ICGP vision for the future of Irish rural general practice

Dr Margaret O'Riordan
Medical Director ICGP

Acknowledgments

The Clare, Galway and Mayo ICGP faculties made a significant contribution to this report. In particular Dr Jerry Cowley, Dr Fergus Glynn, Dr Liam Glynn, Dr Noreen Lineen-Curtis, Dr John McCormack and Dr Peter Sloane. Ms Patricia Patton ICGP Librarian supported the literature review.

The ICGP Board and Dr John Gillman as Chair of the Membership Committee were very supportive of this initiative.

The Irish College of General Practitioners

About the Irish College of General Practitioners

The Irish College General Practitioners (ICGP) is the professional body for education, training, research and standards in general practice.

College Activities

- Teaching, training and education at undergraduate and postgraduate levels
- Accreditation of specialist training programmes in general practice
- Operates a professional competence scheme under arrangement with the Medical Council
- Examining body for membership in general practice (MICGP)
- Continuing education and professional development
- Research
- Practice management support through training, advice and consultancy
- General practitioner health
- Public relations and media liaison on behalf of the profession
- General practice publications, guidelines and protocols
- Advice and support to members
- Advocacy on behalf of the profession with external agencies

Contact Us

Irish College of General Practitioners
4–5 Lincoln Place, Dublin 2
Tel: 01 6763705, Fax: 01 6765850
Email: info@icgp.ie
Web: www.icgp.ie

© ICGP 2015

TABLE OF CONTENTS

© 2015 ICGP

Introduction

Twenty four million consultations take place in Irish general practice each year (Behan et al, 2013) and over one million consultations by the out-of-hours co-ops (NAGP OOH CO-Ops, 2013). 90–95% of patients are managed in the GP setting (DOH, 2001). Satisfaction levels with general practitioners are very high with 94% of patients reporting a positive experience with the doctor they attended most regularly (IMC, 2014). Under investment in general practice in Ireland has made the speciality less attractive for qualifying GPs. Manpower research carried out by ICGP in 2014 (Collins et al, 2014) indicated that 12.5% of trainees are planning on emigrating post qualification and a further 25% are undecided. Most quote uncertainty about security in their professional roles as the most significant cause of concern. Furthermore a recent NUIG paper showed that 90% of medical graduates were considering emigration (Gouda et al, 2015).

GP workload continues to rise with an aging population, chronic disease management and the challenges of multi morbidity. There is an increase in the transfer of hospital related workload into general practice in an unco-ordinated and unplanned manner raising patient safety concerns. Limited access to diagnostics hampers the ability of the GP to deliver the service they are trained to do in a comprehensive fashion (O'Riordan et al, 2013). Access to secondary services can be determined by catchment area criteria limiting options for referral for public patients.

Preliminary ICGP membership data analysis in 2015 reveals that up to a fifth of general practitioners are aged 60 or above with almost 33% aged over 55. There are regional disparities for example 52% of GPs in Mayo are aged over 55 years and over a third (36%) of GPs in Carlow are aged over 60. In Clare, Cork, Laois, and Wexford at least 28% of GPs are aged over 60.

Ireland is facing an urban / rural divide in many areas of life. There is depopulation and running down of services such as public transport, closure of post offices, schools, shops, pubs and Garda stations, and with these factors, there are reductions in social interactions for all members of rural communities and in particular for the elderly.

In healthcare a rural/urban divide which mirrors the existing private/ public divide is emerging. Seven per cent of rural patients live within walking distance of their GP compared to 89% of urban dwellers (Teljeur et al, 2010). The development of large primary care centres may improve access to services in densely populated areas but will not be viable in rural areas. If measures are not introduced to support rural general practice further inequality of access to healthcare amongst rural populations which has never been a feature of Irish primary health care provision will be created.

As more rural GPs reach retirement and are not replaced, residents in rural areas will need to travel greater distances and possibly increased waiting times to see a GP. This will have more implications for older patients than younger patients unless good public transport links are available.

© 2015 ICGP

In a survey of over 2,000 Irish GPs (Gabhainn et al, 2001) rural practices had fewer private patients and more socio-economically deprived patients than those in cities or towns. Rural practices were also more likely to be working from publicly owned purpose built premises and to work longer hours. Non medically qualified spouses were also more likely to be employed in rural practices which may reflect the limited job opportunities in rural versus urban areas.

Despite all these challenges rural GPs remain determined to continue. This stems from the fact that many such GPs live in their remote communities and are anxious to protect rural practice for the good of the profession and most importantly to meet the needs of rural communities. Rural General Practice can be a very rewarding career with the opportunity to practice comprehensive patient centred continuity of care for a defined group of patients. Rural Practice also entails the use of a broad range of skill sets in often challenging situations. It is in the interest of supporting and growing this valued career that the current cohort of rural GPs are seeking to raise awareness of the issues facing rural general practice so that the necessary supports can be introduced to sustain it into the future.

© 2015 ICGP

Current challenges facing Irish general practice in rural areas

Following consultation with ICGP members and in particular the Clare, Galway and Mayo ICGP faculties the following issues have emerged.

1. Loss of viability

Under FEMPI cuts, rural practices have disproportionately suffered due to several different factors which taken together have pushed many rural practices into insolvency.

- High proportion of GMS patients
- Distance band removal
- Rural practice allowance (RPA) has also been removed from many practices. The RPA provides essential support to singlehanded rural practices which are very substantially dependent upon it to deliver services. The arbitrary, unilateral, and non-consultative fashion in which the removal of the RPA has taken place is also of concern. One specific example is of a practice in North Connemara which extends over a large dispersed population catchment area. In the past this practice was viable because of a combination of rural practice allowance, dispensing privileges and distance coding. The practice no longer has a rural practice allowance and distance codes have been abolished. It is now unlikely, due to the financial situation, that this practice will be able to continue. Not alone will this result in the loss of the GP and his practice but patients will have to make in excess of a 50–75 kilometre round trip to see a doctor in an area with poor public transport links.

2. Recruitment and retention

Rural general practice is faring worse in attracting new GPs to replace retiring GPs. This issue came to public attention in 2014 when the HSE was unable to attract a GP to replace the retiring GP in Feakle, Co. Clare. The Feakle community, many of whom are elderly, now have to travel substantial distances to access primary healthcare, in an area which has almost no public transport links. The GP based in Gortnahoe, Co. Tipperary recently retired as he had reached retirement age. Following advertising of the post on two occasions the HSE failed to fill the post and the retired GP has now resumed his former post as a locum at the request of HSE (despite being past the established retirement age). This is obviously only a short term solution. HSE data indicates that this situation is worsening particularly in rural and some inner city areas. There were 18 GMS panels vacant as at 1st February 2015. As of 1st May 2015, there are 21 GMS vacancies (48% rural practices and 52% urban practices) around the country. None of these panels were unoccupied as all had locum arrangements in place.

Of the 18 vacancies in February 2015, 10 (56%) were urban and 8 (44%) were rural. Of the 18 vacancies 10 had been vacant for over a year and four of these were

© 2015 ICGP

vacant for more than two years.

- 8 (44%) were vacant for 6 months or less;
- 3 (17%) were vacant for between 6 months and 12 months;
- 3 (17%) were vacant for 1–2 years;
- 4 (22%) were vacant greater than 2 years

Some specific examples are as follows:

- In Moycullen, Co. Galway, where there are 585 people registered with medical cards, there has been a long term locum in place for 7 years
- A GMS post in Borrisokane, Co. Tipperary has been advertised three times with a panel size of 600 and has had a locum in place for 2 years.

3. Lack of infrastructural support

Provision of a suitable premises is a challenge for all general practices. Traditionally the majority of premises in rural areas are publicly owned. In recent times there has been a move towards non provision of premises when a post is advertised or alternatively offering a publicly owned premises at a high rent. When a rural practice has a relatively small list size with limited ability to grow the business, suitable premises provision may be a deciding factor in viability particularly where more than one premises has to be maintained. RPA are also linked to practice support staff allowances. In the absence of a RPA the GP may have insufficient income to support essential staff employment of the core team of practice nurse and administration. This in turn limits the range and quality of service for patients and threatens practice viability. Limited list size hampers the ability of a rural GP to develop special interests and provision of increased services in the community. At a time when over 92% of GPs use electronic medical records and communication by electronic means with colleagues in community and hospital settings is essential – lack of access to reliable fast broadband also poses a challenge in many rural areas.

4. Out of hours services and locum cover

Many rural practices are single handed, and this is unlikely to change in the near future for a range of reasons including geography, population, and assistant / partner costs. Out of hours cover, sick leave and holiday relief are essential for all GPs to practice in a safe manner but particularly for those in single handed practices. It is increasingly difficult for GPs in rural areas to source locums and when they do the cost of such cover limits their ability to avail of same. The stress associated with inability to source locums also impacts on the GPs family due to difficulty planning holidays or leave of any kind. If a GP cannot source a regular locum then their ability to take on other posts e.g. teaching to develop their career and supplement practice income is also severely curtailed.

© 2015 ICGP

North East Doctor on Call (NEDOC), which provides overnight and weekend GP services for counties Louth, Meath, Cavan and Monaghan, was forced to close its base in Meath four times over a six week period recently (Walsh, 2015). Arlene Fitzsimons, operations manager with NEDOC indicated that there were not enough qualified locums to provide cover and that many doctors were now so busy with their practice during the day, they could not take time off to work overnight. In the West of Ireland in particular the out-of-hours and on-call commitment can be onerous with many practices still not covered by Out of Hours Co-Operatives. There are rural Galway GPs who work every night on a mid-week on-call rota in addition to working every fourth or fifth weekend on-call.

5. Ambulance support and pre-hospital emergency work

Rural ambulance and emergency cover can pose particular challenges. In rural Galway there can be problems with limited ambulance availability and underestimation of the time needed to reach isolated areas on bad roads. The ambulance service increasingly requests that GPs provide backup (when the service is under-rostered or busy) as opposed to being a backup to the GP, or as it should be, a standalone emergency response service. GPs are not paid for providing this extra service. Rural GPs regularly respond to 999 calls and are heavily involved in pre-hospital care supporting the ambulance service; however, rural GPs provide their own equipment and training at their own expense. For example there is non-provision (the cost of sourcing and the availability of supply) of oxygen cylinders for rural practice. If the ambulance or lifeboat service need essential emergency supplies such as Oxygen they are provided free of charge yet the GP is expected to pay for them.

6. Island GPs

Ten GPs provide medical services for over 2,400 residents on ten of the twenty six inhabited offshore islands of Ireland. These GPs are further divided into those who reside on the islands fulltime, and those who make regular, scheduled visits by boat while remaining available by phone for the remainder of their 24/7 contract. A number of GPs also look after the majority of the islanders' medical needs on the mainland but get called to attend emergencies on the islands from time to time.

The unique challenges and difficulties faced by GPs living on or travelling to offshore islands urgently needs to be recognised and addressed. They travel in all types of craft often in inclement weather to attend to their patients, and an acute emergency on an offshore island can take a GP away from their normal (busy) schedule for anything up to six hours. This does not happen on the mainland. In recent years, these GPs have been faced with inequitable cuts and reductions to their service, e.g. the impact of removal of distance codes, to allied healthcare professional services, e.g. marked reduction in nursing services and to the infrastructure, and are stretched to breaking point at present. The vast majority of newly trained GPs are not prepared to commit to the level of service needed by offshore islands and when the current GPs retire or move, there will be nobody

© 2015 ICGP

to take on this onerous responsibility, unless improvements are made to current contracts and infrastructure.

Offshore Irish islands with resident/visiting GP

ISLAND	GP STATUS	POPULATION
Tory Island	Visiting	145
Arranmore	Resident	514
Inishbiggle	Visiting	16
Clare Island	Visiting	160
Inishturk	Visiting	46
Inishbofin	Visiting	160
Inishmore	Resident	845
Inishmaan	Visiting	150
Inisheer	Resident	250
Cape Clear Island	Visiting	124

7. Professional and Social Isolation

Both patients and doctors suffer from loneliness and personal isolation in rural Ireland and there is a significant issue with professional isolation for rural GPs which needs to be addressed.

© 2015 ICGP

Rural general practice – the international experience

Introduction

Recruiting and retaining doctors in rural and underserved areas is an internationally recognised problem. The WHO produced a major report in 2010 highlighting the inability of rural practice globally to achieve economies of scale. Rural practice lists are usually much lower than average and usually have a practice population that is spread over a large area often in conservation areas or areas with a static or declining population. Due to the lack of employment opportunities working age people often move to find work in urban areas leaving behind an increasingly aging population. Retired people often chose to move from the city to the country adding to the aging population. There is no level playing field for rural practices to compete and increase list size. In general, rural practices cover much larger geographical areas than non-rural practices and many have more than one surgery premises in order to improve access to care for the frail and elderly. Inevitably this increases the staff patient ratio and associated costs. In a recent OECD study of 34 European countries the Netherlands was the only country that was not concerned about the distribution of doctors within the country (Ono, 2014).

In the UK, the Royal College of General Practitioners Rural Practice Standing Group produced a report in (Ward, 2009) highlighting work related issues such as the difficulty obtaining holiday, study leave and sickness locum cover in UK rural areas. Geographical isolation was compounded by professional and social isolation. Due to geographical isolation and falling rural population density most rural practices did not have the option to increase resources. The group concluded that money follows the patient policies with a focus on the development of large primary care centres threatens to widen the rural urban divide for access to primary care services. A Scottish report focusing on rural and remote areas came to similar conclusions (Nicholl & McVicar, 2012).

In a national survey of rural GPs in New Zealand (James et al, 2001) lack of locums, onerous on call and GP shortages all contributed to overwork and stress in those providing the service. Goodyear Smith et al (2008) undertook a later survey of New Zealand (NZ) GPs which highlighted worsening workforce challenges due to the aging workforce and intentions to leave rural practice. A third of those surveyed expressed an intention to leave NZ rural practice within 5 years. The younger generation of GPs wanted to work significantly less hours and intended to move on or retire from rural practice at a much younger age than their older colleagues.

Potential solutions

Despite a good deal of research devoted to identifying factors that influence the recruitment and retention of doctors in remote and rural areas, rigorous evidence about which incentive schemes or policies are the most effective in increasing the supply of doctors to underserved areas is lacking (Bärnighausen 2009, Grobler, 2009).

© 2015 ICGP

What is clear is that a multifaceted approach is needed to address this international problem. The WHO (2010) suggest four categories of interventions to improve recruitment and retention of health workers in remote and rural areas. These are Educational, Regulatory, Financial incentives and Professional and Personal support. Buykx (2010) focused on retention problems in Australia and developed a rural and remote health workforce retention framework which illustrates one multifaceted approach. There are six components to the framework staffing, infrastructure, remuneration, workplace organisation, professional environment, and social, family and community support.

1. Undergraduate and Postgraduate Training

Commencing at medical school entry there is evidence to show that students from rural and remote areas are more likely to return there to work after qualification. McGrail (2011) shows a strong association between selection of students with a rural background and increasing the supply of Australian rural doctors. In a systematic review Brooks (2002) also highlighted the importance of a rural upbringing and training factors including commitment to rural curricula and rotations as strongly correlated with retention in rural areas.

Curran (2004) outlines a multifaceted approach that medical schools can adopt to support recruitment and retention of physicians in rural communities. Rural student recruitment, admissions policies, a rural-oriented medical curriculum, rural practice learning experiences, faculty values and attitudes, and advanced procedural skills training can all contribute.

The Jefferson Medical College in Pennsylvania initiated the Physician Shortage Area Program (PSAP) in 1974 (Rabinowitz, 1993). This programme which combines a selective medical school admissions policy and educational programme has been successful in increasing the number of family doctors in rural and underserved areas. Applicants from rural backgrounds who are interested in working in general practice in rural and underserved areas are targeted and admitted. These students receive financial incentives, a family medicine faculty advisor and a special family medicine training programme incorporating rural placements. Overall, PSAP graduates were much more likely than their non-PSAP classmates to practice in a rural area and/or in an underserved area. Furthermore high retention rates were achieved and maintained over time (Rabinowitz, 2005) with increases in both recruitment (eight-fold) and long-term retention (at least 11–16 years) in rural and underserved areas.

In another US review Rosenthal et al (2000) described the success of developing rural training tracts (RTTs) to encourage recruitment into rural general practice. Over a ten year period (1989 to 1999) there were 107 graduates from these training programmes. 76 percent of RTT graduates were practicing in rural America and graduates felt prepared for rural practice.

Recruitment of international medical graduates is an option to meet personnel shortages in all health care settings. Rabinowitz (2012) highlighted the evidence

© 2015 ICGP

to show that Rural Physician Programmes had a much greater relative impact on rural doctor supply compared to an increasing reliance on International Medical Graduates.

2. Views of medical students and junior doctors

Several studies have explored younger doctors opinions on the factors that would make a career in rural practice more attractive. In a Norwegian study (Holte 2015) final year medical students and interns highlighted once more that a multi-faceted approach would be needed. Those who came from a rural area were more likely to consider returning there to work. One of the attractions of a career in general practice was a perceived opportunity to control working hours with opportunities to do this more limited in rural areas. Holte concluded that a combination of controlling working hours, practice size 3 or more doctors), professional development and better off in terms of income by 10% predicted an increase in rural uptake. Hill (2002) explored the views of New Zealand GP Trainees who highlighted the importance of a reduction in on call work, guaranteed time out of the practice for holidays and study leave and consideration of needs of partners and their children.

3. Financial incentives

Bärnighausen and Bloom (2009) undertook a systematic review of financial incentives and identified five different approaches to enhance recruitment to underserved areas. These were scholarships linked to service after training, educational loans linked to service requirements, service option educational loans, loan repayment programmes, and direct financial incentives. The first three approaches involve students committing to participate in the programme either before they start or early in their medical education. The latter two commit after completion of their education. Loan repayment programmes are for completion of educational programmes while direct financial incentives have no restrictions on what the money can be spent on. They concluded that there is substantial evidence to support financial-incentive programmes for return of service in underserved areas leading to both increase in placement and retention. Across 25 programmes included in the meta-analysis an average of 7 in 10 participants fulfilled their service commitment. Programmes that commenced after training had higher recruitment rates. The evidence is limited by the fact that the majority of studies were from the USA (where for instance educational fees are considerably higher than many other countries) and none of the studies included selection effects.

Sempowski (2004) looked at the effect of Return On Service programmes to Canadian rural and underserviced areas and found that short-term recruitment improved but there was less success with long-term retention. They highlighted the importance of other retention strategies, such as medical education initiatives, community and professional support, additional rural payments and alternate funding models. Once again a multifaceted approach appeared to be more successful than financial incentives alone.

© 2015 ICGP

A New Zealand study highlighted financial solutions as part of a multifaceted solution (James, 2004).Proposed solutions to aid retention included improved pay and conditions, more salaried positions and improved continuing medical education. Recruitment solutions included reducing barriers for international doctors to practice in New Zealand, focusing on developing a rural general practice career pathway and increasing the number of GP Registrars trained in rural areas.

Australian General Practice funding models provide income related to location. The retention scheme for GPs and GP registrars offer incentive payments that increase according to degree of remoteness, length of service in a rural area, and workload. For example funding provided for GPs included one off infrastructure and training grants, relocation grants (removal expenses and travel), ongoing retention incentives for those already in rural areas, payments to overseas trained doctors, payments to GP Registrars, higher Medicare (fee-for-service) rebates for some GP items, and higher Practice Incentive Program payments according to geographic remoteness. (Scott 2013)

The Australian Medical Association (2012) identified the following five key priority areas to attract doctors to rural areas:

- provide a dedicated and quality training pathway with the right skill mix to ensure GPs are adequately trained to work in rural areas
- provide a realistic and sustainable work environment with flexibility, including locum relief
- provide family support that includes spousal opportunities/employment, educational opportunities for children's education, subsidy for housing/ relocation and/or tax relief
- provide financial incentives including rural loadings to ensure competitive remuneration
- provide a working environment that would allow quality training and supervision

4. Infrastructural reform

The RCGP Rural Practice Working Group (Ward, 2009) proposed that Primary Care Federations (PCFs) could provide a way forward for rural practices. The PCF outlines a variety of ways in which practices can group together to improve access to services for patients that would not be viable for individual practices to provide themselves. This model could allow each practice to retain traditional ways of working but, by co-operating with each other gain increased negotiating power with the health service regarding the breadth of service provision. The needs of each geographical area vary and need to be taken into account in any planning exercise as one size will not fit all. For example due to geographical isolation a practice may form a federation with a practice in a completely different geographical area united via electronic communications. While individual

© 2015 ICGP

practices may not have premises to provide all of the suggested services the combined practice populations may justify funding for extension/modernisation of one or more of the constituent practice premises on the basis of shared access.

Issues that could be addressed by the formation of PCFs could include:

- Out of hours services
- Holiday and sickness cover
- Combined practice education/training events
- Improving minor injury/minor surgery services
- Improving access to investigations
- Improving transport for test samples to improve result turnover
- Desk top analysers at a designated site
- Improving access to primary care team members
- Improving access to Mental Health Services
- Outreach specialist consultant clinics, GP specialist clinics, nurse specialist clinics
- Potential for improvements in practice management with shared expertise
- Increased purchasing power for practice requisites

The French government have developed a package of incentives to encourage doctors to practice in rural and underserved areas (European Commission, 2014). The package includes training initiatives, financial incentives, review of work practices, development of telemedicine, promoting research in primary care and developing infrastructure in isolated areas. Development of infrastructure includes ensuring access to emergency care and restructuring of health services at local and regional level.

© 2015 ICGP

Recommendations for the future of Irish rural general practice

Having considered the current challenges facing rural practice and a range of interventions that have tried internationally it is clear that a multifaceted approach is needed in address this issue in Irish General Practice. It is also clear that one size does not fit all and that planning at a local and regional level will be needed to meet the needs of communities and patient services.

Therefore the following interventions should be considered:

1. Education and training initiatives

- Medical School applicants from rural backgrounds who are interested in working in general practice in rural and underserved areas should be targeted and admitted. Consideration should be given to providing these students with mentors to guide them through medical school. General Practice rural placements should be incorporated into medical school programmes and the general practice component of the curriculum should be strengthened particularly for universities outside the Dublin area.
- General Practice Training schemes should continue to be delivered at local level in order to promote retention in the areas in which the doctors are trained. The success of this approach has already been demonstrated in Ireland. As an example the Donegal GP Training scheme has had 52 graduates over the past 10 years, 40 graduates are currently working in Irish General Practice and 21 of these are based in Donegal. The Cork GP Training scheme has had 80 Graduates over the past 7 years with 77 working in general practice and 64 in the Cork Region.
- Established GPs in rural areas should be supported to attend CME in whatever form is suitable for them – CME small group network meetings, conferences and on line education.

2. Financial incentives

- Financial incentives should be considered beginning at medical school entry level. At a time when the costs associated with university attendance continue to rise (particularly for graduate entry medical students) a number of financial incentives should be considered. For example these could include scholarships or educational loans linked to service after training.
- Rural practices usually have lower than average-size practice lists, are spread over a large geographical area and often have an increasingly ageing population. Specific financial incentives will be needed to support viable practice in rural areas. The proposed new GMS contract needs to take the needs of rural practice specifically into account. Specific initiatives such as restoration/maintenance of rural practice allowances or equivalent must be included. Restoration of distance codes or equivalent must take place.

© 2015 ICGP

3. Infrastructural support

- As general practice moves towards increasingly complex care provision funding of infrastructure and ancillary staff to support this development will be essential. Many rural practices often have more than one premises in order to improve access to care. Inevitably this increases associated costs. Traditionally practice premises in rural areas are publicly owned – this needs to continue. Where lists are of limited size these premises should be provided rent free.
- Rural practice by its geographic nature requires additional services and skill sets, which will be more demanding and complex in the future with the reconfiguration of Secondary/Tertiary Care and ancillary services. The members of the core general practice team consisting of GP(s), Practice Nurse(s) and administration staff need to be supported in the first instance. Once the core team has been established then the primary care team members should be assigned to work with specific practices.
- Support grants for IT and Practice Equipment will also be necessary.
- A commitment to resource emergency services in a realistic manner to provide services for rural communities must be prioritised. Patients in urban areas expect an emergency service to respond to their 999 call in a timely manner – it should not be any different for those in rural areas.
- GPs must be supported in the provision of appropriate emergency equipment and training.

4. Working hours and locum support

- It is clear that control over working hours are a core issue for all doctors particularly newer graduates. An innovate approach to supporting rotating assistantships between single handed practices or between single handed practices and urban based practices needs to be considered.
- Flexible and part time GMS contracts need to be supported.
- Locum support to provide for CME / Holiday and times of illness, must be guaranteed and fully funded for the maintenance of the professional competence, health and well being of the general practitioner, supporting an uninterrupted and comprehensive service to patients.
- A comprehensive standard National Out-of-Hours is essential to support the rural GP. The provision of Out-of-Hours Services, in rural areas must be fully resourced to ensure that a rural practitioner and patients receive the same service, as in any non rural area. The practitioner's commitment to and provision of out of hours services should be the same as colleagues in non rural areas. Rostering commitment to, and financial compensation for, out-of-hours work should reflect the national norm.
- In areas where the CO-OP is not able to provide cover due to geographical isolation additional measures must be introduced to support doctors on onerous rotas.
- A specific locum agency should be established to supply locums for rural areas.

© 2015 ICGP

5. Community hospitals

Community hospitals are also staffed by rural GPs. They enable local GPs to provide care for the elderly and respite care and to provide step down facilities for general hospitals. They can also prevent the need for admissions to acute units and in some areas provide end of life care. These hospitals are often at the centre of rural communities providing day care facilities and rehabilitation units in addition to long stay beds. These hospitals are a core part of the health service and should be recognised and supported.

6. Island GPs

The unique needs of the Island GP service including contractual, allied health professional and infrastructural support must be addressed.

© 2015 ICGP

Conclusion

Irish Rural General Practice is at a crossroads. Rural GPs value the professional and personal satisfaction that they get from their careers and the essential role they provide for rural communities. Despite all the challenges they have faced from the external environment they continue to deliver a quality service. Rural GPs deserve to be supported in their quest to preserve and grow this service to meet the needs of future generations of Irish rural communities. A range of potential solutions are outlined in this report. It is imperative that the government address this issue as a matter of urgency before it is too late.

References

1. Australian Medical Association Regional and Rural Workforce Initiatives 2012 *https://ama.com.au/position-statement/regional-and-rural-workforce-initiatives-2012*
2. Barnighausen, T and Bloom, DE. (2009) 'Financial incentives for return of service in underserved areas: a systematic review', *BMC Health Service Res*, 29(9), pp. 86.
3. Behan, W. Molony, D. Beame, C. and Cullen, W. Are Irish Adult General Practice Consultation Rates as low as official records suggest? A cross sectional study of six general practices. *IMJ* 2013 Nov–Dec; 106(10):297–9.
4. Brooks, RG, Walsh, M, Mardon, RE, Lewis, M, and Clawson, A. (2002) 'The roles of nature and nurture in the recruitment and retention of primary care physicians in rural areas: a review of the literature', *Academic Medicine*, 77(8), pp. 790–798.
5. Buykx, P, Humphreys, J, Wakerman, J and Pashen, D. (2010) 'Systematic review of effective retention incentives for health workers in rural and remote areas: towards evidence-based policy', *Australian Journal of Rural Health*, 18(3), pp. 102–109.
6. Collins, C. Mansfield, G. O'Ciardha, D. and Ryan, K. Planning for the future Irish General Practitioner Workforce – informed by a national survey of GP Trainees and recent GP graduates. ICGP 2014.
7. Curran, V and Rourke, J. (2004) 'The role of medical education in the recruitment and retention of rural physicians', *Medical Teacher*, 26(3), pp. 265–272.
8. Department of Health Ireland. *Primary care a new direction: Quality and fairness – a health system for you*. DOH 2001.
9. European Commission. (2014) "*Recruitment and Retention of the Health Workforce in Europe: 8 case studies on selected topics addressing recruitment and retention of health professionals – Annex 5*" Luxembourg: Publications Office of the European Union.

© 2015 ICGP

10. Gabhainn, SN, Murphy, AW, and Kelleher, C. (2001) 'A national general practice census: characteristics of rural general practices', *Family Practice*, 22(3), pp. 622–626.

11. Goodyear-Smith, F and Janes R. (2008) 'New Zealand rural primary health care workforce in 2005: more than just a doctor shortage', *Australian Journal of Rural Health*, 16(1), pp. 40–46.

12. Gouda P, Kitt K, Evans DS, Goggin D, McGrath D, Last J, Hennessy M, Arnett R, O'Flynn S, Dunne F, O'Donovan D. Ireland's medical brain drain: migration intentions of Irish medical students. *Human Resources for Health.* 2015 Mar 12;13:11. doi: 10.1186/s12960-015-0003-9.

13. Grobler L, et al. (2009) "*Interventions for increasing the proportion of health professionals practising in rural and other underserved areas (Review)"* The Cochrane Library.

14. Hill, D, Martin, I and Farry P. (2002) 'What would attract general practice trainees into rural practice in New Zealand?', *The New Zealand Medical Journal*, 115(1161).

15. Holte, JH, Kjaer, T, Abelsen, B, and Olsen, JA. (2015) 'The impact of pecuniary and non-pecuniary incentives for attracting young doctors to rural general practice', *Social Science and Medicine*, 128, pp. 1–9.

16. Irish Medical Council 2014 *Talking about good professional practice Views on what it means to be a good doctor.* Irish Medical Council 2014.

17. Janes, R, Dowell, A, and Cormack, D. (2001) 'New Zealand Rural General Practitioners 1999 Survey–Part 1: an overview of the rural doctor workforce and their concerns', *New Zealand Medical Journal*, 114(1143), pp. 275–279.

18. Janes, R, and Dowell, A. (2004) 'New Zealand Rural General Practitioners 1999 Survey–Part 3: rural general practitioners speak out', *New Zealand Medical Journal*, 117(1191).

19. McGrail, MR, Humphreys, JS, and Joyce, CM. (2011) 'Nature of association between rural background and practice location: a comparison of general practitioners and specialists', *BMC Health Services Research*, 11, pp. 63.

20. NAGP OOH Co-Ops 2013 Personal Communication National Association of GP Out of Hours Co-operatives.

21. Nicoll, P. and MacVicar, R. (2012) NES Supporting Scottish Remote and Rural Healthcare, Board Paper Summary, Item 8c. Edinburgh; NHS Education for Scotland.

22. Ono, T, Schoenstein, M and Buchan J. (2014) 'Geographic Imbalances in Doctor Supply and Policy Responses', Working Paper: OECD Publishing.

23. O'Riordan, M, Collins, C. and Doran, G. 2013 *Access to Diagnostics – a key enabler for a primary care health service.* ICGP 2013.

24. Rabinowitz, HK. (1993) 'Recruitment, retention, and follow-up of graduates of a program to increase the number of family physicians in rural and underserved areas', *New England Journal of Medicine*, 328(13), pp. 934–939.

© 2015 ICGP

25. Rabinowitz, HK, Diamond, JJ, Markham, FW, and Rabinowitz, C. (2005) 'Long-term retention of graduates from a program to increase the supply of rural family physicians', *Academic Medicine*, 80(8), pp. 24–27.

26. Rabinowitz, HK, Petterson, S, Boulger, JG, Hunsaker, ML, Diamond, JJ, Markham, FW, Bazemore, A, and Phillips, RL. (2012) 'Medical school rural programs: a comparison with international medical graduates in addressing state-level rural family physician and primary care supply', *Academic Medicine*, 87(4), pp. 488–492.

27. Rosenthal, TC. (2000) 'Outcomes of rural training tracks: a review', *Rural Health*, 16(3), pp. 275–279.

28. Scott, A, Witt, J, Humphreys, J, Joyce, C, Kalb, G, Jeon, S-H and McGrail, M. (2013) 'Getting doctors into the bush: General Practitioners' preferences for rural location.', *Social Science*, 96, pp. 33–44.

29. Sempowski, IP. (2004) 'Effectiveness of financial incentives in exchange for rural and underserviced area return-of-service commitments: systematic review of the literature', *Canadian Journal of Rural Medicine*, 9(2), pp. 82–88.

30. Teljeur C, O Dowd T, Thomas S and Kelly A. (2010) 'The distribution of GPs in Ireland in relation to deprivation', *Health and Place* 16, pp. 1077–1083.

31. Walsh, Louise. No out-of-hours service four times in six weeks over shortage of GPs. *Irish Independent*, 8 July 2015. [Online] Available from: *http://www.independent.ie/irish-news/health/no-outofhours-service-four-times-in-six-weeks-over-shortage-of-gps-31360693.html* [Accessed 12 August 2015].

32. Ward, M. (2009) 'Primary Care Federations: A rural perspective: A paper from the Rural Practice Standing Group', RCGP.

33. WHO. (2010) "Increasing access to health workers in remote and rural areas through improved retention - Global policy recommendations," World Health Organisation: Switzerland.

© 2015 ICGP