IRISH MEDICAL ORGANISATION
Ceardchumann Dochtúirí na hÉireann

AGM 2011 Report

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Report of the Irish Medical Organisation

Annual General Meeting,

28th-30th April 2011

CONTENTS

Prof Seán Tierney, Outgoing President

In one way it seems like such a short time ago since, at last years AGM, I asked the question "What is the IMO for?"

During the past year, I got not one answer, but thousands. For every one of the 6,500 members of the IMO, the answer is a little different. The IMO is a diverse group but there was one thing that almost all those thousands agree on. They agree that it is more important now than ever before that doctors, who work together in their professional roles every day, must also work together to ensure that there is a single coherent voice that represents the whole breadth of the profession. On the most crucial issues that face us as a profession, a cacophony of thousands of voices is simply noise and their message will not be heard. But one voice - thousands of times louder – cannot be ignored. That voice – the single united voice of Irish doctors – is the voice of the IMO.

We have a responsibility to use that voice constructively. Of course, doctors make their living from heathcare and collective bargaining with the government as an employer or contracting body is an important part of what we do. But it is not all that we do – doctors are a group of professionals who get a lot of satisfaction from being able to do our job properly and we do have a unique perspective on health issues that could help better inform the decisions of government. In fulfilling our responsibility, we have consistently put forward proposals of our own for patient-centred change and meaningful reform in how healthcare is delivered in Ireland. This can be seen in our many publications and position papers which have been thoroughly researched and written by experts in our own organisation working with the research and policy unit which has done an outstanding job once again this year. Let me take a few moments to outline some of the ways the IMO has used that voice to speak on your behalf since last year's AGM .

At that meeting, we published our principles of Universal Health Coverage which form the foundation of our ongoing contributions to the debate on this crucial area of health reform. This is a complex issue and we are fortunate in having an incoming president who is particularly well equipped to lead our contribution to the debate which will surely intensify in the next year – indeed we will host a debate on aspects of the Dutch Health system during this years AGM. We have also used the last year to build on our relationship with BMA (NI). We put together a joint policy paper on obesity which was presented to the Irish MEPs in Brussels last July. Since then we have started work on a new joint policy paper on the issue of health inequalities – an ever more important topic in the context of economic recession and ever more aggressive fiscal austerity.

We held the inaugural IMO student debate as part of the Doolin meeting. Students are the future of our organisation and the debate was a tremendously successful way of engaging the entire student body and one on which we hope to build on in coming years.

Former president of the IMO, Prof. Cillian Twomey, in his Doolin lecture set out a new narrative for the history of the Irish health service. A confrontational approach to public sector reform that blames, and even demonises, doctors and public servants is neither acceptable nor is it a recipe for solving problems. In reality, some of the greatest advocates for public sector reform are those working within it.

Prof Seán Tierney, Outgoing President

Cillian advocated for a collaborative approach that is based on mutual respect and the IMO believes this to be essential if we are to see meaningful public sector reform. In February, during the general election campaign, we collaborated with the Irish Dental Association and The Irish Pharmacy Union to host a successful health hustings where all the party spokespeople on health were invited to expand on their health proposals to the organisations and where we set out our offer to contribute to health reform. During the year the IMO signed the European Road Safety Charter and then won an award from the charter from among 700 other organisations for the effectiveness of our campaign.

A campaign to improve road safety built here at the AGM year after year in our motions and debates. Following on a commitment at last year's AGM, we held a national meeting of long service and non-EU doctors to help distil their diverse concerns into a single action plan. These are a group who have been particularly poorly treated by the health service in recent years and the effects of this are now being seen in the difficulties in filling NCHD posts around the country. There may be as many as 450 vacant posts come the beginning of July. The IMO lobbied successfully to have the changes in VISA and immigration requirements that made life so difficult for non-EU doctors reversed. We continue to lobby both the HSE and the Medical Council to recognise the crucial role that these doctors fulfil in our health system.

The IMO has been the only trade union representing doctors at the "Croke Park" Public Service agreement talks and the Chief Executive will brief us all on the considerable progress that has been made in that process tomorrow in his keynote address. We recently produced an updated position paper on Mental Health reviewing what progress has been made since "A Vision for Change" and setting out what the next priorities should be. Finally, we also made a pre-budget submission to the Department of Finance – a budget that was sadly overshadowed by the arrival of the IMF and EU. Our submission advocated a priority based approach to reducing spending where this could not be avoided. Our key recommendations included the prioritisation of prevention and chronic disease management; the implementation of a generic medicine policy; the completion of the Vision for Change strategy in Mental Health; and the ongoing requirement for acute hospital capacity.

The HSE clinical programmes under the leadership of Dr. Barry White has ensured that funding for prevention and chronic disease management will be preserved or enhanced. Indeed, if the proposed efficiencies in acute bed hospital usage can be realised, we may even get the equivalent of at least some of 1,000 beds back into the system. Finally, we called for ill conceived co-location plan to be abandoned – another proposal of ours that has finally been heeded although not before millions of euro and nearly 5 years of planning has been wasted. So it has been a busy year for everyone. None of this would have been possible without the leadership and the stewardship of the CEO, Mr George McNeice.

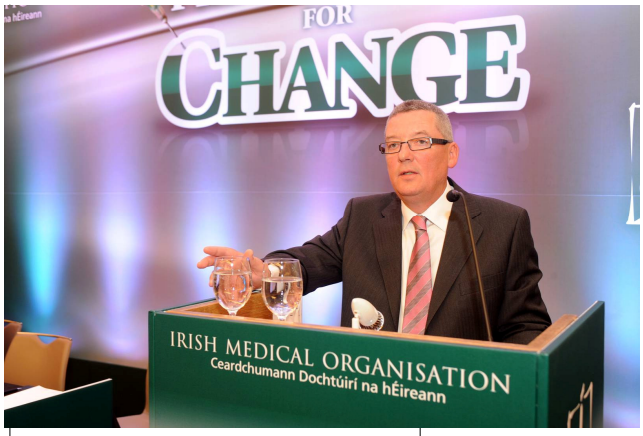
I am personally grateful to George for his support of my presidency during the last year. We are also extremely fortunate to have a strong, effective and cohesive senior management team including; our director of Finance, Ms Susan Clyne: our director of communications, Ms Maria Murphy and our director of Industrial relations. I would like to take this opportunity to welcome our new director - Mr Myles McPartland -who is attending his first ever AGM. I hope the AGM lives up to its reputation. Indeed, we now have a very strong IR team as Myles is supported by two assistant directors Ms Shirley Coulter and Mr Eric Young and a strong team of case officers who grow ever busier. Indeed, the senior management team leads a staff that is capable and motivated. It has been my great pleasure to work alongside and to get to know many of these over the past few years and we are indeed fortunate to have such a well trained and effective staff. On your behalf, I would also like to recognise the contribution of the trustees, my fellow honorary officers, the members of Council, management committee, and the various craft groups committees and, of course those who have chaired those committees.

Chief among those is Dr Ronan Boland who has served as Vice President while also chairing the GP committee and has had a particularly busy year. I wish him continued success and a productive year as President. I also wish I could tell Ronan honestly that the worst is behind him! Last year when Dr. John Morris hung the presidential chain across my shoulders, he told me that he was off to Chad. "It will be no bother" he said. I thought he was reassuring me about the year as president – I now realise that he meant that, after his year as president, six months in Chad would be a walk in the park.

It has been an exhilarating year for me personally and I would like to thank all of you for your support of the IMO and for the extraordinary number of you who have taken the time to express your support to me during the year. I would also like to thank those who took the trouble to point out what I got wrong – where would we be without constructive criticism!

Now, it is with great delight that I invite Dr Ronan Boland to step forward and accept the chain of office of President of the IMO for the coming year.

Mr George McNeice, Chief Executive



To open my remarks I want to say how heartening it has been to meet with members this weekend and how encouraging it is to see the enthusiasm and energy of everyone

who is attending this AGM and I want to thank all of you for taking the time out of your very busy schedules to join us at this very important meeting. These are difficult times for Ireland, for doctors and for their patients. We are meeting at a time of real crisis. As the only Trade Union to represent doctors across the Irish Health services, it has never been so important – both for our members and for the wider community - that we: engage in the debates that are taking place all around us. agree on our policies and priorities and renew our commitment to working together to promote the needs of our patients, our communities and our fellow profesionals.

I am pleased to note that the new Minister for Health, Dr. James Reilly TD will be visiting us later this afternoon. Of course the Minister is no stranger to IMO Conferences and I trust he will enjoy his time in Kerry. I know he can draw on his own experience of Irish healthcare but it is really important that he also takes time to listen to the experiences of everyone attending this weekend. I hope he will reflect on those experiences when he returns to Hawkins House as he prepares for the significant challenges ahead. When I was preparing my remarks for this AGM, I looked back for a moment at the speech which I made to this meeting a year ago. Unfortunately all the fears that I expressed then – for our economy , for our health services and for our society have been realised in the twelve months since we last met.

Twelve months ago I spoke of an "unprecedented decline in our economy" and the fact that as a country we were "facing a very grim economic and fiscal situation". Of course, while we knew then that matters were very, very serious, we hadn't yet been made aware of the full scale of the crisis that was emerging in our public finances and in our banking sector.

The past twelve months have been truly shocking for this country in so many ways.

In December last we faced the humiliation of having to admit our failure to manage our own financial affairs and having to ask for the support of the international community to help us finance this country's basic needs for the coming years. And in the weeks and months since we've seen the consequences of that failure; a budget of unprecedented hardship and deeper austerity measures, a bail-out package that will saddle our generation and the next with huge levels of debt the tragic irony of billions of euro being thrown into a black hole to keep our banks afloat – money that we need if we are to educate our children, treat our sick and care for the most vulnerable in society

And, as pressures grow... wages fall ....and taxation rises, public and private sector workers are being pitted against each other by those same people who told us that the market would provide for all... that the economy would grow forever.... and that competition – rather than solidarity – was the mark of a man. What we need to do is to pull together. But some want to pursue a "divide and conquer" approach rather than the "unite and lead" approach we need.

In the last few weeks, we've seen a wave of ungrounded and inflammatory criticisms of public servants in general and the Croke Park Agreement in particular. Of course, we've seen this before; a concerted effort to ignore the progress being made and the millions being saved through a properly negotiated agreement in favour of populist criticisms that only serve to threaten and divide. Do these people not know that threats are a sign of weakness not strength? It is clear now that we are facing years of hardship as a country. And the impact of that hardship will be felt most by those who can least afford it – including those who rely on essential public services like health care.

Our members, who have dedicated their lives to the health services, know full well the trauma that will be caused to our patients and across communities by this financial crisis. We know full well the health problems that will face individuals and families when jobs are lost, debts increase and stress levels rise. We know better than anyone how the damage in terms of human misery and social upheaval will worsen as our economy weakens. And we also

Mr George McNeice, Chief Executive

know that the ability of healthcare professionals to deal with these problems is itself under unprecedented strain as a result of the same financial pressures.

Those pressures will impact on the health service in many ways as staff numbers decline, beds are closed and services are withdrawn; We will find it harder and harder to treat patients ; Even those that require urgent treatment, will face longer and longer delays There will be more "burden sharing" - not between banks and their bondholders - but between health services and the impoverished patient, and there will be more stress for those on the front lines….not least the stress of not being able to do their job as properly and as effectively as they'd like to.

Nobody who works in the health professions can deny that providing those health services is an increasingly costly business. Some of those rising costs, of course, are as a result of tremendous advances in medical science and practice which are transforming treatments and lives. But there is no denying that modern medicine is hugely demanding in terms of manpower, equipment and facilities. We in the IMO are realists.

And we accept that in these difficult times, we must make difficult decisions and we must share the burden of reducing costs and increasing efficiency. Our theme at this conference is Prescription for Change and it underscores our willingness and our appetite to be constructive in meeting the challenges ahead.

We know better than anyone that change is necessary in the health service. And we will not shirk our responsibility – in fact we will embrace it as we have always done.In rising to that challenge, we have invested in an IMO study of General Practice and later tonight, we will unveil a major new document setting out an optimal business model for General Practice in Ireland today. It is a result of intensive analysis and debate about the challenges facing modern General Practice and how it can better serve the needs of the community. We have also undertaken a review of how our own organisation does its business and in the coming weeks we will unveil our Strategic Plan for the IMO for the next three years. This will set out our priorities for the months and years ahead.

These developments reflect our members' hunger and desire to contribute to the change agenda in a real, meaningful and positive way. We are stepping up to the plate to offer our thoughts... our experience ....and our hopes.... to claim our rightful place as partners in the change agenda.

What we ask in return is that our members are treated fairly and with respect …..and that we are listened to. We don't expect that all our views will be accepted. But we do expect that they will be heard and considered. But the debate about our health services cannot be reduced to a simple financial argument. Organising itself to look after it's sick... it's handicapped...it's newborn and it's elderly is one of the most basic functions of a civilised society ….something which can't simply be measured in "euros" or "cents".

As a civilised society, we invest in health care because it is right that we do so. And money spent on health services is not lost. It is an investment by the community in the community….an investment in returning a parent to their children….or a productive adult to the workforce… or a healthy grandparent to their family… and it is invested to empower a disabled person or to support and comfort a dying person or to save a child's life. We must never lose sight of that. And money invested in the health services increasingly feeds into the broader national economic mix. It is paid to ordinary men and women working up and down this country…paying their taxes and spending their earnings in their local communities … supporting local economic activity and returning more and more money to the exchequer as a result.

And it is paid to small businesses providing services the length and breadth of the country that provide employment to thousands of people who also pay taxes and salaries and support their local economies. We've got to stop people describing the health services as a cost and recognise it as an important economic activity and an investment in our shared future. Of course there has been one significant change since we last met in Conference and that has been the election of a new Government. I know that the new Minister has strong views on the health services and a clear vision on how it should evolve over the coming years. This isn't the first time we've encountered a Minister with strong views and it won't be the last!

For our part, we wish Minister Reilly and the new Government well. They have major challenges on many fronts and health is clearly one of them.

Inevitably we will have differences with both the new Minister and the new Government. It would be odd if it were otherwise. But I hope that both sides can agree on some matters. I hope for example that we can both agree on the importance of mutual respect in the dealings be-

tween the Department of Health and the HSE on the one hand and the medical professionals on the other. Respect should be something we can all take for granted but it's been sorely absent in our experience over recent years. Where has the respect been, for example, in the way the HSE has treated Non Consultant Hospital Doctors where we've had to fight on their behalf to secure the most basic entitlements under the contract such as payment for ALL hours worked and the right to annual leave. And where has the respect been in the failure to recognise the vital work undertaken by our public health and community doctors.

And I hope that both sides can agree on the importance of honesty in our relationship – again a quality that has been sorely missed over the past number of years. Where, for example, has the honesty been in the HSE's attempt to blacken the reputation of Hospital Consultants by using a flawed and biased analysis of the mix between public and private work being undertaken by members across the country. Or where has the honesty been in dressing up local ad hoc committees of GPs as Primary Care Teams when they are nothing of the sort. And I hope we can agree on the need for realism in our discussions; the need, for example, to understand that you can't build a strong health system on a weak foundation of poor morale and vanishing personnel.

We're facing into some monumental challenges in the coming years which will demand hard work and sacrifice from all sides. The IMO demands a working relationship with the new Government that is based on these principles of mutual respect, honesty and realism – and we offer the same in return. Perhaps the biggest challenge in the coming years will be working with the new Government on their proposals to move towards Universal Health Coverage.

There is much to admire in this system. But no system is without flaws and the Government needs to be more open about the complexity involved in this move and the national and personal financial implications of going down this route. I have three particular concerns I want to raise today.

Firstly – not enough has been done to ensure public support for the programme the Government wishes to embark upon.

Surely one of the key lessons of the past decade has been the need not just for a vision .... but to ensure that you can bring the public with you. Remember the HSE has been in existence for a shorter time than the new Government estimate it will take to deliver the Universal Health model – and people have already lost patience with the HSE.

And the debate about financing the service has ignored some home truths. For example, what politician has stood up to acknowledge that whatever system we choose has still got to find broadly the same amount of money from the same small economy to finance a broadly similar health budget to the one we currently have? Some people talk about a system of Universal Health as if it's a pain-free way to finance the health services.

Unfortunately, it's not.

We have seen the dangers of this type of approach to change management in the British Government's attempts to set out a reform agenda in the NHS.

Precisely because the Minister closed his ears to the healthcare professionals in the NHS who deliver the service, the reforms ran into the sand. Now the process has had to be stalled while consultations finally get underway and the Prime Minister himself has had to get involved in trying to get the process back on track. Policymakers in this country should heed that lesson and invest now in the consultations which could save much time, effort and money later in the process.

My second concern is whether the Government is being realistic about the timelines that are being set out? I don' believe that they are. For example, the new Government has indicated that it wishes to end fees for GP services as a priority yet the system is simply not ready for such a move.

The existing financial model for most GP practices is woefully overstretched with many struggling to make ends meet as the gap between demands and resources increases. Yet the new Government thinks it can reduce GP charges. But where is the analysis to back up such claims?

"I HOPE FOR EXAMPLE THAT WE CAN BOTH AGREE ON THE IMPORTANCE OF MUTUAL RESPECT IN THE DEALINGS BETWEEN THE DEPARTMENT OF HEALTH AND THE HSE ON THE ONE HAND AND THE MEDICAL PROFESSIONALS ON THE OTHER. RESPECT SHOULD BE SOMETHING WE CAN ALL TAKE FOR GRANTED BUT IT'S BEEN SORELY ABSENT IN OUR EXPERIENCE OVER RECENT YEARS."

Finally - have we properly thought through the challenges of creating a functioning, competitive insurance market in this small country?

Our experience of insurance competition in the health market has been decidedly mixed to date and our recent record on managing and regulating financial institutions does not particularly inspire confidence. So let's understand the need for caution with a model which relies so much on a competitively functioning insurance market. The big question of course is what do we want to see at the heart of a system of Uni-

Mr George McNeice, Chief Executive

versal Health ? The IMO has already spent a lot of time and resources exploring this agenda and only the IMO has put forward an unambiguous set of principles which must underpin the health services in the years ahead.

There are seven key principles are.

First - Universality and Equity of access Which means that all citizens are entitled to medically necessary care including hospital, GP services, community and long term care services and that access to such services is based only on medical need.

Second - A Health service that is based on solidarity and that is free at the point of access All citizens, not just medical card holders, should be entitled to medically necessary healthcare that is free at the point of access. Any universal health care system requires social solidarity and the State must provide a safety net so that the healthcare is in relative terms affordable to all income groups.

Third - Transparency and Choice Citizens should be able to see clearly what they are paying towards healthcare and what they are receiving in return and the patients must be allowed to choose their GP, their consultant and their hospital.

Fourth - Quality of care and value for money Quality of care must be the cornerstone of health service provision regardless of whether providers are public, voluntary, not for profit or private.

Fifth - Clinical autonomy Doctors must be free to diagnose and treat patients without interference from political or commercial interests. Doctors must also remain free to advocate for services on behalf of patients.

Sixth - Efficiency and affordability The management and flow of funds must be carried out efficiently and in the purchasing or provision of services the money must follow the patient.

Seventh – Sustainability The system must be flexible enough to cope with an ageing population, future trends in health care provision, increasing patient expectations and rapidly changing technology and treatment options.

These are the key principles which must underpin patient centred reform. If reform is worth doing, it's worth doing properly. So let's make sure we get it right.

I want to say a few words about the more immediate agenda of transformation in the health services which is anchored in the Croke Park Agreement. As I've already noted, the Croke Park Agreement has been consistently attacked by those who believe that market forces are the solution. Partnership... solidarity... fairness... and integrity are not dirty words. They are key principles by which Ireland was once governed and they are core principles on which our recovery must be based. Many of the critics of Croke Park are ideologically driven and made by people who can't seem to accept that something worthwhile can be achieved by agreement rather than force.

Even the IMF have recognised the values of the Croke Park Agreement in addressing the public sector finances in a way that the population can sustain. Of course some of those critics were equally loud in championing light touch regulation in the banking sector and the sell-off of state assets like Eircom.

What does it take to make these people humble? We in the IMO remain absolutely committed to the principles set out in the Croke Park agreement. We believe it is critical to achieving reform in the way our public services operate in the short and medium term and is particularly important in terms of healthcare reform. In terms of the pace of change delivered by the Agreement, there is an onus on all sides – particularly the Government – to move this forward as rapidly as possible. But some of the criticisms about the pace of change are unfair and misguided. Conservatively the Agreement has already contributed over €350 million in savings in the running costs of the public sector without dispute. This is important to acknowledge.

But real change does take time and unless we want to write off the next few years to dispute and chaos, the Agreement must be made to work. It would be welcome if the new Government stopped criticising and started encouraging people to implement the changes. For our part, the Agreement has great potential to support the transformation programme in the health services.

Our objective is to ensure that Doctors are at the very heart of the transformation process and that the process can achieve real change that means a better service to patients. The Croke Park Agreement is capable of achieving that and we will continue to defend it on that basis.

I would like now to turn to matters that will be our focus in the coming year. First and foremost, the IMO is a trade union; the only Trade Union with a mandate to represent Doctors across the Health Services…. and protecting the position of our members will always be uppermost in our minds.

During the past year we have revamped our industrial relations unit to enable us to respond more quickly and flexibly to members' needs across the country. We will continue

to prioritise this member service in the months ahead.

Since last year's AGM, we have spent a lot of time meeting with members across the county and reviewing our strategy and our priorities.

In the coming weeks we will unveil a new Three Year Strategic Plan in which we will prioritise the following: the need for a coordinated response to the crisis in manpower across all specialties, preparations for complex contract negotiations, resisting attempts to de-professionalise the health services and ensuring that the regulatory framework for the practice of medicine is grounded in realism.

More generally we will also seek to represent members' shared interests. There are three critical issues that are common for all doctors. The first is the growing manpower crisis in the profession. We're seeing shortages amongst all levels; GPs, Public Health and Community Doctors, NCHDs and Consultants.

This problem is multi-dimensional; Morale is now at rock bottom across the profession. Training opportunities are being reduced or eliminated altogether. And other countries are offering very appealing opportunities to people who have been trained to the highest standards here in Ireland but who may never get the opportunity to practice here because of poor forward planning by the authorities.

Already we have seen the HSE undertake desperate recruitment drives overseas simply to keep the system ticking over. This is a waste of resources and opportunity and we need to sort out this problem once and for all as a matter of urgency. The second common problem is the growing threat of de-professionalisation.

The commitment to the highest standards of professionalism has defined the Irish health services and has been key to the success of the system to date. But increasingly policy makers and commentators seem to want to devalue this and that's well illustrated by the growing use of commercial jargon to discuss health issues.

Viewed though a commercial lens, health care is judged simply by reference to labour costs, units of time, margins and bonuses. Doctors understand that the approach to medicine must incorporate some business principles.

But we must resist the growing corporatisation and commercialisation of health that ignores the patient and we must and will champion the virtues of professionalism which has stood us and our patients in good stead to date.The third common issue is the question of regulation in relation to health service delivery – or more particularly, intrusive over-regulation. At meetings across the country over the past six months, member after member has expressed concern at the threats posed by the over-zealous regulation of facilities at the point of service.

There is a real risk that the Health Information and Quality Authority will put in place regulations that are so unreasonable as to put at risk perfectly safe health care delivery. Let me be clear, we accept that the public interest must be protected by appropriate regulation. But it must be of a type which balances the desirable with the practicable.

Anything more will be counter-productive and damaging. We will continue this debate in one of our sessions tomorrow afternoon.

For our part we will strive for an approach which robustly protects patients without making it impossible to provide them with the care they need.

Turning to the different specialties, for GPs the key focus will be on negotiations on a new GP contract; negotiations that will be conducted now in the context of the Minister's commitment to introduce free GP services. Making GP services free at the point of care is an attractive policy goal but it is not yet clear how realistic it is – certainly in the short term - and in the context of the recent, very worrying comments by the Minister that he is planning to further cut GP fees.

For the majority of practitioners, GP finances are at breaking point; the introduction of cuts to fees through the use of the draconian FEMPI legislation and the attempted extension of GMS work to include items and procedures which were never originally intended for inclusion under the contract have combined to force many GPs to the edge. For our Rural GPs the situation is becoming critical and there is a growing anger at the lack of recognition by the HSE of the flexibility of Rural GPs who act as a catch all safety net for a health service with a rudimentary primary care sector and an overburdened hospital and ambulance service.

They are the difference between a service that is struggling to work and one that would cease to function without them. We're very open to sitting down with the Department to discuss how we can work together on a new contract. But it must be a contract that respects the role and importance of GPs to the wider operation of the health service and that acknowledges the pressure under which GPs are currently operating.

Mr George McNeice, Chief Executive

It should also be a contract which starts to recognise the potential of the GP service to deliver greater efficiencies and value for money across the board. The key is to see GPs not as costs but as facilitators; the key to avoiding unnecessary hospital admissions and to managing chronic health issues efficiently and effectively. We have done a lot of work over recent months in developing a new model for GP services. We will bring this model to the HSE and demonstrate that it offers the potential to empower GPs to play a much more constructive role in the front line health services. Turning to consultants, one of the biggest issues facing the health services is the crisis of morale that has now gripped hospital consultants. We recently published the results of a benchmark survey of attitudes amongst consultants and the findings should be a cause of real concern ...even for the most hardened HSE bureaucrat: One in four consultants contemplating leaving the public health system. One in five describing their morale as "very low". One in three claiming that morale has declined greatly in the last five years. And 70% claiming that attempts had been made to curtail services.

When the researchers presented their findings to us, they expressed the view that these were some of the most extreme findings they had experienced in any comparable professional survey. Unfortunately, we were not surprised. We've seen at first-hand how the HSE has sapped the morale from its key staff and the consequences of their mismanagement of personnel issues.

The IMO has developed a clear strategy to deal with the many issues arising from the benchmark study, including contractual matters such as the measurement of public/private mix and we will be engaging with hospital consultants all over the country in the coming months. Turning to Non Consultant Hospital Doctors, our major focus will be to try to achieve full implementation of the 2010 Contract. Other issues include addressing the manpower crisis by tackling issues like work life balance and working conditions. We are looking at a shortage of NCHDs of as much as 400 by June on the back of the failure of the HSE to retain doctors already working here and to attract doctors from abroad. Why ? Largely due to non-implementation of the contract, excessive working hours & anti-social rosters which raise serious patient care and safety concerns.

The IMO is engaged in discussions with the HSE in the Labour Relations Commission on all of these matters. Another serious concern and contributor to the NCHD shortage is the difficulty in securing a Consultant post at the end of training.

Statistically at the completion of medical school, doctors have an 18% per cent chance of getting a consultant post and this only increases to 25% the day a doctor completes higher specialist training. It is commonly accepted that NCHDs have to work abroad to gain the requisite experience to compete for a Consultant post in Ireland. Many of these NCHDs are staying put in their new countries and are not coming back as previously planned.

Appropriate manpower planning in terms of career paths for NCHDs is essential to the aim of a Consultant delivered Health Service and to stop the current brain drain of doctors out of Ireland.

Public Health and Community Medicine Doctors share many of the issues we've touched on already; a shortage of personnel and the challenge of recruiting doctors and ensuring that they aren't overburdened with work simply and that their professional development isn't ignored or long-fingered. That's neither fair nor respectful.Public Health Doctors and specialists took a decisive clinical lead in commencing the Public Health Emergency Out of Hours Service.

This excellent service has continued to be provided despite the HSE being unwilling to recognise the value or constructively engage with the IMO in the implementation of the Saunders Report.

For our community medicine doctors the attitude of the HSE is similar. Despite reservations about resources, community medicine doctors participated in the nationwide rollout of the HPV Vaccination Campaign.

And I hope that the internal HSE Review of Community Medicine recognises their worth Ladies & gentlemen, I said at the outset that we were meeting at a time of crisis.

But I hope I have also demonstrated to that far from being paralysed by this situation, we are energised by it. Doctors are resilient, patient focussed and professional and, if allowed, we have much to offer in the reform of our health services.

Yes - we have difficult choices to make.

Yes - we will all have to work harder and more cleverly to deal with the new realities.

But our members have never shirked hard work. And we don't shirk it now. We recognise the need for tough choices. But we also recognise that the wisest decisions come from consultation and partnership not dictation or threat.

So today, I want to recommit this organisation and our members to working with the Government on

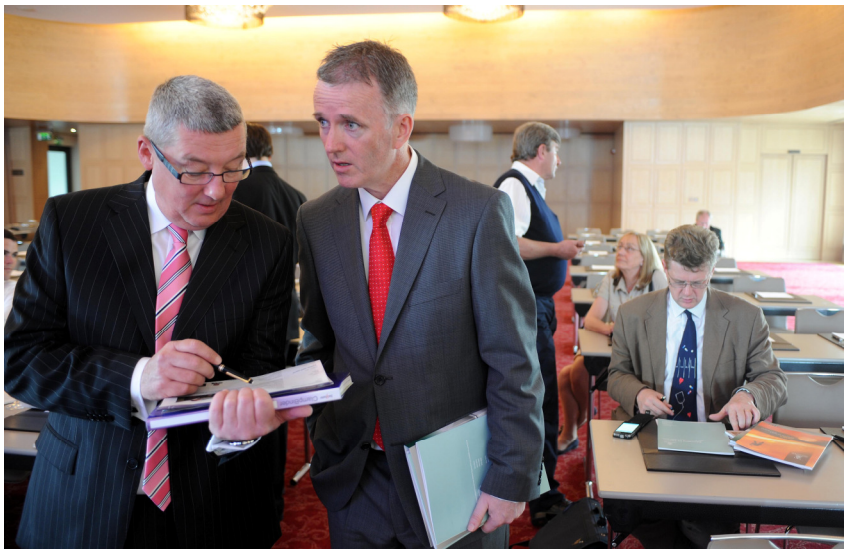
rising to the challenges facing this country. All we ask for in return is consultation, respect, partnership and co-operation. Finally, Ladies & Gentlemen, I want to express my appreciation to a number of people. The IMO is a member organisation and its strength is in the unity and commitment of all its members.

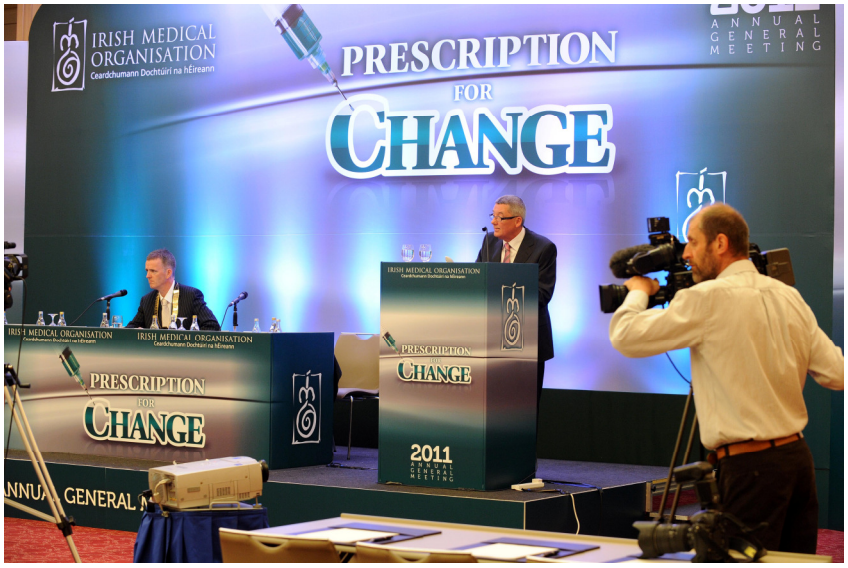
I want to thank those members for their support over the past year. I particularly want to thank those members who have served on the speciality committees, our honorary officers and the trustees who have given so much of their time to the organisation. And I want to thank all my colleagues in the IMO who work so hard for the organisation and who have done so much to organise this AGM.

And finally I want to pay special thanks to our outgoing and incoming Presidents, Sean and Ronan. I know at first hand how much time and commitment Sean has given to the organisation and – on behalf of all members Sean, I thank you for that. Ronan – congratulations on becoming President.

It is a great honour to be President of this organisation and I know that you will fulfil your role with great distinction. I look forward to working with you over the months ahead as we work to advance the interests of our members...our patients and the wider community.

Go raibh mile maith agaimh.





Dr Ronan Boland, IMO President

"An té nach gcuirfidh san earrach, ní bhainfidh sé san fhómhar"

A cháirde, Comhgleacaithe, Aoinna agus a dhaoine uaisle , táim bródúil labhairt libh mar Uachtaráin Ceadchumainn Dochtuiri na hEireann. Táim fior-bhuioch díbh gur tugtar dom an onóir seo agus déanfaidh me mo dhícheall freastail mar ionadaí éifeachtach ar son dochtúirí uiligh ar feadh an bhlian tábhachtach seo atá romhainn.

Friends, colleagues, distinguished guests I am very proud to address you as the President of the Irish Medical Organisation. I am very grateful for the opportunity that has been afforded to me by my colleagues and I will do my utmost to serve as an effective representative of all doctors for the duration of this very important year that is before us.

I began with an old Irish seanfhocal or proverb which reminds us that he who does not sow in the Spring, will not reap in the Autumn. Tomorrow is the first day of May, traditionally celebrated as the festival of Bealtaine. In the Celtic calendar, Bealtaine was the feast of bright fire, the first of Summer, one of the four great quarter days of the year. The early Irish Leabhar Gabhála (the Book of Invasions) tells us that the first magical inhabitants of Ireland, the Tuatha De Danann arrived on the feast of Bealtaine. Great bonfires would mark a time of purification and transition heralding in the season in the hope of a good harvest later in the year.

It is fitting then that we would come together in this splendid settling on the last day of Spring at a time of great change and great challenge for our proud nation and for our health service. It is, of course, also a challenging time for this Organisation, a challenge however which also affords the profession a real opportunity to shape the way our health service evolves and changes.

I have been proud to call myself a member of the Irish Medical Organisation since I qualified as a doctor, twenty five years ago next year. I recognised then as I do now that like many a great football team, the collective is often greater than the sum of its constituent parts.

I have always believed that it is precisely because the IMO speaks for all doctors that it enjoys the status and respect which it undoubtedly does – with our legislators and health service administrators, with the media and, most importantly with the general public. Tá seanfhocal eile ann a chuala me ó bhíos óg –"Giorraíonn beirt bóthar". It's an old Irish proverb which literally means "two shorten the road".

I look forward to working with and representing all doctors over the next year and, by working together, shortening the road toward our common goals and objectives.

In 1987 when I qualified, there were many parallels with the predicament in which Ireland now finds itself. A new government led by Garrett Fitzgerald had just come to power. Unemployment was high, public expenditure levels were unsustainable. Swingeing cutbacks, increases to already high tax rates and reducing public services were the order of the day. Non Consultant Hospital Doctor terms and conditions were so poor and their contracts so habitually broken that, having exhausted all other avenues of redress, an NCHD strike was in progress as I was conferred with my degree.

Some of my classmates did not even receive an Intern place in the country that had trained them. Half of my class left the country immediately after their Intern year in pursuit of adequate training and career prospects in other English-speaking countries – countries which were only too happy to employ them given the extremely high international reputation which Irish-trained medical graduates held and still hold to this day. Many never returned. Several now hold positions of national and international standing in Australia, Britain and North America. Of the minority of my contemporaries fortunate enough to secure a scarce vocational GP training place in Ireland, almost half left the country immediately in 1991 having completed their training programme because of the paucity of opportunities for fully trained General Practitioners in an Ireland which was only starting to come out of recession.

Then, as now, Irish medicine and Irish hospitals did not operate in a vacuum. Highly educated highly trained highly motivated young doctors will do what is required to further their careers and improve their skills and expertise.

And they will go where those skills are optimally utilised in the care of the patients they look after. And yes, they do expect to be reasonably valued for the length of their training, for their expertise and for the onerous nature of the responsibilities they carry and the hours that they work. They should not be placed in a position of apologising for or defending their decisions. When policy makers decry the exodus of Irish doctors from our health service, they need to ask themselves why it is so. Recruitment fairs and expensive adverts offering Irish GPs and NCHDS very attractive packages providing excellent experience and training combined with shorter working hours and better pay and conditions in Australia and Canada are the order of the day.

We have a shortage of GPs in this country, as do most developed countries. We are still not training enough GPs. We already have a situation where the state is finding it very difficult (and in some cases impossible) to replace GPs on a like-for-like basis. It is in replacing single handed rural General Practitioners the state has most difficulty and it is ironic in those circumstances that it is rural practice which has been hardest hit by the latest and deepest round of cuts

implemented under FEMPI legislation.

The manpower and structural deficiencies experienced in General Practice are being replicated in our hospital system. The recent IMO Benchmark Study has shown poor morale amongst Hospital Consultants with more than half of those under 50 years of age stating that they would consider quitting their public posts. Previously sought after Consultant posts are attracting few applicants. About one-third of NCHDs are leaving the country shortly after qualifying to seek other opportunities, partly because NCHDs completing SPR training programmes lack confidence that they will obtain a consultant post on completing training.

It is believed that at least 400 NCHDs posts will go unfilled this July. Despite our international obligations and years of IMO engagement, we still do not have a properly structured and resourced out of hours system for Public Health Doctors.

Yes, everyone recognises that these are difficult times and the IMO has acted responsibly and maturely as the terms and conditions of hard-won contracts have been steadily eroded and, in some cases, simply cast aside. But the IMO has a responsibility to highlight the likely medium-to long term consequences of a drain of our brightest and best young doctors and this is a responsibility which I as your President intend to fulfil.

In these challenging times, as so many people see a steady erosion of their working conditions and standard of living, it is human nature to look for someone to blame. Doctors are human like everyone else. At times their ire has been directed at the IMO, their own representative body, on the basis that it should be more vocal - misguidedly in my view. My late father, who was a fine orator and thoroughly enjoyed formal occasions such as this, often reminded me that an "empty vessel makes most noise". This Organisation has always eschewed the empty soundbite in favour of the considered responsible strategic approach.

We live in a society which is changing rapidly and, as doctors we work in a health service which is changing even more rapidly. John F Kennedy said "Change is the law of life. And those who look only to the past or present are certain to miss the future". The theme of our conference this weekend has been "A Prescription for Change" and we are very fortunate to have in George McNeice a wise experienced CEO who always takes a longer term strategic view which has at its centre the maintenance of strategic relationships based on mutual respect and the achievement of shared understanding.

This is typified by his success in stitching into the Croke Park Agreement a Transformation Programme for General Practitioners and the resolution of the perceived impediment to collective engagement with GPs created by Section 4 of the Competition Act – a subject I will return to presently.

It will always be a challenge to convince some doctors that the IMO delivers for them. It is all too easy to assume that enhancements to the service and improvements to their terms and conditions have happened by accident and eaten bread can be soon forgotten. Lao Tzu, the great Chinese Philosopher lived as far back as the 6th century BC but his writings are still relevant today. He wrote "a leader is best when people barely know he exists, not so good when people obey and acclaim him, worse when they despise him. But of a good leader who talks little when his work is done, his aim fulfilled, they will say: "We did it ourselves".

I believe the IMO's record of delivering for doctors speaks for itself, and is one of which all members can feel justifiably proud.

I want to speak to you about the future of our health service, a subject of great importance to every citizen in our small proud nation, whether one works in the health sector or not. It is easy to lose sight of the major advances which have been made in medicine and in health care over the last 25 years or so since I began to practice medicine . The availability of new surgical and radiological techniques and of new drug therapies has radically altered the way we manage conditions as diverse as Peptic Ulcer Disease, Ischaemic Heart Disease (both in its prevention and treatment), Diabetes, Osteoporosis , Rheumatoid Arthritis and indeed many forms of cancer. Optimum use of many of these therapies depends on the oversight of a General Physician who retains overall clinical responsibility for the care of the patient. 25 years ago this role was filled in most cases the by the General Hospital Physician.

Ironically, at a time when more and more patients are living longer, and needing more and more oversight of more and more co-morbidities, the oversight role has been passed almost by stealth to the General Practitioner.

And yes, GPs can fulfil that role – but only if they are adequately supported in doing so – and support requires administrative staff and managers and nurses and phlebotomists.

GPs are the only generalists left in our system and if that role of Generalist is not supported and fails, the system will fail and the most important person – the patient- will suffer.

It is in that context that our policy makers need to tread carefully when they consider hiving off pieces of the complex jigsaw that is General Practice to third party providers who will tender only for the seemingly profitable pieces of the jigsaw. Government must avoid equating price with value. The fragmentation of hospital services and the ideological shift to the Private Secondary Sector in

Ireland in search of solutions over the last decade would not provide any confidence that a similar move in primary care will be effective.

Dr Ronan Boland, IMO President

We have seen the value of targeted investment over the last decade, particularly in the Cardiovascular Strategy and in the National Cancer Strategy and subsequent National Cancer Control Programme. We finally have a national cervical screening programme to be proud of, delivered almost exclusively in General Practice and exceeding every benchmark set by the NCCP in terms of quality and throughput. These investments will save many lives and will serve as a testament to the foresight of the policy makers who funded them and of the clinicians who designed and run the programmes. All of these initiatives share one common factor – the state and clinicians working together to bring about change.

I believe that the road behind us is littered with examples of how attempts to impose change by dictat on well motivated independent-minded medical professionals are doomed to failure. I believe that the best outcome for patients will always be achieved by a constructive partnership approach between doctors and those who formulate and implement Government policy.

The need for constructive partnership is nowhere more pressing than in the implement of the Transformation programme. Much good work is taking place around the country in relation to Transformation and Reconfiguration in our hospitals.

This will lay the building blocks for real improvement and efficiency in our hospitals going forwards. This change is being driven by clinicians, some of whom are present tonight. Many GPs and Consultants have given freely of their spare time engaged together in finding ways of making services function more effectively in their regions. Much preliminary work is being done on the Clinical Care Programmes.

However, the Transformation Programme will never reach its potential until unfettered engagement between the State and General Practitioners can take place without both sides looking over their shoulder. Delivery of the Transformation Programme and of any system of Universal Health Insurance will require a new GP Contract. I therefore welcome the Minister's commitment at our conference yesterday to make appropriate changes to the Competition Act and his recognition of the primacy of the IMO in representing doctors in any future negotiations with his Government.

It is perhaps a testament both to the success but also to the untapped potential of Primary Care in this country that, as so often before, major Government policy initiatives have at their very heart the strengthening of General Practice so that it can take on additional work currently done in the hospital sector.

It is a regrettable but inevitable consequence of sequential state fee cuts, however necessary from the state's perspective, that the capacity of General Practice to continue to provide existing service levels has been compromised, let alone its capacity to take on new work when the state has so few resources to fund it.

As the IMO predicted time and again for the last two years, General Practice is headed into a period of enforced retrenchment. Nursing and secretarial hours and pay rates are being cut. Fewer locums are being employed and fewer partnerships created.

Employment prospects for new GPs are disimproving literally week by week. Practices are finding they have no option but to divest themselves of services that they were effectively providing out of their own pockets over the last decade when resources were more plentiful. Anecdotal evidence exists of practices having difficulty extending overdrafts from their longstanding bankers, let alone securing major funding to develop Primary Care Centres as envisaged by the HSE.

In Ireland in 2011, almost every sector of society is suffering because of the economic downturn. I am not for one moment suggesting that doctors should be spared their fair share of the correction required to balance our nation's books. However, the state is currently creating a public expectation that it will continue to cut payments to GPs (as well as Consultants) and that it will at the same time occupy a national network of new Primary Care Centres which someone else will build, with those centres and the GPs who work in them taking on a raft of additional work. The term "free GP care for all" has taken on a life of its own.

Let there be some honesty in the public discourse. There is no such thing as free care. Someone has to pay for it, either at the point of delivery, through direct taxation or through insurance or a combination thereof.

On Thursday we had a very interesting and stimulating session on the Dutch model of Universal Health Insurance. A couple of clear take home messages emerged.

The system is not a panacea of itself, it has strengths and weakness and is still a work in progress. It took many years of planning to make a more modest transition than is envisaged here.

General Practitioners and Consultants through the IMO will engage constructively with Government on any changes which the government wishes to enact here, but as independent practitioners who have for generations provided medical services to at least 60% of the population without state input or support, GPs' co-operation or acquiescence should not be presumed upon. Likewise, Consultants already have a new contract on which the ink is hardly dry and many elements of which have never been honoured.

One of the other commitments in the programme for government is the removal of all restrictions on

suitably qualified doctors holding GMS contracts. I have already outlined the difficulty currently experienced in filling rural GP posts. I have referred to the government's stated aim of bringing GPs together in groups working in Primary Care Centres. A complete deregulation of the GMS would potentially lead to the state losing what control it has over the distribution of doctors with a proliferation of GPs with small poorly resourced single-handed practices in urban areas with, in all likelihood ,even greater difficulty in filling GP Posts in rural areas and areas of urban deprivation. Applying a free market ideology is not always the best policy, and our legislators should proceed with care.

To move briefly from deregulation to regulation – the regulation of our profession. We had a stimulating debate this afternoon on the pros and cons of increasing regulation of doctors in this country. We live in a society and in a media age where more accountability is demanded of everyone. Doctors are no exception. They are not immune from scrutiny, nor should they be.

That said, between new mandatory Competence Assurance structures, HIQA and a planned Patient safety Authority, there are understandable fears that a burdensome, bureaucratic, expensive and duplicatory system of overlapping regulation could be imposed on doctors.

Regulation must not be excessive, such that it places unrealistic demands on hospitals, health care institutions or GPs. The more resource that is expended on complying with standards the less that is available to fund patient care. Standards must be readily achievable without excessive additional cost by the large majority of doctors and other providers who already pride themselves in the work that they do and the facilities they offer within the limits of the resources available to them.

We live in challenging times, the like of which we have not seen in a generation. It is, as I have said, undoubtedly a challenging time to lead a professional organisation such as ours. However as General Douglas McArthur summed it up "a General is just as good or just as bad as the troops under his command make him". While the IMO is a deeply democratic organisation without any troops to command, its strength will always depend on the breadth and depth of its membership of over 6,000 doctors. It relies also on members' preparedness to help formulate and shape policy and then to assist the organisation's professional executive, in conjunction with doctors' own elected representative colleagues, in implementing that policy.

It is a testament to the professionalism of the IMO that so many doctors choose to be members and to trust in the advice and direction given to them. That professionalism comes from the top down and I have already referred to our CEO, George McNeice. I can safely say that in working closely with him over the last three years as GP chairman I have never once doubted his judgement or professionalism.

However George would be the first to admit that he would not be able to run the Organisation without the support of many staff but most especially Susan Clyne whose dedication and commitment is unwavering and never less than impressive. To Maria Murphy, our excellent IR team and all of the other staff with whom I have come into close contact in recent years, on my own behalf and on behalf of all our members I sincerely thank you.

I have been asked on many occasions what has motivated me to get involved in the IMO and to ultimately assume a leadership role as many before me have done. For anyone in this position it does of course involve an element of personal sacrifice and a significant commitment. My mother who is here this evening, always taught me that one should stand up for what one believed in because it is right to do so but that one should not expect thanks for so doing. I am sure that there have been times over the last decade in the midst of various public skirmishes between the IMO and the HSE and Department where my mother (never one to relish the limelight) must have rued her words of advice and wished I hadn't taken her advice quite so literally!

Seriously, what has sustained me is the collegiality and sense of common purpose that I have experienced through my involvement in the IMO, with young doctors and older doctors, urban GPs and remote rural practitioners, Irish and overseas graduates, medical students, Public Health doctors, Consultants and NCHDs.

The many doctors I have come to know share at all times a focus not just on terms and conditions but on the care of the patient. We must always remember that we are an organisation of doctors. We have been trained, and are privileged, to serve patients and patient care must always be at the very heart of what we do as an Organisation. This focus is reflected in the many detailed Policy papers we have produced in recent years through our Research and Policy Unit and in the wide-ranging scientific sessions we have hosted, such as yesterday's excellent session on Health Inequalties.

I believe Ireland in 2011 deserves doctors who are passionate about what they do, doctors who are highly skilled and trained and optimistic that they will be facilitated to optimally use their hard-earned skills in this country in the years ahead. But I believe younger doctors also have a responsibility to get involved in shaping the health service they want to work in for the rest of their careers. Martin Luther King said "The ultimate measure of a man is not where he stands in moments of comfort, but where he stands at times of challenge and controversy" At a time of

Dr Ronan Boland, IMO President

potentially great change, it is a source of some concern to me that few younger doctors are prepared to sacrifice their leisure time to engage with the shaping of our health service, even though the proposed changes are arguably of greatest import to doctors of that age group, given the length of the career that extends before them. With this in mind, I think its most appropriate that the IMO is developing a Mentorship programme to assist and facilitate doctors who are prepared to become involved in leadership roles, whether locally, regionally or ultimately nationally.

This country is at a crossroads. We as a society need to decide what kind of health service we want. We the citizens of this country need to hold our legislators to account and tell them what we want. And we the Irish Medical Organisation will continue to help steer that debate as is our duty and responsibility. If we are to have a corporatised, for-profit health service with the state gradually disengaging from its delivery, so be it. But at least, let the doctors and the citizen/patients of Ireland go there with their eyes open, and not simply because they were too busy getting on with their lives to notice it was happening around them.

I say again we need to decide as a society what type of health service we want. At one end of the spectrum we can have Universal Patient Registration with General Practitioner-centred, driven and organised primary medical care in multidisciplinary multi-doctor centres, with the professional support of nurses and administrative staff.

At other end of the spectrum, we can have a free market approach with more and more services provided by pharmacy and other third party providers, with an unregulated supply and distribution of GPs trying to provide the services that other providers cannot (through lack of expertise) and will not (because they are not profitable) provide. We have seen the effect of corporatisation by stealth of elements of our hospital services – Policy makers need to decide, and decide quickly, if this is the direction in which they want General Practice and Primary Care to follow.

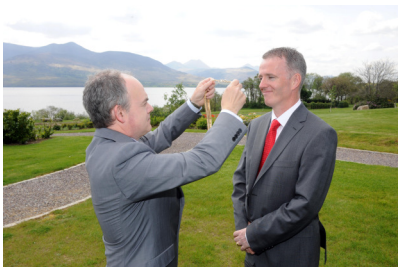
In conclusion, I would like to congratulate my colleagues who have been elected today as honorary officers and Chairs of Committee, and most especially Dr Paul McKeown, who has been elected Vice President. I look forward to working with you Paul , over the year ahead.

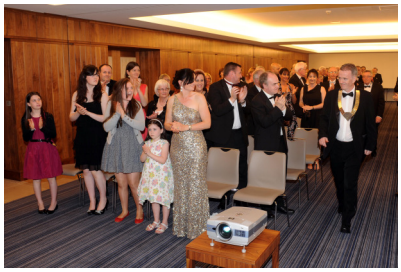
I want to publicly thank my family. My four daughters Zoe, Ailbhe, Sorcha and Aisling are in the audience. They have grown used to my regular absences from home and the missed school concerts, family events and lost family time my IMO involvement has meant. Lastly but most importantly I want to thank Lisa, my wife. She has always been there by my side at events such as this and her support, despite being left to manage at home on her own far too often, has been unconditional.

Ta súil agam go bhfuil sibh ag baint taithneamh as an gcomhdháil agus an deireadh seachtaine san áit speisialta seo agus táim cinnte go mbeidh oiche breá agaibh i measc bhfúr gcáirde. I hope you have enjoyed our conference and I have no doubt you will have a pleasant evening renewing old acquaintances and friendships.

At this potentially momentous time of change, let us work together to get it right, let us nurture the best of what we are and combine it with the best of what we can be. I will finish with a quote from Thomas Carlyle, the great Scottish Historian and Essayist. "Long stormy spring-time, wet contentious April, winter chilling the lap of very May; but at length the season of summer does come"

Go raibh míle maith agaibh.





Dr James Reilly T.D, Minister for Health

It's a great honour to be here today addressing all of you. For me today is a historic day. The first time a past President of the IMO has come back to address this conference as Minister for Health.

When I last stood before you as President of this great organisation, I wondered how my father would have felt. I was sure that he would have been proud. I hope that he would be equally proud today. I believe that this organisation, which was such an influential and large part of my life, can also share in that sense of pride.

Of course, as we all know from a recent survey the public have a very different view of doctors and politicians. Doctors are trusted by almost everyone. Politicians by very few! So I wonder how the public will view a doctor who is also a Minister. Will they split the difference? Probably not. Politicians need to regain the trust of people by delivering on the commitments and promises they made.

Whatever the precise views of the public on politicians, we can be certain of one thing. The Government to which I belong has been given one of the clearest mandates in the history of the State to change things. Particularly in health.

During the election we made it very clear that there could be no quick fix in health (always the political preference). That it could take up to 2 terms of Government to fully bed in. This was a risky decision politically. But it was the right decision. We need to be mature and realistic about what CAN BE ACHIEVED. And then we need to deliver.

This Government's policy is to introduce Universal Health Insurance. A policy that will bring free GP Care at the point of delivery. That will end the 2 tier Health system that we have worked in for so many years. A system where your access to healthcare and often your outcome is determined by your ability to pay - not by your medical need. This is clearly wrong and I know that many people in this organisation are deeply uncomfortable with the current system.

Now I know that you have concerns. Can we afford it? How's it going to work? What it will mean for me? And many others. So let me give you my analysis of the problems and our plans on how to remedy them. The finer details will be ironed out with your very experienced reps negotiators in due course.

The biggest problem is access. Put simply, too many people are trying to get into hospital for treatment. The system cannot accommodate them so we get unacceptable back-up in Emergency Departments. This results in huge distress for patients who are left on trolleys and chairs, sometimes for days. I know that this unacceptable situation also causes great distress for our nursing and medical staff. So how do we address the problem?

Firstly, by reducing the inflow into hospital. This can be achieved by more treatment in the community. This requires more access to diagnostics such as xrays, ultrasound and endoscopy for GPs for their patients in the community, so that they can diagnose and treat the patients without them going to hospital.

Secondly, it requires more chronic illness care in the community for diabetes, heart disease, blood pressure. Just as an example. There is a large hospital in Dublin with a diabetes clinic that has 9,000 people with diabetes attending it. I have little doubt that the vast majority of these people could be cared for by their GP in their community at much greater convenience to the patient and at much lower cost to the state. But less cost doesn't mean no cost. The resources must follow the patient.

I was in Mallow this morning opening a new state of the art Primary Care Centre. 19 GPs working together with nurses, physio's and a pharmacist. Delivering 16 new services. Employing 24 staff in all, supported by the HSE. They see 820 patients a day. They deliver chronic illness care to their patients – in the case of Diabetes for 20% of the hospital cost – saving hundreds of thousands for the HSE a year.

They also have the first primary care based mental health service, a key component of our health policy to destigmatise mental health. We want patients with mental health issues to be treated in the community like any other patient – walking through the same door as everyone else. I have outlined the importance of primary care in our plans to deliver better more cost effective services for patients. To underscore the importance of primary care this Govt has, for the first time, a Minister of State with special responsibility for Primary Care.

Prevention is a key part too and we need more early detection. Let us look at one staggering fact. 70% of all preventable deaths are caused by two factors – obesity and smoking. So whilst we have invested heavily in high tech cutting edge surgical and medical procedures to address the consequence of these two behaviours, we are not spending anything like the money we need to or devoting the resources we should to prevent them in the first place.

I am sure I told you before that I used to run an obesity clinic in my own practice, and that one out of every two people that I found to be obese weren't even aware of the fact

Dr James Reilly T.D, Minister for Health

that they had the problem so how could they ever hope to address it, not realising it was an issue in the first place.

I believe that with more chronic illness care prevention and more access to diagnostics in the community we will reduce the number of people having to attend hospital. A key question on primary care was posed yesterday by your new President, Dr Ronan Boland.

Can I first take this opportunity to congratulate on his appointment to his new role. And wish him and his wife Lisa a great year in office.

His question was this: Can we afford free GP care at the point of delivery? My answer is an emphatic yes. But we will need to work differently. And we will need to work smarter. We are sending over 14 billion of public money and up to 4 billion privately on Health. The entire intake from PAYE was 16 billion. We can't afford not to reform the service!

As the Deputy Leader of one of the Government parties, I am very conscious of the very difficult economic position we find ourselves in. Because of past mistakes we must now engage with external bodies. The IMF/EU bailout agreement states that we must open up the GMS to more competition. We must also do this because we have a shortage of GPS. It makes no sense to have fully trained GPs unable to treat patients in the GMS. This must and will be addressed.

This means more investment in primary care; this means a new GP contract that reflects the new type of work to be done. But all of our efforts must be guided by one principal: that the patient should be treated at the lowest level of complexity that's safe, timely and efficient - and as near to home as possible. If we do this we can see the benefits to all concerned.

Furthermore, within the hospital itself we are not getting the full use out of our existing capacity. We have all heard about the long discharges for patients in some hospitals, patients waiting up to nine months for placement in the community. I know of a case where there are 175 patients in a Dublin hospital with delayed discharges. I asked the CEO of that hospital how many would benefit if they had access to convalescence and rehabilitation facilities in the community. He told me at least 35 of the 175 would.

When I asked him if the remainder (140) would have to go to long term institutional care, he said absolutely. However when I questioned him about what would happen if his patient had access to convalescence and rehabilitation at the appropriate time how many could go home, he said at least half.

We are we costing the state money by having people languishing in beds in our hospitals that don't need to be there. And we are condemning our people to a life of institutional care when they could have otherwise gone home to more independent living.

But it's not that category alone that has the greatest influence on poor use of our beds. It's also delayed discharge in the first 48 hours of care in the hospital. The Clinical Directorship under the stewardship of Dr Barry White has done some sterling work in this area with tremendous help from his colleagues and it has improved the situation.

May I mention one hospital where, on the face of it, they seem to be super efficient. However, when you drill down the fact is that only 39% of their patients are admitted on the day of surgery when international best practice is 75% . This is where improved capacity can be achieved in our hospitals without spending additional money.

In fact it has been put to me that with a different and more effective use of just 10% of our surgical capacity we could improve output by 20,000 cases per year. So its very clear money is not always an issue but the real issue has been management and organisation and the lack of it!

So lets improve the use of the capacity within our hospitals. Lets create within our community in appropriate areas the convalescent beds we need. I have asked my Department to prepare costings for me to go to tender to nursing homes for 30-40 beds with associated physiotherapy , speech and language therapy so that we can move people from hospital seamlessly back nearer to their communities where they can continue their convalescence and ultimately go home with homecare packages and home support.

So you can see our problem is not unsolveable and is fixable. We have the capacity to do this. A key part of this is the Special Delivery Unit that was used in Northern Ireland. Where Clinicians and Managers went into a hospital and agreed with the Managers and Clinicians at that hospital a target that was immoveable and they went back on a weekly basis to see how they were getting on.

Where there were problems they were addressed. If that problem happened to be personnel who needed to be retrained that was addressed also.

But we also need to change how hospitals are financed by introducing Money Follows the Patient. So that hospitals are paid for what they do. By doing this we will make the system more transparent and accountable, and more efficient. We

will also put the patient at the centre of the system. If the patient is not seen, the hospital will not be paid.

As I've said many times before, I want patient treated at the lowest level of complexity, in a manner that is timely, efficient and safe. To give a rough example:

We don't want nurses taking a blood sample where phlembotomists can do it.. We don't want GPs taking blood pressures where nurses can do it..

We don't want consultants doing ECGs when GPs could be doing it.

There's an awful lot of inappropriate work being done in our hospitals that should be done in primary car. There's an awful lot of work that GPs are doing that nurses could be doing. There's an awful lot of work that Pharmacists could be doing. 800 pharmacists are trained to do vaccinations. Why not free up the GP to do other work and move this work over to the Pharmacists?

So clearly what's required here are new contracts that will facilitate all of this. All the Medical groupings will be represented in ongoing work on this – GPs, Hospital Doctors, Public Health Doctors, Pharmacists.

I haven't mentioned NCHD's but again I am shocked to find that things have changed so little. When I was an intern, I was a glorified gopher! Go get that xray – Go find that blood result. Having studied and trained for 5 years or maybe slightly longer, this always struck me as poor use of rather expensive resources. We need to restructure our work and how NCHDs relate to consultants.

Consultants of course are a key part of the service, highly trained and should be well paid. But they have to be prepared to be flexible too! We will all have to be prepared to do more with less – to work smarter and not just harder.

Public health Doctors and especially community medicine Doctors, who stood up to the plate when the swine flu epidemic threatened and who are key to many of our programmes, must also be allowed to explore new ways of delivering these schemes more cost effectively. I'm sure the events of yesterday didn't escape you're notice.

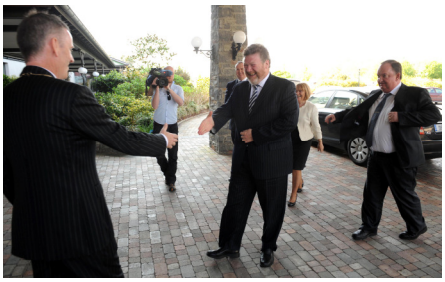
The Board of the HSE offered to step down to facilitate the changes needed to implement our new policy. I want to thank them for their service on the Board and for the leadership and generosity of spirit they have shown.

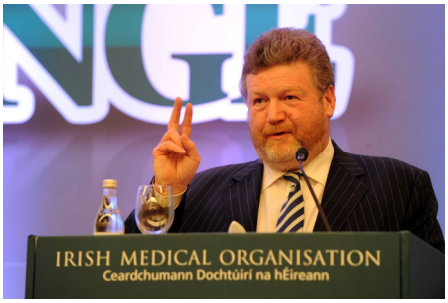
The people have spoken emphatically and their voice must and will be heard. The train is leaving the station, come on board to be part of, and help shape this new service. A SERVICE for patients that puts their medical need and not their ability to pay first.

For some people it's easy to point at doctors and say that they are part of the problem.

And, I suppose, you can be if you wish to be. However, I see doctors and the IMO as a key part of the solution and I look forward in a spirit of cooperation and consultation in joining with your representative organisation in negotiating a new contract that will reflect the needs of a modern health service. A Health Service that you will feel proud to work in and be part of, but most importantly, one that the patient will feel safe in.

Thank you.





Motions 2011

AGM Motions 2011 Results

General Motions

Care of the Elderly

11/01 The IMO calls on the Minister for Health to replace the Nursing Home Support Scheme with a fair and equitable system of financing and accessing long-term care for our elderly population.

Carried

Organ Donation

11/02 The IMO calls for the Minister for Health to resource and support an on-going media campaign to increase public awareness and discussion about organ donation.

Carried

11/03 The IMO calls for suitably trained transplant coordinators to be permanently based in hospitals to identify potential donors and to provide their families with accurate and complete information on the donation process.

Carried

Pharmaceutical Industry

11/04 This meeting calls on the pharmaceutical industry to try and plan ahead to ensure that there is a continuous supply of frequently prescribed medications so as not to have supplies interrupted.

Carried

Gun Licences

11/05 The IMO again calls on the Department of Justice to cease issuing gun licences until medical criteria has been clarified and agreed with IMO.

Carried

HSE

11/06 The IMO calls upon the Government to amend the Health Act 2004 such that it would remove the Minister for Health's sole subjective prerogative in appointing members to the board of the Health Service Executive.

Carried

Medical Practitioners Act

11/07 The IMO calls upon the government to amend the Medical Practitioners Act 2007 to reduce the number of members of the Medical Council who are appointed at the discretion of the Minister for Health.

Carried

11/08 The IMO calls on the Government to consider significant amendments to the Medical Practitioners Act 2007 to address the legislation deficiencies regarding limitations on doctors currently on the training register, doctors on the general register being able to practice without sufficient competence assurance and issues around doctor safety.

Carried

11/09 The IMO calls on the Minister for Health and the Medical Council to review Section 94 Subsection (1) of the Medical Practitioners Act with a view to a process being agreed whereby retired doctors can be permitted to remain on the medical register. The current interpretation of this Section will result in retired doctors being removed from the medical register thus preventing them from intervening in any emergency or accident.

Amended as: The IMO calls on the Minister for Health and the Medical Council to review Section 94 Subsection (1) of the Medical Practitioners Act with a view to a process being agreed whereby retired doctors can be permitted to remain on the medical register. The current interpretation of this Section will result in retired doctors being removed from the medical register thus preventing them from intervening in any emergency or accident.

Amended motion carried

11/10 This meeting calls upon the IMO to urgently explain to the Minister for Health, to all IMO members and to the general public the full and dire implications of the Medical Practitioners Act 2007, especially in the way that Section 94 Subsection (1) is being interpreted by the Medical Council in agreement with the Royal Colleges.

Carried

Public Information and Education Initiatives

11/11 The IMO calls upon the Minister for Communications to introduce mandatory quotas on factual and scientific broadcasting for children in the schedule.

Carried

11/12 The IMO calls upon the Minister for Communications as well as the Minister for Education and Skills to establish regular television events which showcase Irish scientific research and innovation.

Carried

Legislation

11/13 The IMO calls on the Government to expedite legislation such as the Mental Capacity and the Health Information Bill which both could lead to significant improvements in both patients' lives and patients' care.

Carried

Drugs, Alcohol & Tobacco

11/14 The IMO call on the Ministers for Education, Health and Justice to come together and set up a plan for dealing with one of Ireland's biggest social problems that being drug abuse.

Carried

11/15 The IMO calls on the Minister for Education to restore support for the local and regional drug task forces.

Carried

11/16 The IMO calls on the Minister for Health to reinstate the penalties for those in breach of the Public Health (Tobacco) Acts 2002-2004 so that those who are found guilty of selling tobacco products to children will lose their licence to sell tobacco products for at least three months.

Carried

11/17 The IMO calls on the Minister for Justice, Equality and Defence to commence Section 9 (structural separation) of the Intoxicating Liquor Act 2008.

Carried

11/18 The IMO calls on the Government to place a ban on public sector employees from being used to promote alcohol on behalf of the alcohol company, when they are clearly identified as public sector workers.

Carried

11/19 The IMO calls on the HSE to place a ban on the use of its facilities, or the facilities of any agency funded by the HSE, being used to advertise alcohol.

Carried

11/20 The IMO calls on the Minister for Justice, Equality and Defence to introduce and commence the regulations developed under Section 16 (1) (b) and Section 16 (1) (c) of the Intoxicating Liquor Act.

Carried

11/21 The IMO calls on the Government to publish Ireland's combined alcohol and illicit drug strategy without delay.

Carried

11/22 The IMO calls on the Government

to place 'polluter pays' levy on tobacco and alcohol manufacturers.

Amended as: The IMO calls on the Government to place 'polluter pays' levy on tobacco and alcohol manufacturers in order to make a contribution to the healthcare costs relating to the use of these substances.

Amended motion carried

11/23 The IMO calls on the Government to place a ban on the use of state or semi-state facilities to promote or advertise alcohol.

Carried

11/24 The IMO calls on the Government to increase the price of all tobacco products by at least 10% annually at the next and subsequent budgets.

Carried

11/25 The IMO calls on the Government to establish a cap on the price of tobacco products that the tobacco industry and/or retailers can charge.

Carried

Sex Industry

11/26 The IMO supports the Turn Off The Red Light Campaign which has been organised by Ruhama, the Dublin-based group that works with women involved in prostitution, and calls on the government to introduce legislation which makes it illegal for men to buy sex.

Carried

Road Safety

11/27 The IMO calls on the Minister for Transport to commence the provisions of the Road Traffic Act 2010 to reduce drink driving limits from 80mg/100ml to 50mg/100ml for qualified drivers and 20mg/100ml for learner, novice and professional drivers.

Carried

11/28 The IMO calls on the Minister for Transport to immediately implement the legislation, to ensure that there is mandatory alcohol testing of all surviving drivers in road crashes where a person is injured.

Carried

Lifestyle and Public Health

11/29 The IMO calls for the establishment of a Minister for Public Health in view of the large contribution social determinants make to the health status of the population of Ireland.

Carried

11/30 The IMO implores the HSE to immediately draft a nationwide standard of healthier menus to which all hospital canteens in the country must adhere to.

Amended as: The IMO implores the HSE to immediately draft a nationwide standard of healthier menus to which all hospital canteens in the country must adhere.

Amended motion carried

11/31 The IMO calls on the Minister for Education and Skills to introduce compulsory regular physical education up to the end of the senior cycle.

Amended as: The IMO calls on the Minister for Education and Skills to introduce compulsory health education up to the end of the senior cycle.

Amended motion carried

11/32 The IMO calls on the Department of Transport, Tourism and Sport with a view to improving public health, to implement the construction of 50m-swimming-pools in every Irish city and certain towns.

Carried

11/33 The IMO calls on the Department of Transport, Tourism and Sport to support the development of alternative outdoor sporting pursuits, such as the construction of Coillte supported mountain bike circuits, with a view to improving public health.

Carried

11/34 The IMO calls for the introduction of a pricing structure to discourage the consumption of food with high sugar, high fat and high salt content.

Carried

11/35 The IMO calls on the Minister for the Environment to provide funding for more playgrounds, cycle lanes and other measures to promote improved physical activity in all ages and especially schoolchildren.

Carried

11/36 The IMO calls for the government to address the health concerns which current Daylight Saving's Time creates.

Carried

11/37 The IMO calls for a review of current inequalities and inequities in health. This review should include variances in access to health care and inequalities in health status, either by economic grouping or geographic location.

Amended as: The IMO calls on the Taoiseach for a review of current inequalities and inequities in health. This review should include variances in access to health care and inequalities in health status, either by economic grouping or geographic location.

Amended motion carried

Health & Safety and Quality Issues

11/38 The IMO calls upon the Minister for Health and the HSE to ensure that every clinical site in the country is adequately equipped to provide for the safety of medical staff.

Carried

11/39 The IMO supports the WMA Statement on Environmental Degradation and Sound Management of Chemicals and calls on the HSE to continually reassess the impact of health care delivery on the environment and work towards more sustainable practices.

Carried

11/40 This meeting calls on the HSE, RCPI, RCSI and other agencies to evolve a nationally integrated process and methodology of quality assurance across the hospital and primary care domain, based on proven infrastructure, analysis, and information governance framework of Health Intelligence Ireland.

Carried

11/41 The IMO calls upon the government to establish a regulatory and licensing body which would approve all health claims made on food and other products.

Carried

Overseas Aid

11/42 The IMO recognises the esteemed contribution the Department of Foreign Affairs and Trade has made internationally, specifically targeting the UN's Millennium Development Goals. However, in light of the impending detrimental health effects which will ensue from overpopulation, the IMO would like Irish Aid to focus on strategies to address this specific problem in the priority nations we directly fund.

Defeated

Severe Weather Conditions

11/43 Given the medical implications of the recent episodes of severe weather the IMO calls upon the Government to draft adequate severe weather legislation which would clarify issues regarding responsibility and liability of actions such as public clearing of icy pavements.

Carried

Motions 2011

11/44 The IMO calls upon the Government to provide for a significant public information campaign directed at how to cope with severe winter weather (such as how to clear pavements, driving on ice, etc..etc..)

Carried

11/45 The IMO calls upon the Minister for Transport to consider possible schemes to reduce the cost of winter weather tyres given the medical implications of recent episodes of severe weather.

Carried

Drug/Medication Costs

11/46 In response to escalating drug costs the IMO calls on the Department of Health, in collaboration with the relevant bodies such as the IMO and IPHA, to implement a regulatory structure in respect of prescribing taking into account the principles as outlined in the IMO policy on Generic Prescribing.

Amended as: In response to escalating drug costs the IMO calls on the Department of Health, in collaboration with the relevant bodies such as the IMB and IPHA, to implement a regulatory structure in respect of prescribing taking into account the principles as outlined in the IMO policy on Generic Prescribing.

Amended motion carried

Commercial Health Claims

11/47 The IMO calls on the Government to tackle the issue of commercial entities who use "Health claims" to promote their businesses without evidence to support such claims.

Carried

Media Reporting

11/48 The IMO calls upon all media outlets to responsibly report medical and scientific stories and to promote the development of guidelines on the reporting of same.

Carried

Suicide

11/49 Given that copy cat suicide accounts for about 2% - 3% of all suicides and 15% of adolescent suicide the IMO calls all national and local newspapers in Ireland to publically adopt and comply with the National Guidelines on the Reporting of Suicide (published by the Irish Association of Suicidology and the Samaritans) in all publications.

Carried

11/50 Given that copy cat suicide accounts for about 2% - 3% of all suicides and 15% of adolescent suicide the IMO calls on the Minister for Communications to introduce adequate sanctions against any media organisation which does not sign up to or breaches the National Guidelines on the Reporting of Suicide.

Carried

Patient Confidentiality

11/51 The IMO calls on the HSE and other employers to engage with the IMO to develop national protocols regarding appropriate meetings with patient's relatives, the disclosure of confidential patient information, in keeping with Medical Council Guidelines, and the conduct of such meetings.

Amended as: The IMO calls on the HSE and other employers to implement existing Medical Council guidelines and IMO guidelines regarding appropriate meetings with patient's relatives, the disclosure of confidential patient information and the conduct of such meetings.

Amended motion carried

Child Health

11/52 The IMO deplores the underfunding of child development services and calls on the HSE to fund community child health services appropriately.

Carried

11/53 The IMO urges the HSE to implement without delay the WHO agreed programme for the elimination of measles & rubella in Europe and, at the same time, provide the necessary resources to deliver said programme. The original target date for this programme which has been agreed by the Irish Government was 2010.

Carried

11/54 That the IMO strongly recommends the HSE immediately institutes Universal Neonatal Hearing Screening Services in accordance with international evidence and best practice.

Amended as: The IMO strongly welcomes the onset of the rollout of Universal Neonatal Hearing Screening Services and calls for its immediate implementation without delay.

Amended motion carried

Domestic Violence

11/55 The IMO calls on medical education and professional bodies in Ireland to ensure that doctors are aware of the likelihood of exposure to violence, its consequences, and the evidence on preventative strategies that work, and adopt recommendations outlined in the WMA Declaration on Family Violence, the WMA Resolution on Violence Against Women and Girls and the WMA Statement on Violence and Health.

Carried

Mental Health

11/56 The IMO calls upon the Minister for Health and the HSE to introduce specialist treatment options for personality disorders both at national and local level.

Carried

11/57 The IMO requests the Minister for Justice, Equality and Defence to publish the number of cases that have been prosecuted under Section 185 of the Criminal Justice Act 2006.

Carried

11/58 The IMO calls upon the Minister for Health and the HSE to provide sufficient funding so that Dialectic Behavioural Therapy, which has been shown to be an effective and cost effective therapy for those with repeated self harm, can be available in every area of the country.

Carried

11/59 The IMO calls upon the Government to create a national regulatory body for all psychotherapists and counsellors practicing in Ireland who are not already covered by other statutory regulatory bodies.

Amended as: The IMO calls upon the Government to create a statutory regulatory body for all psychotherapists and counsellors practicing in Ireland who are not already covered by other statutory regulatory bodies.

Amended motion carried

11/60 The IMO calls upon the Mental Health Commission to create national qualification standards for those who provide psychotherapy and counselling commercially.

Carried

11/61 The IMO calls upon the Mental Health Commission to create a national licensing scheme for all those who provide psychotherapy and counselling commercially.

Carried

11/62 The IMO proposes that 0.5% of the HSE annual budget is allocated to mental health promotion to run an evidence based public mental health campaign similar to the ones on stroke, breast cancer, heart disease etc.

Amended as: The IMO proposes that 0.5% of the HSE annual budget for mental health is allocated to mental health promotion to run an evidence based public mental health campaign similar to the ones on stroke, breast cancer, heart disease etc.

Amended motion carried

11/63 The IMO deplores the failure to develop adequate services for those with learning disabilities and mental illness and asks the Minister to set out the timelines to remedy this.

Carried

11/64 The IMO is appalled at the denial of human rights & citizenship of those with learning disabilities and mental health illness that result in many dozen citizens being placed abroad for many years due to the failure to meet their needs in this country and seeks urgent statement from the Minister for Health on the national plan to address this national scandal.

Carried

11/65 The IMO seeks a statement from the Taoiseach on the cross departmental plans to develop supported community residences for those with enduring mental health illness so that institutionalisation is avoided.

Carried

11/66 The IMO highlights the lack of fairness in prescription charges for those attending public psychiatric services and demands that the Minister remedy this.

Carried

11/67 The IMO demands an explanation from the Minister for Health as to the reason for not progressing the recommendations on mental health care for those with learning disabilities as set out in A Vision For Change.

Carried

11/68 The IMO calls on the Minister for Health and the HSE to ensure that patients have direct access to publicly funded counselling and psychotherapy services in primary care for disorders that do not require specialist mental health services.

Carried

Manpower Issues

11/69 The IMO calls upon the HSE to ensure that every medical graduate is guaranteed an intern post and a structured career path to a permanent position.

Amended as: The IMO calls upon the HSE to ensure that every EU graduate of an Irish Medical school is guaranteed an intern post and a structured career path to a permanent position.

Motion referred to Council

11/70 The IMO is totally opposed to all forms of indentured service for Irish Medical Graduates.

Amended as: The IMO is totally opposed to all forms of compulsory service for Irish Medical Graduates.

Amended motion carried

11/71 The IMO calls on the HSE to immediately cease their moratorium on recruitment of frontline healthcare staff and in particular any professional on maternity or sick leave.

Carried

Health Systems & Policy

11/72 The IMO calls on the newly appointed Minister for Health to immediately take steps to bring an end to two tier medical care in Ireland

Carried

11/73 The IMO supports the introduction of a single tier health system in Ireland.

Carried

11/74 The IMO calls on the Government to cost and validate social health insurance V's taxation-predominant funding of any future universal health system, espousing the principles of equity and free-at-the-point-of-contact access to all resources, before proceeding headlong with a UHI model.

Amended as: The IMO calls on the Government to cost and validate competing private insurers V's taxation-predominant funding of any future universal health system, espousing the principles of equity and free-at-the-point-of-contact access to all resources, before proceeding headlong with a UHI model.

Amended motion carried

11/75 The IMO calls on the Minister for Health to recognise that reform of the health system requires a coherent capital investment plan.

Carried

11/76 The IMO calls on the Minister for Health to produce and cost a sustainable health policy for our country into the future.

Amended as: The IMO calls on the Government to produce, cost and set out an implementation plan for a sustainable health policy for our country into the future.

11/77 The IMO calls on the Minister for Health to ensure that the IMO Principles on Universal Health Systems are incorporated into any development of a Universal Insurance model for the provision of healthcare in Ireland.

Carried

Motions from National

Consultants Meeting

30th April 2011

Hotel Europe, Killarney, Co Kerry

1 The IMO is concerned regarding the unacceptably prolonged delay in the full implementation of the consultant common contract 2008 and calls for full implementation without delay.

Carried

2 The IMO calls on the HSE and the Department of Health to establish a research and education fund for Type A contract holders which would be funded by the income made by Type A contract holders when they treat private patients.

Motion noted

3 The IMO calls on the Consultant Applications Advisory Committee to approve the appointment of Type C 2008 contract holders in an attempt to recruit and retain the best consultants in Irish hospitals.

Amended As : The IMO calls on the HSE, in consultation and agreement with the relevant recruitment institution to utilise all types of contacts available as part of the strategy to recruit and retain the best Consultants in Irish hospitals.

Amended motion carried

4 The IMO calls on the Department of Finance to reconsider the application of a 10% decrease in pay for consultants who are new entrants to the public service.

Carried

5 In light of the new rules in regulation to competence assurance, the IMO calls on the Medical Council to agree to a process whereby retired medical consultants can be permitted to remain on the medical register.

Amended As : In light of the new rules in relation to competence assurance, the IMO calls on the Medical Council to agree to a process whereby retired medical consultants can be permitted to remain on the medical register and request that the Minster for Health write to the Medical Council instruct-

Motions 2011

ing them to do this as entitled under Section 11 (1) of the Medical Practitioners Act 2007 and amend Section 94 (1) of the Act.

Amended motion carried

6 The IMO calls on the HSE and ESRI to provide clear and transparent information in relation to how HIPE data is collated, measured and verified.

Carried

Motions from National GP Meeting

Saturday 30th April

AGM 2011

1 - Patient Information

This meeting calls on the HSE to inform GPs of patient deaths in HSE hospitals immediately after the patient has died.

Carried

2 The IMO calls on the HSE to advise GPs in writing details of patients being discharged from or transferred to HSE facilities detailing the treatment /investigations they've had as well as medication lists at the time of discharge/transfer.

Carried

3 - Medical Indemnity

This meeting calls on providers of medical indemnity to refrain from using small print clauses in their contracts as a reason for denying coverage. There should be no small print clauses. All coverage should be clearly stated.

Amended as:

This meeting calls on providers of medical indemnity to refrain from using small print clauses in their contracts and to include what is and what is not covered

.**Amended motion carried**

4 - Cervical Check Programme

This meeting calls for a Free Post system to be put in place for cervical smears under the Cervical Check Programme.

Carried

5 - Phlebotomy

This meeting calls for the provision of phlebotomy services for residents in all Nursing Homes.

Carried

6 This meeting calls for dedicated Community Phlebotomy services for public patients to be made available in each county to support Primary and Secondary care services to patients.

Amended As :

This meeting calls for dedicated Community Phlebotomy services for public patients to be made available on a daily basis in each county to support Primary and Secondary care services to patients.

Amended motion carried

7 - GP Unit Doctors

The IMO proposes the abolition of the HSE posts of the GP Unit Doctors.

Motion referred to Council

8 - Co-Ops

This AGM deplores the withdrawal of payment/recognition of out of hour's house calls in Co-Op's as this will affect patient care at home and result in more referrals to A/E.

Carried

9 - Co-Ops

This meeting deplores the HSE's proposed abject neglect of co-op out of hours cover and insist that it immediately negotiate a meaningful and properly resourced national service.

Carried

10 - Primary Care Reimbursement Services

This meeting condemns the Primary Care Reimbursement Service for the delay in payment of fees and the allowance of the GMS GPs in particular appropriate nursing homes payments and practice staff grants.

Carried

11 - Primary Care Reimbursement Services

That this meeting calls upon the PCRS to discuss with the IMO all issues relating to IT systems as they apply to General Practice.

Carried

12 - Primary Care Reimbursement Services
That this meeting request the PCRS to make payment to GPs for agreed payments of study leave and practice nurse allowance in respect of level 1 and 2 Methadone GP Contracts agreed in January 2003.

Carried

13 - Financial Emergency Measures in the Public Interest Act

That the IMO will, under the review process as provided for in the FEMPI Act, strongly press for a reversal of the fee cuts in view of the particular affect they are having on rural practice.

Carried

That the AGM rejects totally the abolition of the distance code allowance in determining capitation payments.

Amended As : That the AGM rejects totally the abolition of the distance code allowance in determining capitation payments in the absence of appropriate direct funding for rural practice.

Amended motion carried

15 This meeting proposes that recent changes in distant codes payments and payments for visits be reversed as these changes have a disproportionate effect on rural practice and therefore on rural society.

Carried

16 This meeting proposes that the GMS Distance coding be restored to remove discrimination against rural practices and to preserve services to rural patients.

Carried

17 That this meeting condemns the withdrawal of Practice Development Grants and lack of funding for practice development particularly given that there is increased workload transferred to primary care.

Carried

18 This meeting deplores the changes to the domiciliary fee from GMS capitation as it will affect care of the elderly in rural areas.

Carried

19 This meeting condemns the Department of Health for implementing a 50% reduction in capitation fees for nursing home patients who are a vulnerable ageing population and require best care.

Carried

20 This meeting calls for the capitation rates for patients in nursing homes be restored to preserve services to these patients.

Carried

21 This meeting endorses the GP Strategy and in particular commits to continuing to highlight the adverse affect on patient care as a consequence of reduced resources to General Practice through IMO policy, the FEMPI Review Process and communication opportunities.

Carried

22- Primary Care

This meeting declares that Primary Care Teams cannot be effective if the HSE employment embargo continues to be implemented in respect of vacant primary care team posts.

Carried

23 The IMO asks that the HSE and Department of Health recognises that the Primary Care Team concept, in its present structure, has failed to produce measurable positive outcomes and an immediate review should take place.

Carried

24 - Health Transformation Programme

This organisation welcomes the Transformation Programme and the roll out of chronic

care in Primary Care. It must however be backed up by a transfer of resources which follow the patient.

Carried

25 - Deregulation of General Practice

This meeting believes the complete deregulation of General Practice as outlined in the Four Year Programme is not in the best interest of patients.

Motion referred to Council

26 - HIQA

This meeting believes that HIQA has no role to play in the regulation of General Practice as General Practice is already sufficiently regulated by the Irish College of General Practitioners, the Medical Council and the Health & Safety Authority.

Amended As : This meeting believes that HIQA has no role to play in the regulation of General Practice as General Practice is already sufficiently regulated.

Amended motion carried

27 - GP Models

In line with its GP Strategy, the IMO will develop a GP model which will be designed to deliver optimum general practitioner services which are adequately developed and resourced and will promote this model to the Department of Health.

Carried

- Competition Act

This meeting calls upon the Government to urgently amend the Competition Act as provided for in previous Government undertakings and in the Public Service Agreement 2010-2014.

Motion referred to Council

29 - Nursing Home Medical Officer

This meeting calls upon the HSE to introduce and fund a dedicated Nursing Home Medical Officer post for service to nursing homes.

Amended As : This meeting calls upon the IMO to engage in discussions with the HSE to discuss a dedicated Nursing Home Medical Officer post/contract for service to nursing homes.

Amended motion carried

Motions from National NCHD Meeting

Saturday 30th April

AGM 2011

01This meeting calls for the renegotiation of contracts for CID Holders with distinct terms and conditions of service reflecting the nature of such positions.

Carried

02 This meeting calls for discussions between the IMO and the Training Bodies to address the situation whereby after four years of training and despite payment for and completion of training models no certification is issued to the participating doctors who are not on training schemes. Such issues are leading to career arrest for many doctors working in the Irish Health Services.

Carried

03The IMO calls on the HSE and other employers to either provide a mobile phone or fully fund the cost of a mobile phone for those NCHDs expected to work on call from home or for whom a mobile phone is used as the primary mode of communication during work.

Carried

04The IMO calls on the HSE and other employers to address the legal, ethical and social difficulties imposed upon NCHDs in contacting them out of hours via mobile phone or otherwise, and calls upon the HSE to develop a national policy pertaining to contact NCHDs who are not rostered on call.

Carried

05The IMO is opposed to the introduction of application fees for those applying for training schemes and calls upon the Postgraduate Training Bodies to cease this practice.

Carried

06The IMO calls on the government to legislate for an amendment of the Medical Practitioner's Act to allow certain NCHDs work outside their training site, permitting volunteerism and the possibility to locum.

Amended As :

The IMO calls on the government to legislate for an amendment of the Medical Practitioner's Act to allow NCHDs, with appropriate competencies, work outside their training site, permitting volunteerism and the possibility to locum.

Amended motion carried

07The IMO calls on the Department of Health to support a local reassignment of the working roles of NCHDs in some Irish hospitals to aid the current manpower crisis and improve NCHD training.

Amended As :

The IMO calls on the Department of Health to support a local reassignment of inappropriate tasks from NCHDs in some Irish hospitals to aid the current manpower crisis and improve NCHD training.

Amended motion carried

08The IMO calls upon the HSE to publish full details of the HSE funding to the Postgraduate Training Bodies in respect of the training of NCHDs and the reports of the expenditure from the Bodies associated with such funding.

Carried

09The IMO calls upon the HSE to provide for wireless internet access in every medical residence in the country.

Carried

10The IMO calls upon the HSE to undertake a review of doctors' residences in HSE and HSE funded hospitals to ensure they at least meet the National Guidelines for Residence Standards and where facilities fail to meet such standards appropriate measures are taken to rectify the situation.

Carried

Motions 2011

11The IMO calls upon the HSE to devise and provide for an easily understood, uniform and transparent method of recording NCHD overtime.

Carried

12The IMO calls upon the HSE to immediately provide each NCHD throughout the country with access to all major journals via an e-library account.

Amended As :

The IMO calls upon the HSE to support each NCHD throughout the country to access to all major journals via an e-library account and to ensure all NCHDs are aware of this entitlement.

Amended motion carried

Motions from National Public Health Doctors Meeting

30th April 2011

01The Departments of Public Health are the only component of the HSE which has not yet been restructured following the establishment of the four HSE Regions, the integration of services and the dissolution of the Population Health Division. This motion proposes that the IMO prioritise reaching agreement with the HSE management in relation to transferring public health departments to the Integrated Service Directorate and ensuring an equitable balance of resources are placed specifically with the splitting of the Public Health Department in the east between Dublin North East and Dublin Mid – Leinster.

Carried

02This meeting requests the HSE to strengthen the provision of child health services within Community Medicine. The administration and provision of Programmes such as Pandemic (H1N1) 2009 and the roll out of the HPV Programme has reduced significantly the capacity of the existing limited medical resources to provide essential and statutory child health services.

Carried

03This meeting believes that the moratorium on the recruitment of Community Health Doctors should be lifted.

Amended as;

This meeting believes that the moratorium on the recruitment of Community Health and Public Health Doctors should be lifted.

Carried

04This meeting believes that as HPV Vaccination is now a core programme the necessary resources should be in place on a permanent basis.

Carried

05That the IMO urgently achieves the upgrade of AMOs to SMO status and end this anomaly of pay without further delay.

Carried

IMO Committees 2011-2012

Dr Trevor Duffy, Chair

Consultant Committee

Dr Bernard Walsh
Dr Clive Kilgallen
Dr John Morris
Dr Michael O'Leary
Dr Naishadh Patil
Dr Neil Brennan
Dr Niall Sheehy
Dr Pat Manning
Dr Peter A Healy
Dr Seamus Healy
Dr Siobhan Barry
Mr Finbarr Condon
Mr Hugh Bredin
Prof Sean Tierney
Dr Christine O'Malley
Dr John Higgins

Dr Mary Gray, Chair

General Practitioners Committee

Dr Ciaran Donovan
Dr Colm Loftus
Dr David Moloney
Dr Declan Connolly
Dr Donal Coffey
Dr Eleanor Fitzgerald
Dr Jim Keely
Dr Martin Daly
Dr Michael Mehigan
Dr Niall Macnamara
Dr Padraig McGarry
Dr Ray Walley
Dr Ronan Boland
Dr Truls Christiansen
Dr Henry Finnegan
Dr Illona Duffy
Dr Michael Kelleher

Dr Mark Murphy, Chair

NCHD Committee

Dr Dela Osthoff
Dr Arshad Hussain
Dr David Flanagan

Dr Iftikhar Ahmad
Dr Jean Donnelly
Dr Joe Baker
Dr Kishan Browne
Dr Maitiu O'Faolain
Dr Matthew Sadlier
Dr Michael Barrett
Dr Michael Murphy

Dr Muhammad Razi
Dr Myles Smith
Dr Remi Mohammed
Dr Ronan O'Leary
Dr Toby Gilbert
Dr Éimhín Ansbro
Dr Nalini Somaiah

Dr Johanna Joyce Cooney, Chair

Public Health Doctors Committee

Dr Heidi Pelly
Dr Anthony Breslin
Dr Bridin Cannon
Dr Orlaith O'Reilly
Dr Brett Lynam
Dr Paul McKeown
Dr Howard Johnson
Dr Mary Conlon
Dr Phil Jennings
Dr Darina Fahey
Dr Mary O'Mahony
Dr Patrick O'Sullivan
Dr Catherine O'Malley
Dr Ina Donoghue
Dr Mary Fitzgerald
Dr Deirdre Murray

IMO Council 2011-2012

Elected members to IMO Council 2011-2012 with IMO Chief Executive, Mr George McNeice (Fr 3rd left), President Dr Ronan Boland and Dr Paul McKeown, Vice President

IMO Management Committee

Dr Ronan Boland, President

Dr Paul McKeown, Vice President

Mr George McNeice, Chief Executive

Dr Trevor Duffy, Honorary Treasurer and Chair Consultant Committee

Dr Matthew Sadlier, Honorary Secretary

Prof Seán Tierney, Immediate Past President

Dr Mary Gray, Chair, GP Committee

Dr Mark Murphy, Chair, NCHD Committee

Honorary Officers

LR: Dr Trevor Duffy, Hon Treasurer, Dr Paul McKeown, Vice-President, Mr George McNeice, Chief Executive, Dr Ronan Boland, President, Dr Matthew Sadlier, Hon Secretary

Council Members 2011-2012

Dr Brett Lynam

Dr David Flanagan

Dr Eleanor Fitzgerald

Dr Jim Keely

Prof Joe Barry

Dr Johanna Joyce Cooney

Dr Kishan Browne

Dr Mark Murphy

Dr Martin Daly

Dr Mary Gray

Dr Matthew Sadlier

Dr Neil Brennan

Dr Paul McKeown

Dr Peter A Healy

Dr Ray Walley

Dr Remi Mohammed

Dr Ronan Boland

Dr Ronan O'Leary

Dr Seamus Healy

Dr Siobhan Barry

Dr Toby Gilbert

Dr Truls Christiansen

Scientific Session I—Going Dutch, Perspectives on Health System Reform in the Netherlands

Political Challenges and Opportunities in reforming the Dutch Health System

Dr Henk van der Velden – Senior Health Policy Analyst FNV explained the political context which brought about reform in the Dutch Health care system. The changes in the Dutch health care system are twofold. In 2006 the Health Insurance Act became operative which introduced a universal health insurance for curative health care. Managed competition: a new deal in responsibilities between government, health insurers, health care providers and patients/insured. The central notion is that part of the responsibility for cost effectiveness, cost containment and quality of care are transferred from the government to competing insurers and health care providers. This liberalisation of health care requires further changes in legislation and is still hotly debated and very much work in progress.

It is important to understand that the changes in the health care system had to solve some specific Dutch problems. Foremost the problems of a two-tier system of health insurance with its high financial burden on people with low incomes or bad health.

The Netherlands did not and still does not have a two-tier system of delivering health services. Most Dutch health care organisations are privately owned, but they are also subject to government regulations concerning price and volume to the extent that they are considered to be part of a public health care system. It is nearly impossible to buy yourself some extra health care outside the public system. This explains why even minor waiting list problems – minor if compared to the situation in some other countries – produced a public outcry during the 1990's and made politicians nervous.

The short term solution was the introduction of 'money follows the patient' shortly after the year 2000. This proved to be very successful in reducing waiting lists, but it was also very expensive. During the last decade expenditure on hospital care doubled from about 10 billion euro tot over 20 billion euro.

The long term solution had to come from one health insurance system for all and by shifting the responsibility for efficiency towards competing insurers and health care providers.

Under the Health Insurance Act every citizen is obliged to buy private health insurance for specific health services. In order to allow people to fulfil this obligation, health insurance is subject to regulations you would normally associate with a social health insurance system: Insurers are obliged to accept everyone. Insurers are obliged to contract sufficient care. Partly income related premium (50%). Partly nominal premium for adults (50%) but with an income related subsidy. Mandatory employer's contributions. Mandatory access payment of €175 per year (2011). Risk Equalisation. The nominal premium is determined by the insurance companies (about €1200 in 2011) and people can change insurance on a yearly basis

The new Health Insurance Act does work in the sense that most Dutch citizens still have proper health insurance, as they used to have. Also, it did shift some of the financial burden from low income groups to higher income groups and from people with bad health to people with good health. The Health Insurance Act was important because it solved a long standing politcal debate on health insurance and not because the content of the Act was so revolutionary. It simply combined characteristics of the old two-tier health insurance system. Managed competition is the real experiment. Competition on premium between health insurers seems to have worked well during the first years. Most insurers have drained their resources in order to attract insured and premiums have increased less than the cost of health care. However, competition also resulted in mergers and at the moment there are only four large health insurance companies left. In 2011 they were able to raise premium by about €100 on average.

It is too early to tell whether negotiations between insurers and health care providers will produce a more efficient health care. Partly because the liberalisation of health care legislation is a slow and fiercely debated process. An important fear is that market forces will not produce cost-containment but instead will increase expenditure even faster. In that scenario we might expect government to reduce the services provided by the Health Insurance Act in order to cut public expenditure on health care. People will have to spend more on health care themselves, buy more supplementary insurance, some will succeed and some will not. Then we might end up with a two-tier system of delivering health services after all..

Caring for patients in an evolving market – orientated system

Dr Wim Heres, General Practitioner, The Netherlands

'You can always get what you need, but not always what you want'

Dr Wim Heres opened with these classic lines penned by the Rolling Stones, which he said perfectly encapsulates the Dutch Health Care system today.

After providing a brief overview of the historical background to the modern reforms, Dr Heres described the Basic Health Insurance Package that every citizen in the Netherlands is obliged to pay. There are currently more than twenty insurance companies operating in the Netherlands, however five companies have more than 80% of the market. Insurance companies, doctors and hospitals must all compete in the market in the Netherlands and should compete under antitrust-laws.

Dr Heres presented the comparison of spending on healthcare between the Netherlands and other OECD countries, where the Netherlands ranked number one overall for their quality of care, access, efficiency, equity and health expenditure.

Dr Heres went on to explain that 10% of the GNP of the Netherlands is spent on healthcare, and stated that politicians will always be in control of the system, because in the case of overspending, 'there is always the possibility of polishing the deficits away by changing the content and amount of the healthcare package.'

The cost of GP care in the Netherlands is only 3% averaging €150 per person, with more than 90% of all health-problems are dealt with by the GP. GPs practice list in 2340 patients, with 60% of GPs in group-practice and 40% in single or double practice. GPs are remunerated through a mixed system of capitation and fee for service, with the tariffs being set which limits negotiation to a minimal amount between GPs and insurance providers. Dr Heres further explained that payment structure, stating that an ideal payment system is yet to be invented.

GPs in the Netherlands average 30 consultations a day and offer a 24/7 out of hours system. However, given the size of practices and the amount of consultations that a GP has to make in a day, Dr Heres stated that this is a very difficult balancing act. Due to this, practices in the Netherlands have taken on more support staff to take on more routine tasks, leaving the GP to focus on more complex issues.

Dr Heres discussed the advantages and challenges of General Practice in the Netherlands, stating that GPs provide a safe, cheap, continuous and evidence based care which is inclusive to all in the Netherlands. However, there are significant challenges with GPs being seen as an obstacle to secondary care in their gatekeeper role, and have difficulty in balancing patients wants versus their needs. Additionally, it has become less patient-centered,

with many GPs wanting to spend more time with their patients, but not wanting their income to fall.

For the future, Dr Heres stated that the biggest challenge will be efficiency, and does not think the solution will be found in 'more competition between doctors, but in more cooperation between GP's and Specialists. More staff are required to deliver the services in the Netherlands and looking at support roles within the health care system. Clearly there are more challenges ahead for the Neth-

Patients or Consumers in a Mandatory Private Health Insurance Market ?

Ms Lisa Matassa, Journalist, The Netherlands

Lisa Matassa had her first encounter with the Dutch health care system which she moved to the Netherlands with her husband and young son. Ms Matassa went on to describe the efficient process in registering with the local council for health care services, and the range of care than was immediately delivered for her young son through the child development program.

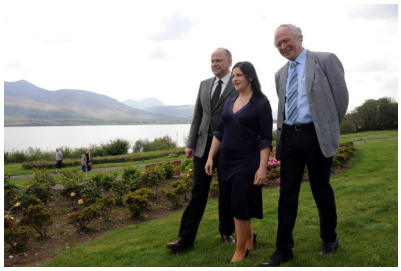
After being a patient in both Ireland and the Netherlands, Ms Matassa went on to compare the basic Dutch package mandatory for the entire population with that of a private health package offered in Ireland. While cost was clearly different, the benefits included within the packages are vastly different, with the Netherlands providing extensive coverage options.

In the Netherlands the basic coverage package offers all medical care, including access to GPs, hospitals, medical specialists and midwives/obstetricians, some medication, patient transport and paramedical care. There are also limited coverage for physiotherapy, speech therapy, occupational therapy and dietary advice.

Ms Matassa also discussed the very important role of the GP in the Dutch health care system, and described her own experiences with her GP, and the personal difficulty in adjusting to some elements. The role of patient organisations is also very important in the Netherlands particularly in handling complaints and issues in the delivery of care.

However, the 'cracks' in the Dutch system have started to appear. With rising costs, and debate over who should bear the bill, there is also a consequence of moving away from proactive care to 'reactive' care. Ms Matassa also stated the move from 'localised' care to a more 'nationalised' system of care, with the example of insurance companies previously offering assistance to establish patient support groups in their local area and these benefits slowly slipping away. The debate of cost versus care is also of concern in the Netherlands.

As a patient who has experienced both health care systems, Ms Matassa discussed whether of not the Dutch system could be applied in Ireland, recognising considerable difficulties in reconciling differences between the two countries, the current systems, and the different mindset of each nations patients.



Scientific Session II— Missing Presumed Forgotten: Neglected Areas of Health Reform

Prioritising Prevention when the money is tight

Prof Anthony Staines, DCU School of Nursing

Health Promotion and Prevention is a key area where obvious long term savings can be made Governments seem reluctant to commit any

funding. Prof Anthony Staines, Lecturer in Health Systems at DCU School of Nursing explained why prevention programmes should be higher on the list of priorities.

Prof Staines took a single case study - food, obesity and cardiovascular health. Obesity is a major looming health issue. There is a risk that our children will die younger than us, because of spiralling levels of obesity. Prof Staines argued that much of the heavy burden of cardiovascular disease is caused by dietary intake of sugar, salt, and fat, especially trans-fatty acids. These are food elements which are hard for the consumer to regulate as much of the daily intake of these items is hidden in processed food, notably breakfast cereals. These foods are very heavily promoted to children, with predictably bad consequences.

The standard food industry response to these charges is 'consumer choice'. As they had sabotaged EU proposals for comprehensible food labeling (traffic lights), and have replaced these with the '% recommended daily intake labels', which consumers do not understand, Prof Staines does not see any need to take the industry seriously.

The Food Safety Authority of Ireland has a voluntary scheme with spotty participation, to reduce salt (only) in food. This is too slow, and too uncertain. The US and Denmark have shown the way with bans on toxic trans-fatty acids. There is good evidence that cheap affordable regulations could have a major effect on cardiovascular disease risk, and we cannot afford to pass up any cheap wins for our health.

Meeting the Long-term care needs of an ageing populations

Professor Desmond O'Neill, associate professor in Medical Gerontology at Trinity College Dublin and Consultant Physician in Geriatric and Stroke Medicine AMNCH

The collective ageing of our populations has been one of the great advances of the last century. For medicine, the biggest challenge is that the healthcare professions have not yet

adequately adapted to the added complexity that increasing numbers of older people bring to the system. Much of healthcare provision still reflects a mindset of single-organ disease, a failure to factor in functional losses (eg, cognition, mobility and continence), and limited understanding of chronic disease. Rather than looking to the state, all branches of the professions (other than paediatrics and obstetrics) need to undertake reflection as to whether or not their practice incorporates sufficient expertise on health and illness in ageing in undergraduate and postgraduate training.

For example, in public health, to consider whether instruments to measure population needs reflect modern gerontological expertise and practice – a glaring example is the continued use of outdated instruments to measure 'appropriateness' of bed usage. The development of a Single Assessment Tool to measure needs in the UK also displayed a virtually complete failure of public health to understand modern princpiples of managing complexity that we need to avoid when adopting similar instruments in the Republic of Ireland.

Whether in family practice, surgery, psychiatry or medicine, major changes in practice need to

occur, and will require academic and clinical leadership. Having better assessment tools on their own is not enough – experience with a severity score for community acquired pneumonia (CURB-65) shows that doctors almost routinely avoid measuring one of its most critical components – cognition.

Finally, the public-private system has an underdebated role in how we develop age-attuned services, as evidenced by differences in GP prescribing for private and public patients over the age of 70 (1). We need to give serious reflection as to whether or not a private medicine hospital system based on procedures rather than process serves older people – the main client group of the service – well. Current indications are that this is not the case, and the profession needs to think how it can engage in such dialogue in a mature and meaningful way and play a leading role in developing services that are age-attuned and fit for purpose.

This is particularly important given that the policies of the last government (co-located hospitals) and the current government (trying to employ only category A consultants in the public hospital system) seem to suggest a policy of diverting those older people with private insurance away from the public system and into a private system that is geared for elective care but less clearly so for complex and acute care of older people.

1) Ir Med J. 2004 Sep;97(8):234-6

Dr William Flannery, Consultant Psychiatrist in Addictions, Chair of the Faculty of Addictions, College of Psychiatry of Ireland.

'One drink is too many for me, and a thousand not enough' – Brendan Behan

Dr Flannery today presented his perspective on addiction services in Ireland, detailing the size of the problem and what is required to meet current and future demand.

First presenting the science behind addiction, Dr Flannery gave a brief outline of the evidence associated with the influence of genetic risk and the environmental risk factor associated with the use of drugs. Dr Flannery also went on to discuss the evidence of effective treatment, highlighting a number of programs.

Neglected concepts such as what actually is addiction, and the broad spectrum of alcohol and substance abuse disorders are often forgotten, particularly the lower end of the scale disorders. Dr Flannery discussed the significant demand for treatment in Ireland, but acknowledged the difficulty in assessing the real need due to geographic dispersion of addiction and the concentration of treatment in urban areas of Ireland. Looking at what has been done, and the 'Good versus Bad Plans' that have been presented by government,

professional bodies and interest groups is an important step in looking to the future. Dr Flannery identified a number of positive and influential papers, such as the IMO's own position paper on Mental Health. Dr Flannery then discussed Methadone as template for developing addiction services. As Methadone was a program developed by health professionals, which needed to be matched by civil service structure and came from a crisis that required political action. These are valuable in looking forward to the development of further addiction services.

Moving forward, Dr Flannery discussed the direction for addiction, citing a combined plan with leadership from the CPI, IMO, ICGP etc and the role of doctors in advocating for this particular group of patients. A supportive civil structure is also required to provide a foundation for these services.

Scientific Session III— IMO AGM Debate
Motion: This house believes that Over-regulation of medical practice will undermine the doctor-patient relationship.

Speaking at the first IMO AGM Debate were Dr Anthony O'Connor, NCHD Member and Dr Richard Brennan GP and Former Chairman of the ICGP.

Proposing the motion - This House believes that Over-regulation of medical practice will undermine the doctor-patient relationship – Dr O'Connor began by drawing attention to a number of articles that had appeared in the media in recent weeks. The first was a survey by the Medical Council which was published in the Irish Times where it emerged that doctors are the most trusted profession. The second article appeared in the medical media announcing that the incoming process of competence assurance was enforceable for the moment the Medical Council passed the rules and that their passage through the Oireachtas was a mere formality. The third was an article in the Daily Mail that referred to consultants as "muggers". Dr O'Connor suggests that:

"Every move that has been made in this country relevant to the regulation of doctors in the last four years has been made to appease the lunatic fringe of anti-medicalism".

We have a bizarre situation where fitness to practice hearings are conducted in public with the guilt of the doctor is presumed until proven otherwise and whatever the verdict his or her reputation is left in tatters. Defensive medicine is a real and increasing cost. Dr O'Connor questioned why we are pandering to the prejudices of hysterical, uniformed anti-medical commentators, forcing doctors to attend "independent" CME activities sponsored by big pharma companies, when 88% of people trust their doctor and don't care if he or she has not carried out an audit in the last five years? In a final word on regulation and regulators, Dr O'Connor argued that regulations have been in place for years to protect doctors and patients regarding the hours worked by NCHDs which have been uniformly and brazenly ignored. What is needed is better regulation, better enforced, but not over regulation.

Dr Richard Brennan, opposing the motion, argued that he does not believe in the concept of over-regulation - regulation is either appropriate or inadequate for purpose. Regulation exists to protect both patients and doctors. It is about maintaining standards accountability and trust. Most doctors subscribe to the ideals of professionalism and excellence therefore do we not all support the concept of patient safety and quality in healthcare?

"It is not about over regulation, it is new regulation which incorporates many of the best values and aspirations of medical professionalism together with the voice of the patient"

If the patient is to be put first, then Dr Brennan suggests that it is time to rebalance the doctor-patient relationship and that we should perhaps now refer to the patient-doctor relationship which is a relationship of partnership, based on trust, mutual respect, individual responsibility and appropriate accountability. It is a relationship governed by values, behaviours, cultures and quality of communication. Deficits in our values systems and behaviours undermine trust. Basic behaviours of courtesy, kindness, understanding, honesty and humility are ore often absent and perception and reality about communication between doctors and patients can significantly differ. Contrary to the motion proposed, Dr Brennan believes that the balance and thrust of regulation to date is appropriate and not over-punitive, it rebalances the patient-doctor relationship in a way that reflects modern societal values and it provides a safety net and accountability for patients. Medical professionalism is about doing the right thing and our best for patients. Regulation is the flip side of the coin and is complimentary rather than conflicting.

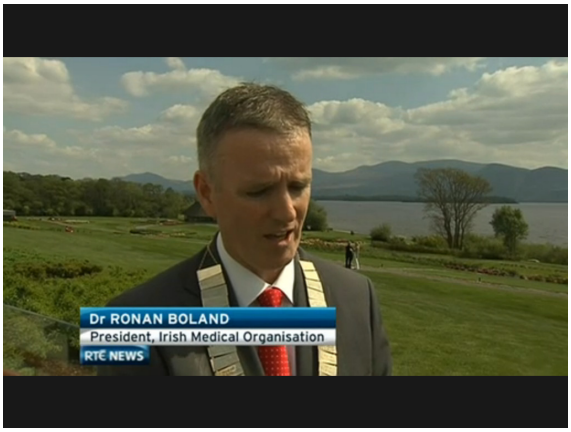
Following further questions and answers, IMO doctors in attendance voted marginally in favour of the motion.

Media Coverage of the AGM

RTE Six One News,

Thursday 28th April 2011

IMO questions universal health insurance plans



Dr Ronan Boland

The first and most obvious question is can we afford it and there has been, what would concern me slightly is there's been some loose talk about free care and free GP care. There's no such thing as free care.

http://www.rte.ie/news/av/2011/0428/media-2949546.html

Morning Ireland, Thursday 28th April 2011

Robert Shortt

Now every healthcare system has a lot of complicated detail but in general what is the IMO view, or is there an IMO view, of the Dutch model?

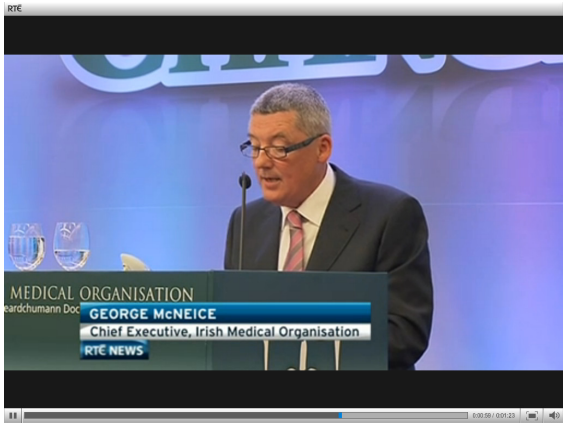
Prof Sean Tierney

We don't have a particular model, I think you're absolutely right to say that the systems are very complicated and we have a particularly complicated system of our own that's developed here over the last twenty years. I don't think we can turn around in one day, turn a switch and adopt a model that evolved in Holland over the same time period. So I think there are good things in the Dutch system, I think there are good things in our own system. We've seen good things in the UK in the NHS in the past fifty years, I think we actually need to adopt the best parts of all of the systems and try to get something that will work, will be sustainable and will be affordable.

http://www.rte.ie/news/av/2011/0428/media-2949546.html

RTE Nine News,

Friday 29th April 2011



Fergal Bowers

The Chief Executive of the IMO said there may be a shortage of around 400 junior doctors by June.

George McNeice

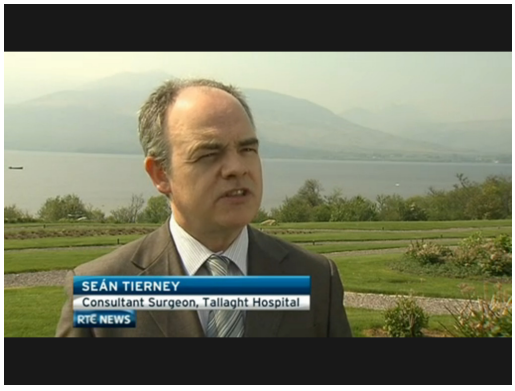
Morale is now at rock bottom across the entire profession. Training opportunities are being reduced or eliminated altogether and other countries are offering very appealing opportunities to people who are being trained to the highest standards here in Ireland.

http://www.rte.ie/news/av/2011/0428/media-2949546.html

RTE Nine News,

Saturday 30th April 2011

IMO Concerned over unnecessary tests



Prof Sean Tierney

In fact those tests incur considerable expense, there's radiation involved, there's often injections of contrast material involved which can be quite toxic.

http://www.rte.ie/news/av/2011/0428/media-2949546.html

Full videos are on the rte website enter the text below each video into your browser/search engine.

IMO concern at use of public resources to promote alcohol—Medical Independent, 05/05/11

IMO to go to equality authority about AMO upgrade—Irish Medical News, 03/05/11

IMO President warns against more pay cuts— Sunday Business Post, 01/05/11

Phlebotomy not a GP task—IMO —Irish Medical Times, 06/05/11

GPs hit out at shortage of medicines—Irish Independent, 29/04/11

Doctors call for buying sex to be made illegal—Irish Times. 29/04/11

GPs staying proactive on new policy changes—Irish Medical Times, 06/05/11

Warning over consultants' fracture of commitment—Irish Medical Times, 06/05/11

IMO is considering discrimination action—Irish Medical Times, 06/05/11

Hip problems—shortage of doctors partly to blame–Irish Examiner, 30/04/11

IMO to strengthen GP branch structure–Irish Medical News, 03/05/11

NCHDs get work calls during their holidays–Irish Medical Times, 06/05/11

You and the IMO

If your contact details change please contact the membership unit.

membership@imo.ie

Date for Your Diary

AGM 2012

Next year's AGM will take place from

Thursday 12th—Saturday 14th April 2012

Please contact the Industrial Relations Unit via the following email addresses:

GPissues@imo.ie

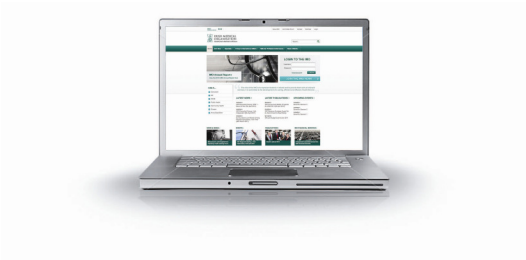
Consultantissues@imo.ie

NCHDissues@imo.ie

Publichealthissues@imo.ie

personalcases@imo.ie

To see an online version of this report please go to www.imo.ie



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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