was successfully argued by the IMO that the contractual entitlement to historic rest days did not come under the auspices of the PSA. The matter was referred to the Labour Court for a non-binding recommendation. The decision of the Court was to reduce the HSE proposal by 50%. This was not accepted by the IMO and the HSE was informed that members had the right to exercise their contractual entitlement and the IMO would support any members should their right be denied.

Level 1 Consultant/Pay reduction

As highlighted in this report the decision of the Minister for Health to introduce a new Level 1 Consultant grade was replaced with a unilateral decision to impose a further salary reduction on 'new' Consultants.

The real reason for the original proposal was nothing to do with the stated intention to provide greater career opportunities for NCHDs and to retain doctors in the Irish health service. It was about money, with no regard to the damage that it would cause to the retention of doctors, attracting doctors to Ireland, morale or equity of treatment. Despite offers from the IMO to meet and discuss the issue, none were taken up by the Minister for Health, the Department of Health or the Department of Public Expenditure and Reform.

The damage created by the illogical decision to reduce salaries by between 30% and 40% was exasperated further by the absurd decision to apply the reduction, in certain circumstances, to existing Consultants – permanent, temporary and locum.

The IMO Consultant and NCHD Committees jointly affirmed their opposition to the policy and will continue the campaign into 2013 to have the inequitable decision reversed.

CME

A proposal to centralise the administration of CME to the training bodies was contained in the work practice proposals in May. This came on the back of payments being postponed until 2013; i.e. CME activity could be authorised, but payment held back.

The IMO argued that the administration should remain with the HSE, however, this did not win through. It was then argued that the proposal to centralise should be suspended pending further negotiation on the practical application of the decision and the detail of the Service Level Agreements with the training bodies. This was agreed by the HSE and these negotiations are due to commence in early 2013.

Consultant Strategy

The IMO Consultant Strategy presented at the Annual General Meeting in April 2011 remains a key focus of the Consultant Committee. Work groups were established to take forward each strand of the strategy.

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Consultants

These continue to be:

1. *Professionalism* – the continuing attempts of the HSE and Government to devalue the work of doctors in an effort to generate additional capacity is not addressing the fundamental issue of adequate resourcing. The Consultant Committee continues to provide additional effort into highlighting the issue and how it is linked to low morale amongst Consultants.
2. *Capacity Planning* – building on the statistics available on the number of Consultants in each specialty per head of population, the IMO continues to review how the Health Service can be delivered in the most effective and efficient method to patients.
3. *Membership Strategy* – the IR Unit has established an Organising strategy which will be rolled out in Q1 of 2013. This will focus on identifying IMO members in workplace locations who will undertake the role of IMO Rep. This will be supported by training, literature, use of the website to share experiences and co-ordinate activities and a dedicated resource from the IR Unit.

   The strategy will cover all IMO craft groups and support the Consultant Committee's membership strategy.

Medical Council

The IMO maintained contact with the Medical Council on matters of mutual interest and met during the year.

Issues discussed included:-

1. Professional Competence/Performance Assessments
   a. Performance Assessments – Medical Council plans for 2012/13;
   b. CME/CPD;
2. Retired Doctors
   a. Doctors wishing to continue to practice on an occasional basis;
   b. Retention on the specialist register;
   c. Using professional knowledge and experience in non-clinical activities, such as providing advice to voluntary groups and charities, and examining for diplomas and teaching.
3. Medical Graduate Registration – overlap of conferment of degrees between Ireland and the UK.
4. Medical Provision in Prisons – conditions faced by doctors working in a prison setting.
5. Professional Qualifications Directive (2005/36/EC)
6. IMO AGM Motions – specific to the Medical Council.

The Medical Council response to the issues was reported to members in the IMO Newsletter.

The IMO continued to highlight matters of concern to the Medical Council and this relationship will be developed further in 2013.

VHI Healthcare

The Schedule of Professional Fees was due for review in 2012. A delegation from the IMO met with Vhi Healthcare to provide information on issues that we were seeking to have considered and included in the revised schedule.

Occupational Health

The previous efforts of the HSE to diminish the service provided by the in-house Occupational Health Service continued in 2012. A review of the service was commissioned with the HSE appointing an external chairperson.

One meeting was convened to debate the Terms of Reference for the review. The IMO, along with our sister unions, submitted amendments however no further meeting was held.

There is little doubt that there is a desire within the HSE to outsource a significant element of the service. This will be resisted should the issue be raised again in 2013.

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Non-Consultant Hospital Doctors

NCHD Committee 2012/2013

Dr Mark Murphy, Chairperson

Committee Members: April 2012 – April 2013

Regional Representatives

Dublin/Mid Leinster
Dr Tadhg Sullivan
Dr Sarah Sexton

Dublin/North East
Dr Remi Mohammad
Dr Grainne O'Kane

South
Dr Anthony O'Connor (resigned Feb 2013)
Dr Patrick Kelly

West
Dr David Flanagan
Dr Micheline McCarthy

Speciality Representatives

General Practice
Dr Mark Murphy

Radiology
Dr John Donnellan

Research/Education
Dr Matthew Sadlier

Psychiatry
Dr Dela Osthoff

Surgery
Dr Myles Smith

Anaesthetist
Dr Muhammad Razi Shaikh

Dr Hwei Lin Chua
Dr Roisín Plunkett (Co-opted)
Dr Catherine O'Connor (Co-opted) (resigned Jan 2013)

William Courtney (student)

NCHD Engage for Change Campaign

Throughout 2012 the IMO continued to roll out the NCHD 'Engage for Change' campaign launched in August 2011, the aim of which is to foster a culture of positive engagement among NCHDs working in Ireland to ensure that the Irish Health Service can attract the best doctors and provide excellent training, defined career paths and the highest standard of patient care and safety. This engagement is particularly crucial given the ongoing difficulties in both the recruitment and retention of NCHDs in the HSE. In light of developments the original objectives of the campaign have been enhanced to read as follows;

- A better, safe and efficient Irish health service with the highest standards of patient care
- An engaged, proactive & positive NCHD cohort
- Reduction in onerous working hours and appropriate application of EWTD
- Equitable treatment of new and existing Consultants
- Full implementation of NCHD Contract 2010
- Improved working conditions and removal of inappropriate tasks
- Improved structured training in terms of access & funding including the introduction of more flexible, family friendly training and restructuring of current non-training posts
- A strategic planned approach to manpower planning to determine defined career paths for all grades & specialities including addressing career progression of long service hospital doctors

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Non-Consultant Hospital Doctors

Dr Paul McKeown and Dr Mark Murphy present Senator Colm Burke with the Boarding Pass Campaign

IMO NCHD Committee members launch the Boarding Pass Campaign

- Increase in the number of Specialist and GP posts
- Continued roll out of Clinical Care Programmes and expansion of primary care to contribute to a reduction in the reliance on NCHDs in staffing hospitals

Following on from the Engage for Change Hospital meetings in August and September 2011 a further series of 13 hospital meetings took place across the country in March 2012 which afforded the IMO and NCHDs an opportunity to meet and discuss a number of important issues. Hospital meetings during the month of March included St James's Hospital, Beaumont Hospital, Mater Hospital, St Vincent's Hospital, Cork University Hospital, Galway University Hospital, Waterford Regional Hospital, AMNCH Tallaght, Mid-Western Regional Hospital (Limerick), Cavan General Hosptial, Coombe Hospital, Our Lady of Lourdes Hospital (Drogheda) and Letterkenny General Hospital. A further 18 hospital meetings took place in October and November 2012. Issues discussed at the meetings included the consultant pay cut, non-payment of overtime in certain hospitals, Annual Leave, Living Out Allowance, GP Registrar Allowance, Working Hours, Training and the increased emigration of Irish trained doctors.

Consultant Pay Cut and IMO NCHD Boarding Pass Campaign

In April 2012 the Minister for Health issued a discussion paper on a proposed new Consultant Level 1 post. The IMO wrote to the Minister twice in May 2012 seeking a meeting to discuss the proposal but we were informed that the Minister was consulting first with the Forum of Postgraduate Training Bodies. The IMO convened a subgroup of NCHDs and Consultants to examine and assess this proposal and wrote again to the Minister insisting that negotiations commence prior to the establishment of this post or the offering of contracts. The IMO subgroup concluded that the proposal was a Consultant pay cut in all but name and would create a two tier workforce. The feedback from the Forum on the proposal was overwhelmingly negative and the matter appeared to be dropped. In September 2012 during the discussion on changes to Consultant work practices in the Labour Relations Commission the term 'Support for the introduction of a new Consultant grade' was included in the HSE proposals. As there were no details on what this would look like the IMO argued that this should be changed to reflect the commitment already provided to the Minister for Health, i.e. agreement to enter into negotiations, with a view to reaching agreement, on the proposal to introduce a new Consultant grade. During the talks this disappeared from the proposals and was replaced by an intention to "substantially reduce the salary" for new Consultants. This is unacceptable and not within the scope of the PSA. The HSE removed the reference but stated that it was their intention to introduce the change. After the talks concluded the Minister made the announcement on Monday 17th September 2012 that it would amount to a 30% reduction. An emergency National NCHD meeting was held on 24th September 2012 to outline the IMO's strategy for dealing with the issue under the following headings:

- Engagement with other Trade Unions
- Industrial Action
- Legal Avenues
- Media Campaign
- Political lobbying

Work has been ongoing under all of these headings over the last number of months including much correspondence between the IMO,HSE and the Department of Health. The IMO wrote to the HSE in December 2012 outlining the formal position of the IMO in

Non-Consultant Hospital Doctors

relation to the Consultant pay cut announced on 17th September 2012 and the subsequent announcement of its application in certain circumstances to existing consultants on 4th December 2012 and requesting a tri-partite meeting between the IMO, HSE and Department of Health which it has been confirmed will be held early in early 2013. Further detail on the Consultant pay cut can be found in the Consultant section of this annual report.

As part of the Engage for Change campaign a symbolic boarding pass campaign was launched to highlight the serious consequences for the Irish Health Service of the intolerable decisions taken by the Minister for Health and the HSE including the 30% Consultant pay cut. Through this campaign the IMO emphasized that the HSE will continue to experience difficulties in both recruiting and retaining NCHDs who are critical to the delivery of front line health services unless the issues outlined above are addressed. Over 800 NCHDs signed and returned a symbolic boarding pass indicating their intention to leave the Irish Health Service to pursue their medical careers overseas and making the point clearly that unless there is real change for NCHDs there will be more NCHDs in our airports than in our hospitals. The Boarding Pass campaign was delivered to Senator Colm Burke, Fine Gael Health Spokesperson in the Senad on Friday 30th November 2012. The campaign garnered significant media coverage and a meeting has been requested with the Minister for Health to discuss the implications for the future of the Irish Health Service.

European Working Time Directive

In 2000, the European Parliament outlined a nine-year transition periods for Member States to become compliant, gradually bringing down the average working hours per week. The timelines that had to be met were:

- 1st August 2004: maximum of 58 hours on average per week
- 1st August 2007: maximum of 56 hours on average per week
- 1st August 2009: maximum of 48 hours on average per week

On Friday 22nd January 2010 the IMO secured a favourable settlement of the EWTD High Court case including a collective agreement ensuring the HSE cannot make unilateral changes to NCHD contracts and reinforcing the entitlement of the IMO to negotiate on behalf of NCHDs. The Collective Agreement deals with issues relating to EWTD implementation which will allow for the EWTD to be implemented in a more flexible, appropriate and uniform manner while ensuring protection of NCHD training, income and health and safety. These include an agreement that NCHDs may be rostered to work up to a maximum of 24 consecutive hours subject to provision of equivalent compensatory rest and on no more than a one in five basis. The Agreement also provides for new arrangements for protected training time for NCHDs which will not count as working time for the purposes of the EWTD but which shall be treated the same as working hours for payment purposes.

Despite this the EWTD continues to be breached and in September 2011 the European Commission wrote to the Department of Health asking them to explain the reasons for non-compliance with the EWTD and what steps would be taken to comply with the Directive. Ireland submitted, on 13th January 2012, a plan to achieve compliance with the Directive. This was in response to the Reasoned Opinion forwarded by the Commission to Ireland on 30 September 2011 stating that NCHDs work average hours which exceed the limit fixed by the Directive and are not provided with minimum daily and weekly rest in accordance with the protections in the Directive. The response addresses the Reasoned Opinion in the following manner:

- It affirms Ireland's commitment to achieving compliance with the Directive.
- It sets out a timeframe for achieving EWTD compliance over the next 3 years.
- It identifies the establishment of a national high level EWTD Implementation Group by the HSE.
- It commits to implementing other measures that will support compliance, including:-
  1. The implementation of new work patterns for medical staff
  2. Transfer of work undertaken by NCHDs to other grades
  3. Organisation of hospital services to support EWTD compliance. This will complement the reform of acute hospital care currently being advanced by the SDU in association with the HSE's National Clinical Programmes and new governance arrangements being developed for the HSE.
- It also commits to providing the Commission with an annual progress report.

  This response is now being considered by the European Commission. This response may decide to refer the matter to the European Court of Justice which would have the power to give substantial fines to Ireland for continued non-compliance. It is expected that the Commission will want to meet with the Department of Health prior to taking this step.

The IMO have also written to the Commission on the matter making the point that the continued non implementation of the EWTD was leading an increasing number of NCHDs to leave the Irish Health System. It seems these points have been taken on board with a Commission spokesman recently stating:

> *"Over-tired doctors risk making mistakes which can have serious consequences for their patients. Moreover, exhausting working conditions for doctors risk exacerbating already-high rates of emigration and drop-out, when there is already an international shortage of qualified medical professionals,"*

In the same correspondence the IMO also pointed out several factual inaccuracies in the Department of Health's submission with regard to EWTD compliance and asked to meet with the Commission. The IMO further wrote to the European Commission in March 2012 with an official complaint that national law and practice in Ireland does not comply with the Working Time Directive (2003/88/EC). The complaint is being considered by the Commission and the complaint is registered under reference CHAP (2012)02690. There was a two year bar on any legal action with regard to working hours following the High Court settlement in February

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2010. The prepared and compiled a case for counsel in March 2012 and received the legal advice with regard to options for taking an action under the Directive in June 2012. This advice is now being considered by the NCHD Committee having due regard to recent developments at both local and European level.

NCHD Contract 2010 - Annual Leave

Since its introduction in February 2010 the IMO has been engaging with the HSE on an ongoing basis on a number of issues regarding implementation of NCHD Contract, including discussions under the auspices of the Labour Relations Commission. NCHD annual leave has been the subject of a dispute between the IMO and the HSE since implementation of NCHD Contract 2010. On each rotation in January and July from 2010 to July 2012 the HSE reduced NCHD leave to 12 days per 6 months with the full leave only being reinstated on the understanding that the IMO would enter into discussions with the HSE on the issue. Protracted discussions took place under the auspices of the LRC throughout 2012 including in February, May and September 2012. A final LRC conciliation hearing was held in October 2012 at which agreement on the annual leave issue was reached on the correct application of the leave entitlements contained in NCHD Contract 2010. The agreement was discussed in detail and accordingly endorsed by the NCHD Committee of the IMO at a meeting on Wednesday 24th October 2012. The following key points from the agreement are:

- The IMO was successful in ensuring that the majority of NCHDs (all NCHDS with an on call liability) retain their public holiday entitlement on an 'up front' basis. In practice, NCHD leave entitlements have increased from the traditional '3 weeks' leave per 6 months to 17 working days leave from July to January which equates to 3 weeks and 2 days and 16 working days from January to July which equate to 3 weeks and 1 day. This is an increase of 3 working days leave on what has in practice to date been a 3 week per 6 month entitlement.
- The status quo for community based GP Registrars of 3 weeks leave per 6 months is reinstated
- Importantly, all annual leave/public holiday entitlement is to be calculated on the basis of working days / working hours and not calendar days. Saturdays and Sundays are not to be included in the calculation of leave e.g. if an NCHD takes a Friday off, this is counted as 1 working days leave and not 3 calendar days as has been the practice to date.
- NCHDs who work on the public holiday (including on call on site and off site) will be paid the relevant rate applicable for the hours worked (e.g. the period of a public holiday is defined as any hours worked between midnight on the eve of a public holiday and midnight on the public holiday) and do not need to take a day's annual leave or an unpaid days leave for the day.
- NCHDs who are not rostered for a public holiday may opt to either use one of their 16/17 days leave in order to receive a paid day off on the public holiday or they may opt to take an unpaid days leave
- NCHDs now have the option of taking 33 annual leave days per year plus up to an additional 9 days unpaid leave per year if not rostered for all public holidays
- NCHDs should now be in a position to avail of their full 33 days leave entitlements as any leave remaining at the end of each rotation which commonly NCHDs are not in a position to take may now be allocated to the public holidays at that time (e.g. the Christmas and New period for July – January rotation and the May and June bank holidays for the January – July rotation)
- Any NCHD categorised as a Monday to Friday worker will receive 12 working days annual leave up front and will receive public holidays as a paid day off as it arises.
- If an NCHD who does not normally undertake on-call is rostered on-site or on-call on a public holiday, (s)he will receive a day off in lieu at another time. If this occurs on a regular basis the NCHD can seek to be moved to Category A and receive their public holiday entitlement up front. This request will be examined by the Hospital in the first instance and if no agreement is reached within 2 weeks of the request, the issue may be referred by either party to the IMO/HSE Working Group.

Unrostered Overtime

Non-payment of unrostered overtime continued to be a key difficulty for NCHDs in a number of Hospitals across the country throughout 2012. The strategy in each hospital is to issue formal correspondence to the hospital and hold a local meeting with NCHDs. Failure to confirm payment of all hours worked by a hospital and/or non-payment will result in a ballot for industrial action of NCHDs in that hospital. A number of cases of non-payment were successfully resolved in 2012 including in Cork University Hospital and Beaumont. The IMO will continue to fight instances of non-payment at local level as they arise and the matter is always a key agenda item in National discussions with the HSE.

Establishment of NCHD IMO Rep Structure

The IMO held a series of hospital meetings throughout the country during October and November 2012 with over twenty hospitals being visited.

The purpose of the meetings was to discuss issues such as:

- Consultant Pay Cut
- IMO Boarding Pass Campaign
- Non Payment of Overtime
- Annual Leave Arrangements
- Reinstatement of GP Registrar Out of Hours Allowance following IMO ballot of GP Trainees
- Update on Living Out Allowance, removal for new entrants

These issues are dealt with in detail elsewhere in this report. At each meeting IMO reps were also sought in order to help build a network of Reps throughout the various hospitals.

We have identified a number of IMO members (over 30 in various hospitals nationwide) who have volunteered to act as reps and we are tracking these NCHDs through their various

Non-Consultant Hospital Doctors

rotations in order that their active presence on the ground is not lost once they rotate hospitals.

In the coming year we further plan to introduce an IMO rep booklet as well as looking at the possibility of Rep Training in order to help IMO reps deal with issues on the ground while linking into the Executive in IMO house.

An active and engaged NCHD rep structure should help considerably enhance the IMO's profile in various hospital locations as well as encouraging more members to get actively involved in the organisation. An organised and motivated rep structure will augment the IMO's ability to deliver results for its members, particularly at local level, and we hope to further develop this over the coming year.

DPER Review of Public Sector Allowances –NCHD Living Out Allowance and GP Registrar Out of Hours Allowance

From 1st February 2012 the Department of Public Expenditure and Reform suspended all public sector allowances for new beneficiaries pending completion of a review of said allowances. From an NCHD perspective the two allowances involved were the Living Out Allowance and the GP Registrar Allowance. The review was to take approximately 6 weeks.

By July 2012 the review was still not complete and a number of NCHDs became "new beneficiaries" at this point including interns and 3rd year GP Registrars. A decision was taken to ballot all GP Trainees with regard to the suspension and threatened removal of the GP Registrar Out of Hours Allowance. This allowance was in the nature of pay and for a defined service. As such the IMO view was that it was protected by Croke Park. The ballot was passed with 98% of IMO GP Trainee members in favour of Industrial Action. The result of the ballot was communicated to the HSE and the Department with written notice of intention to take Industrial Action to be served in early October. On foot of this the IMO were made aware that a positive outcome was likely and hence notice was not served pending confirmation of the decision of Cabinet with regard to the future of the allowance. The memo sanctioning payment of the allowance, including back payment, was duly issued on 12th October 2012.

The Living Out Allowance was removed for new beneficiaries and the IMO has written to the HSE outlining that the removal of the living out allowance from Interns is a breach of NCHD Contract 2010 and the IMO/HSE High Court Settlement Agreement 2010. We are awaiting a response to this letter and will refer the matter to the Labour Court for adjudication should a positive response not be forthcoming. In the interim the IMO received correspondence from the HSE in December 2012 outlining that as part of the DPER Review of Allowances the HSE has been requested by DPER to engage immediately with staff representatives with a view to securing the elimination of allowances (living out allowance and GP Registrar Out of Hours Allowance) for current beneficiaries also. In light of this correspondence the IMO will be meeting with the HSE in early 2013 in order to fight for both the reinstatement of the living out allowance to interns and the retention of the living out allowance and out of hours allowance for current beneficiaries and new entrants.

Centralisation of Intern Applications

The intern application process was centralised for the first time in July 2012. Serious mistakes were made in the application process and a number of job offers were made in error. Furthermore applicants were not properly screened leading to errors in the ranking percentile of students. The IMO contacted all student members to explain the process and confirm that we would seek compensation for those who had expended money on accommodation on foot of an erroneous intern placement offer. Thankfully given that the new offers were released a matter of days after the initial offers there was limited financial loss to those involved however the issue did cause considerable anxiety and stress to the incoming interns and their families. 2013 will see the first of the additional graduate medical students graduating but there has been no corresponding increase in Intern places. This will inevitably lead to a shortage of Intern posts in July 2013. The IMO wrote to the Minister for Health in May 2012 to which a response was received stating that *"The Department and the HSE are actively pursuing a range of initiatives to cater for the 2013 intake and beyond"*. This issue was also raised at a meeting with the HSE. A follow up letter was sent to the Minister in November 2012.

NCHD Language Competency Requirements

The HSE issued a circular in December 2012 outlining new language competency requirements. While the IMO acknowledges the necessity of English skills to practice medicine in Ireland we are concerned by the distinction being made in the IELTS requirements for NCHDs applying for training and non-training posts. According to the circular any NCHD (not having completed a medical degree in an English speaking country) registered with the Irish Medical Council prior to 9th July 2012 is not required to provide an IELTS certificate when applying for a non-training post but will be required to provide one if applying for a training post. This anomaly may result in NCHDs who are already employed by the HSE and are working in the Irish Health Service having to undertake the IELTS exam if applying for a training post. This time consuming and costly exercise is an unfair burden to place on current HSE employees who evidently already meet the English requirements to work in the Irish Health Service. Furthermore, the differing requirements for training and non-training posts is completely iniquitous given that there should be no distinction in the language requirements for any NCHD post in Ireland. The IMO has requested urgent written confirmation that this anomaly will be rectified in order that all NCHDs who were registered prior to 9th July 2012 will be treated in the same manner and will not be required to sit the IELTS regardless of whether they apply for a training or non-training post.

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Ceardchumann Dochtúirí na hÉireann

Personal Cases Unit

The Personal Cases Unit (PCU) of the IMO remains the principal point of contact for Members with the Organisation. This past year, the PCU has taken over ten thousand calls from Members on every conceivable issue. The PCU is staffed by dedicated industrial relations personnel and its remit is to advise and to help Members deal with matters that are specific to that Member. Naturally, this involved close collaboration with the National Unit as Department of Health and HSE policy changes are often implemented inconsistently or just incorrectly.

Taking a broader view, many of the queries that come to the PCU are driven by these national changes. For instance, many NCHD Members contacted the PCU to discuss Annual Leave on being notified that the method of measuring their Annual Leave was to be clarified. While many GPs sought individual help in dealing with the PCRS alongside the ongoing national level negotiations.

In addition, individual Members sought assistance in relation to contractual issues, disciplinary issues or in having their rights upheld at third parties. The PCU has achieved several notable successes this past year, including having unrostered overtime paid in several locations, resulting in a number of NCHDs receiving substantial monies due. Staying with NCHDs, the PCU succeeded in having Contracts of Indefinite Duration awarded to several long serving Doctors whose employment status had been jeopardised.

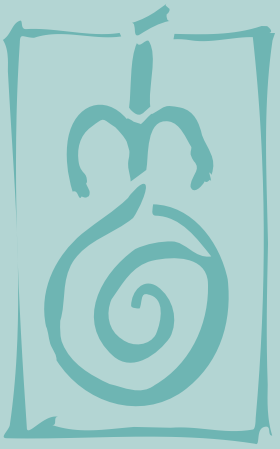
Increasingly, as Government supports are reined in, GPs have asked the PCU to assist in helping them to alter their cost base so as to ensure that their practice remains on a reasonably sound financial footing. The PCU has also intervened in several parts of the country to ensure that GPs existing arrangements are maintained or that proper negotiation takes place prior to any change in their arrangements.

The LRC and Labour Court processes have caused an upsurge in calls from Consultant Members. As the IMO had predicted, many newly appointed Consultants have experienced severe disappointment on taking up posts – those that have gotten through the system – and sought PCU assistance.

In serving the needs of our Public Health and Community Medicine Members, the PCU has taken up the cases of several Members whose local and other arrangements had been unilaterally changed by management. The PCU has also assisted Public Health and Community Medicine Members whose contractual status needed to be clarified.

In light of the decision announced in the Budget of December 2012 to reduce health spending by over €700m in 2013, it is inevitable that the medical spend will be reduced. It is equally inevitable that various managers within the health service will view reducing the medical spend as a opportunity to get out in front of the looming cuts. It is vital, therefore, that doctors become more aware of what their contracts say and that they remain vigilant of their contractual rights and notify the IMO should these rights be breached.

The PCU is an excellent resource and has helped hundreds of IMO Members. In these challenging times, uncertainty is the only certainty and, no doubt, 2013 will be every bit as busy as 2012.



Dr Ray Walley, Chairperson

General Practitioners

General Practitioners Committee 2012/2013

Committee Members: April 2012 – April 2013

Regional Representatives

Dublin/Mid Leinster
Dr Garrett McGovern
Dr Padraig McGarry
Dr Truls Christiansen

Dublin/North East
Dr Ray Walley
Dr Jim Keely
Dr Declan Connolly
Dr Joan Maguire (Co-opted)

South
Dr Ronan Boland
Dr David Molony
Dr Tadhg Crowley
Dr Kevin Kelly
Dr Derek Forde
Dr Ciaran Donovan (from floor)
Dr Niall McNamara

West
Dr Martin Daly
Dr Mary Gray
Dr Michael Kelleher
Dr Colm Loftus
Dr Denis McCauley (Co-opted)

North East
Dr Illona Duffy (from floor)

1. Government Announcement on Reduction in Professional Fees

It was announced in Budget 2013 that professional fees under the GMS are to be cut by €70M. In addition savings of €32M are to be made by the change in criteria for eligibility to a medical card as well as for those who are to change to a GP Visit card. It is a step too far to apply this level of reduction to general practice which is already creaking with the shortage of resources and the increased demands being made on the service. There has been significant disquiet from GP members in relation to the impact of these cuts, in particular in rural practices and in those with a large number of nursing homes. The IMO is working to oppose these cuts.

The devastating impact this will have on general practice has been forcefully communicated to the government through the Department of Health. It was announced by the Department in December that this reduction would be included in the Financial Emergency Measures in the Public Interest Act (FEMPI) review in January 2013. The IMO will make every use of the consultation process required under the legislation to drive the points home to the decision makers.

In order to avoid a catastrophie in general practice the Minister will be strongly asked by the IMO to consider:

(i) The cumulative impact of various cuts in payments to GPs already introduced in 2010 and 2011 and 2012.

(ii) The inability of GPs to continue to cross subsidise GMS Patients as a result of falling incomes from private patients.

(iii) The downstream impact on overall secondary care health costs caused by the imposition of further cuts on primary

General Practitioners

care service providers. This is being seen already in respect of an increase in the rate of referrals to secondary care centres.

(iv) The increasing demands being placed on GPs as a result of the recession and the increased incidence of recession related illness.

(v) The relative inflexibility of the GP cost base where fixed costs account for a dominant proportion of the costs of a typical General Practice Surgery. Recognition of the inflexibility of these costs occurs in the UK where targeted specific funding for most of General Practise infrastructure and cost base occurs. It is accepted in the UK / NHS that the cost basis is at the level of an average of 63% turnover and funded accordingly. This is National Published data. This figure has relevance to the GMS GP service as patient profiles are similar to the UK population. Not giving due recognition to these fixed costs will endanger the continued success of the GMS GP service.

A matter of particular concern to the IMO is the effect of the cuts on the health and well being of GPs. With the majority of GPs reporting a significant increase in daily working hours coupled with more difficulty taking leave. This is also characterised by an increase in work related illness. When these effects are combined with the difficulty a majority of GPs have in sourcing locums the scale of the problem is obvious.

The approach outlined is detrimental to the future plans for general practice best illustrated by the running down of capacity to provide for chronic illness management. The longer term impact has also been to postpone for at least 5 years the ability to provide universal GP service.

Earlier on 10 May the Minister conducted a review of the effects of the legislation which concluded on 8 June. The IMO made written submissions on 24 May setting out the effect of the cuts and the impact they are having on services. It was also highlighted that the effects were ongoing and have a worsening effect on general practice in general and on rural practice in particular.The effect of the cuts on the health and well being of GPs is also a matter of concern. On 5th June an IMO delegation of GPs, Opthalmologists and IMO staff made an oral submission to the Department of Health and other public body officials. The IMO gathered forensic information from GPs affected by the cuts and this information is the cornerstone of our submissions under the FEMPI legislation. The Minister has confirmed that on conclusion of the review there will be no changes to existing arrangements. The case of 11 GPs who appear to have an above average increase will be investigated further.

GP Strategy

The GP committee held a number of workshop meetings in the Autumn to consider the strategic challenges facing general practice and to formulate appropriate strategies to deal with the issues. Increasing demands of patients experiencing the effects of recession at a time of depleted resources is taking its toll on GPs. This is not only in terms of service delivery but also on the health and well-being of GPs. The IMO is working to resolve the issues and is organising to highlight these challenges as well as supporting GPs in meeting them head on.

In formulating a response to the issues the committee identified the areas of Chronic Disease Management, The GP Value Proposition, Additional FEMPI Cut, Universal Healthcare, and PR/Communications to work on. Considerable work has been undertaken on these areas and the committee is concentrating efforts on the immediate issues of FEMPI 3 and Chronic Disease Management. The challenges faced by an Additional FEMPI Cut is considerable and will reduce the capacity to provide existing services as well as remove the ability to provide for any additional services to patients. While it is worthwhile to expand and develop the scope of practice this can only be done by protecting quality and high standards through adequate resourcing. This remains the priority of the committee.

1. GMS Contract Issues

The IMO has communicated to members how vital it is that the current GMS contract is preserved and protected in its entirety. It is noteworthy that members have been proactive in highlighting any incident of breach of the contract. Attempts to undermine the contract by reinterpreting it and changing arrangements at both a local and national level have been forcefully resisted locally and nationally. Recent attempts by HSE to shift work to general practice, particularly from Public Health Nurses, secondary services as well as attempts to challenge GPs about phlebotomy has been resisted and its important this continues to be challenged where it occurs.

The personal cases unit has been closely involved in setting out what is covered by the contract and what's not, which has been useful to members. These issues have been taken up directly with PCRS. The IMO has communicated to members the services covered by the contract and identifying whats outside it which has been of great use to many practitioners. There have been some attempts by the HSE to pressure some GPs to provide services not covered by the contract which has been challenged by the IMO

2. Primary Care Teams

Primary Care Teams arose as a key feature of transformation. GPs participating must be enabled to do so optimally through further negotiation. The IMO has discussed with the Department of Health the standardisation of care provision and access to primary care services for all General Practitioners. There must be equity of access of primary care facilities to all GPs. The HSE ran road shows setting out to local GPs their proposition for new centres. The IMO has consistently communicated that participation must make sense for benefit of patients and how GP can deliver.

Profiling GPs and General Practice:

Discussions were held between the IMO and the RTÉ Programme Operation Transformation

General Practitioners

to highlight the rise in diabetes and to show what GPs can do to counteract this disease which is increasing. The programme also illustrated the work undertaken by GPs which was shown in early 2012.

Competition Act: Following the passing of the Public Service Agreement (Croke Park Deal) the IMO continues to pursue the implementation of the following section:

Discussion with the Irish Medical Organisation

Further discussions will take place with the Irish Medical Organisation in relation to the Government commitment to make appropriate changes to the Competition Act and a transformation agenda for General Practitioners (GPs). These discussions will be completed within two weeks.

It is a cause of concern that progress is so slow and the IMO has previously written to the Minister for Enterprise, Trade and Innovation and the Secretary General of the Department of the Taoiseach to implement the agreed legislative changes. The IMO has been in touch with Emmet Stagg TD on his efforts to amend the legislation through the introduction of a private members bill.

3. GP Manpower Group

The standing working group established between the IMO/HSE and the Department of Health & Children to examine issues of GP Manpower. The Group examines the whole area of GP manpower, GMS access/entry, the creation of a number of zero panel lists and the marking schedule for GMS interviews. On-going meetings have taken place between the parties.

A presentation on the broad proposals for the delivery of the diabetes chronic care programme was delivered and the HSE were to subsequently set out their proposals in writing. It has been made clear that the use of a pilot is not acceptable to the IMO and a different approach is required. The HSE/DoH has established an implementation group which is looking at the options and will set out its proposals to the IMO when they have clarified the approach it wishes to take. There has been no progress on this to date.

The group was also informed when the Minister had signed the commencement order providing for open entry to the GMS the provisions of which are now active. The proposals to introduce a new marking system for entry to existing GMS posts have been effected by these changes and discussions on this scheme are on-going.

The IMO raised a number of issues of concern about Community Intervention Teams (CITs) and asked the HSE to review the document which was forwarded to the IMO. The amendments to the document were made and were considered by the committee. The document has been noted and the HSE were informed that GPs reserve the right to provide these services which are provided by some GPs.

The HSE provided a presentation from the HSE Estates section on their plans for the development of primary care centres in the coming year. It was accepted that GP involvement in these centres is very important. The HSE also recognises that any proposal for GP involvement will need to be attractive and enhance patient services

4. PCRS / GMS Contract Issues

Registration/Decentralisation

The IMO continues to engage with PCRS on the application and processing of medical cards. The issue of delays in the processing of applications as well as the difficulties experienced by clients has been highlighted. A number of meetings were held and a joint IMO/ PCRS documents was agreed dealing with the 17 IMO recommendations contained in the IMO submission to the Joint Oireachtas Committee. The system went live in March and was used to add new borns, reinstate patients as well as remove patients from the system. In addition the system provides for sensitive renewals. The IMO continues to keep the process under review with PCRS.

The main focus for the IMO in engaging with this issue was to ensure:

(a) the proposed new processes as they apply to GPs are practical and workable for GPs and their staff

(b) the proposed new procedures do not impact on current contractual arrangements

(c) patient lists remain the responsibility of the HSE and any agreed proposals on list verification/additions/deletions will not infer responsibility on GPs nor can GPs be penalised for unforeseen errors.

Out of Hours Payments:

A number of payments have been withheld by PCRS from some GPs on the basis that they consider the level of claims to be very high. This is not provided for by the contract. While legal correspondence was exchanged between the parties, the IMO sought to agree a process with PCRS whereby individual queries in respect of out of hours payments could be addressed. While some progress was made it was agreed with PCRS that the outstanding issues would be resolved through an agreed process which was to conclude by 27 June. The process was never completed and did not address the issue. It was decided to refer the issue to an arbitrator. Correspondence has exchanged between the parties on the appointment of the arbitrator and the issue was discussed with Roisin Shorthall and Laverne Mc Guinness. In December it was agreed that Tom Mallon SC would work with the parties to resolve the outstanding issues. The drafting of the terms of reference is ongoing and are written to ensure the guidelines do not change the existing contract.

Study Leave Payments:

The IMO raised the issue of non payment of study leave applications to members with the PCRS. After some correspondence and discussion the issue has been resolved and the outstaning payments were issued

Flu Vaccine Portal

PCRS established a portal to claim for flu vaccines that was not agreed with the IMO and increased the work for GPs. The IMO wrote and set out objections to the portal and

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this was discussed at a meeting with PCRS. A workable solution was found to deal with the IMO objections and produce a functional solution where relevant data can be captured.

Following discussion with the HSE the new arrangements were brought into place from 1 November where GPs can make claims on the basis of the GMS number. It was agreed that claims before this time would be paid in line with existing arrangements.

Temporary Residents

PCRS produced guidelines for payments to temporary residents and made payment on account to a small number of GPs at a reduced rate. In these cases they had queried some of the payments claimed and followed up on an explanation from the GPs concerned. IMO asked that the full rate was paid and that a proper process was put in place to deal with this issue.

It was agreed this would be dealt with in parallel with the process agreed dealing with the out of hours arrangements when agreed. This will be in line with the terms of reference and will not change the existing contract.

Outstanding Payments

The issue of outstanding payments due to GPs was raised with PCRS who accepted that they would pay the amounts due in accordance with the contract. PCRS has suggested they have paid appropriately and will redress any error they are aware of. They would accepted there is a need to co-ordinate the information on residents in nursing homes and would relate to the other agencies as a means of cross referencing. PCRS has agreed to provide more transparency in the reports so GPs can track payments.

In addition PCRS agreed to;

1. Clarify how nursing home patients are classified and paid.
2. Issue clarification on how PCRS is interpreting Circulars relating to increment point allocation for practice nurse and practice secretary and clarify how this will be dealt with
3. Clarify how they interpret support grants payments to partnerships where one list is <100 patients e.g

Outstanding adjustments

In November the HSE applied adjustments to GPs for outstanding payments going back to 2005. These relate to payments for clients who had passed away but were not updated from the register and for underpayments in respect of adding new born babies of eligible Medical/ GP Visit cardholders who were not added to the register from date of birth from 2005 through 2011.The maximum amount deducted in a month was 20% of the monthly payments.

The approach was challenged by the IMO who informed the HSE that it is not acceptable to make these adjustments without proper notice. The timing of the deduction at the time of tax payments for GP was particularly intolerable.

Other GMS Payments

A listing with examples of payments that had not been dealt with was supplied to PCRS who have undertaken to respond. They suggested they had made the payments due to GPs The IMO submitted a list of outstanding payments due to GPs in December and it is expected these will be paid to GPs

5. GPs Specialising in Substance Abuse

The IMO continues to deal with a number of on-going issues concerning General Practitioners who specialise in Substance Abuse. Following a meeting, Doctors Specialising in Substance Abuse agreed to progress in action plan. The main issues of Clinical Indemnity, Professional Added Years, 7 Day Dispensing, Changes to working hours and New Posts continue to be relevant.

The IMO has dealt with changes in work practices and other issues on a local basis. Most of the issues relate to Dublin North and Dublin Mid Leinster and these issues continue to be under discussion.

The IMO has also raised the issues of subsidies due to GPSAA doctors and these discussions are on- going.

6. GP Unit Doctors

The IMO continues to seek a resolution to the non-payment of national wage rounds which was rejected by The Labour Court. The Court decided it could not hear the case of GP unit doctors The IMO is looking at other options to pursue this case

7. Prison Doctors

The Irish Prison Service (IPS) continues to refuse to apply all outstanding national wage rounds to Prison Medical Officers. The IMO met with the IPS to discuss the non payment and other issues of concern for prison doctors. This issue could not be heard by the Labour Court. The IMO is seeking to have the issue referred to an appropriate independent third party for resolution.

The IMO met with the new Director General of the Prison Service and raised a number of issues of concern within the prison service. These involved dealing with issues of overcrowding in prison and issues of patient care. The IMO also engaged with the Prison Service on issues related to changes in working practice.

Public Health Doctors

Public Health Doctors Committee 2012/2013

Dr Mary Conlon, Chairperson

Committee Members: April 2012 – April 2013

Regional Representatives

Dublin/Mid Leinster
Dr Mary Conlon
Dr Howard Johnson
Dr Johanna Joyce Cooney

Dublin/North East
Dr Paul McKeown
Dr Patrick O'Sullivan

South
Dr Orlaith O'Reilly
Dr Brett Lynam
Dr Bridin Cannon
Dr Mary O'Mahony
Dr Ina Donoghue
Dr Kathleen O'Sullivan

West
Dr Anthony Breslin
Dr Mary Fitzgerald
Dr Heidi Pelly
Dr Darina Fahey
Dr Ann Hogan

Deferral of Continuing Medical Education (CME) / Continuous Professional Development (CPD) Supports

As a consequence of the severe financial deficits that the HSE experienced in mid 2012, a memorandum was issued by the HSE on 29th August, 2012 initiating an immediate cessation of approval for all medical education supports. This decision fell hardest on Public Health Doctors who, unlike Hospital or General Practice colleagues, cannot avail of some types of supports from third bodies for training activities.

The IMO viewed this as a breach both of the Medical Practitioners Act of 2007 and of the 2003 Agreement and contacted the HSE seeking urgent clarification and confirmation that Public Health Doctors could continue to avail of these vital supports. Following engagement with the HSE, the IMO secured a commitment that outstanding amounts would be discharged in 2013 and that the three year 'roll over' facility would continue until, at least, the end of 2013.

The decision of the HSE to defer CME / CPD supports runs counter to the State's commitment to continually refresh the skills of medical professionals. While it was possible to secure a commitment to reinstate these supports in 2013, this area requires continued vigilance, particularly in specialties like Public Health and Community Medicine where discretion in choosing training options is of crucial importance.

Public Health Emergency Out of Hours Medical Service

Some three and a half years into the establishment of a Public Health Emergency Out of Hours Medical Service on a six month interim basis, the management side still resist the insistence of the IMO that the Service be placed on an effective and enduring footing.

IRISH MEDICAL ORGANISATION
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Public Health Doctors

Pressing the case, the IMO met with the HSE (and the Departments of Health and Public Expenditure / Reform) on 30th May 2012 at which time the HSE confirmed that they were examining the possibility of restructuring the Service in order to save money. The IMO sought and received assurances that any proposals in this regard will be subject to the usual negotiations. The IMO also advised the Management side that proposals that had been deemed unacceptable during the long negotiations leading to the establishment of the Service could not be dusted off an re-presented as new options.

In the absence of any further contact from the Management side, the IMO wrote to the Labour Relations Commission (LRC) on 29th August, 2012 requesting a mediated discussion on the Service with particular emphasis on the lack of sufficient staff to fill agreed rosters and the inability of the HSE to put expected support services in place. The sides met on 27th November and agreed a three month timeframe during which the activity levels of the Service would be evaluated and agreed protocols would be put in place. It was also agreed that the management side would advise other parts of the health service of their responsibility to support the Service.

The parties are due to reconvene at the LRC at the end of the first quarter of 2013 to review progress and assess if there are other issues on which mediation is required.

Consultant in Public Health Medicine Status

Throughout 2012 there have been detailed recent discussions between the HSE and hospital Consultant representatives under the auspices of both the Labour Relations Commission and the Labour Court. The potential implications for Public Health Specialists / Directors of Public Health have been considered by the IMO Public Health Committee and it was felt that, in order to show support for Hospital Consultant and NCHD colleagues, the Committee would not recommend that any Public Health Doctor seek or accept appointment or re-designation as a Consultant on the reduced salary levels offered by the Department of Health and the HSE.

Anomalous Position of the Remaining Area Medical Officers

Almost a decade after the negotiation of the 2003 Agreement, the HSE still refuse to recognise the contribution of the long standing Area Medical Officers to the delivery of health services in Ireland. Having pursued this matter through the normal industrial relations channels, the IMO took the decision to lodge a complaint with the Equality Tribunal citing breach of the Employment Equality Acts. After legal advice was received, it was decided that the wisest course of action was to tie in long service with discrimination on the grounds of age.

Dr Kathleen O'Sullivan agreed to let her name go forward and the IMO and the HSE met for a mediated session under the auspices of the Tribunal in May 2012. This session did not yield a positive outcome and a submission on Dr O'Sullivans behalf has been lodged with the Tribunal.

The HSE's response has also been lodged and has been forwarded to the IMO. This response will be considered by senior management in the IMO and also by Dr O'Sullivan and her colleagues. It can be taken for granted that the HSE will strongly defend their position and that much work is needed in this regard.

Future Structures of Public Health Medicine

The Public Health subgroup has drawn up a position paper arguing for a more flexible and horizontal structure for the future delivery of Public Health Medicine services. Following consultation with the wider Committee and with the Public Health Membership, the subgroup is considering that responses received and, where appropriate, will incorporate these into their proposal.

It is hoped that this proposal will form the basis of the IMO's Public Health policy into the future and act as a counterpoint to any proposals in this regard that emanate from the Department of Health or the HSE.

Review of Community Health Medicine

The Report of the Community Medicine Review has been in circulation for some time. However, the HSE have not responded to IMO requests to meet to discuss the material contained therein.

The IMO Public Health Committee have come to be of the opinion that no initiatives can be expected to arise out of the Review. Notwithstanding this, there are details contained within the Review that should be developed upon and may form part of an IMO position paper / mission statement in this regard, analogous to the policy paper from Public Health.

Method of Election for the Public Health Committee

A position paper is being worked upon to allow for a more directly elected Public Health Committee, possibly based on former health board electoral areas. More details to follow as the Public Health Committee works on a policy proposal.

The IMO Public Health Committee examined several options in this regard but it has been decided that the means of electing the Public Health Committee would be best expedited as part of the overall review of IMO structures that was initiated in October 2012.

Winter Meetings

Over a two month period in late 2012, the IMO held a series of winter meetings for Community Medicine and Public Health members. These meetings provided an opportunity for members to raise issues of concern, to be briefed on national and regional issues and to participate on CPD/CME events. (Given the reluctance of the HSE to fund CPD/CME this was an extremely worthwhile component of the meetings).

It is intended that meetings of this sort will become an annual event and heading into 2013, meetings will be arranged in those parts of the country that were not on the roster for 2012.

Community Ophthalmic Physicians / Community Eye Specialists

Unfortunately, despite the promise of progress, this past year has proven to be a frustrating one for the Ophthalmologist membership of the IMO. Despite numerous attempts by the IMO, the HSE still refuse to enter into negotiations on the Michael McGinley report into the future of the Community Ophthalmic Physician Service. In the absence of engagement from the HSE, the IMO has been left with little option but to write to the Minister for Primary Care, Mr Alex White TD, to ask for thorough engagement with the IMO to explore the potential of the Community Ophthalmic Physician Service, which let us not forget, provides specialist medical service in community settings, as envisaged in the Government's health service agenda.

The IMO did meet with the HSE to discuss the potential roll out of the Community Ophthalmic Service Medical Treatment Scheme (COMSTS) twice during the year. Despite the IMO strongly pressing the case for the extension of the scheme, and recognition by the HSE that each patient experience in the scheme cost the State approximately half of the corresponding figure for the secondary setting, no progress was forthcoming. It is a matter of considerable regret that the HSE has proven unwilling to invest in expanding this Scheme despite its demonstrable cost effectiveness. To compound matters, the fees payable under the Scheme were encompassed within the €70m in professional fee reductions announced in the Budget of December 2012.

Communications

"Irish Medical Organisation Partner RTE Operation Transformation For National Diabetes Screening Day"

The Irish Medical Organisation partnered with a national television campaign through *RTÉ Operation Transformation* to organise a National Type 2 Diabetes Screening Day aimed at the general public.

The main objectives were to:

- Highlight the growing incidence of Type 2 Diabetes amongst the general public and raise awareness on the diabetes epidemic in this country and the alarming health consequences that diabetes can have on people's lives.
- Reinforce the central role of General Practice in the Healthcare Infrastructure.

To ensure the screening day could go ahead the IMO had to secure over 54 General Practitioners to volunteer their time to screen 1,000 at-risk members of the public for Type 2 Diabetes in nine centres across the country. The locations were: Dublin (Blanchardstown & Dundrum), Limerick, Cork, Galway, Athlone, Waterford, Dundalk and Sligo.

Following months of preparation the National Diabetes Type 2 Screening Day took place on January 19th and was a huge success exceeding all targets with almost 1,600 people being screened.

A detailed breakdown of people screened by location, age group, sex and diabetes risk was provided to the Operation Transformation production team following IMO analysis.

- **15 cases of previously unknown Diabetes** were provisionally diagnosed and nearly
- **160 more patients** were advised to attend their GP for further evaluation of possible diabetes.

The programme proved hugely popular with viewership figures of over 575,000 per programme, representing a 35% audience share. The *Operation Transformation* website had over 4.4 million page impressions. The John Murray show on RTÉ Radio 1 as the radio home for Operation Transformation attracted over 332,000 listeners.

Below is a synopsis of how the IMO featured:

Presenter Kathryn Thomas:
"Last Thursday was an historic day in the five year history of Operation Transformation…The ***Irish Medical Organisation*** *and the GPs of Ireland gave their time free of charge. Doctors were amazed by the massive turnout at the nine centres around the country.*

These people were worried that they may have this potentially killer condition so they took this simple capillary prick test which indicates the presence of high glucose in the blood stream."

Male participant: "We have a huge history of diabetes in the family. I'm here for peace of mind today."

Female participant 1: "Really relieved because I was really worried that I might have diabetes, and I got a reading just under seven."

Presenter Kathryn Thomas: "In a number of people the results were cause for serious concern…"

Female participant 2: "I got a reading over eleven. I was watching the programme last night and I wouldn't have been expecting to be bordering on anything. I'll go to my doctor now and see it through. I'd never have gone otherwise."

Female participant 3: "My blood sugar was 19.3. I'll go see my doctor in the morning and take it from there."

Dr Niall MacNamara, Waterford GP:
"I just had a woman there whose blood sugar was particularly high; it was 26. This takes it beyond, what we were doing today. This is actually someone who we would be quite worried about, not just on an intermediate or long-term basis, but we are quite worried about her today. There are people walking around who are not just diabetic but dangerously so. Even to pick up one diabetic like that, I think makes it worthwhile."

Dr Michael Mehigan, Dublin GP: "I think this is hugely valid. This is something that needs to be repeated, possibly on a yearly basis. This is a disease that can be prevented."

Dr Ronan Boland, Cork GP: "The campaign is also aimed to encourage people who did not get tested on the National Screening day to be aware of the risk factors and to attend their own GP if they had not done so in recent times."

Presenter Kathryn Thomas: "Over 160 people were advised to attend their own GP for further testing and 15 cases of previously unknown diabetes were provisionally diagnosed, with urgent follow up by the patients' own GPs being advised.

A huge thank you is owed to the Irish Medical Organisation and their GPs and because of them many peoples' lives have already changed."

Communications

Prof Sean Tierney, Mr Séan Kelly MEP, Dr Ronan Boland and Dr Paul McKeown in the European Parliament, Brussels presenting joint IMO/BMA NI policy document on Health Inequalities

Joint IMO/BMA NI Health Lobby Initiative

Doctors call for co-ordinated policy initiatives to address health inequalities

The Irish Medical Organisation [IMO] and the British Medical Association Northern Ireland [BMA (NI)] in March 2012, launched a joint policy document in the European Parliament, Brussels, setting out cogent recommendations and calling on the EU to use its influence to ensure that co-ordinated policy initiatives to address health inequalities are prioritised at national, regional and local level.

The joint document was introduced at the launch by Irish MEP, Mr. Sean Kelly.

The joint policy document***– Health Inequalities – The Medical Profession highlighted their concerns to MEPs representing the North and South.***
The IMO and the BMA NI called for:

- Governments to ensure health inequalities are addressed in a holistic manner.
- Government policies to be "health proofed" through the use of Health Impact Assessments to ensure that policies potentially deleterious to health are engineered in such a way to have the maximal health benefit for as large a proportion of the population as possible.
- Governments to recognise that reducing health inequalities through reduction in societal inequalities is the best long-term investment that any Government can make on behalf of its citizens
- Recognise the importance of as large a proportion of the population as possible having rewarding, productive and secure employment, and urge their respective Governments to adopt policies that encourage growth.

IMO President, Dr. Ronan Boland said; "In addition to extending the lives of our citizens, policies that aim to reduce social and health inequalities will also have the effect of compressing morbidity in later years resulting in 'adding more years to life and more life to years'. In order for this to happen, as many of our citizens as possible should feel that they belong and are needed as useful and important members of the society in which they live."

Dr. Boland said; "In Ireland evidence shows that lower socio-economic groups have relatively high mortality rates, higher levels of ill health and few opportunities and resources to adopt healthier lifestyles."

Throughout Northern Ireland there is considerable evidence of health inequalities with average life expectancy differing by as much as six years between deprived areas and more affluent areas. Male life expectancy ranges from 73.5 in the most deprived areas to 79 years in the wealthiest and female life expectancy ranges from 79.6 years in the most deprived areas to 81.5 years in the wealthiest.

Dr. Paul Darragh, Chair of Council, BMA NI said; "Children from the poorest families are four times more likely to die before the age of twenty and fifteen times more likely to die in accidents."

He said; "Health and wellbeing are inextricably linked. The greater the control and security a person feels, the greater is the wellbeing s/he experiences and the healthier s/he is likely to be."

AGM 2012

Doctors call on Government to 'Health Proof' future policy to avoid costly lessons that cost lives

Doctors from all specialties within the medical profession attended the 2012 annual conference and debated a range of factors that prevents access to our health service from being efficient, effective and properly planned within our country.

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IMO President, Dr. Ronan Boland said; "The theme of our conference is ***Our Patients - Our Priority*** and one of the pivotal issues is inequality. Ireland has significant levels of health inequalities. Throughout the boom years of the 'Celtic Tiger', these inequalities were evident and since the recession, these inequalities appear to be worsening."

"Improving the health of all our citizens, particularly the poorest and most deprived, will reap long-term dividends by ensuring a healthier population, and more productive workforce, who will have less need for expensive health interventions and social economic supports."

Launching the IMO's Position Paper on Health Inequality at the Pre AGM Press Conference the IMO called on the Government and the Minister for Health to ensure that health inequalities are addressed in a holistic manner.

Dr. Boland said: "Government policies should be "health-proofed" through the use of Health Impact Assessments to ensure that all policies are engineered in such a way to have the maximal health benefit for as large a proportion of the population as possible."

The IMO also investigated health inequalities further at the first of two Scientific Seminars during the AGM.

Childhood Obesity in addition to alcohol and drug misuse amongst our children was the focus of the second scientific seminar. This seminar discussed the current and future health implications and what interventions are urgently needed to protect our children.

Doolin Memorial Lecture speaker Dr Declan Bedford

AGM and the Media

The AGM was attended by sixteen members of the media; representing three main medical newspapers (IMN, IMT and Medical Independent), RTÉ news and national newspapers (Irish Examiner, Independent, Irish Times, Sunday Business Post and Irish Daily Mail).

A pre-AGM media briefing held in March was well attended by the national print and medical press. RTÉ Health Correspondent, reported from IMO House for RTÉ News and UTV media recorded for radio broadcast (includes FM 104, 98FM, LMFM, Limerick 95Fm etc).

During the AGM RTÉ news, radio and television, covered stories daily. Morning Ireland as well as Newstalk Breakfast highlighted the main scientific seminars and motions for debate on the day each morning and newly elected President, Dr Paul McKeown did live interviews with both.

Live and pre-recorded packages went out each evening during the AGM on RTÉ Six One and Nine O'Clock News. IMO president provided a live interview with RTÉ Six One on Friday 13th April. Following a motions topic, Dr Daly recorded a piece on medical cards for RTÉ news on Saturday 14th April.

There was widespread interest in the scientific sessions and these were covered on air (Dr Edna Roche spoke to Radio One's Sean O'Rourke on Friday and a soundhire from Dr Own Metcalfe on Thursday 12th April). Several of the print journalists attending also covered the story.

Phone call requests for updates and interviews from local and national radio stations were constant throughout the AGM. Interviews and sound bites were organised as required. Dr Ronan Boland spoke on RTÉ Drivetime, Drs Joe Barry and Ciaran Donovan each spoke with Radio na Gaeltachta, Dr McKeown spoke with Louth Meath Radio, Castlebar Radio and Kildare Radio amongst others.

IMO AGM issues got daily coverage in each of the national newspapers. Onsite doctor-journalist interviews were arranged throughout the AGM. Copy of keynote addresses and scientific sessions were promptly made available to journalists.

The Sunday Business Post (15th April) included a feature on the inaugural speech of the IMO President as well as the CEO's speech. Newspapers the following week also covered several of Saturday's motions and matters arising out of committee meetings.

Doolin 2012

Public Health Specialist criticises delays in development of National Alcohol Policy

The failure of successive Governments to develop a National Alcohol Policy has had a "devastating" impact on Irish society in general and family life in particular according to Public Health Specialist, Dr. Declan Bedford.

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Following a request from the *Irish Medical Times,* Dr Paul McKeown was asked to consider a response in general terms on the findings of the HIQA Report on Tallaght Hospital. Dr McKeown provided a response reflecting on issues at a national level as opposed to solely concentrating on Tallaght Hospital. The article titled "Hospitals are victims of their own success – IMO " was featured in May edition. In brief Dr. McKeown stated that the report was 'comprehensive and far sighted', but that shortage of beds and staffing needed to be addressed before the hospital trolley scenario could be fully rectified. While the population had been static, better patient survival and outcomes for several conditions meant people who would have died in the past could now receive treatment, inadvertently burdening the health service. In a way, we are victims of our own success. This, he said, having already increased their performance significantly – with many doctors working 60-70 hours per week and some even 80 hours – doctors have had to "up their game" from that high standard.

NCHD Overtime Payments

The topic of NCHD overtime payments was covered by Gordon Deegan (freelance). Dr Mark Murphy spoke strongly in defence of NCHD overtime payments resultant from inappropriate, illegal and excessive working hours; a breach of EWTD. Articles featured in Irish Times and Irish Examiner. Another article in Irish Times (Healthplus) titled "Overtime bills proof of grossly illegal work practices in HSE".

A full page feature by Danielle Barron in the Irish Medical News focused on an interview with Dr Mark Murphy regarding NCHD issues including working hours, new hospital grade and the on-going talks on the 2010 NCHD contract.

Professional Fees

The *Sunday Business* Post requested a comment on professional fees and advertising price list guidelines. A statement was issued by the Communications unit. The article titled "Taking the pain out of charges" featured in June. The following is the reference made to fees and advertising: *"Huge variations in the prices charged by doctors and dentists were also highlighted by the 2010 study, which indicated that doctors' fees ranged from €35 to €70. The national average price for a routine GP consultation was €51. However, the latest price data from the Central Statistics Office brought good news for consumers, showing that doctors' fees fell by 0.6 per cent in the last year... Doctors have also taken steps with regard to price display. The Irish Medical Organisation recommended that its members introduce price lists for routine medical treatments from December 1st last. The Medical Council of Ireland guide to profession conduct and ethics states that the fees doctors charge "should be appropriate to the service provided" and "patients should be informed of the likely costs before the consultation and treatment."* The Competition Authority also commented on pricing and price display for professionals.

Waiting Lists

Dr Trevor Duffy was interviewed for RTÉ Six One News television [May] on hospital waiting lists increases over six months.

On foot of the HSE report on excessive waiting lists, the IMO issued a press release condemning waiting times for patients, and outlined factors influencing delays for patients being seen by hospital consultants. Both Prof. Sean Tierney and Dr Trevor Duffy provided information and were available for interview. Prof. Tierney did an interview for Ulster Radio News (FM 104, 98 FM etc), and with RTÉ News. Dr Niall MacNamara also spoke with Drivetime radio concentrating on long delays in Waterford Orthopaedics. Several news articles included IMO comment based on press release.

PATIENT WAITING TIMES UNACCEPTABLE FOR OUR PATIENTS - IMO

Adequate financial and manpower resources must be provided to cope with the throughput of patients.

The failure to implement appropriate health policy by successive Governments, poorly organised services and inadequate manpower capacity have led to the unacceptable waiting times for our patients, said IMO Consultant Chairman, Dr. Trevor Duffy.

Responding to the most recent figures released by the Special Delivery Unit on patient waiting times, Dr. Duffy said; "The IMO acknowledges that the Special Delivery Unit is doing a good job in bringing focus on numbers of patients rather than on hospital budgets. However, previous and current Governments have continued to ignore the main issue, which is a 'capacity gap'. One example of this is Orthopaedic Surgery – one of the specialities highlighted as having the longest waiting times. Ireland has one Specialist Surgeon for every 54,000 people. Elsewhere in Europe that figure is four times higher with one Specialist Surgeon for every 15,000 people."

He said; "We need to run services efficiently and the HSE Clinical Programmes are clearly making efforts to address this, however this capacity gap must also be addressed if we are to see an end to patients waiting years to be seen and more years for their procedure. For the Special Delivery Unit to succeed, hospital capacity must reflect demand and adequate financial and manpower resources must be provided to cope with the throughput of patients."

The Irish Medical Organisation's Consultant Committee have campaigned vigorously over many years in an effort to highlight initiatives with Ministers for Health to tackle unacceptable waiting times for patients. As far back as 2001 the IMO Consultant Committee called on the Minister for Health and the HSE to cease the practice of presenting competing targets to hospitals that include demands for reduced expenditure and containment of activity while insisting on reducing waiting lists. Most recently in 2011 they highlighted the critical shortage of consultants in a wide range of specialities and the consequential impact on the health of the population.

Former IMO President, Prof. Sean Tierney, Consultant Surgeon said; "Since 2007, employment in the health services has fallen by 6,654 and yet activity levels have been sustained and even increased in some areas despite the staff reduction, indicating that more is being done with less. It must be acknowledged that our population has increased, people live longer and more illnesses can be treated due to medical science evolving. We are therefore treating

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'more' patients with 'less' – we are effectively 'victims of our own success'.

"However, for those reliant on the public health system, access to hospital care is becoming increasingly more difficult. We must ensure that no further hospital beds are closed until alternative services are in place, protect funding for hospital services and prioritise the recruitment of essential frontline staff," said Prof. Tierney.

FEMPI

The IMO's FEMPI Submission was highlighted to the media. A full page news focus on the IMO submission was published in the Irish Medical News (June).

Newstalk's Right Hook contacted the Communications Unit after seeing part of the 'GP survey' in The Sun newspaper (14th June). Clarification was provided on the nature of the survey; that it was a consultation process in completing the FEMPI report. The broadcaster declined the offer of an IMO spokesperson for the programme. Commentary reflected on the IMO GP figures by their regular GP contributor.

A feature article in Irish Times Healthplus, focused on the IMO submission and effects on GP services.

SICK PEOPLE MAY FACE WAITING LISTS JUST TO SEE GPs FOLLOWING BUDGET CUTBACKS – GP Committee

The ability of GPs to see sick people on the day they call may be at an end following the latest round of cutbacks introduced in this month's Budget, doctors have warned.

The GP Committee of the Irish Medical Organisation (IMO), the representative group for medical professionals, said doctors feared the latest proposed cuts could turn out to be a "tipping point" beyond which GPs could no longer provide the services that sick people need.

The Budget proposed cuts of 10% to payments for the General Medical Card Scheme, following on from cuts of up to 37% over the past two years.

Dr. Boland said "The IMO predicted many of the problems, which are occurring now"

Live interview with Brian Dobson,
RTE Six One News – HSE Delays in Processing Patients Medical Cards

Phlebotomy Services

At various times in June local radio station discussed GPs charging for blood tests with local councillors weighing in on the discussion. The IMO was contacted in a couple of instances, not all. Where required the IMO's statement was provided. The Communications Unit informed the IR Unit of the various local councillors who were making 'inaccurate' statements and suggested direct communication with them to inform them of the facts.

The Issue was covered again by the media in early August. Again, IMO statement was issued and referenced in several of the national newspapers.

GPs sick certs

The IMO was contacted on Friday 29th June for a comment on an investigative piece by a journalist in the Sunday Times that found 7 out of 10 GPs gave her a sick cert though she admitted that she was not unwell. Having established the manner in which the journalist approached this story it was agreed that a statement would be issued to the journalist.

The following statement was issued:

Dr. Ray Walley, Chairman, IMO GP Committee said; " As a General Practitioner the starting point for any consultation is that the patient is telling me the truth. A professional relationship between a doctor and their patient is based on trust. All GP assessments are on an individual holistic basis looking at psychological as much as physical symptoms/signs. We must take into account any emotional or vulnerable symptoms a patient may present with."

He said; "A 'sting' like this is unfair. Doctors see patients often in difficult and stressful circumstances and they have to make judgements and weigh up different factors when dealing with requests such as this. Doctors assume that those people they are dealing with are honest and well-intentioned."

The story was published on the front page of The Sunday Times [1st July] and included part of the IMO statement. A number of media outlets picked up the story through the week these included, Newstalk, RTÉ News, Today FM's The Last Word and TV3. The IMO decided not to put forward a spokesperson and continued to issue the agreed statement. The item was closely monitored. The Communications Unit suggested to the IR Unit that a letter be sent to ISME.

An article published in the Irish Examiner on the 8th October specifically mentioned that a businessman in Limerick had written to the IMO regarding a sick cert being issued to one of his employees. It was agreed that a clarification be sent to the businessman and

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the journalist who wrote the article informing them that the Medical Council of Ireland is the body to whom the public can make a complaint against a doctor. A journalist from the Limerick Leader also contacted the Communication Unit regarding this article and clarification was also sent to him.

NCHD Boarding Pass and Postcard Campaign

As a follow up to the 2011 "Engage for Change Campaign" the Industrial Relations Unit along with the Communications Unit formulated a boarding pass postcard campaign. Boarding cards and postcards were designed and distributed to NCHDs all over the country. In a statement the issues were highlighted.

IMO survey finds 800 NCHDs may leave Irish Health System

IMO President warns of "disaster for the country"

Over 800 NCHD's (Non Consultant Hospital Doctors) have written to the Minister for Health warning that they may be forced to seek work abroad as a result of the Minister's policies in respect of Consultants. The 800 supported a "write-in" campaign by the Irish Medical Organisation in which symbolic airplane boarding passes were signed by NCHDs to indicate that they were considering working abroad rather than staying in the Irish healthcare system.

Dr. Mark Murphy, Chair of the NCHD Committee of the IMO said; "We are approaching a crossroads for the NCHD grade in the Irish healthcare services. There is deep unease amongst my colleagues that medicine is becoming a tainted profession and that there is an agenda to portray the medical profession as though they are driven by greed."

Lending his support to NCHD's IMO President, Dr. Paul McKeown said; "These figures represent a deep well of disquiet and apprehension amongst some of the most talented and skilled young professionals in this country and they make me fear for the future delivery of medical care in our health service. We have put in place a policy that is leading to the export of our brightest and best and while we may not feel the repercussions for a few years, I have no doubt that our Health Service will suffer if these figures become a reality."

"NCHDs are the source of our specialist physicians and surgeons in Ireland. These doctors have been educated and trained here yet more and more are now planning not just to spend a few years abroad but to permanently relocate overseas. That is disastrous for this country."

Consultant Negotiations

Information provided to the medical press to coincide with the IMO meetings with the HSE regarding work practice and other changes to the consultant contract. Steve Tweed spoke with members of the press. IMO reaction was covered in the national and medical press.

Communications Unit was contacted by a number of media outlets for briefing on consultant talk's contract negotiations. IMO's participation in the talks was mentioned in all of the coverage for the duration of the talks.

IMO CONSULTANT COMMITTEE TO REVIEW LRC PROPOSALS

Following lengthy negotiations between the IMO and the HSE under the auspices of the Labour Relations Commission regarding consultant work practices, the IMO will now put forward the proposals to the IMO Consultant Committee.

HSE RISK LOSING GOODWILL OF CONSULTANTS - IMO

The Irish Medical Organisation (IMO) is dismayed at the approach adopted by the HSE when both parties met yesterday afternoon with regard to Consultant Work Practices.

The IMO informed the HSE of its decision to ballot members on the LRC recommendations and if accepted that the proposals would form the basis of an agreement to be implemented at hospital level.

However, the HSE changed the 'goal posts' and sought a commitment that IMO members would fully co-operate with the proposals by their own deadline date of 5th, November.

IMO Director of Industrial Relations, Steve Tweed said;

"Information was requested by the IMO as to what plans were in place for the 5th November but, astonishingly, the HSE could not provide any details. The HSE were not even in a position to state if preliminary plans had commenced at hospital level, as required under the Croke Park Agreement, in preparation for implementation should the proposals be accepted."

At the meeting, the IMO proposed that preliminary plans should be commenced by hospital managers and be in a position to commence the consultation process at local level once an agreement between the IMO and HSE was in place. This would be preferable to wasting further time conducting the preliminary work after an agreement was in place.

Steve Tweed said; "Inexplicably, the HSE rejected this approach and instead stated that it would be referring the full set of proposals to the Labour Court. This is despite two outstanding issues having already been referred to the Court."

He said; "This approach being taken by the HSE is illogical and effectively unravels the progress made last month at the LRC."

"The IMO are in the middle of a process and waiting for a ruling from the Labour Court on two outstanding items. By going down the road of confrontation unnecessarily, the HSE risks losing the goodwill of Consultants and unravelling previous progress made to date. It is difficult to understand," said Steve Tweed.

General Practie and P.C.T.

A full page feature article in the Irish Medical News (9th October) focused on an interview with Dr Ray Walley examining the role of the GP and why general practice and primary care were suffering amid ongoing cutbacks.

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RTÉ Morning Ireland - Dr. Ray Walley, GP Chairman explains Primary Care Centres:

Presenter:

Let's get GPs perspective on Primary Care Centres and why they do or don't matter to Patients. Dr. Ray Walley is Chair of the Irish Medical Organisation's General Practice Committee

Dr. Walley, they are a good thing are they?

Dr. Walley:

Certainly the IMO welcomes the allocation of resources to primary care centres. There's a little bit of a hangover from the previous administration where there was an obsession on premises and certainly provision of care through primary care is the most efficient and economic way to do that. But the delivery of primary care involves just more than buildings. It involves staff, it involves other resources towards infrastructure, and the building is only one part of the service.

Presenter:

Are you saying the recession has made doctors much more leery about putting their money into developing a PPP on a Primary Care Centre?

Dr. Walley:

Well there are many good premises out there and GPs are locked into 20 or 30 year business mortgages. Other GPs have 10 year leases on premises, some are near retirement. Then on top of that you've got younger GPs who don't have the confidence to take on financial responsibility and they are also tied into personal finance. Each story is an individual story.

Presenter:

Thank you Dr. Ray Walley, Chair of the Irish Medical Organsiation's General Practice Committee.

National Health Budget

IMO President says impact of changes will be to "seriously corrode the fabric of the State's Primary Care infrastructure."

Threefold increase in prescription charges marks a shameful U-Turn by Minister O'Reilly

The Irish Medical Organisation has expressed its shock and disappointment at the health aspects of today's budget. The President of the IMO said that the impact of the changes would be to seriously corrode the fabric of the State's primary care infrastructure.

President of the IMO, Dr Paul McKeown, said that budget changes would have a significant and damaging impact on frontline health services; "The threefold increase in prescription charges, the withdrawal of full medical cards from many elderly patients are particularly damaging. In addition we believe that a further round of cuts in fees for GPs will force practices to restrict services - increasing pressure on patients seeking care and help and putting further pressure on secondary care services."

IMO President responds to HSE announcement of health cuts.

The President of the Irish Medical Organisation, Dr Paul McKeown has criticised the HSE announcement of sweeping cuts in the health services budget for the remainder of the year. Dr. McKeown said that many of the cuts would be counterproductive and would ultimately lead to higher costs in hospital care. Dr. McKeown also said that the cuts were likely to have a disproportionate impact on the most vulnerable sections of the community.

"The IMO will study the HSE announcement carefully. However on the basis of the information in the public domain at present, we are seriously concerned at this announcement which appears to fail the basic tests of fairness and equity."

"In relation to health services, policymakers have a particular duty to ensure that any cuts they are forced to impose have minimum impact on the most vulnerable sections of the community. They also have a responsibility to ensure that their actions save money rather than just give the illusion of saving money. Cuts in relation to homecare services could end up being more expensive to the public purse than the current system while adding to the pain and misery of elderly and infirm patients and their families."

The Irish Medical Organisation supports campaign to criminalise payment for sex

The Irish Medical Organisation submitted their recommendations to the Department of Justice and Equality with a Committee due to consider the laws surrounding prostitution in Ireland.

The IMO is a supporting member of 'Turn off the Red Light' (TORL) Campaign, calling on government to protect those involved in the sex industry and outlaw paying for sex.

The IMO submission considers the health implications for those in the sex industry.

IMO Statement *Hand Hygiene Day*

May 5th has been designated by the World Health Organisation (WHO) as Hand Hygiene Day.

Dr Paul McKeown President, IMO welcomed the initiatives undertaken by the RCPI/ HSE clinical programme on prevention of healthcare-associated infection (HCAI).

"Hand Hygiene Day reminds us that all healthcare workers, particularly doctors, have a role in preventing infections in healthcare settings", said Dr McKeown," and that hand hygiene contributes significantly to keeping our patients safe, by preventing the spread of multiple antibiotic resistant bacteria and C. *difficile* infection between patients."

"Doctors have a crucial role to ensure that hand hygiene become second nature for everyone, and we can lead by good example", he said. "There is however room for improvement; the latest hand hygiene audit undertaken by the HSE in October 2011 showed that the overall hand hygiene compliance of doctors was 68% for doctors – in other words, almost one third of doctors need to improve their hand hygiene practices".

Communications

While the reduction in MRSA bloodstream infection in Ireland is very welcome, we can have no room for complacency – our patients still acquire HCAI in our hospitals and we need to ensure that we prevent as much as possible'

Irish Medical Journal

The Communications Unit very successfully promoted the Irish Medical Journal in the national media during the year. Articles from each issue were identified as being of public interest and promoted in the media by preparing and distributing press releases and organising any follow up interviews or information.

The following press releases were issued to the media:

Cork Study Shows Greater & Complex Challenges Facing Homeless Mental Health Service Users

Irish Study Highlights the health benefits of breastfeeding against illness in infants

Irish Uptake of Assisted Reproduction Treatment well below European Average

Study finds significant increase in moderate and extreme obesity in pregnancy

Social networking sites posing new hazards to teenagers

The need for GP home visits will not disappear – IMJ Study Indicates

To Hydrate or Not at the End of Life – IMJ Editorial

Provision of mental health services for young people must improve: Research highlights levels of Child Suicide in Ireland

Mothers from Disadvantaged Backgrounds Most At-Risk for Inadequate Folic Acid Use

Rural background and age are found to be key factors in concealed pregnancies study

Food choices for infant's vital in children's development

Web Based Referral System:
A solution for an overburdened healthcare system?

Coverage from these press releases was widespread in the print media such as Irish Times, Irish Independent, Irish Star, Irish Daily Mail and included interviews on RTÉ Radio News at one and Morning Ireland and RTÉ TV Six One news with various authors.

IRISH MEDICAL ORGANISATION
Ceardchumann Dochtúirí na hÉireann

Research and Policy

Mr Séan Kelly MEP, Dr Paul McKeown and Dr Paul Darragh at the IMO/BMA NI Health Inequalities briefing in Brussels

As the representative body for the medical profession, the IMO in its mission statement is committed to the development of a caring, efficient and effective Health Service and thus a key activity of the IMO is advocacy. The Research and Policy Unit conducts research and develops IMO policy on a wide range of Health Service and Societal issues and aims to influence Government proposals in a constructive and practical way. In 2012 the Research and Policy Unit produced the following work:

- General Motions 2012 Update
- IMO/BMA NI Joint Paper on Health Inequalities
- IMO Position Paper on Health Inequalities
- IMO Position Paper on the Market Model of Health Care – *Caveat Emptor*
- IMO Position Paper on Child Health
- IMO Budget Submission 2013
- Miscellaneous Submissions as requested by external bodies

The IMO increasingly contributes to consultations from the Department of Health, the Medical Council, HIQA and other Government Departments and bodies. In 2012 the IMO was also invited to hearings before the Joint Oireachtas Committee on Health and Children on the Children First Bill, the Joint Oireachtas Committee on Public Expenditure and Reform on the IMO Budget 2013 Submission and the Joint Committee on Justice Equality and Defence on the future of prostitution legislation.

In 2012, the IMO Council Committee established a number of working groups to focus on particular areas of health policy. This year the Research and Policy Unit and the working groups focused on the Children First Bill, the IMO Position Paper on Child Health and the Budget 2013 Submission.

General Motions 2012 Update

The General Motions from the IMO AGM are managed by the Research and Policy Unit. Following the 2012 AGM the Unit wrote to the Minister for Health and Children, other Government Departments, the HSE, the Medical Council and relevant bodies, informing them of the motions passed and requesting a response. Many motions from 2012 and previous years are also included in the different policy papers and submissions written during the year. For example motions on immunisation and health screening, alcohol, tobacco and obesity, as well as motions on resources for child health services, obstetric services, suicide prevention and mental health services all fed into the IMO Position Paper on Child Health and the Budget 2013 Submission.

IMO and BMA NI Joint Paper on Health Inequalities

The IMO prepared a Joint Paper with the British Medical Association Northern Ireland (BMA NI) on Health Inequalities in Ireland which was presented to MEPs in Brussels in March 2012.

In the Joint Paper the IMO and the BMA NI call on the EU to use its influence on National Governments to ensure that coordinated policy initiatives to address health inequalities are prioritised at national, regional and local level.

Health and wellbeing are inextricably linked. The greater the control and security a person feels, the greater is the wellbeing s/he experiences and the healthier s/he is likely to be. In addition to extending the lives of our citizens, policies that aim to reduce social and health inequalities will also have the effect of compressing morbidity in later years resulting in “adding more years to life and more life to years”. In order for this to happen, as many of our citizens as possible should feel that they belong and are needed as useful and important members of the society in which they live.

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In the paper, the IMO and BMA NI urge their respective Governments

- to ensure that health inequalities are addressed in a holistic manner. Government policies should be "health-proofed" through the use of Health Impact Assessments to ensure that policies potentially deleterious to health are engineered in such a way to have the maximal health benefit for as large a proportion of the population as possible.
- to recognise that reducing health inequalities through reduction in societal inequalities is the best long-term investment that any Government can make on behalf of its citizens
- to recognise the importance of as large a proportion of the population as possible having rewarding, productive and secure employment, and would urge their respective Governments to adopt policies that encourage growth.
- Dr Samuel Johnson said that "A decent provision for the poor is the true test of civilization". This should be the metric by which we as a society determine how successful we are.

IMO Position Paper on Health Inequalities

The Research and Policy Unit also prepared an IMO Position Paper on Health Inequalities for launch at the press conference for the IMO AGM 2012, followed by a Scientific Session on Health Inequalities at the 2012 AGM.

The Paper examines health inequalities in Ireland and calls for a Health-in-All-Policies approach to addressing the social determinants of health. The paper also highlights the Role of Health Systems, in particular Primary Care and Child Health Services, in reducing Health Inequalities.

Recommendations include:

Public Health and Health in all Policies

- An explicit statement from Government that health is a basic human right and its protection should be a core aim of Government and the State;
- An explicit statement that the State recognises the crucial importance of prevention and that preventing ill-health through the reduction of health and social inequalities would be a stated priority of Government;
- An immediate review of inequalities and inequities in health to include inequalities in health status, and inequities in access to health care by socio-economic grouping, geographic location and ethnic minority;
- The establishment of an inter-sectoral committee to prioritise the development and implementation of evidence-based initiatives across departments and across sectors that tackle the unequal distribution of wealth and ensure that all children have the opportunity to realise their maximum potential including;
  - Economic policies that focus on growth and provide as large a proportion of the population as possible with rewarding, productive and secure employment;
  - Fiscal policies that are progressive;
  - Social welfare policies that ensure a minimum standard of living for all;
  - Family policies to eliminate child poverty
  - Education policies that focus on early childhood including:
    - formal statutory preschool access for all children;
    - active collaboration between the Department of Education and the Department of Health to deliver on early educational intervention.
- In view of the large contribution social determinants make to the health status of the population of Ireland, the IMO recommend the establishment of a Minister of Public Health with direct responsibility for overseeing the delivery and implementation of Public Health Policy and to ensure that public policy is health proofed across all Government Departments;
- The Minister for Public Health should have a statutory function in each of the Departments involved and funding within each Department should be ring-fenced for Public Health initiatives;
- The Office of the Minister for Public Health should also be responsible for ensuring that Health Impact Assessments are carried out on all new government policies at design, implementation and review stages. In addition a national Public Health Executive Agency should be established to ensure that the core functions of public health (Health Protection, Health Intelligence and Service Public Health), drive progress and are accountable for implementing policies set by the Public Health Minister;
- The contribution, to the overall economic strength and well-being of Ireland, of Public Health interventions and measures should be recognised through priority funding. Secured funding for Public Health is of vital importance, particularly in view of the Government's plans to introduce universal health insurance – a funding mechanism which traditionally caters poorly for Public Health requirements.
- Develop an integrated public and community health workforce plan.

Equity of Access to Healthcare

- Ensure equity of access to healthcare services based on medical need and not on ability to pay or any other criteria including age, gender, place of residence or cultural identity.

Primary Care

- Urgent consultation and negotiation on the funding and provision of universal access to Primary Care Services including resources for the prevention and management of chronic disease in the Primary Care setting.
- Building on the HSE Health Status reports which measure deprivation using the Haase and Pratschke Index and the SAHRU Index of Material Deprivation, a model for the allocation of resources to Primary Care is needed which takes

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into account patterns of co- and multi-morbidities and GP utilisation in areas of deprivation.

- The Government must ensure that vulnerable rural and deprived urban communities have adequate GP cover.

Community Child Health Services

- Renewed focus and investment in Child Health Services.

IMO Position Paper on the Market Model of Health Care – *Caveat Emptor*

Faced with spiralling costs of health care, policy makers are increasingly looking to competition in health care markets in an effort to increase efficiency and quality of care and drive down costs. However health care markets are imperfect markets and the consequences of free competition in health care can conflict with policy goals. Because of market failure and because health is a major political issue most governments intervene in health care markets. In reality most countries rely on different mixtures of market mechanisms and regulation.

Health care markets can be considered in the context of private health insurers competing for enrolees and private providers (hospitals and physicians) competing for both patients and contracts with insurers.

The Government is proposing major reform of the Irish healthcare system, based on the Dutch model with managed competition between public and private health insurers and between public and private providers. This Position Paper examines the impact of the market approach in health care and some of the negative consequences of competition in both the private health insurance (PHI) market and the curative health care provider market. We look at the experiences of competition in the US, the largest health care market, the impact of managed competition in the Netherlands as well as our own experiences of healthcare markets in Ireland in order that we can learn from other systems and address the undesirable features in advance.

The IMO Position Paper on the Market Model of Health Care was launched at the IMO AGM 2012 following the AGM Debate on this topic.

IMO Position Paper on Child Health

Following on from the IMO Position Paper on Health Inequalities, the IMO Research and Policy Unit with the Council Committee Working Group prepared a Position Paper on Child Health for launch with the Budget 2013 Submission in October 2013.

The health of our children is vital to the social and economic growth of our country. There are many reasons for investing in the health of our children from antenatal health through to teenage years.

Many lifelong illnesses and disabilities originate in early childhood, and sometimes as early as prenatally. Ensuring that children have the healthiest start in life provides the basis for good health in adulthood. Investment in early childhood health and development also increases the likelihood that children will attend school, earn higher income as adults, and be less dependent on welfare support. Giving children the opportunity to realise their maximum potential is key to addressing inequalities in health and ensuring a healthier more productive workforce.

Obesity is one of the most serious public health challenges affecting children of all ages with major implications for health and health services into the future. An urgent multidisciplinary programme is needed to tackle childhood obesity.

As young people reach adolescence they are exposed to new risks and choices affecting their health including, tobacco, alcohol consumption and illicit drug use as well as unsafe sexual behaviour. It is important that strategies to reduce harmful lifestyle choices are implemented and that young people are not deterred from seeking appropriate advice from their physicians.

Suicide and self harm is a major issue among young people today and a range of population measures and targeted interventions are required to improve mental health and help-seeking among adolescents.

With approximately one quarter of the population under 18, Ireland has the youngest population in the EU. With the appointment of the Minister for Children and Youth Affairs and the establishment of a separate Department, the Government is showing its commitment to delivering policy and legislation to improve the lives and rights of children. In this position paper the IMO calls for renewed focus on child health promotion and services and makes a number of recommendations under the following headings:

1. Early Childhood Development
   a) Antenatal Health
   b) Child Health Surveillance
   c) Childhood Immunisation
2. Childhood Obesity
3. Adolescent Health
   a) Tobacco
   b) Alcohol
   c) Illicit Drugs
   d) Sexual Health
4. Suicide and Self Harm in Adolescents
5. Health and Social Services for Children and Adolescents
   a) Primary and Community Child Health Services
   b) Paediatric hospital services
   c) Child and Adolescent Mental Health Services
   d) Disability Services
   e) Child Protection Services
   f) Parental Education Programmes

IMO Budget Submission 2013

The IMO Budget 2013 Submission focuses on Addressing Health Inequalities through improvements to Child Health, A Health-in-All-Policies Approach and Access to Primary Care. The Submission also looks at improving Patient Care through Integrated Care.

There are numerous reasons for investing in the health of children from antenatal care through to adolescence. Many chronic illnesses and disabilities originate in early childhood and in adolescence, young people are exposed to new risks and lifestyle choices that impact on their health.

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Investing in the health of our children is vital to the growth of our economy and society. Early Childhood Development can make a key contribution to addressing the health inequalities that begin in childhood and persist into adulthood. A Health-in-All-Polices approach and equal access to primary care can also play a significant role in reducing inequalities in health.

Finally the Government is embarking on major reform of the Irish health system based on the Dutch model of managed competition between private and public insurance companies and private and public providers. The IMO supports a universal health care system in Ireland but is concerned that the new model will further fragment health care in Ireland with negative impacts on quality of care and outcomes. The IMO has identified a range of issues that need to be addressed if the government is to achieve its stated goal of an integrated system primary and hospital care.

The Budget 2013 Submission was prepared in conjunction with the IMO Council Committee working group for launch with the Position Paper on Child Health in October 2013.

On Friday 9th of November the IMO was invited to present our Pre-Budget Submission to the Joint Oireachtas Committee on Finance, Public Expenditure and Reform. Responding to questions relating to GP charges to GMS patients for blood tests, and GP letters and whether the IMO saw any financial barriers to its members becoming involved in Primary Care, former President and Honorary Treasurer of the IMO, Professor Tierney responded:

"The IMO and GPs are not happy that patients are being charged for blood tests ...The situation is that de facto, patients who attended hospitals regularly for many different conditions are being discharged back to their GPs who have to take on a greater role in their day-to-day management. Given the number of times they attend the GP, the cost of providing services to them is increasing. Similarly, phlebotomy services are being withdrawn by hospitals with patients being told to go to their GPs for the blood tests....Ultimately, the problem is we do not have a proper model of chronic illness care in the community which is organised, structured and funded...We are willing, as an organisation, and GPs are more than eager to look at providing proper services in that regard and we have waited and offered to speak over the past number of years. We have not had a meeting about this issue so far in terms of the contractual implications...

...Over the years, our organisation has consistently shown that we are committed to universal primary care as the first step in universalising access to health care.... We need to plan carefully the introduction of universal primary care to ensure it provides an adequate level of service to everyone. ...We are not opposed to universal primary care. We are anxious to introduce it. On a number of occasions, we have endeavoured to open negotiations on the issue with the Department of Health, the HSE and the Minister, with limited success to date."

Other questions from the Committee included a question on the IMO's views on the imposition of a fat tax on high-sugar and high-fat content products.

Prof Tierney responded that in our position paper on Child Health, launched with our Pre-Budget Submission, we suggest the introduction of a pricing structure to discourage the consumption of food with high-sugar, high-fat and high-salt content. Childhood obesity is an enormous problem in this country that affects more those from disadvantaged communities. Addressing childhood obesity will need a comprehensive policy approach rather than just a simplistic approach to new taxes.

Summing up the IMO Pre-Budget Submission, Prof Tierney said;

"We focused on three issues this year. Those are child health, about which we talked, improving access to primary care, about which we also talked, and if there was one issue I would pick out, it is that there needs to be a health consideration in all policies. We need to test the long-term impact on health of measures such as changes in taxation and changes in provision of services because many short-term measures and short-term cost savings have long-term cost increases attached to them. We had a recession 30 years ago and there was a huge reduction in investment in health promotion and health prevention. I see the results of that every day in my clinic and in our hospital and I hope the same will not be the case in 30 years time."

IMO Questionnaire on the Role of the Doctor as Advocate

In July 2012, the carried out an online survey of members on the Role of the Doctor as Advocate. The survey went out to 4302 members with email addresses. The survey ran for 3 weeks and the IMO would like to thank the 401 members who responded online. The results will feed into an IMO Position Paper on the Role of the Doctor as Advocate to be published in 2013.

Miscellaneous Submissions as requested by external bodies

HSE Draft Emergency Medicine Programme

In January 2012 the IMO Council Committee was invited to review and comment on the Draft National Emergency Medicine Programme. The IMO Council Committee responded, raising a number of issues under the following headings:

- Resources – Capital and Operational funding for the extensive Programme
- Medical Manpower Issues – including difficulties in relation to the recruitment of NCHDs
- Performance Indicators
- Patient Experience
- Information and Communication Technology/ Electronic Medical Records
- Future Health System Developments

In response to the IMO submission, the Clinical Lead of the National Emergency Medicine Programme agreed that significant resources are required and that this is a significant challenge in our current economic climate. The need for need for comprehensive workforce planning for doctors working in EM and the difficulties experienced by NCHDs working in EM were also recognised.

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NCEC Consultation on the Development of a National Suite of Clinical Guidelines

In January 2012, the National Clinical Effectiveness Committee (NCEC) called for submissions on a National Suite of Clinical Guidelines. The Research and Policy Unit prepared a broad submission on the general development of a National Suite of Clinical Guidelines reiterating comments made to the Health Information and Quality Authority (HIQA) in relation to the Draft National Quality Assurance Criteria for Clinical Guidelines. Comments related to:

- The Scope and Purpose of Clinical Guidelines
- Stakeholder Involvement
- The Application of Clinical Guidelines
- Resource Constraints
- The Dated Nature of Guidelines
- Clinician Ownership of Quality Assurance
- Medical Advancement

HIQA Consultation on eHealth Interoperability Standards

The IMO made a submission to the Health Information and Quality Authority (HIQA) on eHealth Interoperability Standards recommending that the eHealth Standards Advisory Committee prioritise the adoption of a messaging standard to be applied to appropriate information systems. It is likely that a meaningful standard for messaging will also require some regularising of the minimum dataset to be used within these systems. The IMO also urged that Guiding Principles for the development of interoperability standards must include reference to Patient Safety and Patient Confidentiality. In December 2012 HIQA published Guidance on Messaging Standards for Ireland.

Dept of Public Expenditure and Reform Consultation on the Regulation of Lobbyists

In Feb 2012, the IMO made a short submission to the Department of Public Expenditure and Reform on the Regulation of Lobbyists stating that the proposed legislation should differentiate between the transparent activities of professional representative bodies and the more opaque activities of professional lobbyists. The IMO awaits further details of the proposed legislation.

BAI Consultation on Draft Children's Commercial Communication Code

Following on from their public consultation in 2011, in April 2012 the Broadcasting Authority of Ireland (BAI) published a draft code for further consultation which proposed to ban the advertising of High fat Sugar and Salt (HFSS) foods during Children's programming and a cap of 25% of sold advertising across the day.

The IMO believes the draft proposals are insufficient to protect children from exposure to advertising of unhealthy foods and maintains the need for a ban on all advertising of HFSS food and drink on TV and Radio between 6am and 9pm.

Department of Health Consultation on the Public Health Policy Framework

In May 2012 the Department of Health held a second consultation on Public Health Policy Framework 2010 -2012. In the first submission and in the IMO Position Paper on Health Inequalities the IMO calls for the establishment of a Minister for Public Health and a national Public Health Executive Agency to ensure that the core functions of public health (Health Protection, Health Intelligence and Public Health), drive progress and are accountable for implementing policies set by the Public Health Minister.

In the consultation paper the DoH models subgroup developed five models for the delivery of the public health function however none proposed are directly accountable to a Minister for Public Health. Model 2b proposed combines the core functions of Public Health in a National Health and Well-Being Agency with linkages to other agencies and accountable directly to the Minister for Health. The IMO recommends the adoption of Model 2b but answerable to a Minister for Public Health who has a statutory function within each Department.

The submission also repeats IMO recommendations from the IMO Position Paper on Health Inequalities and the first submission in relation to Public Health and adopting a Health-in-all Policies Approach (HiAP). The IMO also welcomed proposals for a comprehensive Public Health Act and urges public consultation on the details of the proposed Heads of Bill. Finally the IMO felt the consultation period was too short (one week for this question) to examine the strengths and weakness of all the Essential Public Health Operations (EPHOs) in detail to provide meaningful commentary. However in relation to EPHO 8 - Assuring a competent public health and personal health care workforce - the IMO repeated that:

- The significant role that Public Health and Community Health Doctors make to population health must be recognised and resourced. Public Health and Community Health Doctors have been particularly hard hit by the HSE's moratorium on recruitment. An integrated public health workforce plan should be developed;
- Steps must be taken to ensure that Public Health Medicine and Community Health Medicine are made attractive options to medical students and doctors in training in order to maintain the capacity of the specialty;
- At present there is insufficient training available specific to the needs of Community Health Doctors. The IMO would like to see the establishment of a faculty in this specialty.

HSE Consultation on a Draft National Consent Policy

In a short submission on the HSE Draft National Consent Policy the IMO raised issues in relation to the dated nature of the guidelines and the need to provide quality information to support patients understanding and enable them to make informed decisions about their care. The IMO recommended:

- As legislation is enacted, the HSE National Consent Advisory Group should ensure that this document can be updated rapidly and at minimal cost.
- There is a need to provide evidence-based standardised material and explore new approaches such as multimedia tools to improve the quality of information available to patients and/or their legal guardians.

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HSE Consultation on Draft National Incident Management Policy and Procedures

In a short submission to the HSE on the Draft Incident Management Policy and Procedures, the IMO recommended that:

- In addition to developing an Incident Management Policy there is a need to develop a Risk Management Policy and assure that systems are in place that prevent error and incidents that lead to harm rather than focussing on apportioning blame when errors occur.
- The procedures in relation to assessments of competence need to be aligned with the Medical Council Performance Review process.
- Clarity on principles and/or procedures for remediation is required to build confidence in the incident management process.
- Issues in relation to indemnity need to be clarified.

Dept of Health Review of the Nursing Homes Support Scheme

In the Submission to the Department of Health Review of the Nursing Homes Support Scheme the IMO repeated a number of issues in relation to access, reliance on the private sector and financing of long-term care:

- Older people have the right to equal access to and equal resourcing of health care, including long-term community and residential care. Neurodegenerative disease (stroke, dementia etc.) is the most common reason for admission to nursing home care, therefore nursing home care should be an integral part of the health services. Demand for long-term care must be properly assessed and adequate resources-including capital investment, operational funding and manpower-must be provided to meet that demand.
- In search of value for money, the model of care provision under the Nursing Homes Support Scheme is to shift from public provision to private provision with the closure of between 555 to 898 public beds in 2012 and all new funding is to go to the private system. Although private nursing homes can manage care for some older people, patients with higher medical need and/or higher dependency levels benefit from more intensive nursing and therapy support provided for in the public sector. There is a clear need to provide a significant increase in the proportion of care in public nursing homes.
- Older people consistently state a preference to live their lives in their own homes and again demand for community-based care must be properly assessed and adequate resources provided. The contribution made by carers must be recognised and supported and a review of medical cover for elderly patients living in nursing homes and in the community is urgently required.
- Given the direct relationship between poverty and both disability and mental Illness, the extension of the Scheme to Disability and Mental Health Services will further accentuate existing health inequalities. The IMO opposes any plan to extend the Nursing Homes Support Scheme to Community-based Services and to other sectors such as Disability Services and Mental health Services.
- The principle of solidarity must be applied to the funding of long-term care where the cost is spread over a wider population and access to the service is based on medical need, with minimal bureaucracy.

Dept of Health Consultation on a National Strategy for Dementia

In the Submission to the Department of Health the IMO urged the development and implementation of a comprehensive National Strategy for Dementia which should include all the elements as highlighted in Creating Excellence in Dementia Care: A Research Review for Ireland's National Strategy (Cahill et al, 2012). The IMO also recommended that:

- an investment approach to prevention and early diagnosis of Dementia is required;
- demand for community-based care must be properly assessed and adequate resources provided;
- carers must be provided with adequate financial support, support services, and respite to enable them to care for someone as long as they wish and are able to do so, without jeopardising their own health and wellbeing;
- this year the Independent Monitoring Group of A Vision for Change reported a worrying lack of development of Old Age Psychiatry Services and that these should be prioritised as a matter of urgency;
- priority must be given to Legal Capacity legislation to replace Ireland's archaic mental capacity legislation and the ward of court system.

The IMO again raised it concerns about reliance on the private sector to provide long-term care as well as the funding of long-term care under the Nursing Homes Support Scheme.

Children First Bill and the Criminal Justice (Withholding of Information on Offences Against Children and Vulnerable Persons) Bill

In May and June 2012 the IMO made a submission and a presentation to the Oireachtas Committee on Health and Children on the Children First (Heads of) Bill which introduces mandatory reporting of suspected incidences of child abuse. The IMO raised concerns about diagnosis and adequate reporting as well as issues regarding the reporting of consensual sex among minors. These were reflected in the following observations and recommendations published in the report of the Oireachtas Committee:

<u>Resources and Training</u>

Giving effect to the Bill, particularly in the early stages of its implementation, will require a substantial investment in resources, including personnel, training, support and feedback. Planning and provision for this should begin as early as possible. Without a clear and dependable commitment by the State to provide resources, training and support, the implementation of the Bill could be undermined and confidence in the State's child protection services damaged.

<u>Emotional Abuse</u>

Emotional abuse can be devastating and have effects long after the end of childhood. It is essential that, consistent with Children

Research and Policy

IMO submission and presentation to the Oireachtas Committee on Health and Children on the Children First Bill

First and the Protection for Persons Reporting Child Abuse Act 1998, the Bill include it in the definition of "abuse". Failure to do so creates the risk of a hierarchy of abuse, with some forms being perceived as less serious than others. While there may be difficulties in defining and diagnosing emotional abuse for the purposes of prosecution, the Joint Committee is strongly of the opinion that the Bill should give equal recognition to the need to report emotional abuse as well as other types of abuse.

Consensual Sexual Activity

The definition of "sexual abuse" in the Bill and provisions requiring reporting must be clarified. Nothing in the Bill should:

- *require consensual and non-abusive sexual activity between underage persons to be reported or dealt with as a criminal matter;*
- *undermine the confidentiality of the doctor-patient relationship in any case involving non-abusive activity; or*
- *deter teenagers who take part in consensual and non-abusive sexual activity from seeking appropriate medical advice and care.*

The Bill and the Withholding of Information Bill must be consistent with the Criminal Justice Act 2006 in this regard.

The IMO also met with officials from the Department of Children and Youth Affairs and wrote to the Minister for Children and Youth Affairs and the Minister for Justice, Equality and Defence and to relay the IMO's concerns that an obligation to report consensual sex among minors under both the Children First Bill and the Criminal Justice (Withholding of Information on Offences Against Children and Vulnerable Persons) Bill will deter minors from seeking legitimate medical advice in relation to contraception and sexually transmitted infection.

The Minister for Children and Youth Affairs responded that her Department is developing *Guidance on the Reporting of Abuse* to assist designated officers and certain named professionals, including doctors in determining whether to report abuse.

This Guidance will deal with issues such as definitions, thresholds and appropriate routes for the reporting of abuse... It is my intention that the Guidance for Reporting will explicitly set out grounds for considering abuse where underage sexual activity is known to be occurring.

The office of the Minister of Justice and Equality responded that:

It was not feasible to enact sexual offences legislation in advance of the Criminal Justice (Withholding of Information on Offences Against Children and Vulnerable Persons) Bill. The Sexual Offences Bill will be a very wide-ranging piece of legislation following on from an extensive review of the law on sexual offences. The review is close to completion and the Minister expects to bring his legislative proposals to Government shortly. The age of consent to sexual acts will be decided by the Government in that context.

Mandatory Clinical Indemnity Insurance

In August 2012, the IMO was contacted by a member of the Seanad in relation to a proposed amendment to the Medical Practitioners Act introducing a legal requirement for certain medical practitioners to have professional indemnity insurance.

In response the IMO wrote raising concerns that regulating the market for commercial clinical indemnity insurance and assuring that all medical practitioners are adequately indemnified is complex and costly. The Medical Council in order to fulfil this role would need to develop a whole new area of expertise, no doubt duplicating or overlapping with the expertise of the Financial Services Regulator.

Discretionary indemnity insurance such as provided by the Medical Protection Society would not meet the criteria of insurance as defined in the Draft Bill. There is a danger that unless adequately defined and regulated that insurance becomes uneconomic for practitioners and indemnifiers alike.

Medical Council Ethical Guide in relation to Doctors' Interactions with Pharmaceutical and Medical Device Companies

In a submission to the Medical Council on the Draft Ethical Guide in relation to Doctors' Interactions with Pharmaceutical and Medical Device Companies the IMO made a number of comments particularly in relation to the introduction on Competence Assurance Schemes and the corporate sponsorship of CPD events.

Clarification of how hospitality interacts with the sponsored educational meeting would be beneficial to doctors as it is unclear how these two aspects intertwine. Should these meetings be accredited for CPD credits, the organisers should declare the sponsorship of the meeting.

Detail in this section should also advise that if sponsors provide either material or non-material support for an event, such as speakers or material for speakers that declarations are necessary and should be considered essential in providing transparency in such meetings.

Furthermore, the use of participants' details who have attended sponsored events to send further advertising or to make other unsolicited contact, as well as passing on participant details to partner or third party companies to utilise is inappropriate unless consent has been given to the sponsor.

Medical Council Consultation on Amendments to Part 10 Education and Training Rules

In November 2012, the Medical Council held a consultation on an amendment to Part 10 Education and Training Rules clarify the rules in relation to the intern training to ensure compliance with Article 24 of EU Directive 2005/36/EC.

The amendments incorporate the intern year into the total period of basic medical training period to be provided by or under the supervision of a university and clarify that the training post must comprise a minimum aggregate period of 1,200 hours.

The IMO largely supports this amendments but further comments on the practical implications that may follow such a change are necessary particularly any changes to the employer role or working and there is concern about how this aggregate period will be calculated, and indeed where this figure comes from.

The International Affairs Unit has undertaken significant work at a European level both through and outside of our European representative organisations to ensure the IMO's perspective is well presented during the revision process of this Directive. The IMO understands that the revision underway is likely to result in more prescriptive text, particularly given that the Commission's current proposal is likely to change the wording of Article 24 to 5,500 hours of theoretical and practical training to be completed within a minimum of 5 years (subject to further amendments and legislative procedure). The IMO drew the Medical Council's attention to Rule 1 (4) of Part 10 Rules that *'The 5,500 hours referred to in the Directive must be completed in a programme which is of a duration which is no less than four years.'*

The IMO has considerable concerns about the practical implications that may result from such a change, particularly given the interplay of other actors in the intern year, namely the HSE as employer; the universities and postgraduate training bodies who all have key existing roles in delivering the intern year. Interns are currently employed under an NCHD contract and provide necessary services while receiving further training required to pursue the medical profession. Any changes to this arrangement require the input of the IMO on behalf of their intern members as well as student members who will be interns in the future.

The IMO also highlighted the fact that currently not all graduates of medicine in Ireland can secure an intern post. If the intern year is to be considered part of basic medical education, it requires that each medical student be attached to an intern post to ensure they adequately complete their basic medical training.

The IMO continues to reiterate that time and duration should not be disproportionately weighted against other components that are important to training such as content, structure, quality and evaluation of training and education programmes.

In December 2012, the Medical Council approved the amendments and included an amendment to Rule 1.4 as recommended by IMO International Affairs.

HETAC and the Department of Health Review of Academic Programme Validation of Certain Complementary Therapies

Since 2002, the Irish Medical Organisation (IMO) has been calling on the Government to regulate complementary/alternative practitioners and suppliers of complementary/alternative medicines and products.

Many people in Ireland use complementary/alternative therapies and remedies such as acupuncture, chiropractics, osteopathy, herbal and Chinese medicine, in the treatment of various illnesses and ailments despite the fact that the evidence base for many of these therapies is poor.

In a short submission to HETAC and the Department of Health the IMO recommended the establishment of a statutory body to regulate complementary/alternative therapies which would set professional standards of practice, education, training and ongoing competence of providers of complementary/alternative therapies. The statutory body would be responsible for assuring that processes are in place to assure that professional standards are met and to investigate complaints.

The IMO also supported the conclusions of the HETAC and the Department of Health Review in relation to expertise criteria for national qualifications frameworks. For the protection and safety of service users we strongly endorse the need identified in the review for *"The establishment of legitimate expertise... which is expressed in published practice standards which...are based on evidence of efficacy of practice"*.

HSE Draft Acute Surgery Programme

In November 2012 the IMO was asked to comment on the Draft Acute Surgery Programme. In a brief submission the IMO welcomed the Draft Programme and alerted the Clinical leads to discussions by the European Committee for Standardisation (CEN – Comité European des Normes) and the Standardisation of Aesthetic Surgery Services which has raised considerable concern among the medical professional representative bodies at a European level.

- As this standard has been created independently from the expertise of the European medical professional representative bodies, there is a concern that this standard will create parallel structures and lead to legal uncertainty, ambiguities, conflicting legal regimes, a lack of supervision and possibly to a loss of quality in service provision.
- The distinct character of healthcare services is acknowledged in national laws as conferred to Member States by each constitution and the European medical

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professional representative bodies have questioned the legislative basis for the extension of CEN's remit into the standardisation of healthcare services.

The IMO International Affairs Unit is contributing to discussions at both national level, with the National Standards Authority of Ireland (NSAI), and at international level within our representative European Medical Organisations.

The IMO also commented that:

- The regularisation of SHOs and Registrars on contracts of indefinite duration also requires negotiation and agreement with the IMO.
- And Surgeons in all specialties have a responsibility to ensure that medical devices chosen comply with national and/or international standards.

Joint Oireachtas Committee on Justice, Equality and Defence Consultation on the Future of Prostitution Legislation

On December 12th, IMO Vice-president Dr Matthew Saddlier and Senior Policy Executive Vanessa Hetherington attended the hearing of the Oireachtas Joint Committee on Justice, Equality and Defence on the future of Prostitution Legislation in Ireland.

IMO members passed a general motion at the IMO 2011 AGM supporting the Turn Off the Red Light Campaign and calling on the government to introduce legislation which makes it illegal to buy sex. (General Motion 11/26). On foot of the IMO's submission to Joint Committee on Justice, Equality and Defence earlier in 2012, the IMO was called to the committee hearing.

International research shows that sex-workers and women and adolescents trafficked for sex are exposed to a wide range of physical and mental health problems in addition to HIV/AIDS and sexually transmitted disease. Mortality rates are higher among females in prostitution than the general population. Most women do not choose prostitution; but are forced into prostitution because of poverty, homelessness or drug addiction. Purchasers of sex exploit their desperation. A wide range of measures are necessary to combat prostitution and sex trafficking and experience from Sweden shows that criminalising the purchase of sex and not the sale of sex has reduced demand and contained the extent of prostitution. The IMO supports the Turn Off the Red Light Campaign and calls on the Government to introduce legislation which makes it illegal to purchase sex.

All IMO Policy Paper and Submissions are available on the IMO website **www.imo.ie**

International Affairs

The International Affairs Unit manages the international policy of the Irish Medical Organisation

Dr Neil Brennan (Chairman)

International Affairs Committee Members:

Dr Neil Brennan
Dr Bridin Cannon
Prof Cillian Twomey
Dr Trevor Duffy
Dr Liam Lynch
Dr Martin Daly
Dr Mark Murphy
Dr Patrick Kelly
Prof Sean Tierney

The Irish Medical Organisation is a member of the following organisations:

- The Standing Committee of European Doctors (CPME)
- European Junior Doctors Permanent Working Group (EJD)
- The European Union of General Practitioners (UEMO)
- The European Union of Medical Specialists (UEMS)
- The World Medical Association (WMA)

Overview

The International Affairs Unit manages the international policy of the Irish Medical Organisation which is the remit of a standing committee, the International Affairs Committee.

EUROPEAN ISSUES

European Working Time Directive (EWTD)

Late in 2011, the social partners agreed to enter into negotiations to resolve the outstanding issues highlighted in the previous phases of the consultation. The social partners then had nine months to agree on solutions and were given a deadline of September 2012 to inform the Commission of any agreements reached.

For the duration of the social dialogue, the social partners have the right to agree on amendments to the existing legislation which are then presented to the Council of Ministers for its consent. If the Social Dialogue fails, the European Commission is then allowed to initiate a proposal for new legislation.

In September 2012, the European Commission approved a joint request submitted by the social partners to extend the duration of the social dialogue on the review of the EWTD. While the extension was granted until 31 December 2012, on the 14th December it was reported that the discussions had failed and that the Commission may attempt to present a new legislative proposal during 2013.

Professional Qualifications Directive

On the 19th December 2011, the European commission published the draft amendments to modernise the Professional Qualifications Directive. The Professional Qualifications Directive is the legislative instrument responsible for the recognition of qualifications in regulated professions within the European Union. By setting minimum requirements in education, training and outlining comparable specialties in the EU, it is also the instrument that assists professionals moving and practising their profession in other Member States.

The key elements of the proposal for doctors:

1. **The Introduction of a European Professional Card:** This is hoped to speed up the recognition process of qualifications, and assist in facilitating temporary mobility. The European Professional Card is likely to be an e-certificate rather than a physical card, to minimize risk of falsified cards and information.

   The process around the application for and verification of the card will be outlined in the Directive.

2. **Updating minimum training requirements:** The current legislation states that basic medical training is to be a minimum duration of six years or 5,500 hours. The Commission's proposal is to change this wording to a minimum of five years and 5,500 hours. This change has been a heavily debated component of the revision, with the duration and conditions of basic medical training varying substantially throughout the EU.

3. **Recognition of new specialties:** Under Article 26 (types of specialist medical training) the Commission will be empowered to adopt delegated acts concerning the inclusion of new medical specialties common to at least one third (changing from the current ratio of two fifths) of Member States.

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4. **The Introduction of an alert mechanism for health professionals benefiting from automatic recognition:** Competent authorities of a Member State will be obliged to alert competent authorities of all other Member States about a health professional who has been temporarily or permanently restricted or prohibited from exercising their professional activity.
5. **Rules on Language skills:** In the case of doctors (and other professions with implications for patient safety), competent authorities can check or supervise the checking of language skills.

In February, the IMO drafted a position paper on the proposals that was utilised at a European level both within and outside of the European Medical Organisations. The IMO made representations to Ms Phil Prendergast MEP who is a member of the Internal Market and Consumer Protection Committee which has responsibility for the Directive. Many of the positions within the IMO statement were reflected in her proposed amendments to the IMCO Committee, ensuring that the Irish medical profession was heard in Europe.

The European Medical Organisations also issued a joint statement on common agreed principles to ensure solidarity on the most important aspects that concerned the medical profession. This was utilized by the signatory bodies to great effect.

The revision of the Professional Qualifications Directive (PQD) has gathered momentum over the latter half of the year with the submission of formal amendments being completed in October. The Internal Market and Consumer Protection Committee received over 700 amendments for consideration.

The IMCO Committee is due to vote on the amendments in late January 2013. If passed, it will then move to the next phase of the legislative revision process. The revision will be completed in 2013.

European Standardisation of Medical Services

2012 saw a considerable push from the European Committee for Standardisation (CEN) who have resolved to address the standardisation of services in the field of Aesthetic Surgery Services (ASS).

While quality and patient safety are at the heart of any discussion surrounding standardisation in the delivery of medical services, there are significant concerns amongst the medical profession regarding the development of such standards through this process, particularly that the standardisation of medical services should be left to and regulated by the designated competent authorities who can enforce the technical qualifications, ethical requirements, professional duties, treatment procedures and quality assurance requirements that necessitate quality of care and patient safety at a national level.

Following the consultation process which ended in spring 2012 to which both UEMS and CPME have contributed to, it seems that the majority of CEN's members, i.e. the national standardisation bodies still supported the initiative and the adoption of a standard on ASS by CEN.

The IMO has since been discussing the issue directly with the National Standards Authority of Ireland (NSAI) who are the Irish representatives to CEN, and we will continue to consult with the NSAI and other stakeholders in Ireland and Europe as this topic evolves.

Standing Committee of European Doctors (CPME)

2012 was another busy year for CPME who worked across a variety of policy areas. Focus this year was on the ever changing nature of the proposal on the Professional Qualifications Directive, with CPME dedicating much time to ensure that the voice of European doctors was accounted for by the European Commission and relevant politicians involved in the dossier.

The Tobacco Products Directive 2001/27/EC was also a significant issue in 2012. The Directive stalled when the Commissioner for Health and Consumers Mr John Dalli was replaced by Mr Tonio Borg. The latest proposal was published towards the end of 2012, and work will continue in 2013.

The Spring meeting of CPME was held in Brussels on the 4th and 5th of May. The pre-conference for the Spring meeting was held in conjunction with the European Centre on Disease and Prevention Control (ECDC) on childhood vaccination.

Elections were held in the Spring meeting, with the following candidates elected:

President
Dr Katrin Fjelstead – Icelandic Medical Association

Vice-Presidency
Dr Heikke Palve – Finnish Medical Association
Dr Milan Kubek – Czech Medical Chamber
Dr Jacques De Haller – Swiss Medical Association
Dr Eger – Hungarian Medical Chamber

Documents that were adopted:

- CPME call for increased surveillance of Medical Devices
- Draft Joint EMOs Statement on Professional Qualifications
- CPME Statement on the Alcohol - Related Harm to Children and Young People

During the summer, CPME were active in progressing discussions and formalizing positions on the Professional Qualifications Directive to ensure that the organisation was prepared for the upcoming discussions. The IMO contributed through the working group on the topic, participating in teleconferences and contributing via email with other National Medical Associations to reach a compromised position that could be presented as the views of doctors in Europe.

The Autumn meeting of CPME was held on the 23rd and 24th November in Cyprus and was addressed by Dr Androulla Agroutou, Cyprus' Minister of Health.

Documents that were adopted:

- CPME Statement on Data Protection
- CPME Statement on clinical trials
- CPME Statement on non-prescription medicines
- CPME Statement on the situation of healthcare in Greece

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Throughout the year, the IMO representatives to CPME along with the International Affairs Officer actively participated in Working Groups on Tobacco; Medical Devices; Pharmaceuticals; eHealth, Antimicrobial Resistance; Healthy ageing and the Professional Qualifications Directive.

European Junior Doctors – Permanent Working Group (EJD)

The European Junior Doctors marked a significant milestone in 2012 when on 1st of October the EJD signed a contract to engage services of a Brussels office to assist with the work of the EJD in Europe. The establishment of an office in Brussels will enable the organisation to have an increased presence in Brussels and will also inform the EJD of relevant issues while supporting the Executive Board in lobbying activities.

Throughout the year, it was evident that NCHDs in other member countries are also under severe pressure, with the specific targeting of working conditions of doctors in training resulting in various forms of industrial action taken to improve their conditions. Many other countries were facing similar issues and reported the emigration of junior doctors for better working and training conditions; cuts to remuneration packages and entitlements and reduced working options after completion of training.

The Spring meeting of the EJD was held in Zurich on the 11-12th of May. Due to the resignation of the Treasurer, an election was required to replace his position on the Executive Committee. Dr Noora Ritimaki from Finland was elected. Dr Helena Haskaj from Slovenia was elected as the new Chair of the Medical Workforce Committee, replacing Dr Ritimaki.

A Working Group on 'Task Shifting' was implemented at the previous Autumn meeting, which had been assigned to explore the impact of the issue specific to the training and workload of NCHDs. Perceptions of this issue differ between individual workplaces, regions and Member States. There is a difficulty to establish what each country sees as positive/negative, and how other health care professionals impact in this process. A comprehensive survey will be developed to try and establish a picture across Europe.

Work in Spring also began on a survey regarding the working conditions and remuneration of Junior Doctors, and was disseminated during summer. The survey is hoped to better map situations in the member countries. While preliminary results were compiled in the Autumn meeting, further investigation is required before comparisons can be extrapolated.

The Autumn meeting was held in Malaga on the 19-20th of October, where a change of working structures has led to a more output driven meeting.

The situation of the Professional Qualifications Directive was updated by a Spanish guest speaker from the European Association of Physiotherapists.

The Bologna process is still an issue throughout medical education in Europe, with only some countries adopting the second and third cycles. The EJD has decided to update its position on the issue, and a draft will be presented in early 2013 ready for decision at the Spring meeting.

The future of Postgraduate training is also an issue that EJD want to address, and are hoping to work on this particular issue with UEMS. The President and the Vice-President gave a review on their presentations held at international congresses about the future developments in postgraduate training and work on this topic will continue in 2013.

European Union of General Practitioners (UEMO)

SMART Project

In 2011, UEMO decided to participate in tendering for a European project for 'Benchmarking deployment of eHealth among General Practitioners II' which is also known as SMART 2011/0033. The European Commission (EC) endorsed a Consortium (including UEMO) to deliver the project.

The project will measure the use of ICT and e-Health applications by primary care physicians throughout the European Union, Norway, Iceland, Croatia and Turkey. The Commission decided to grant the tender because of having the UEMO network as a proof to have a valid reach of general practitioners/family physicians. Work on the survey was undertaken at the Spring meeting in Madrid in the Ad Hoc Working Group chaired by Dr Liam Lynch to ensure the appropriate questions were being asked in order to deliver the most relevant and informative data.

The SMART project was launched on the 22nd of November, with 1200 GPs selected in the first quota, with the next group rolled out late in 2012. This survey is vitally important as feedback will be utilised by the European Commission and will help inform policy making. GPs who participated in the survey will be issued with a Certificate of Participation to keep for their Professional Competence portfolio.

General Practice as an EU recognised Specialty

The Commission decided early in 2012 that they would not be addressing General Practice as a specialty as part of the revision of the Professional Qualifications Directive. While it is a recognised specialty in many Member States (including Ireland), General Practice/Family Medicine has not yet received European recognition as a speciality.

It was decided at the Autumn meeting that a defined strategy would be developed within the context of the Professional Qualifications Directive to ensure the best possible route to the specialisation could be realised. While the Commission has clearly said that they will not address recognition, it is important to develop a considered approach on this topic to ensure its success.

TELL ME Project

Another project that UEMO is contributing to in Europe is the TELL ME project: Transparent communication in Epidemics: Learning lessons from experience, delivering effective messages and providing evidence. The duration of the project is over 36 months,

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and aims to provide evidence and to develop models for improved risk communication during times of infectious disease crises. UEMO will participate in two components of the project: health care professional communication requirements and a testing phase which is aimed at health professionals in the EU. The member countries selected to contribute to this project are Finland, Hungary, Italy, Slovenia, The Netherlands and the United Kingdom.

At the Spring meeting held it Madrid on the 8th and 9th of June, the Secretary General of the Spanish Ministry of Health opened the meeting and presented a review of recent reforms of the healthcare system in Spain.

The Meeting was also addressed by Prof Marianne Samuelson, who discussed improving interprofessional collaboration in Primary Care and a position paper on the topic from the European Forum of Primary Care.

The Specialist Training working group presented findings of the survey mapping the specialist training conditions of General Practitioners/Family Physicians in Europe. Results of this survey are hoped to inform the strategy on the recognition of General Practice/ Family Medicine as a specialty in Europe.

The working group on the Competencies of GPs in the Management of Complexity proposed to start working on a draft paper looking at the added value of teamwork in General Practice/Family medicine.

The CME working group continued work on the different systems that are in place around member countries. The importance of CME in General Practice and how this is recognised throughout the EU will continue to evolve, and it was decided that further work on a recommendation document should take place prior to the Autumn meeting.

The Preventive Activities working group focused on the TELL ME project, and the work that was required to ensure UEMO's commitments were delivered.

The Autumn meeting of UEMO was held in Berlin on the 16th and 17th November.

The Specialist Training working group continued to discuss the strategy for the recognition of General Practice as a Specialty. It was agreed that countries where General Practice is not a recognised specialty should be targeted with UEMO members from these countries noting where opportunities lie for progressing this issue internally. A draft structure for a statement on this issue was developed, and will be further detailed ahead of the next meeting.

The working group on the Competencies of GPs in the Management of Complexity continued from the last meeting in determining the focus of their paper to define the functions of General Practitioners as diagnosticians, prescribers, leaders, coordinators of care and team players including their work in conflict resolution and quality measurement. Teamwork also requires agreed therapeutic goals, delegation and overall identification of clinical responsibility, with clear definition for each professional required.

The working group of CME decided to accept the concept document and to hopefully look at the very specific nature of CME in relation to General Practice. There was significant debate over the issue of revalidation as being the main driver in modern times for undertaking CME rather than quality improvement. The working group hopes to have a concrete document ready for the next meeting.

European Union of Medical Specialists (UEMS)

UEMS work in 2012 was again extensive, both on a practical level with the European Accreditation Council for CME, the European Council for the Accreditation of Medical Specialist Qualifications and on a policy level with significant contributions of the Professional Qualifications Directive. The Commission has indicated that it intends to work closely with UEMS on European consultant matters, including the revision of Annex V of the Professional Qualifications Directive.

Work continues on the creation of a Domus Medica Europaea, with planning work on the premises continuing in 2012 and an opening for the building scheduled for 2013.

At the Spring meeting of UEMS held in Brussels on the 20th and 21st of April, UEMS discussed the possibility of accrediting the UEMS Council Meetings for CME points.

The meeting also heard an update from the European Accreditation Council for CME (EACCME) taskforce which outlined its work on drafting amendments to the document regarding 'The Accreditation of Live Educational Events by the EACCME', with key areas of focus on conflict of interest with speakers; a central database of speakers and transparency in the financing of large CME events. Incorporating these points into the document would then be presented at the following meeting.

The meeting also heard an update on pilot tests of knowledge-based assessments that are being undertaken by the European Council for the Accreditation of Medical Specialist Qualifications (ECAMSQ) which is a part of UEMS. The pilot projects have been launched in Anaesthesiology, Cardiology, Intensive Care and Radiology.

The Council for European Specialty Medical Assessments (CESMA) heard that further work on the e-platform supporting the assessment of medical competence was required. Assessments are already underway in some countries where particular specialty assessments do not currently exist. Further work will continue throughout 2013 on its evolution.

The Postgraduate Training Working Group identified a need to update the current structure of 'Chapter 6' in specialties, and work was undertaken to present a new structure in time for the Autumn meeting.

Dr Trevor Duffy as the rapporteur for the working group on CME highlighted the necessary ongoing work of the group, particularly in regards to such topics as active and inactive participation in CME events, and how this could be measured in time to come. As Dr Boorman took over his role of Secretary General of the organisation, Dr Hanu Halila from Finland took over the chair of the CME working group.

Prof Cillian Twomey as chairman and rapporteur of the eHealth working group

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discussed the importance of participation in EU projects to ensure that consultants raise their expectations and concerns in areas of eHealth so that the process is driven by the profession as well as industry. The Working Group would develop a position paper on eHealth which would be circulated on completion.

The Quality of Patient Care working group discussed the development of a set of ethical principles in each specialty with an aim to implement a common ethical framework for medical specialists.

The Specialist Practice in Current Health Systems continued its work in Spring to elaborate on the existing questionnaire on specialist practice, and that 26 new questions on specialist education would be worked on by the Working Group.

The following documents were adopted at the Spring meeting:

- Chapter 6 in Anaesthesiology
- Chapter 6 in Neurology
- Chapter 6 in Angiology
- Chapter 6 in Dermatology & Venereology
- Chapter 6 in Nuclear Medicine

The Autumn meeting was held in Limassol, Cyprus on the 23rd and 24th of November. The opening of the meeting heard that UEMS currently has 39 Sections and Boards and 11 Multidisciplinary Joint Committees, and that a review of processes regarding the nomination and maintaining of representatives to Sections and Boards would begin late in 2012 for issue in 2013.

The Discussion forum was on the Self-Regulation of the Medical Profession, which explored the themes of bureaucracy, external standardisation and administrative and financial pressures. This resulted in the drafting of a statement on Professional Autonomy which was adopted in the General Assembly the following day.

The EACCME proposed and adopted the revised Criteria for the Accreditation of Live Education Events, which will come into effect on the 1st January 2013.

One of the biggest decisions taken by UEMS at the meeting was in regards to updating the Template for European Training Requirements for Medical Specialties to replace the 'Chapter 6' documents that were previously written. This is particularly important as this document outlines the framework for training in medical specialities.

The working group on Continuing Medical Education and Professional Development continued the work it discussed at the Spring meeting, particularly the counting of CME points and the possibility to value different activities depending on engagement of participants and how presenters should be considered in CME/CPD. The working group will also undertake work in the future on gathering information from UEMS member countries regarding CME/CPD practices.

The working group on Post Graduate Medical Training presented the updated template moving from the 'Chapter 6' structure to the new Training Requirements document. This was significant work over the Summer, and the working group's consultation on the issue incorporated national perspectives on the issue to provide a comprehensive structure.

The Quality in Patient Care working group spent their session formulating their next body of work and considered whether the UEMS should produce a Statement on Environmental Health, and will continue this work into 2013.

Prof Cillian Twomey updated the meeting on the working group on eHealth's progress on the MOMENTUM Project, which has been an ongoing EU project regarding the use of telemedicine that UEMS are contributing to. Other eHealth projects that UEMS contribute to include the eHealth Users Stakeholders Group and the ReNEWING HeALTH User Advisory Board.

The Specialist Practice in Current Health Systems has almost concluded the development work on the questionnaire regarding specialist practice, and it is hoped to be disseminated shortly. Other topics that require further work include the rationing mechanisms in medicine and the impact on specialist practice and the modernizing of the definition of 'Specialist Medicine'.

The Constitution of Governance Boards for the UEMS Standing Committees was also adopted, which established the key interest areas of UEMS, namely: Continuing Medical Education and Professional Development (CME-CPD); Postgraduate Medical Training (PGT) and Quality Assurance (QA). The UEMS Executive elaborated a document providing the structure and mission for Governance Board to pilot the Standing Committees.

The following decisions were also taken:

- Endorsement of Chapter 6 in Pathology
- Endorsement of Chapter 6 in Plastic, Reconstructive and Aesthetic Surgery
- Endorsement of Chapter 6 in Pneumology
- The creation of a Multidisciplinary Joint Committee in Manual Medicine
- The creation of a Thematic Federation of Legal and Forensic Medicine

World Medical Association (WMA)

In 2012, the IMO drafted a Statement on the Prioritisation of Immunisation in conjunction with the Icelandic Medical Association. The paper was submitted to the Socio-Medico Affairs Committee, who decided at the Council meeting in April that the paper would be disseminated to national medical associations for comment.

After receiving and incorporating comments from other associations the IMO was appointed as the rapporteur on the paper. The International Affairs Officer then presented the paper to the Socio-Medico Affairs Committee in Bangkok on the 10th of October.

As there were no proposed amendments from the Committee, the paper was then formally recommended for adoption by the American Medical Association, whose motion was seconded by a number of Committee members. The paper then came before Council, who subsequently forwarded the statement to the General Assembly with the recommendation for adoption. The paper was formally adopted by the General Assembly of the World Medical Association, and is now the WMA Statement on the Prioritisation of

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Immunisation and available online at www.wma.net (see paper at end of report)

The WMA General Assembly was held in Bangkok from the 10th-14th October 2013.

The President to be installed for 2012-2013 was Dr Cecil B Wilson, USA, and the President elected for 2013-2013 was Dr Margaret Mungherera from Uganda.

The Scientific Session theme for this hear was 'Megacity – Megahealth?' where examples from around the globe were presented on the challenges and successes of delivering health care to large populations in condensed cities. Examples from Bangkok, Tokyo, Chicago and Sao Paulo gave interesting insight into the unique conditions and requirements for ensuring health care to inhabitants of Megacities.

The Myanmar Medical Association and the Sri Lanka Medical Association were granted membership of the WMA.

Other statements that were adopted at the WMA General Assembly in Bangkok, Thailand:

- WMA Statement on Organ and Tissue Donation
- Reaffirmed the WMA's prohibition of Physician Participation in Capital Punishment
- Revision of WMA Declaration on Medical Ethics and Advanced Technology
- Revision of WMA Regulations in Times of Armed Conflict and Other Situations of Violence
- WMA Statement on Electronic Cigarettes and Other Electronic Nicotine Delivery Systems
- WMA Statement on Violence in the Health Sector By Patients and Those Close to Them
- WMA Statement on the Ethical Implications of Collective Action by Physicians
- WMA Statement on Forced and Coerced Sterilisation
- WMA Statement on the Prioritisation of Immunisation
- WMA Resolution on Political Abuse of Psychiatry
- WMA Resolution on a Minimum Price for Alcohol
- WMA Resolution on Plain Packaging of Cigarettes
- WMA Resolution in Support of Professor Cyril Karabus

Update on Activities for Doctors in Bahrain

The IMO has been kept up to date by the World Medical Association working closely with Amnesty International on reports over the past year regarding the treatment of 20 health professionals detained in Bahrain over a number of serious allegations regarding their role in protests in protests in the early part of 2011.

The IMO has written to officials in both Bahrain and in Ireland, including:

- May 2011: Dr. Fatima bint Mohammed Al Balooshi, Ministry of Social Development
- October 2011: Tánaiste Eamon Gilmore in his capacity as Minister for Foreign Affairs and Trade
- February 2012: King Shaikh Hamad bin 'Issa Al Khalifa
- June 2012: King Shaikh Hamad bin 'Issa Al Khalifa
- July 2012: King Shaikh Hamad bin 'Issa Al Khalifa: Minister of Interior; Minister of Justice and Islamic Affairs

The letters stress the following points:

- All measures to ensure the protection of medical care and the independence of health professionals.
- All healthcare personnel must be protected and supported in their moral, ethical and professional responsibilities to provide care for the sick and injured.
- Doctors, nurses, paramedics and other health workers must be able to carry out, without discrimination, their professional responsibilities to provide emergency and other medical care to those in need, without interference or fear of reprisal.
- To protect the rights of people to access healthcare, as they need it without fear of reprisal.
- Urge the Bahraini authorities to carry out an immediate and independent investigation into the allegations of torture and other ill-treatment against some of the health professionals, as well as against other detainees in Bahrain, and to make these results public and to bring to justice those responsible.
- Confessions obtained under torture must not be submitted or used as evidence in the trial of the 20 health professionals or any other trials in Bahrain.
- Bahrain must ensure the protection of medical care and the independence of health professionals as they undertake their duty to provide impartial medical care.
- Calling on the Bahraini government to hold all those responsible for violations of international law accountable under the law.

This issue was also discussed at the IMO Annual General Meeting 2012 where motions were adopted statements provided to the media.

"The IMO calls on the Irish Government to denounce known contraventions of the protection of medical personnel in times of civil or international conflict and support global health personnel in their obligation to treat and care for patients independently and regardless of their gender, race, religion, political orientation or status within a community".; And

"This meeting supports the action taken by the IMO in line with the WMA regarding the recent conflict in Bahrain and reinforces the protocols of the Geneva Convention".

The IMO continues to monitor development on this issue, and will undertake activities necessary to highlight the unjust situation facing these doctors.

IMO Hosting Spring meetings in 2013

- CPME – The IMO will host the 2013 Spring meeting of CPME on the 26th and 27th April 2013.

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- UEMO – The IMO will host the 2013 Spring meeting of UEMO on the 24th and 25th May.

WMA Statement on the Prioritisation of Immunisation

Adopted by the 63rd WMA General Assembly, Bangkok, Thailand, October 2012

PREAMBLE

Vaccination use to prevent against disease was first done successfully by Jenner in 1796 when he used cowpox material for vaccination against smallpox. Since then, vaccination and immunisation have been acknowledged as an effective preventive strategy for several communicable diseases and are now being developed for the control of some non-communicable diseases.

Vaccine development and administration are some of the most significant interventions to influence global health in modern times. It is estimated that immunisation currently prevents approximately 2.5 million deaths every year, saving lives from diseases such as diphtheria, tetanus, whooping cough (pertussis) and measles. Approximately 109 million children under the age of one are fully vaccinated with the diphtheria-tetanus-pertussis (DTP3) vaccine alone.

Mostly the ultimate goal of immunisation is the total eradication of a communicable disease. This was achieved for smallpox in 1980 and there is a realistic goal for the eradication of polio within the next few years.

The Global Immunisation Vision Strategy (GIVS) 2006-2015 was developed by the WHO and UNICEF in the hope of reaching target populations who currently do not have immunisation services or who do not have an adequate level of coverage.

The four strategies promoted in this vision are:

- Protecting more people in a changing world
- Introducing new vaccines and technologies
- Integrating immunisation, other linked health interventions and
- Surveillance in the health systems context
- Immunizing in the context of global interdependence[i]

Vaccine research is constantly revealing new possibilities to protect populations from serious health threats. Additionally, new strains of diseases emerge requiring the adaptation of vaccines in order to offer protection.

The process of immunisation requires an environment that is resourced with appropriate materials and health workers to ensure the safe and effective administration of vaccines. Administration of vaccines often requires injections, and safety procedures for injections must always be followed.

Immunisation schedules can vary according to the type of vaccine, with some requiring multiple administrations to be effective. It is vitally important that the full schedule is followed otherwise the effectiveness of the vaccine may be compromised.

The benefits of immunisation have had a profound effect on populations, not only in terms of preventing ill health but also in permitting resources previously required to treat the diseases to be redirected to other health priorities. Healthier populations are economically beneficial and can contribute more to society.

Reducing child mortality is the fourth of the United Nation's Millennium Development Goals, with immunisation of children having a significant impact on mortality rates on children aged under five. According to the WHO, there are still more than 19 million children who have not received the DTP3 vaccine. In addition, basic health care services for maternal health with qualified health care personnel must be established.

Immunisation of adults for diseases such as influenza and pneumococcal infections has been shown to be effective, not only in decreasing the number of cases amongst those that have received immunisation but also in decreasing the disease burden in society.

The medical profession denounce any claims that are unfounded and inaccurate with respect to the possible dangers of vaccine administration. Claims such as these have resulted in diminished immunisation rates in some countries. The result is that the incidences of the diseases to be prevented have increased with serious consequences for a number of persons.

Countries differ in immunisation priorities, with the prevalence and risk of diseases varying among populations. Not all countries have the same coverage rates, nor do they have the resources to acquire, coordinate, distribute or effectively administer vaccines to their populations, often relying on non-governmental organizations to support immunisation programmes. These organizations in turn often rely on external funding that may not be secure. In times of global financial crisis, funding for such programmes is under considerable pressure.

The risk of health complications from vaccine-preventable diseases is greatest in those who experience barriers in accessing immunisation services. These barriers could be cost, location, lack of awareness of immunisation services and their health benefits or other limiting factors.

Those with chronic diseases, underlying health issues or other risk factors such as age are at particular risk of major complications due to vaccine-preventable diseases and therefore should be targeted to ensure adequate immunisation.

Supply chains can be difficult to secure, particularly in countries that lack coordination or support of their immunisation programmes. Securing the appropriate resources, such as qualified health professionals, equipment and administrative support can present significant challenges.

Data collection on vaccine administration rates, side effects of vaccines and disease surveillance can often be difficult to achieve, particularly in isolated and under-resourced areas. Nevertheless, reporting incidents and monitoring disease spread are vital tools in combating global health threats.

International Affairs

RECOMMENDATIONS

The WMA supports the recommendations of the Global Immunisation Vision Strategy (GIVS) 2006-2015, and calls on the international community to:

- Encourage governments to commit resources to immunisation programmes targeted to meet country specific needs.
- Recognise the importance of vaccination/ immunisation through the continued support and adoption of measures to achieve global vaccination targets and to meet the Millennium Development Goals, especially four (reduce child mortality), five (improve maternal health) and six (combat HIV/AIDS, malaria and other diseases).
- Recognise the global responsibility of immunisation against preventable diseases and support work in countries that have difficulties in meeting the 2012 targets in the Global Polio Eradication Initiative[ii].
- Support national governments with vulnerable populations at risk of vaccine-preventable diseases, and the local agencies that work to deliver immunisation services and to work with them to alleviate retrictions in accessing services.
- Support vaccine research and development and ensure commitment through the adequate funding of vital vaccine research.
- Promote vaccination and the benefits of immunisation, particularly targeting those at-risk and those who are difficult to reach. Comply with monitoring activities undertaken by WHO and other health authorities. Promote high standards in the research, development and administration of vaccines to ensure patient safety. Vaccines need to be thoroughly tested before implemented on a large scale and subsequently monitored in order to identify possible complications and untoward side effects. In order to be successful, immunisation programmes need public trust which depends on safety.

In delivering vaccination programmes, the WMA recommends that:

- The full immunisation schedule is delivered to provide optimum coverage. Where possible, the schedule should be managed and monitored by suitably trained individuals to ensure consistent delivery and prompt appropriate management of adverse reactions to vaccines.
- Strategies are employed to reach populations that may be isolated because of location, race, religion, economic status, social marginalization, gender and/or age.
- Ensure that qualified health professionals receive comprehensive training to safely deliver vaccinations and immunisations, and that vaccination/immunisations are targeted to those whose need is greatest.
- Educate people on the benefits of immunisation and how to access immunisation services.
- Maintain accurate medical records to ensure that valid data on vaccine administration and coverage rates are available, enabling immunisation policies to be based upon sound and reliable evidence.
- Healthcare professionals should be seen as a priority population for the receipt of immunisation services due to their exposure to patients and to diseases.

The WMA calls upon its members to advocate the following:

- To increase awareness of national immunisation schedules and of their own (and their dependents) personal immunisation history.
- To work with national and local governments to ensure that immunisation programmes are resourced and implemented.
- To ensure that health personnel delivering vaccines and immunisation services receive proper education and training.
- To promote the evidence base and increase awareness about the benefits of immunisation amongst physicians and the public.

[i] World Health Organization and United Nations Children's Fund. Global Immunisation Vision and Strategy, 2006-2015. Geneva, Switzerland: World Health Organization and United Nations Children's Fund; 2005. Available at: http://www.who.int/immunisation/givs/related_docs/en/index.html

[ii] World Health Organization. Global Polio Eradication Initiative: Strategic Plan 2010-2012. Geneva, Switzerland: World Health Organization; 2010. Available at: http://www.polioeradication.org/Portals/0/Document/StrategicPlan/StratPlan2010_2012_ENG.pdf

IMO Financial Services

IMO FINANCIAL SERVICES

IMO Financial Services

Board Members

Dr Martin Daly, Chair

Patrick Dineen

James Brophy

Willie Holmes

IMO Financial Services (IMOFS) provides members of the Irish Medical Organisation with a professional and cost effective service. In light of the increasingly difficult economy and its impact on members, the company offered free financial reviews to all IMO members. This was designed so that doctors could have a concise view of their current financial situation and enable them to plan better for the future. IMOFS Financial Advisors engaged with over 400 IMO members during 2012 on a wide range of services and products including pensions, life and income protection and financial reviews.

Group Schemes

A key objective for during 2012 was to conclude a detailed review of the commercial arrangements which were in place in respect of all Group Schemes – Group Life, Income Protection and Waiver of Premium. To achieve this we engaged the services of an independent actuarial consultant who oversaw a review and detailed tendering process for each of the Group. As a result, the Board was able to secured significantly better terms and benefits for members from the selected provider, Zurich.

Some of the significant new benefits include:

Doctors under 30 years joining Income Protection Scheme

- FREE Income Protection for 6 months
- FREE Life Cover of €150,000 until the age of 30
- NO medical underwriting

Doctors between age 30 and 40 years joining Income Protection Scheme

- FREE Life Cover of €150,000 for 2 years

Doctors between age 40 years and 45 years joining Income Protection Scheme

- FREE Life Cover of €150,000 for 1 year

Doctors who are existing members of Group Life

- Members of the Life Scheme now have the option to increase Life Cover WITHOUT medical evidence. On the birth of a child or joining/establishing a practice a doctor can get one unit of live cover with only an "active at work" declaration. The maximum age this is allowed is up to 45th birthday.

Waiver of Premium Scheme for GMS Doctors

- This scheme has been greatly enhanced with NO extra cost in premiums. Significantly the deferred period has been reduced to 52 weeks and on reaching the age of 64 the deferred period is even shorter – just one month.

Our Group Schemes have a combined membership of almost 3,500 and these enhancements are designed to ensure the schemes are competitively priced for the vast majority of members over the lifetime of the policies. However, at all times, our Financial Advisors are committed to ensuring you avail of the best product to meet your own personal financial requirements and circumstances.

Pension Planning for IMO Members

With ever changing legislation the whole area of pensions has become increasingly complex. Our Financial Advisors are there to assist members in planning for their retirement in the most tax efficient manner. In 2012 we launched our E-Newsletter service with a special edition dedicated to Pensions. This detailed pension options, revenue issues and included a very

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IMO Financial Services

special offer for IMO members with one of the most competitive pricing structures available in the market for new pension contributions and transfers.

It is our aim to keep members up to date about their options at retirement and we are currently designing a range of information seminars to assist members nearing retirement in making the best choices for the pension funds.

Committed to providing a high quality professional service to IMO Members

In addition to our group schemes and pension planning, we also offer a broad range of individual products to members and provide professional advice on a range of personal financial matters. In the past year we have enhanced our Financial Advisors Team s to ensure we have a breadth of knowledge in all financial areas for our members and we consistently ensure that all our Advisors are up to date with the latest developments and products in the financial services and investment .

In terms of the property syndicates in which some members invested between 2005 and 2008 we remain committed to minimising losses to individual doctors. The IMOFS has engaged experts to deal with the banks in terms of the disposal of these properties, which have, due to the global economic downturn, lost their value. It is important to note that any outstanding liabilities left upon the sale of such properties are not the responsibility of individual investors as the loans were on a non recourse basis.

As a company IMOFS seeks to meet best practice in terms of Governance and Compliance and we engage the services of an independent compliance firm to monitor our business practice and to advise us on developments in this area.

The Board of IMOFS met with IMO Honorary Officers in 2012 to give a full review of its operations. More recently we have committed to participating in the IMO Governance Review in an effort to ensure the relationship between IMO and IMOFS is fully transparent and works best for members. As part of that process you will see in the IMO Financial Statements the accounts for IMO Financial Services which is a significant asset of the IMO and there for the benefit of members.

Membership

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

The Irish Medical Organisation is committed to representing the best interests of its members, and our key strength is on the support of a united membership.

This year the IMO recorded a membership figure of 5053 as at 31st December 2012.

The services and benefits available to members continue to expand in order to meet changing demands.

- As well as offering national representation and negotiation, the IMO now offers individual support from our dedicated team of professional Industrial Relations Officers in the Personal Cases Unit who are there to deal with individual problems.
- In association with the Irish Medical Journal, IMO members are now able to avail of CPD activity online.
- All members can contribute to IMO Policy to develop an equitable health service for patients and promote the role of the doctor. The IMO, as your representative body, engages in a full range of research, advocacy and communication activities.
- Also through IMO Financial Services we offer members savings on financial services specifically developed for the medical profession.

For the membership unit, the capacity to keep up to date with all individual member details is greatly enhanced through prompt notification to the IMO. Of equal importance, is that we are kept informed of your new position as your career progresses. This helps us to provide you with relevant information and material that you may find to be of benefit.

We offer Overseas membership to all our members when they pursue their career abroad. This is free of charge and means you will be kept up-to-date on developments here through a monthly email newsletter. It may be of use to you to be kept informed of these issues particularly if you are planning to return to Ireland at some point in the future.

The IMO website is dynamic and helps to assist the Organisation in being more efficient and effective. Members are now able to pay renewal subscriptions online securely and can also edit your profile information at any time.

Members can choose from a number of payments options in terms of paying their annual subscription:

- Annual Cheque
- Direct Debit monthly/annually
- Credit card annually (online option)
- GMS via the Primary Care Reimbursement Service (GPs only)

The Membership Unit is available to assist with your detail changes, to discuss your membership benefits and options.

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Irish Medical Journal

Dr John FA Murphy, Editor, Irish Medical Journal

Irish Medical Journal Annual Report 2012

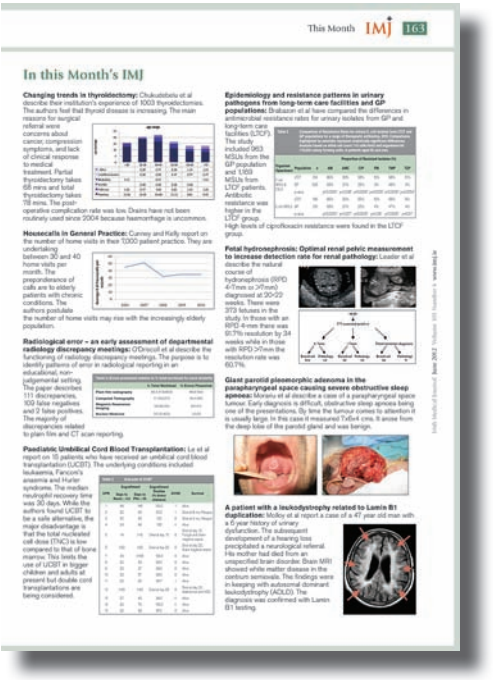
In 2012 there were 10 editions of the Irish Medical Journal. There were 10 commentaries, 17 editorials, 53 original papers, 9 short reports, 13 research correspondence, 22 case reports, 36 letters to the editor, 9 book reviews and 4 poetry pieces.

The IMJ is a general medical journal that addresses all the issues that affect clinical practice. Bruce-Brand et al (2012;105:15-18) reported the results of a survey of Irish junior doctors in training. Fifty per cent are dissatisfied and a further third are extremely unhappy with practicing medicine in Ireland. The 2 principal concerns are lack of quality training and doubtful long term prospects. In addition they feel that they carry an excessive burden of service duties.

Yessel et al (2012;105:57-59) described the role of a movement disorder clinic. Over 500 patients are seen annually, two thirds have Parkinson's disease. Dystonia accounts for 6% of cases. Following referral to this specialist clinic, the diagnosis was changed in 38% of cases and treatment altered in 74%. The authors estimate that there are 5,500 patients with Parkinson's disease in Ireland.

Dunne et al (2012;105:71-74) provided a detailed analysis of mental health problems encountered in homeless patients and the findings compared with the general adult service. They more likely to be male, unemployed, unmarried, young and to suffer from schizophrenia and personality disorders. The complexity of their disorders and poor treatment compliance poses a major challenge for care givers.

O'Duffy and O'Dwyer (2012;105:101-102) highlighted the growing epidemic of HPV associated oropharyngeal malignancy . HPV



is the most common sexually transmitted viral infection. The high risk strains found in Ireland are HPV 16 and 18. HPV oral cancers present in younger patients and has a male preponderance. The authors recommend that boys should be included in the HPV vaccination programme. Without intervention the annual number of oropharyngeal cancers in men will exceed cervical malignancies in women by 2020.

Daly et al (2012;105:114-115) surveyed 48 GPs about the new Medical Council competence scheme. Three quarters were concerned about the time required and 67% wanted further information about the process. Sixty per cent had never had teaching on clinical audits. Only 48% felt the scheme was practical in the current pressurised health service.

Irish Medical Journal

Abdelmaboud et al (2012;105:146-148) reported on maternal obesity in Galway. The prevalence of obese women BMI>35 was 9.6 per 1000. The rate has increased from 2.1 per 1000 twelve years ago. These high obesity numbers have led to increased emergency caesarean section rates.

Cunney and O'Kelly (2012;105:170-171) had a paper on housecalls in general practice. In a 7,000 patient practice they make 30-40 home visits per month. The majority of calls are to the elderly with chronic conditions. The paper suggests that home visits will rise because of the increasingly elderly population.

Malone et al (2012;105:231-233) reported that the rate of suicide in children has increased between 1993 and 2008. The rate has increased from 9.3 to 13.5/100,000 in males and from 2.4 to 5.1/100,000 in females. The rise is centred in the 15-17 year olds. They are the group that require earlier invention and better treatment provision.

Thynne et al (2012;105:263-265) described how women who conceal their pregnancy differ from age matched match control. Two thirds of the concealed pregnancy group were rural compared with 33% in the controls. The majority feared a negative parental reaction. The prevalence of concealed pregnancy is 1 in 148.

We have come full circle in relation to targeted lower blood sugar levels in patients undergoing intensive care (Murphy JFA .2012;105:292). A study undertaken in 2001 concluded that insulin therapy to control blood sugar in ICU patients reduced morbidity and mortality. The NICE sugar study 2009 did not find tight glycaemic control to be beneficial. In hindsight the biological plausibility of hyperglycaemia causing infection should have been more critically challenged at an earlier stage.

Fahy et al (2012;105:333-335) stated that there is a continued need for general paediatric surgery in a regional setting. In Castlebar there were 453 general paediatric surgery procedures, 240 orthopaedic and 160 dental operations. The commonest emergency operation was appendicectomy and the commonest elective procedures were circumcision and upper GI endoscopy.

In 2012 we introduced IMJ CPD online and this has proven to be a great success. We are currently planning for a new IMJ website which we hope to launch next year.

JFA Murphy
Editor

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financial statements

For Year ended 31-12-2012

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Ceardchumann Dochtúirí na hÉireann

Financial Statements

For the Year Ended 31st December 2012

(These pages do not form part of the audited consolidated financial statements)

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Trustees and other information

The Irish Medical Organisation is a Trade Union registered under the Trade Union Act 1941.

TRUSTEES:	Dr. Henry Finnegan Dr. Larry Fullam Dr. Mary Hurley Dr. Michael Thornton Prof. Cillian Twomey
MANAGEMENT COMMITTEE:	Dr. Paul McKeown - President Dr. Matthew Sadlier - Vice President Professor Sean Tierney - Treasurer Dr. Brett Lynam - Honorary Secretary Dr. Ronan Boland - Immediate Past President Dr. Ray Walley Dr. Trevor Duffy Dr. Mark Murphy Dr. Mary Conlon
PRINCIPAL BANKERS:	Allied Irish Banks Plc., 40/41 Westmoreland Street, Dublin 2.
SOLICITORS:	John O'Connor & Co., 9 Clare Street, Dublin 2.
AUDITORS:	HSOC, Chartered Accountants, Registered Auditors, Adelaide House, 90 Upper Georges Street, Dun Laoghaire, Co. Dublin.

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THE IRISH MEDICAL ORGANISATION

Report of the Management Committee for the Year Ended 31 December 2012

The Management Committee has pleasure in submitting its report together with the audited financial statements of the organisation for the year ended 31 December 2012.

Principal activities and review

The Organisation continues to be a Trade Union representing the interests of the members of the medical profession.

The results of the organisation for the year have been significantly affected by two material items, namely the termination package with former CEO and a write down due to the reduction in valuation of the properties at 10/11 Fitzwilliam Place.

Results for the year

The accounts presented incorporate the consolidated activities of the Organisation comprising its Trade Union and Publishing activities, Financial Services division and Property Holding company.

The summary Balance Sheets of the individual entities are appended for information purposes.

The organisation's deficit for the year was €6,177,192 which includes the material items of €4,178,711 (Termination package) and €2,994,365 (Reduction in property value). It should also be noted that a further €1,321,379 of a Revaluation Reserve, arising from a previous uplift in value, has also been written off.

Principal Risks and Uncertainties

The committee has considered the principal risks and uncertainties faced by the organisation, including economic risk, competition risk and financial risk. Financial risk includes the need to consider if there is any risk from property revaluations, in which regard the committee has obtained a professional valuation which is reflected in the accounts.

Post Balance Sheet Events

There have been no significant events affecting the organisation since the year end.

Future Developments

There are no future developments envisaged that would materially affect the nature and level of the organisation's activities.

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THE IRISH MEDICAL ORGANISATION

Report of the Management Committee for the Year Ended 31 December 2012

Statement of Management Committee's Responsibilities

The Management Committee are responsible for preparing the Annual Report and the financial statements in accordance with applicable Irish law and Generally Accepted Accounting Practice in Ireland including the accounting standards issued by the Accounting Council and published by Chartered Accountants Ireland.

Irish law requires the Management Committee to prepare financial statements for each financial year which give a true and fair view of the state of affairs of the organisation and of the surplus/ deficit of the organisation for that period. In preparing those financial statements the Management Committee are required to:

- select suitable accounting policies and then apply them consistently,
- make judgements and estimates that are reasonable and prudent,
- prepare the financial statements on the going concern basis unless it is inappropriate to presume that the organisation will continue in business.

The Management Committee confirm that they have complied with the above requirements in preparing the financial statements.

The Management Committee are responsible for keeping proper books of account which disclose with reasonable accuracy at any time the financial position of the organisation and to enable them to ensure that the financial statements are prepared in accordance with accounting standards generally accepted in Ireland and with Irish statute comprising the Trade Unions Acts 1871-1990 and the Companies Acts 1963-2012. They are also responsible for safeguarding the assets of the organisation and hence, for taking reasonable steps for the prevention and detection of fraud and any other irregularities.

The Management Committee are responsible for the maintenance and integrity of the corporate and financial information included on the organisation's website. Legislation in the Republic of Ireland governing the preparation and dissemination of financial statements may differ from legislation in other jurisdictions.

On behalf of the Management Committee:

Paul McKeown — President
Dr Paul McKeown

Sean Tierney — Treasurer
Prof Sean Tierney

Date: 06 March 2013

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Treasurer's Report

As Treasurer of the Irish Medical Organisation, and on behalf of my colleagues on the IMO Management Committee, I present my report and the Financial Statements of the Organisation for the year ended 31st December 2012.

As part of our programme of renewal for the IMO, we are committed to increasing the level of transparency provided about the management and financial position of the Organisation. In that spirit we have included additional information in these Financial Statements in respect of IMO subsidiary companies, IMO Financial Services and IMA Ltd, so as to be as transparent as possible in terms of reporting to members and to assure members of the financial stability of the Organisation for the future.

I am happy to report that, despite a difficult and challenging year financially for the Organisation, these Statements demonstrate that the IMO has a net value of €3,287,742 (31 December 2012).

There are two material items contained within these Financial Statements:

1. Settlement with Former Chief Executive

Following a comprehensive review - including detailed legal opinion - of the contractual entitlements of the former Chief Executive, the IMO was left with no option but to secure a settlement with the former Chief Executive. Following intensive negotiations we secured an agreement which reduced the Organisation's legal obligations by approximately 50%. Full details of this agreement, which was approved by both Council and the Management Committee, have been notified to members along with plans for dealing with the issues arising from the matter.

Within the context of this report I wish to detail the financial arrangements as they affect the Financial Statements for 2012. It was always our intention to reflect the full cost of the settlement in these financial statements so that the agreement was transparent to members and to demonstrate that, notwithstanding the significant obligations, the IMO remains in a position to continue operations and provide services to members. Critically, now that we have taken the full cost into our accounts we are in a position to assure members that no income from future membership subscriptions will be required to fund this agreement.

While the total cost of the Settlement Agreement amounts to €9.75m, €4.5m had already been set aside in Mr McNeice's pension plan so the balance of the exposure in present day values is €4,178m and the full amount is detailed within these accounts.

Critically, we have secured an agreement whereby, while accounting for all costs in these financial statements, over half of the liability will be paid in staged payments between 2016 and 2032 so as limit the impact on the the Organisation.

While the terms of this Settlement Agreement have been extremely controversial I can assure you that we, as your representatives, acted at all times in the best interests of the Organisation so as to assure it's future as a trade union representing the medical profession in these critical times

THE IRISH MEDICAL ORGANISATION

Treasurer's Report

2. Property Revaluation

A second significant issue impacting on these Financial Statements arises in respect of Property Valuations.

The IMO owns two properties at No 10 and No 11 Fitzwilliam Place. We considered it prudent in the context of preparing an accurate financial statement to have the properties re-valued at this time. Due to the economic circumstances, particularly as they affect property values, the revaluation has resulted in a drop in value of €2,994,365. The revaluation has also resulted in the elimination of the revaluation reserve of €1,321,379 which arose from an uplift on a previous revaluation. The properties are held by IMA Ltd, a wholly owned subsidiary of the IMO, and these financial statements reflect the full write down of the revaluation. However, it is important to state that while the write down is reflected in the overall value of the Organisation it does not impact on cash reserves or ongoing operations.

Conclusion

In financial terms this has been a difficult and challenging year for the Organisation however, after taking into account the two material items above, the IMO has a net value of €3,287,742 and is in a strong financial position to continue to represent members in what can only be described as a time of unprecedented attacks on the pay of doctors. This is your union and we are here to fight on your behalf and to ensure we have the resources to fight that fight for you and your patients.

Treasurer

Prof Sean Tierney

IRISH MEDICAL ORGANISATION
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Independent Auditors' Report to the Trustees of the Irish Medical Organisation

We have audited the financial statements of the Irish Medical Organisation for the year ended 31 December 2012 on pages 10-23, which comprise the Consolidated Income and Expenditure Account, the Consolidated Statement of Recognised Gains and Losses, the Consolidated Balance Sheet, the Consolidated Cashflow Statement and the related notes. These consolidated financial statements have been prepared under the accounting policies set out on page 14.

This report is made solely to the Trustees of the Organisation, as a body, in accordance with Section 11 of the Trade Unions Act 1871. Our audit work has been undertaken so that we might state to the Trustees those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Organisation and the Organisation's Trustees as a body, for our audit work, for this report, or for the opinions we have formed.

Respective Responsibilities of the Management Committee and the Auditors

The Management Committee of the Irish Medical Organisation is responsible for the preparation of the financial statements in accordance with applicable law and Generally Accepted Accounting Practice in Ireland including accounting standards issued by the Accounting Council as set on page 5 in the Statement of Management Committee's Responsibilities.

Our responsibility, as independent auditor, is to audit the consolidated financial statements in accordance with relevant legal and regulatory requirements and International Standards on Auditing (UK and Ireland).

We report to you our opinion as to whether the financial statements give a true and fair view and are properly prepared in accordance with the Trade Union Acts 1871 -1990 and all relevant legislation.

Our responsibilities do not extend to other information.

Basis of Audit Opinion

We conducted our audit in accordance with International Standards on Auditing (UK and Ireland) issued by the Financial Reporting Council. An audit includes examination, on a test basis, of evidence relevant to the amounts and disclosures in the financial statements. It also includes an assessment of the significant estimates and judgements made by the Management Committee in the preparation of the financial statements, and of whether the accounting policies are appropriate to the Organisation's circumstances, consistently applied and adequately disclosed.

We planned and performed our audit so as to obtain all the information and explanations which we considered necessary in order to provide us with sufficient evidence to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or other irregularity or error. In forming our opinion we also evaluated the overall adequacy of the presentation of information in the financial statements.

IRISH MEDICAL ORGANISATION
Ceardchumann Dochtúirí na hÉireann

Independent Auditors' Report to the Trustees of the Irish Medical Organisation

Opinion

In our opinion the financial statements give a true and fair view, in accordance with Generally Accepted Accounting Practice in Ireland, of the state of the Organisation's affairs as at 31 December 2012 and of its deficit for the year then ended and have been properly prepared in accordance with all legal requirements.

In our opinion, the information given in the Management Committee report is consistent with the financial statements.

Emphasis of Matter

In forming our opinion, which is not qualified, we have considered the adequacy of the disclosures made in note 1 of the financial statements concerning the organisation's ability to continue as a going concern. The organisation incurred a net deficit of €6,177,192 after taxation, due to exceptional items, during the year ended 31 December 2012. However, at that date, the organisation's total assets exceeded its current liabilities by €6,763,763 and exceeded its total liabilities by €3,287,742.

HSOC
Chartered Accountants
Registered Auditors
Dun Laoghaire
Co. Dublin

Date: 08 March 2013

IRISH MEDICAL ORGANISATION
Ceardchumann Dochtúirí na hÉireann

THE IRISH MEDICAL ORGANISATION

Consolidated Income and Expenditure Account For The Year Ended 31 December 2012

	Notes	Continuing Operations 2012 €	Continuing Operations 2011 €
Income	**2&3**	5,070,662	5,709,567
Expenditure	**Schedule 2**	(3,998,132)	(4,803,824)
Former CEO termination package	**4**	(4,178,711)	–
Property revaluation	**5**	(2,994,365)	–
(Deficit)/Surplus for the Year before Taxation	**6**	(6,100,546)	905,743
Taxation	**7**	(76,646)	(99,716)
(Deficit)/Surplus For The Year After Taxation		(6,177,192)	806,027

The accounting policies and notes on pages 14 to 23 form part of these financial statements.

The financial statements were approved and authorised for issue by the management committee on the 06 March 2013 and signed on its behalf by:

Paul McKeown. President

Dr Paul McKeown

Sean Tierney Treasurer

Prof Sean Tierney

IRISH MEDICAL ORGANISATION
Ceardchumann Dochtúirí na hÉireann

THE IRISH MEDICAL ORGANISATION

Consolidated Statement of Total Recognised Gains and Losses for the Year Ended 31 December 2012

	Notes	2012 €	2011 €
(Deficit)/Surplus For The Year After Taxation		(6,177,192)	806,027
(Reduction) in revaluation reserve on property valuation	**18**	(1,321,379)	–
Unrealised (loss) on investments		–	(159,701)
Total recognised (Deficit)/Surplus for the year		(7,498,571)	646,326

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THE IRISH MEDICAL ORGANISATION

Consolidated Balance Sheet as at 31 December 2012

	Notes	2012 €	2011 €
FIXED ASSETS			
Tangible Assets	**8**	3,824,291	8,167,626
Deposit with the Court of Justice	**9**	10,640	10,640
		3,834,931	8,178,266
FINANCIAL ASSETS			
Investments	**10**	803,170	355,735
		4,638,101	8,534,001
CURRENT ASSETS			
Debtors	**11**	457,887	581,167
Cash & Bank Balances	**12**	5,145,135	5,964,588
		5,603,022	6,545,755
CURRENT LIABILITIES			
Creditors (amounts falling due within one year)	**13**	(3,477,360)	(3,186,035)
NET CURRENT ASSETS		2,125,662	3,359,720
TOTAL ASSETS LESS CURRENT LIABILITIES		6,763,763	11,893,721
Creditors (amounts falling due after more than one year)	**14**	(3,476,021)	(1,107,408)
		3,287,742	10,786,313
FINANCED BY			
Accumulated Revenue Surplus	**17**	3,287,742	9,464,934
Revaluation Reserve	**18**	–	1,321,379
Members' Funds	**19**	3,287,742	10,786,313

The accounting policies and notes on pages 14 to 23 form part of these financial statements.

The financial statements were approved and authorised for issue by the management committee on the 06 March 2013 and signed on its behalf by:

Paul McKeown. President
Dr Paul McKeown

Sean Tierney Treasurer
Prof Sean Tierney

IRISH MEDICAL ORGANISATION
Ceardchumann Dochtúirí na hÉireann

THE IRISH MEDICAL ORGANISATION

Consolidated Cashflow Statement for the Year Ended 31 December 2012

	Notes	2012		2011	
		€	€	€	€
Reconciliation of Operating Profit to Net Cash (Outflow)/Inflow from Operating Activities					
Operating (deficit)/profit			(6,100,546)		905,743
Depreciation on tangible assets			288,061		299,429
(Profit)/Loss on disposal of tangible assets			–		(18,112)
Interest received			(120,353)		(71,457)
Interest paid			16,250		31,648
Reduction in property value			2,994,365		–
(Increase)/Decrease in debtors			123,280		(234,263)
Increase in creditors			2,999,955		173,386
Net cash inflow from operating activities			201,012		1,086,374
Taxation paid			(76,646)		(99,716)
Returns on Investment and Servicing of Finance					
Interest received		120,353		71,457	
Interest paid		(16,250)		(31,648)	
			104,103		39,809
Capital expenditure and financial investment					
Payments to acquire tangible assets		(277,019)		(191,424)	
Acquisition of investment bond and shares		(450,000)		–	
Receipts from sales of tangible assets and shares		19,114		39,674	
Net cash (outflow) for capital expenditure			(707,905)		(151,750)
Net cash (outflow)/ inflow before management of liquid resources and financing			(479,436)		874,717
Financing					
(Decrease) in Capital element of finance lease contracts			(33,478)		(35,936)
(Decrease)/Increase in Cash	**20**		(512,914)		838,781

IRISH MEDICAL ORGANISATION
Ceardchumann Dochtúirí na hÉireann

THE IRISH MEDICAL ORGANISATION

Accounting Policies for the Year Ended 31 December 2012

The significant accounting policies adopted by the organisation were as follows:

A. Basis of Accounting

The financial statements have been prepared on a going concern basis in accordance with the historical cost convention and financial reporting standards as prescribed by the Accounting Council as modified by the revaluation of certain fixed assets.

B. Basis of Consolidation

The financial statements reflect the results for the year and the financial position of the Organisation and its wholly owned subsidiary entities:

Fitzserv Consultants Limited t/a IMOFS	–	Financial Services Company
The Irish Medical Association Limited (A Company Limited by Guarantee and not having a Share Capital).	–	Property Holding Company

C. Subscriptions Received

Subscriptions received in the income and expenditure account are accounted for on a cash receipts basis, as adjusted for subscriptions received in advance.

D. Fixed Assets and Depreciation

Tangible fixed assets are stated at cost less depreciation with the exception of land and buildings which are stated at open market value based on an independent professional valuation.

Depreciation is calculated to write off the original cost less the expected residual value of the assets over their expected useful lives at the following annual rates:

Freehold Premises	2% Straight Line
Motor Vehicles	20% Straight Line
Fixtures and Fittings	10% Straight Line
Office Equipment	20% Straight Line

E. Leased Assets

The cost of fixed assets acquired under finance leases are included in fixed assets and written off over the term of the estimated useful life of those assets, while the capital portion of the outstanding lease obligations is included in creditors. The interest portion is written off to the income and expenditure account over the term of the primary lease period.

F. Taxation

Taxation is calculated on non-subscription income.

G. Financial Assets

Financial Assets are stated at cost or valuation. Provisions are made for financial assets which have suffered a permanent diminution in value.

H. Pensions

The organisation operates a defined contribution scheme. Payments are made to a pension trust, which is a separate legal entity from the organisation.

THE IRISH MEDICAL ORGANISATION

Notes to the Consolidated Financial Statements for the Year Ended 31 December 2012

1. Empahsis of Matter

As a result of the material items set out in Notes 4 & 5, the organisation incurred a deficit of €6,177,192 during the year ended 31 December 2012.

It is noted, that the long term liability as set out in Note 14 which represents the Deferred Pension Commitments for the former CEO has been fully provided for as at 31 December 2012, based on the latest actuarial valuations, and the organisation has significant cash balances of €4,910,530 at 31 December 2012. Further information about the former CEO's settlement is included in Notes 4, 13, 14, 15 and 21.

Management have considered the likely out-turn for the coming year and expect that 2013 will, in the absence of unforeseen material items, see a return to profitability, which is expected to continue for the foreseeable future, and accordingly have adopted the going concern basis of accounting.

2. Income

	2012	2011
	€	€
Membership Subscriptions	3,307,708	3,614,452
IMOFS sales	1,781,597	1,965,214
Rental Income	45,004	58,550
Publishing Royalties	(26,298)	15,324
Interest received	120,353	71,457
Investment surplus/(deficit)	(15,249)	(6,136)
Publishing Contribution (Schedule 1)	(142,453)	(9,294)
	5,070,662	5,709,567

3. Analysis of Members

	2012	2011
	No's	No's
General Practitioners	1,885	1,959
Consultants	696	705
Public Health Specialists	109	122
Community Health	54	51
Non Consultant Hospital Doctors	2,082	2,121
Other	32	33
Student	195	348
	5,053	5,339

4. Former CEO Settlement Agreement

A Settlement Agreement between the IMO and the former Chief Executive was reached during the financial year. Detailed legal advices were received by the Organisation in respect of the negotiations leading to the settlement. The Settlement Agreement provides for a termination payment of three year's salary payable on 31st March 2013 and a pension payment over a sixteen year period, commencing 2016.

	€	Present Value €
From 22 April 2016 to 21 April 2021 €200,000 Gross per annum	1,000,000	844,069
From 22 April 2021 to 21 April 2032 €250,000 Gross per annum	2,750,000	1,838,792
	3,750,000	2,682,861

In accordance with the provisions of FRS 17, Trident Consulting, Actuarial Consultants, have placed a Present Day Value on this obligation of €2,682,861. In coming to this value they have used a discount rate of 3%, based primarily on the iBoxx €Corporates AA 10+ index which was yielding 2.69% at 31 December 2012.

It should be noted that varying interest rates in future may necessitate an adjustment to this figure.

Accordingly a provision has been made in the accounts as follows:

	€
Termination payment – payable 31 March 2013	1,495,850
Deferred pension commitments (see note 14)	2,682,861
	4,178,711

5. Property Revaluation

Valuation of the premises at 10 & 11, Fitzwilliam Place was carried out by Kelly Walsh, (Property Advisors & Agents) on 10 December 2012. This valuation is below the cost price of the property and, accordingly, an amount of €2,994,365 has to be written against the reserves of the company.

In addition, the Revaluation reserve which had been created on an earlier uplift of property valuation has also had to be written off and this is reflected in the Consolidated Statement of Total Recognised Gains and Losses.

6. (Deficit)/Surplus for the Year

		2012 €	2011 €
(Deficit)/Surplus for the year is stated after charging:			
Auditors' Remuneration –	Audit services	35,463	35,393
	Non-audit services	42,171	40,259
	Taxation	–	–
	Other assurance	–	–
Depreciation		288,061	299,429
Loss/(Profit) on disposal of assets		–	(18,112)

7 Taxation

	2012 €	2011 €
Current Year Charge	76,646	99,716

The organisation is exempt from taxation on its trade union activities and subscription income. Taxation is based on its publishing and investing activities and the profits of its subsidiary Fitzserv Consultants Limited, which is liable under the Corporation Tax Acts.

Profits for Fitzserv Consultants Limited	429,761	582,194
Tax at standard Irish Corporation tax rate (12.5%)	53,720	72,774
Effects of:		
Depreciation addback	3,976	4,870
Capital allowances	(2,259)	(2,240)
Other tax adjustments	21,209	6,869
	76,646	82,273
Income tax IMO	–	17,443
	76,646	99,716

THE IRISH MEDICAL ORGANISATION

Notes to the Consolidated Financial Statements for the Year Ended 31 December 2012

8. Tangible Assets

	Freehold Premises €	Office Equipment €	Fixtures & Fittings €	Motor Vehicles €	Total €
Cost:/Valuation					
At 1 January 2012	8,300,000	392,677	104,897	308,739	9,106,313
Additions	202,795	5,014	14,392	54,818	277,019
Disposals	–	-	(2,372)	(24,300)	(26,672)
Revaluation	(4,983,795)	–	–	–	(4,983,795)
At 31 December 2012	3,519,000	397,691	116,917	339,257	4,372,865
Depreciation:					
At 1 January 2012	498,702	273,123	83,796	83,066	938,687
Charge for Year	170,056	40,575	10,808	66,622	288,061
Disposals	–	–	(1,177)	(8,239)	(9,416)
Revaluation	(668,758)	–	–	–	(668,758)
At 31 December 2012	-	313,698	93,427	141,449	548,574
Net book value at 31 December 2012	3,519,000	83,993	23,490	197,808	3,824,291
Net book value at 31 December 2011	7,801,298	119,554	21,101	225,673	8,167,626

Valuation of the premises at 10 & 11, Fitzwilliam Place was carried out by Kelly Walsh, (Property Advisors & Agents) on 10 December 2012.

Included in the above at the balance sheet date were assets held under finance leases and hire purchase agreements as follows:

Net book value	2012 €	2011 €
Motor Vehicles	54,967	85,103
Office Equipment	763	1,907
	55,730	87,010

Depreciation charged to the Income and Expenditure Account in relation to the above was:

Motor Vehicles	30,136	30,136
Office Equipment	1,144	1,144

THE IRISH MEDICAL ORGANISATION

Notes to the Consolidated Financial Statements for the Year Ended 31 December 2012

9. Deposit with The Court of Justice

The deposit with the Court of Justice under the Trade Union Act, 1941 is invested in a fund called the BIAM GRU cash fund strategy.

10. Investments

	2012	2011
	€	€
Listed Investments at Market Value	262,891	243,035
Unlisted investments at Market value	–	22,421
Investment Bond at cost	450,000	–
	712,891	265,456
Other Investments at Cost	90,279	90,279
	803,170	355,735

Unlisted investments related to a Property fund which has been wound up.

The Investment Bond was purchased in December 2012 and there is no material difference between the cost price and valuation at 31 December 2012.

11. Debtors

	2012	2011
	€	€
Trade debtors	214,804	219,178
Other debtors	120,759	118,914
Prepayments	122,324	243,075
	457,887	581,167

12. Cash at bank and in hand

	2012	2011
	€	€
Own funds	4,910,530	5,581,223
IMOFS Client funds	234,605	383,365
	5,145,135	5,964,588

THE IRISH MEDICAL ORGANISATION

Notes to the Consolidated Financial Statements for the Year Ended 31 December 2012

13. Creditors (amounts falling due within one year)

	2012	2011
	€	€
Creditors and Accruals	1,749,414	2,760,625
IMOFS Client funds	234,605	383,365
Gross Termination payment for CEO	1,477,065	–
Bank overdraft	5,882	12,421
Lease and Hire Purchase Finance	10,394	29,624
	3,477,360	3,186,035

Creditors and accruals include the following outstanding taxes

	2012	2011
	€	€
PAYE/PRSI	66,110	68,345
VAT	2,389	–
Income tax	–	17,443
Corporation tax	–	9,098
	68,499	94,886

14. Creditors (amounts falling due after more than one year)

	2012	2011
	€	€
Bank loans	787,977	1,087,977
Deferred Pension Commitments	2,682,861	–
Lease and Hire Purchase Finance	5,183	19,431
	3,476,021	1,107,408

Analysis of Bank loans

	2012	2011
	€	€
Wholly repayable within five years	787,977	1,087,977

Bank loans are secured by legal charges over properties at 10 & 11, Fitzwilliam Place, Dublin 2 vesting in the name of Cumann Doctuiri na hEireann, The Irish Medical Association Limited.

THE IRISH MEDICAL ORGANISATION

Notes to the Consolidated Financial Statements for the Year Ended 31 December 2012

14. Creditors (amounts falling due after more than one year) (Contd)

Analysis of Deferred Pension commitments	Actual €	Present Value €
In more than two years but not more than five years	350,000	309,710
In more than five years but not more than ten years	1,087,500	868,314
In more than ten years but not more than fifteen years	1,250,000	864,254
In more than fifteen years but not more than twenty years	1,062,500	640,583
	3,750,000	2,682,861

Analysis of Leases and Hire Purchase	2012 €	2011 €
Wholly repayable within five years	15,577	49,055
Included in current liabilities	(10,394)	(29,624)
	5,183	19,431

Lease and Hire Purchase maturity analysis		
In more than one year but not more than two years	5,183	19,431
In more than two years but not more than five years	-	-
	5,183	19,431

15. Staff Pension Scheme

The organisation currently operates a Defined Contribution pension scheme in respect of its employees. The assets of the scheme are held separately from those of the organisation in an independently administered fund. Contributions within the year amounted to €310,236 of which €1,612 was unpaid at the year-end.

As set out in Note 4, as part of the Settlement Agreement for the former Chief Executive has an entitlement to a total pension fund of €4.5m as at 31 March 2013. As at 31 December 2012, the fund requires an additional €50,000 and this has been provided for in full at the balance sheet date.

16. Staff Numbers and Costs

The average number of persons employed by the organisation during the year was as follows:

	2012 No's	2011 No's
Total Employees	34	33
Analysed as follows:		
Directors	5	4
Trade Union administration	23	23
Financial Services sales & administration	6	6
	34	33

The aggregate payroll costs of these persons were as follows:	2012 €	2011 €
Directors remuneration and fees	139,000	158,577
Directors Pension Costs	18,000	18,000
Wages and Salaries	1,776,119	2,013,788
Social Welfare Costs	214,118	191,548
Other Pension Costs	292,236	370,175
	2,439,473	2,752,088

17. Movement in Revenue Reserves

	2012 €	2011 €
Reserves at start of year	9,464,934	8,817,693
Retained (deficit)/surplus for year	(6,177,192)	647,241
Reserves at end of year	3,287,742	9,464,934

18. Revaluation reserve

	2012 €	2011 €
Reserve at start of year	1,321,379	1,322,294
Revaluation during year	(1,321,379)	(915)
Reserve at end of year	–	1,321,379

THE IRISH MEDICAL ORGANISATION

Notes to the Consolidated Financial Statements for the Year Ended 31 December 2012

19. Reconciliation of Movement in Members' Funds

	2012	2011
	€	€
Total recognised (Deficit)/Surplus For The Year	(7,498,571)	646,326
Members' Funds at Start of Year	10,786,313	10,139,987
Members' Funds at End of Year	3,287,742	10,786,313

20. Analysis of Net Funds

	1 January 2012	Cashflow	31 December 2012
	€	€	€
Net Cash:			
Cash at bank in and hand	5,964,588	(819,453)	5,145,135
Overdrafts and Loans	(1,100,398)	306,539	(793,859)
	4,864,190	(512,914)	4,351,276

21. Related Party Transaction

Included in Legal fees is an amount of €20,603 including VAT paid to the legal representatives of the former CEO, Mr George McNeice, under the terms of the settlement agreement.

22. Comparative Figures

Where necessary comparative figures have been regrouped on a basis consistent with the current year.

23. Approval of the Financial Statements

The financial statements were approved by the Management Committee on the 06 March 2013.

IRISH MEDICAL ORGANISATION
Ceardchumann Dochtúirí na hÉireann

THE IRISH MEDICAL ORGANISATION

Management Information for the Year Ended 31 December 2012

SCHEDULE 1

Publishing Contribution	**2012** **€**	**2011** **€**
Income	128,729	122,207
Printing and Editorial Costs	(54,828)	(68,254)
Wages	(32,458)	(32,458)
Postage and Stationery	(31,896)	(30,789)
Write off uncollectable income	(152,000)	–
Publishing Contribution	(142,453)	(9,294)

(This page does not form part of the audited financial statements.)

IRISH MEDICAL ORGANISATION
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THE IRISH MEDICAL ORGANISATION

Year Ended 31 December 2012
Management Information

SCHEDULE 2	IMO	Fitzserv t/a IMOFS	IMA	Total 2012	Total 2011
	€	€	€	€	€
INCOME					
Subscriptions	3,307,708			3,307,708	3,614,452
IMOFS sales		1,781,597		1,781,597	1,965,214
Rental Income	170,004			170,004	183,550
(Less) Rent from IMOFS	(125,000)			(125,000)	(125,000)
Publishing Royalties	(26,298)			(26,298)	15,324
Interest Received	48,691	71,662		120,353	71,457
Investment income	1,400	(17,249)	600	(15,249)	(6,136)
Publishing Contribution	(142,453)			(142,453)	(9,294)
	3,234,052	1,836,010	600	5,070,662	5,709,567
EXPENDITURE					
Wages and salaries	1,445,681	297,980		1,743,661	1,981,330
Employers PRSI	180,299	33,819		214,118	191,548
Staff Pensions	275,345	16,891		292,236	370,175
Directors remuneration		139,000		139,000	158,577
Directors Pension		18,000		18,000	18,000
Staff training and development	8,245	2,215		10,460	2,799
Rates	29,057	3,084		32,141	28,982
Light and heat	22,019	8,245		30,264	31,186
Insurance	15,659	16,841		32,500	31,830
Repairs and maintenance	59,607	8,655		68,262	65,119
Printing, Postage & Stationery	121,100	40,237		161,337	152,073
Advertising	5,476	44,121		49,597	89,501
Telephone	25,671	13,676		39,347	48,770
Computerisation	120,159	192,090		312,249	334,224
Travel and branch meeting expenses	139,571	40,871		180,442	218,214
International affairs	78,653			78,653	80,863
Professional fees	101,291	315,530		416,821	245,461
Legal fees	(431,064)	21,248		(409,816)	138,550
Audit	18,450	12,708	4,305	35,463	35,393
Accountancy	25,227	16,944		42,171	40,259
Bank charges	8,386	860		9,246	10,574
Corporate Events	82,503			82,503	111,221
Strategic planning and restructuring	73,800			73,800	63,692
Subscriptions and donations	36,670	4,696		41,366	42,518
Depreciation	256,256	31,805		288,061	299,429
(Profit) on Disposal Fixed Assets	0			0	(18,112)
Lease interest	3,330	1,733		5,063	6,332
Loan Interest	11,187			11,187	25,316
	2,712,578	1,281,249	4,305	3,998,132	4,803,824

(This page does not form part of the audited financial statements)

IRISH MEDICAL ORGANISATION
Ceardchumann Dochtúirí na hÉireann

THE IRISH MEDICAL ORGANISATION

Summary Balance Sheet as at 31 December 2012

	2012 €	2011 €
FIXED ASSETS		
Tangible Assets	260,814	293,783
Deposit with the Court of Justice	10,640	10,640
	271,454	304,423
FINANCIAL ASSETS		
Investments	91,562	91,562
	363,016	395,985
CURRENT ASSETS		
Debtors	2,835,841	5,767,882
Cash & Bank Balances	2,009,599	2,427,987
	4,845,440	8,195,869
CURRENT LIABILITIES		
Creditors (amounts falling due within one year)	(3,119,460)	(2,613,858)
NET CURRENT ASSETS	1,725,980	5,582,011
TOTAL ASSETS LESS CURRENT LIABILITIES	2,088,996	5,977,996
Creditors (amounts falling due after more than one year)	(2,688,044)	(16,820)
	(599,048)	5,961,176
FINANCED BY		
Accumulated Revenue (Deficit)/Surplus	(599,048)	5,961,176
Members' (Deficit)/Funds	(599,048)	5,961,176

(This page does not form part of the audited financial statements.)

IRISH MEDICAL ORGANISATION
Ceardchumann Dochtúirí na hÉireann

FITZSERV CONSULTANTS LIMITED T/A IMOFS

Summary Balance Sheet as at 31 December 2012

	2012 €	2011 €
FIXED ASSETS		
Tangible Assets	44,477	70,173
Investments	694,353	246,785
	738,830	316,958
CURRENT ASSETS		
Debtors	360,593	335,521
Cash & Bank Balances	2,900,931	3,154,236
Client Bank account balances	234,605	382,365
	3,496,129	3,872,122
CURRENT LIABILITIES		
Creditors (amounts falling due within one year)	(112,281)	(269,146)
Client Premium amounts due	(234,605)	(382,365)
NET CURRENT ASSETS	3,149,243	3,220,611
TOTAL ASSETS LESS CURRENT LIABILITIES	3,888,073	3,537,569
Creditors (amounts falling due after more than one year)	–	(2,611)
	3,888,073	3,534,958
CAPITAL & RESERVES:		
Share capital	1,283	1,283
Profit and loss account	3,886,790	3,533,675
Shareholders' funds	3,888,073	3,534,958

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IRISH MEDICAL ORGANISATION
Ceardchumann Dochtúirí na hÉireann

THE IRISH MEDICAL ASSOCIATION LIMITED

(A Company Limited by Guarantee and not having a Share Capital)

Summary Balance Sheet as at 31 December 2012

	2012 €	2011 €
FIXED ASSETS		
Tangible Assets	3,519,000	7,803,670
Investments	18,537	18,671
	3,537,537	7,822,341
CURRENT LIABILITIES		
Creditors (amounts falling due within one year)	(5,777,547)	(5,442,902)
NET CURRENT (LIABILITIES)	(5,777,547)	(5,442,902)
TOTAL ASSETS LESS CURRENT LIABILITIES	(2,240,010)	2,379,439
Creditors (amounts falling due after more than one year)	(787,977)	(1,087,977)
	(3,027,987)	1,291,462
CAPITAL & RESERVES:		
Revaluation reserve	–	1,321,379
Profit and loss account	(3,027,987)	(29,917)
Members (Deficit)/Funds	(3,027,987)	1,291,462

(This page does not form part of the audited financial statements.)

IRISH MEDICAL ORGANISATION
Ceardchumann Dochtúirí na hÉireann

Notes

IRISH MEDICAL ORGANISATION
Ceardchumann Dochtúirí na hÉireann

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Notes

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IRISH MEDICAL ORGANISATION
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