IRISH MEDICAL ORGANISATION
Ceardchumann Dochtúirí na hÉireann

IMO Pre-Budget Submission 2025

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Introduction

Our healthcare system is at a critical juncture, facing persistent and escalating crises in Emergency Department overcrowding, ongoing and significant deficits in bed capacity and serious shortfalls in medical staffing and long waiting lists. . A decade of underinvestment through the years of austerity, matched with a increases in population and in particular the ageing population, has led to a situation where our health services are not in a position to meet the challenges of dealing with the healthcare needs of the population in a timely manner.

The HSE Recruitment Freeze has simply been replaced with an unrealistic recruitment ceiling, resulting in posts approved in the previous year being suppressed and significant obstacles to recruiting the right number of staff to deliver current services. The consistent failure to proportionally fund and resource health services to meet the needs of a growing and ageing population with increased prevalence of chronic disease has directly led to sustained and critical risks on a daily basis to both patients and healthcare staff.

Doctors are dedicated to providing high quality care, yet the health system is caught in a vicious circle: We do not have enough doctors and healthcare resources to meet the ever-increasing demand, leading to increased pressure and burnout among the existing workforce which in turn leads to poorer patient outcomes and increased doctor attrition.

The consistent narrative of record-level health budgets and the additional numbers employed in the health service masks the harsh reality of ongoing demands on the health service and funding deficits that have persisted for over a decade.

Against this background, radical and sustainable investment urgently is needed now to build capacity, ensuring that our health system can become resilient into the future. Without such investment, the cycle of burnout, attrition, waiting lists and poorer patient outcomes will continue.

In this last budget of the current Government before elections, the IMO is calling for investment in a range of measures across our health services.

Demand on the Health System - Ireland's Ageing and Growing Population

Ireland has a growing and ageing population.[1] While this is to be celebrated and supported, it must be recognised that this has an impact on our health services as more patients seek care, and that care is more complex:

- In the last decade the population has grown by 14.4%, from 4.6 million in 2013 to 5.3 million in 2023. According to the most recent CSO projections Ireland's population will reach between 5.65-5.9 million by 2032, and between 5.7- 7 million by 2057.
- the proportion of the population aged 65 years or over increased from 12.3% in 2013 to 15.3% in 2023 - this represents an increase of more than 40% in the past 10 years of those aged 65+ (569,200 in 2013 to 806,300 in 2023).
- the population of those aged 65+ expected to exceed 1 million by 2032 in all CSO projection scenarios (18-19% of the total 2032 population) and reach 1.81 – 1.94 million by 2057 (28-32% of the total 2057 population).
- 83% of the population reported their health as very good or good and while the majority of older people are in good health an ageing population creates additional pressures on the system .
- Those with a long-standing illness or health problem increases by age, with half (49%) of those aged 75+ years old stating they have a long-standing illness.[2]
- 57% of bed days are used by patients aged 65+ in 2022 (54% in 2021)[3] while chronic disease accounts for 80% of all GP visits, 40% of hospital admissions, and 75% of hospital bed days.[4]

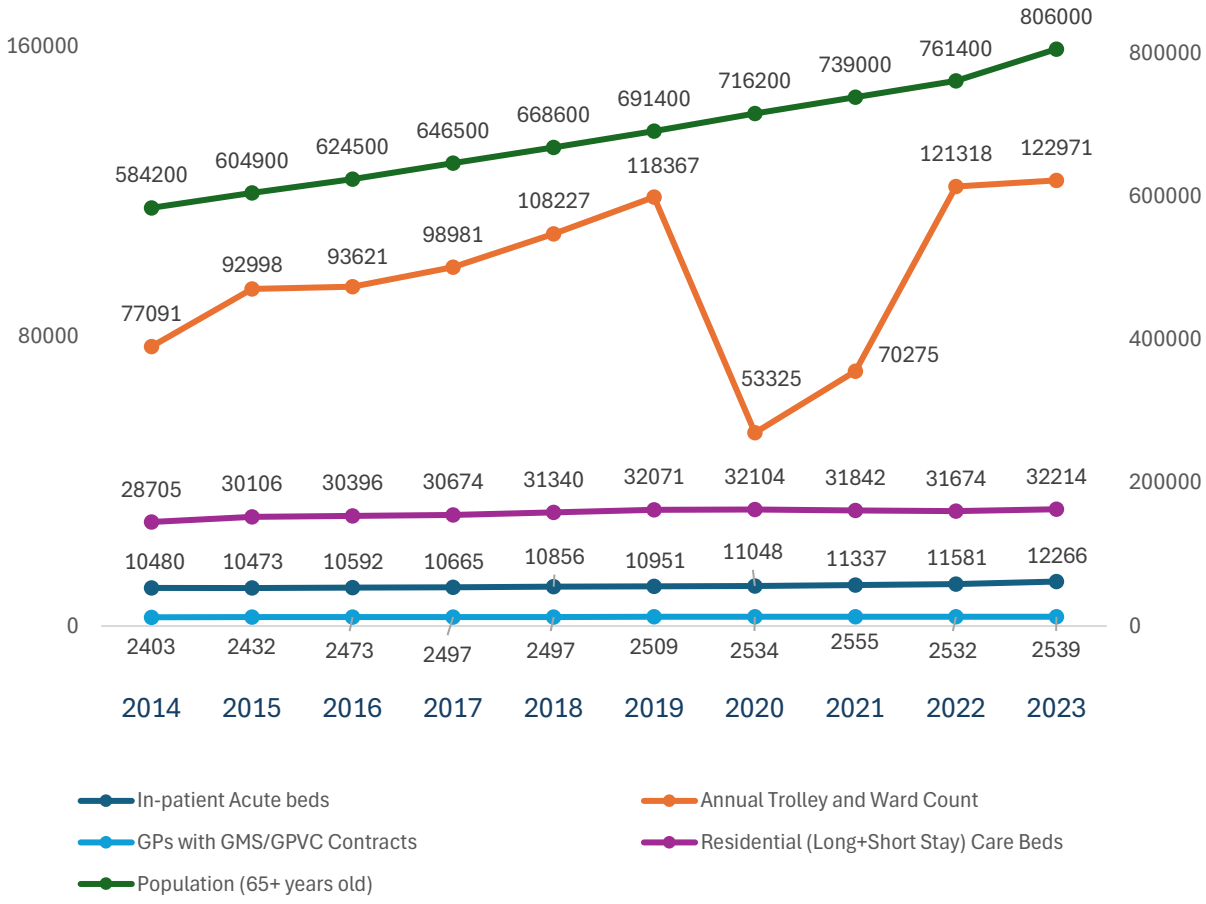
The capacity of our health services has not kept pace with demand, resulting in hospital overcrowding, patients on trollies, and prolonged waiting in emergency departments.

- The number of in-patient acute beds has increased by just 11.2%, from 10,411 in 2013 to 11,581 in 2022[5], with little or no increase over the past 20 years.
- The annual INMO Trolley and Ward count has seen an 81.2% increase from 2013-2022 (67,863 in 2013 to 122,971 in 2013).[6]
- At an average of 90% bed occupancy[7], and many operating beyond 105% occupancy overcrowding is a year round problem impacting on patient safety and staff welfare.
- As of July 2024, there are 599,458 people waiting for an outpatient appointment with a hospital consultant of which 18% (108,612) are waiting longer than a year[8]
- Hospital waiting lists have almost tripled from 353,500 in 2013 to over 896,000 in June 2024

[1] Population and Labour Force Projections 2023-2057 www.cso.ie
[2] The Health System Performance Assessment Platform https://hspa.gov.ie/
[3] Dept of Health, Health in Ireland Key Trends 2023 https://www.gov.ie/en/publication/ccc4b-health-in-ireland-key-trends-2023/
[4] Department of Health, 2016, Better health, improving health care.
[5] Key Health Trends in Ireland 2023
[6] INMO Trolley Watch Analysis https://www.inmo.ie/News-Campaigns/Trolley-Watch/
[7] OECD and European Union (2022). Health at a Glance: Europe 2022.
[8] National Treatment Purchase Fund https://www.ntpf.ie/home/nwld.htm

- Over the past decade there has been a net increase of just 136 GPs (5.6%) holding GMS/DVC contracts with the PCRS.[9]

Chart 1: Health Service Demand Versus Capacity



Our healthcare system requires substantial investment each year to meet demographic pressures, unfortunately current the Government's plans for an additional €1.2bn in 2025 will only allow the system to stand still while maintaining a staffing ceiling at December 2023 levels will further impact on patient safety.

Only with careful planning and maintained investment in our healthcare capacity and medical workforce can we ensure a robust and sustainable healthcare system capable of meeting the needs of a growing and ageing population with complex needs. We cannot see a return to the cutbacks and recruitment embargos that had such a devastating impact on our health system during the austerity years.

[9] PCRS Data https://www.sspcrs.ie/portal/annual-reporting/

Health Service Funding

Although the healthcare budget has increased in recent years, our health services have been chronically underfunded most particularly through the years of austerity and recent increases in the health allocation have merely maintained the current status quo of chronic Emergency Department overcrowding and lengthy waiting lists and has not fully reflected the health needs of the population.

Annual budget over-runs show that our health services require significant additional income each year just to stand still. Although an additional €1.5 billion has been allocated to the HSE this year this year, and a further €1.2 billion next year has been approved in the Government's Summer Economic Statement[10] to maintain existing services, this funding will not lead to any significant expansion in our health services but merely allow the system to operate at its current level while gaps in services will continue to grow.

Over the coming years our public acute hospitals are going to lose revenue from Private Health Insurance providers which will result in a significant deficit for many hospitals. In order to maintain service levels this income must, as promised, be replaced with exchequer funding which should be assessed in a transparent manner.

Recommendations

- Health service funding both capital and operational must be based on a comprehensive assessment of current and future population needs ensuring timely and equitable access to care
- Funding to address existing deficits in services must be provided.
- Income from private care in public hospitals must be replaced with exchequer funding

[10]Department of Finance 'Summer Economic Statement 2024'

Health Service Capacity

Acute Bed Capacity

Increased demand for healthcare, combined with decades of underfunding, has resulted in a critical shortage of acute hospital beds. The practice of boarding patients on trolleys in EDs, poses an increased risk or mortality and poor outcome for patients while the use of surge capacity leads to cancellation and delays to patients awaiting elective or scheduled care.

New HSE data[11] shows how demand on our EDs have increased in just one year:

- overall ED attendances and admissions have increased by 9.7% and 9.8% respectively in the first 6 months of 2024 (compared with the same period in 2023).
- ED Attendances and admissions by patients over 75 years old have risen by 13.9% and 13.4% respectively in the first half of 2024
- just over half (54%) of patients over 75 are admitted or discharged within 9 hours.
- YTD surge capacity use was 68,155 bed days - up 34.2% for the same period in 2023

The IMO welcomes the recent *Acute Hospital Bed Capacity Expansion Plan* which aims to deliver an increase of 3,438 net additional in-patient beds between now and 2031.
It is now imperative that the government move with urgency to secure planning permissions, prepare for the required infrastructure works, and develop a plan to recruit the medical and support staff necessary to ensure that these beds can be used effectively and on schedule. This commitment must be honoured in full and implemented as part of a wider initiative to address the shortfall of 5,000 beds that currently exist in our public hospital system.

Further an adjacent plan to increase psychiatric beds, currently omitted in this plan, is required. A recent report on bed capacity in our mental health services[12] found that there are 1,134 public acute psychiatric beds in approved centres, representing a rate of 23.8 per 100,000. Falling well below the recommended ratio of 50 beds per 100,000 recommended by the Oireachtas Joint Committee on the Future of Mental Health.

In addition to the shortage of inpatient beds, delays in accessing diagnostics including radiology and laboratory services all contribute to bottlenecks in Emergency care. To date no assessment has been carried out of diagnostic requirements across the health system.

While access to home care services for older people has increased, approximately 400 patients at any time continue to be delayed hospital while awaiting transfer to more appropriate nursing home or rehabilitative care.

Recommendations

- Increase the number of new inpatient beds from 3,438 to 5,000 under the *Acute Hospital Bed Capacity Expansion Plan*[13] to meet the needs of our growing and ageing population.

[11] HSE Urgent and Emergency Care Weekly Performance Update 2023-2024 Sunday 30th June 2024
[12] HSE Acute Bed Capacity – Report of the Specialist Group, Sharing the Vision A Mental Health Policy for Everyone
[13] Department of Health 2024, Acute Hospital Inpatient Bed Capacity Expansion Plan 2024-2031

- Assure sufficient capital funding and planning to support the expansion of acute inpatient beds in full and on time
- Develop and implement an adjacent plan to increase psychiatric inpatient beds to meet population needs.
- Health care planning must include a detailed assessment of diagnostics, radiology and laboratory service requirements across acute and community care to meet current and future demands.
- Increase the number of rehabilitative care beds, long-term nursing home beds and the financing of home care packages

Support the Independent GP Contractor model

The independent contractor model for GPs emphasises patient-focused, high-quality care, equitable access, and cost-effectiveness. This model is predominant in most developed health systems and has proven to be effective.[14]

GPs operating under the independent contractor model are more likely to establish lasting practices in their communities, provide continuity of care that is both equitable and accessible, have higher patient satisfaction, and to be flexible in responding to health crises as they arise.

While Govt policy has been to expand access to GP care through Doctor Visit Cards there has been a net increase of just 136 GPs (5.6%) holding GMS/DVC contracts with the PCRS over the last 10 years.[15]

A recent survey shows that while different career options may be attractive to GP trainees initially, the vast majority of recent GP graduates (69.1%) plan to become a GP principal/partner in 5 years' time.[16] Responsibility for finance, property and employees continues to act as a barrier to young GP graduates wishing to establish in practice.

For young GPs seeking to establish themselves in a new community, the initial investment costs in premises, equipment, IT systems, insurance etc. are particularly prohibitive and specific grants and supports are required to support this cohort of GPs.

As far back as 2015 the Department of Health commissioned a report from Indecon[17] which recommended incentives to support GP investment and infrastructure but those recommendations have never been enacted.

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[14] IMO Submission to the Oireachtas Health Committee on General Practice Manpower and Capacity Issues 2017 https://www.imo.ie/news-media/news-press-releases/2017/imo-opening-statement-to-/Submission-to-OHC-GP-Capacity-issues-Final.pdf

[15] PCRS Data https://www.sspcrs.ie/portal/annual-reporting/

[16] Rethinking Career paths, Career Intentions of GP Trainees and Recent GP Graduates ICGP Report of the 2023 Survey https://www.irishcollegeofgps.ie/Portals/0/Clinical%20Hub/Publications%20and%20Journals/Current%20Publications/CH_Pub_Current_Career_Intentions_of_GP_Trainees-2023_Report_v2.pdf

[17] Indecon International Economic Consultants 2015 Analysis of Potential Measures to Encourage the Provision of Primary Care Facilities , Dublin 2015

Recommendations

- Targeted measures are required to enable GPs to establish and sustain GP practices through an independent GP contractor model including:
    - Additional targeted supports and grants are required that support newly qualified GPs in establishing themselves as GP partners/principals.
    - the current cohort of GPs should be supported with options to take on newly qualified GPs with a view to partnership.
    - Implement recommendations from Government commissioned Indecon Report 92015) to support GPs in the development of practices.

Investment in Electronic Health Records and IT Infrastructure

To facilitate effectively the effective delivery of safe, high-quality, and integrated care, as well as enhance health service planning, management of disease, and research and innovation, we urgently require significant investment in electronic health records (EHR) and IT infrastructure.

The Health Information Bill lays out an ambitious legal framework, which if implemented correctively, will bring considerable benefits to the delivery and planning of health care in Ireland through the sharing of electronic patient information between health professionals to to support the care and treatment of patients. However it is vital that any system of electronic health records is secure, fit for purpose in a busy clinical environment and resourced appropriately EHRs must not add to the administrative workload and compromise or reduce valuable patient facing time.

Recommendations

- Provide a full economic impact assessment of the Health Information Bill
- Publish and resource an investment plan to fully digitalise the health service over the next 5 years.

Medical Workforce Planning

Poor workforce planning and decades of under- investment has left us with a chronic shortage of medical specialists with long waiting lists to access specialist care.

- Based on our current population approximately 5,600 consultants are required to assure a consultant delivered healthcare service.
- However of 4,500 approved consultant posts, just 3,700 posts are filled on a permanent basis – with both figures falling far below the numbers recommended to provide a consultant delivered service.
- With one-fifth of consultants posts unfilled or filled on a temporary/locum basis.[18] The HSE is still experiencing delays and difficulties in recruiting consultants to certain posts - Of 445 unfilled posts, 161 have been unfilled for at least 1 year.
- Patients continue to experience long delays in accessing outpatient appointments . Of the 838,996 on waiting lists in July 2024, of which more than 712,191 (84%) are yet to even receive a date for their appointment or procedure.[19] Where patients do receive a date, the next challenge is when can treatment (diagnostic, surgery, or follow-up) be completed.

NCHDs in training are our future workforce, however numerous studies have shown that staff shortages, deteriorating working conditions, lack of opportunities for career progression, poor work-life balance, and burnout, are all driving emigration among our newly qualified specialists.[20] Our health system relies on International doctors, who fill 80% of non-training NCHD Service posts and without whom the system could not function, but their commitment to our patients is not matched by the HSE or the Government who are failing to provide them with training opportunities and career structures.

After narrowly avoiding industrial action the IMO reached an agreement with the HSE and the Dept of Health in December 2022 to address unsafe and illegal working hours of NCHDs. However our survey of NCHDs carried out earlier this year shows ongoing failures by the HSE to implement the terms of the 2022 agreement:

- 83% of NCHDs routinely working more than 48 hours a week, creating an environment that is inherently unsafe for patients and doctors.
- 68% have been required to work for more than 10 consecutive days. In almost half of cases without compensatory pay or additional rest days.
- And 77% of NCHDs are being pressurised by their employer to work extra shifts, often at short notice, to cover gaps in the rota. This is a key factor in high levels of NCHD burnout and stress.

[18] NDTP Medical Workforce Report 2023-2024 https://www.hse.ie/eng/staff/leadership-education-development/met/plan/medical-workforce-report-23-24-digital.pdf
[19] NTPF July 2024
[20] Humphries et al. COVID-19 and doctor emigration: the case of Ireland, Hum Resour Health (2021) 19:29 https://doi.org/10.1186/s12960-021-00573-4

The IMO welcomes the on-going recruitment of consultants, however the IMO has warned that the new public-only consultants' contract will not, in and of itself, solve the chronic problems the health service is facing. Doctors are trained over many years to deliver high quality and appropriate care to patients. However the lack of investment in our public health services make it almost impossible for doctors to deliver safe care in a timely manner.

Difficulties facing consultants include

- Access to diagnostics, inpatient beds, clinic and theatre space all cause on-going backlogs to patient care.
- Insufficient staffing of multi-disciplinary teams, allied health care professionals as well as admin staff, all place additional burdens on existing employees,
- poor IT infrastructure and delays in the roll out of electronic health records all impact on the efficiency and quality of patient care.

In February this year, the Minister for Health, published the Final report of the National Taskforce on the Non-Consultant Hospital Doctor Workforce[21] with recommendations across priority areas of Work-Life Balance and The Working Week; the Working Environment; Education and Training; ICT; and Workforce Configuration.

While the IMO acknowledges that the NCHD Taskforce Report and recommendations go some way to addressing the issues faced by NCHDs today, we need to see major investment and implementation to make those recommendations a reality and bring about meaningful reform. This includes developing a medical workforce plan to match the aspirations of the report and ensuring a supportive and robust working environment for NCHDs in order to provide high standards of patient care, enhance NCHD welfare, and improve retention rates.

29% of consultants in the HSE[22] and 32% of GPs[23] are over the age of 55. Raising the Standard Fund Threshold (SFT) to encourage doctors who are nearing retirement age to remain in the medical workforce. At present once a doctor reaches the SFT the pension amount above this threshold is effectively taxed at 72% which may lead some consultants to choose to retire given the marginal value to their pension of continuing to work. The SFT should be aligned with workforce planning rather than working against it to ensure we retain experienced consultants where possible. In the UK one of the key considerations in abolishing their version of the SFT, the Lifetime Allowance (LTA), was to simplify the pension system and encourage senior NHS staff to remain in the workforce without worrying about breaching the LTA.

Transfer of tasks from doctors to other healthcare professionals, should only take place where there is evidence of improvement to quality of care and never a substitute for the employment and training of highly trained medical specialists. Current policies to transfer tasks from doctors to other healthcare professionals such as pharmacists and physician assistants, have raised concerns among IMO members in relation to the potential impact on quality of care and patient safety.

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[21] Depat of Health 2024 Final report of the National Taskforce on the Non-Consultant Hospital Doctor Workforce https://www.gov.ie/en/publication/631e7-national-taskforce-on-the-non-consultant-hospital-doctor-nchd-workforce-final-recommendations-report/

[22] NDTP Medical Workforce Report 2023-2024

[23] Medical Council, Workforce Intelligence Report 2023 https://www.medicalcouncil.ie/news-and-publications/reports/medical-workforce-intelligence-report-2023.pdf

Recommendations:

- Update the current and future medical workforce requirements taking into account:
    - predicted geographical and demographic changes in population
    - new clinical programmes and models of care
    - strategic requirements such as laid out in Sláintecare
    - demand should be based on Whole Time Equivalents (to take into account part-time working) and predictable attrition rates.
- Develop and fund a comprehensive medical workforce plan with actions laid out to:
    - increase the number of consultants and training posts in line workforce requirements. (The NCHD Taskforce recommended a target ratio of 110 consultants per 100,000 of the population and an increase the number of NCHD postgraduate training posts to a minimum of 5,800-6,000)
- Address ongoing challenges in recruitment and retention
    - Urgently address issues of on-going chronic staff shortages and workload pressures that impact on safety and well-being of patients and doctors
    - Ensure all additional supports are in place to so that consultants can deliver safe, quality and timely care.
    - Deliver on the recommendations contained in the Report of the National Taskforce on the Non-Consultant Hospital Doctor Workforce.
    - Increase the umber of training posts to ensure access to training programmed for our International doctors.
    - Raise the Standard Fund Threshold (SFT) to encourage doctors who are nearing retirement age to remain in the medical workforce.

- Transfer of tasks from doctors to other healthcare professionals, including pharmacists and physician assistants should only take place where there is evidence of improvement to quality of care and never a substitute for the employment and training of highly trained medical specialists.

Improve and Enhance Services in General Practice and the Community

Expansion of the Chronic Disease Management Programme

While National Policy is focused on expanding access to GP care through Doctor Visit Cards, there is a need to further improve and enhance the range of services provided in General Practice. The Chronic Disease Management Programme, negotiated with the IMO in 2019, has reached its target of 430,000 patients enrolled in a CDM programme and a further 100,000 opportunistic case findings were made.

Open to all GMS/DVC card holders with specified chronic conditions included in the CDM are Type 2 Diabetes; Asthma; Chronic Obstructive Pulmonary Disease and Cardiovascular Disease inc. Heart Failure, Ischaemic Heart Disease, Cerebrovascular Disease (Stroke/Transient Ischemic Attack, Atrial Fibrillation), the programme has contributed to a 16% reduction in hospital admissions for chronic conditions. [24]

The prevalence level of chronic conditions is estimated at 10% for those aged 18 to 49 and 31% for those aged 50 + [25]and eligibility should be expanded beyond GMS/DVC holders.

Recommendation

- Expand the Chronic Disease Management Programmes on a universal basis to all patients with specified chronic conditions over 18 years old.

Invest in a Comprehensive Women's Health Programme in General Practice

Government policy to improve womens' health services has included the introduction of free contraception for women aged 17-35 and the development of specialist menopause clinics, however women's health is not just about contraception and there are waiting lists of up to 6 months to access specialist menopause clinics.

Continuity of care in General Practice can ensure that women access a range of services over their lifetime from advice on contraception, screening of STIs, advice on fertility and pre-conception as well as advice on the menopause. Issues such as informed consent, patient safety, coercive situations, young people – all require the privacy and the skills of a vocational trained doctor. In addition the consultation provides an invaluable opportunity for GPs to check in on particularly vulnerable patients including:

- teenagers, (those underage and trying to be responsible)
- victims of domestic abuse, (the consultation provides an opportunity to ask how everything is going at home)
- asylum seekers (particularly where there are concerns relating to FGM).

[24]HSE 2024, Community care improving health outcomes and experiences for patients across Ireland https://about.hse.ie/news/community-care-improving-health-outcomes-experiences-patients-across-ireland/

[25]Terms of Agreement between the Department of Health, the HSE and the IMO regarding GP Contractual Reform and Service Development 2019https://www.hse.ie/eng/about/who/gmscontracts/2019agreement/agreement-2019.pdf

Recommendation

- Invest in a comprehensive women's health programme in General Practice to include:
    - Advice on Contraception to all women in their reproductive years,
    - Advice on sexually transmitted infection (STI), screening and testing for STIs
    - Advice on fertility and pre-conception
    - Advice on menopause

Review the Model of Community-based Mental Health Services

The Independent Review by the Inspector of Mental Health Services has highlighted significant deficits in relation to the Provision of Child and Adolescent Mental Health Services in the State.[26] Inadequate funding and difficulties in recruiting and retaining key staff leading to long delays for young people accessing services and a large variation in the service provide both across and within CHOs. The report also highlighted clear evidence of silos in the provision of services to children a need to better integrate CAMHS into the wider health services.

Many of the findings reflect widespread issues across community mental health services including:

- particular challenges in recruiting and retaining consultant psychiatrists - one-third of consultant psychiatry posts are unfilled or filled on a temporary/locum basis.
- A crucial need to integrate mental health services more effectively into the wider health system. For example, patients seeking help at the Emergency Department for acute self-harm require access to liaison psychiatry and age-appropriate inpatient care. Similarly, individuals with long-term mental illnesses often have multiple coexisting health issues.

Recommendations

- Undertake an urgent review of the current model and governance of community-based mental health services to
    - ascertain its impact on staffing levels and patient care.
    - And facilitate better integration of specialist mental health services within the larger health system.

Invest in Community Ophthalmic Medical Treatment Scheme (COSMTS)

The Community Ophthalmic Medical Treatment Scheme has been in operation in a small number of practices since 2004 and offers a number of advantages including:

- COSMTS practices are based in the community relieving the burden on Emergency Departments of Eye Hospitals or Eye Units within General Hospitals.
- Acute emergency eye cases can be seen on the same day, urgent cases can be seen within 1-2 days and routine cases within 1-2 weeks

[26] Independent Review of the Provision of Child and Adolescent Mental Health Services in the State by the Inspector of Mental Health Services into https://www.mhcirl.ie/sites/default/files/2023-07/Mental%20Health%20Commission%20Independent%20Reviews%20of%20CAMHS%20services%20in%20the%20State.pdf

The failure to reverse FEMPI cuts means that the fee in 2008 is still 15% higher than the current fee some sixteen years later. At the same time costs have risen inexorably, particularly in the last number of years to the point where the scheme may now collapse.

Recommendation

- reverse FEMPI cuts to the Community Ophthalmic Medical Treatment Scheme (COSMTS) and increase the fee in line with inflation in the intervening period to 2024.

Public Health Campaigns

Social Media and Youth Mental Health

The IMO has become increasingly concerned about the impact of Social Media on the Mental health and well-being, particularly of young people . Numerous international studies have revealed a correlation between social media use and a range of mental health issues among young people including increased depressive symptoms, self-harm and suicidal ideation[27] [28] cyber-bullying, [29] body image issues and eating disorders. [30]

In Ireland, the My World 2 Survey of Youth Mental Health[31] which surveyed over 10,000 adolescents 12-19 years old in 2019 found that:

- Just over one-third of adolescents (34%) reported spending more than three hours online per day, 29% reported spending 2-3 hours online a day
- the proportion of adolescents who fell into the severe and very severe categories for depression and anxiety had doubled since 2012
- adolescents who reported spending more than three hours online were more likely to be in the very severe range for depression. A similar pattern was observed for anxiety.
- A clear trend was also observed between low levels of body esteem and time spent online.

In 2023 the US Surgeon General issued an advisory calling attention to the growing body of evidence relating to the harmful impact of social media on youth mental health and recommended a multi-faceted approach to better safeguard the mental health and well-being of children and adolescents from the harms of social media including actions by policymakers, technology companies, researchers, families, and young people.

Recommendation

- urgently develop a well-funded public health strategy modelled on successful "tobacco free" policies to combat the harms related to social media.

[27] Twenge JM, Joiner TE, Rogers ML, Martin GN. Increases in depressive symptoms, suicide-related outcomes, and suicide rates among US adolescents after 2010 and links to increased new media screen time. Clinical Psychological Science. 2018 Jan;6(1):3-17.
[28] McTernan N & Ryan F, Updated Aug 2023, The Harmful Impact of Suicide and Self-Harm Content Online: A review of the Literature, NSRF, Ireland, https://www.nsrf.ie/wp-content/uploads/2023/09/Harmful-impact-of-suicide-and-self-harm-content-online-Review-of-the-literature-Update-August-2023-Final.pdf
[29] Cosma A, Molcho M, Pickett W. A focus on adolescent peer violence and bullying in Europe, central Asia and Canada. Health Behaviour in School-aged Children international report from the 2021/2022 survey. Volume 2. Copenhagen: WHO Regional Office for Europe; 2024. Licence: CC BY-NC-SA 3.0 IGO.
[30] Dane A, Bhatia K. The social media diet: A scoping review to investigate the association between social media, body image and eating disorders amongst young people. PLOS Global Public Health. 2023 Mar 22;3(3):e0001091.
[31] Dooley, B, O'Connor, C, Fitzgerald, A, & O'Reilly, A, My World Survey 2, The National Study of Youth Mental Health in Ireland.UCD School of Psychology and Jigsaw,

Vaccine Hesitancy

Vaccine hesitancy refers to delay in acceptance or refusal of vaccination despite availability of vaccination services and is one of the WHO's top 10 threats to global health. [32]

Uptake of some recommended childhood immunisations in Ireland remain below the 95% World Health Organisation target for herd immunity while recent out breaks of measles are a growing concern.[33] A recent report from UNICEF shows that the perception of the importance of childhood vaccination fell 6% from 91.5% to 85.5%.[34]

The causes of vaccine hesitancy are complex and multi-factorial, with misinformation on-line contributing to reduced confidence in proven vaccines.

Doctors can play a key role in overcoming vaccine hesitancy. In addition experience from the HPV vaccine campaign shows that vaccine hesitancy can be reversed through a well-funded and coordinated public health campaign.

Recommendation

- develop and fund a coordinated public health campaign to tackle vaccine hesitancy,

[32] WNO, Ten Threats to Global Health https://www.who.int/news-room/spotlight/ten-threats-to-global-health-in-2019
[33] Ceannt R, Vaccine hesitancy 2023 https://www.hse.ie/eng/health/immunisation/hcpinfo/conference/nio-lunch-and-learn-vaccine-hesitancy.pdf
[34] UNICEF; The State of the World's Children 2023. UNICEF 2023. Access here: https://www.unicef.org/reports/state-worlds-children-2023#Reportarea

Climate Change Adaptation and Mitigation

Climate change is one of the greatest societal challenges of the 21st Century, and has direct and indirect impacts on population health and healthcare. This includes, but is not limited to, climate related illness and its effects, increasing health service demand, and risks to critical infrastructure including health infrastructure which affect the health services' ability to care for our patients. With mean annual temperatures projected to increase by 1–1.6 degrees Centigrade by 2041–2060 compared to the reference period 1981–2000, recent ERSI research shows the impact of climate change on health[35]:

- Using data from HIPE over the period 2015-2019, emergency hospital admissions for temperature-affected diseases were 8.5% higher on hot days (22–25C) compared to moderate temperature days (10–13C) in Ireland.
- The largest increases in hospitalisations on hot days were seen for circulatory, respiratory and infectious diseases, and amongst younger people (0-14 years).
- Hospital admissions for health conditions linked with temperature are projected to increase by 12.2% during hotter weather in the period 2041–2060 period while climate change could lead to 1,400 additional deaths per annum in Ireland by the end of the 21st century.

To these ends, effective climate action is urgent and of critical importance for our current and future populations.

In line with the recommendations of the WHO on Environmentally sustainable health systems, the HSE Climate Health Strategy lays out a range of actions and targets for the HSE to take both reduce the environmental and social impact of the delivery of healthcare and help the population prepare and adapt to climate-related impacts.

Recommendation

- Ring-fenced funding must be provided to ensure that effective sustainability and adaptation actions laid out in the HSE Climate Health Strategy are implemented in full.

[35] Duffy, K., De Bruin, K., Henry, L., Kweku Kyei, C., Nolan, A., and Walsh, B. (2024). Health impacts of climate change and mitigation policies in Ireland , ESRI Research Series 188, Dublin: ESRI, https://doi.org/10.26504/rs188

Medical Negligence and Tort Reform

The current adversarial system of litigation following adverse events is not in the interests of patients, doctors or the State.

In addition to the rising financial cost of resolving and managing ongoing claims (€538.1m in 2023 - up 33%on 2020)[36], the emotional strain of an inefficient and lengthy courts process whereby on average, claims in Ireland take 1,462 days to conclude[37] creates significant stress for patients and doctors alike with consequential impact on their mental and physical health.

For the practice of medicine itself, fear of litigation encourages defensive medicine thereby ordering extra diagnostic tests, procedures or visits and avoiding high-risk patients or procedures.[38] While both fear of litigation and lack of confidence in the risk management process leads to poor engagement and learning from adverse events. [39]

A wide range of measures are needed to address the culture of litigation following an adverse event. Over the past number of years the IMO has made a number of submissions on the rising cost of indemnity insurance and open disclosure, and are consistent in the much needed changes required.

Recommendations

- While legal provisions have been made to support reforms regarding pre action protocols, case management rules, and greater use of periodic payment orders, on-going barriers preventing the acceleration of these key reforms must be identified and addressed.
- efforts must continue to promote resolution of disputes through mediation and other alternative mechanisms. Recourse to the courts should be a last resort
- detailed assessment of No-Fault Claims Systems and their implementation in different jurisdictions could address concerns and ensure the development of a no-faults claim system that is fit for purpose.
- People with disabilities should have automatic entitlement to health care and social supports including access to community therapy services so that patients and their carers are not required to take legal action to secure appropriate long-term care and support.

[36] NTMA '2022 Annual Report and Financial Statements'
[37] Medical Protection 'The Human and Financial Cost of Clinical Negligence Claims'.
[38] Baungaard, N., Skovvang, P., Hvidt, E.A., Gerbild, H., Andersen, M.K. and Lykkegaard, J., 2020. How defensive medicine is defined and understood in European medical literature: protocol for a systematic review. *BMJ open*, *10*(2), p.e034300.
[39] Forrest C, O'Sullivan MJ, Ryan M, O'Tuathaigh C, Browne TJ, Rock K, O'Leary MJ, Madden D, O'Reilly S. Patients' and doctors' views and experiences of the patient safety trajectory of breast cancer care. Breast. 2024 Jun;75:103699. doi: 10.1016/j.breast.2024.103699. Epub 2024 Feb 29. PMID: 38460442; PMCID: PMC10943021.