



IRISH MEDICAL  
ORGANISATION

Ceardchumann Dochtúirí na hÉireann

## **Supporting and Developing Rural General Practice**

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## Introduction

General Practice is the most cost effective and efficient part of the Irish Health Service, but unfortunately due to successive reductions and cuts it is in severe difficulty. It is only continuing to operate due to the commitment and work of the Practitioners providing the service.

One of the hardest hit areas of general practice is Rural General Practice.

The difficulties faced by Rural General Practice are many and have a variety of different causes. The purpose of this paper is to set out some of the more prevalent causes of these difficulties, the problems these cause Rural Practitioners and finally to look at short, medium and longer term solutions to these issues going forward.

It is the position of the IMO that a strong and progressive Rural Practice is vital to delivery of healthcare in Ireland. We would hope and expect this is a view which is widely shared.

In addressing Rural General Practice it is important to bear in mind the wider problems facing Rural Ireland in general. Rural Ireland has suffered disproportionately as a result of the economic collapse, with businesses closing, services being reduced, high levels of unemployment and resultant movement to urban areas or indeed emigration [**see graph 1**] (CSO, 2011).

Instances of rural poverty are on the increase and as per the CSO report in 2013, the percentage of the Rural Population defined as living in poverty was 10.7% as against 6.6% in urban areas (CSO, 2013).

The 2011 census also showed that the average age of the population in rural areas was two years above that in urban areas. This is further emphasised by the dependency rates of older persons within the population, with 35.7% of the population in Rural Ireland being dependents as against 31.4% in urban areas. Of these dependents again there are a greater proportion of elderly dependents in rural areas as against urban areas [**see graph 2**] (CSO, 2011).

In examining this issue it is important to bear in mind the overall context of rural Ireland, and where General Practice fits into this context. For example in considering the contributors to social exclusion among rural elderly population NUI Galway and the Irish Centre of Gerontology found there to be five interconnecting domains of exclusion within older rural population, which are:

- i. Social connections and social resources;
- ii. Services;
- iii. Transport and mobility;
- iv. Safety;
- v. Security and crime.

(Walsh, O'Shea, & Scharf, 2012)

Of these domains the GP is relevant in relation to social connections and resources, services, transport and mobility and to safety. This shows the importance of the GP in this context.

This paper will now explore the specific problems of Rural General Practice and the causes of these difficulties.

## The Problems facing Rural General Practice

Over the course of the Financial Emergency the Government has used the FEMPI mechanism to cut funding to general practice. Since the first reduction in 2009 the payments to General Practitioners have been reduced by in or about 38%. While these cuts have had detrimental effects on many practices, some have been more damaging to Rural Practice. One of the most significant cuts was the removal of distance coding, but other actions such as reductions in capitation rates, issues about renewal of medical cards, and changes to the interpretation of the criteria for the awarding of the Rural Practice Allowance have all caused difficulties.

For the reasons set out above, and as exhibited below, these cuts have been counterproductive, and we would suggest that have had a greater cost, than any savings which were achieved.

### Workload

The first issue to look at is the type of workload in rural practice. The changes and reduction in 24 hour accident and emergency in rural areas has had a predictable effect on the General Practitioners. When a hospital either closes or stops providing a 24 hour service then a portion of the resulting workload falls on General Practitioners. Combined with difficulties regarding the availability of ambulance services this means that GP's have to provide service over a wide area to patients who have significant medical needs. The reduction in capitation and remuneration, as well as the removal of the distance coding, which we will address at length later, means that this workable is simply not sustainable.

As the capitation was reduced the number of medical cards increased, with 1.35 million cards in 2008 (HSE, 2009) going to up 1.9 million cards at the end of 2013 (HSE, 2013). This led to an increase in the number of consultations undertaken, so more work was require for a decreasing payment.

To further exacerbate matters, given the older age profile of patients in these communities, the reduction in weighting of over 70's patients on panels for practice support subsidies, has had a disproportionate negative effect on Rural Practices.

Rural GP's provide a number of services which would not be provided in an urban setting where patients can more easily access outpatient services. The principle examples being phlebotomy and suturing. While the provision of phlebotomy is a service which the HSE is statutory obliged to provide, either due to distance or the services not being provided by the local hospital to do so, it often falls on the GP to do so. Despite undertaking work outside the provisions of their contract GP's have had to then face political pressure and threats of deductions from the HSE, and in some cases actual deductions, where they have charged an administration fee. In relation to suturing, while this is covered under the provisions of the GMS contract, the fee is completely unsustainable, a point made by the Minister for Health Leo Varadkar at the IMO AGM in April 2015.

The other significant workload issue faced by many General Practices is the requirement to operate "branch surgeries." These are secondary centres of practice, which the HSE require to provide care to extremely remote communities. The running of these centres takes significant time and resource, and the only contribution made by the HSE is in many cases the provision of a premises. In many cases these premises are extremely out of date and not at all fit for the purpose of the delivery of 21<sup>st</sup> century health care.

## **Out of Hours**

The next issue, while related to workload is the Out of Hours Commitment of General Practitioners. Under the GMS contract GP's are responsible for providing 24 hour care, which is generally done through formal out of hours arrangements such as Co-Operatives.

These arrangements are under pressure in many rural areas. Firstly due to manpower issues there are often a lack of General Practitioners to participate in the Out of Hours rotas. In more urban areas there is the potential to have a reduced roster commitment this is not possible in many rural areas.

The difficulties faced by rural practitioners in providing Out of Hours care were examined in a study in 2001, and the underlying issues set out in this have still not been addressed. GP's still have unsustainable rota's, there are still a lack of supports and the difficulty of finding locums for leave is now worse than before. The study noted the effect that this commitment had on the lives, performance and quality of life of GP's. It concluded by saying that "*a coherent and integrated strategy for the recruitment and retention of all rural primary care practitioners needs to be developed.*" (Cuddy, Keane, & Murphy, 2001)

This has yet to be done. Given that the payments related to locum expenses were also substantially reduced through the FEMPI process this situation has deteriorated since the time of the study.

Secondly, due to the distance code issue a number of the Out of Hours calls are loss making. This is due to the travel time required to attend to patients who may be located a significant distance from the GP's surgery.

## **Manpower**

There is a manpower crisis in General Practice, with rural general practice being amongst the hardest hit areas. The age profile of GP's working in rural areas is increasing, and there have been difficulties in securing replacements when these doctors retire or resign.

As doctors retire and they are not replaced, the manpower issue worsens for the doctors still in the area. The reasons for this include a high workload population which is dispersed over a wide area, the removal of supports and the high upfront investment required in order to establish in practice.

Attracting new GP's becomes more difficult as the income reduces, and the fact that the lifestyle is one which many would not find attractive (Teljeur, O'Dowd, Thomas, & Kelly, 2010)

As the population of GP's continues to age and vacancies continue to be unfilled, the position of the remaining GP's will continue to worsen and make the posts less attractive. This vicious circle needs to be stopped.

The difficulties in attracting GP's does not just apply to permanent recruitment. There are significant problems in sourcing appropriate locum cover. When it can be located, it can be very expensive. While a resource issue, the payments provided by the HSE does not cover a sufficient proportion of the locum cost, which in areas with little scope for private practice makes it difficult to afford. This leads to GP's not being in a position to take annual leave or indeed leave for CME. This again goes to the attractiveness of working in rural practice.

In addition to the manpower issues in relation to General Practitioners, there are also difficulties in attracting practice staff. Given the type of workload undertaken and the patient population the requirement for high skilled practice staff is very high. It can be difficult to attract such staff to work in rural practice, from both a cost and location point of view.

## Resources

All of the above issues on their own have created significant difficulties for the sustainability of Rural Practice. However, the reduction of resources provided has been the most damaging. This has not just been one reduction but a number of different cuts. We will lay out the most significant of these reductions, but it should be noted that while these are the most damaging, these do not encompass all of the cuts which have been imposed on rural practice

### 1. Removal of distance codes

The distance code system provided a weighted capitation and out of hours fee based on the geographic distance a patient lived from the surgery. This mechanism provided compensation based on the “footprint” of the practice, and encouraged the location of practices in rural areas, with highly dispersed patients.

It effectively bridged the gap between having a dense population in an urban area and having a more sparse population in a rural area. The removal of this did not save a significant amount of money from the primary care budget, but the effect was felt disproportionately as it largely affected rural practitioners.

The other issue with distance codes was that they provided a mechanism to cover the costs of house call's which could be a significant distance from the practice. This also helped with the provision of services through cooperatives. Without distance codes many house calls are now actually loss making. For calls undertaken during practice hours the increased capitation payment reflected the necessity to attend, and for those calls undertaken out of hours the increased payment reflected this, and also made it viable for co-operatives to undertake these calls.

### 2. Removal of Rural Practice Allowances

Changes to the interpretation of the criteria for the award of the Rural Practice Allowance has stopped a number of practice from retaining the allowance. This allowance was paid to the most rural and remote practices to make the practices sustainable despite the small population. Where the HSE has used the district part of the census rather than the town, this has led to a number of practices not receiving the allowance.

This had made it difficult to attract new GP's, and for established GP's to attract new doctors into their practice, given they will not be in a position to confirm that the allowance will be paid, and thus making the practice potentially unviable.

### 3. HSE Premises

While in many cases GP's provide their own premises either through ownership or rental, in a number of situations the HSE provides centres, and indeed are encouraging GP's to take up spaces in Primary Care Centres. Indeed in some cases there were attempts to make it a term of taking an appointment to the GMS that you would locate in a Primary Care Centre.

While there are a number of issues with these centres, there are 2 primary issues which are of concern. Firstly the duration and terms in place are unfavourable and are tilted in the HSEs favour. For example a duration of 5 years is standard which makes planning into the future difficult. Secondly there is a standard rent/licence fee in place for all centres, no

matter where they may be in the country. There is no regard given the particular local circumstances.

#### 4. Successive reduction in Capitation and other payments

The FEMPI reductions which have applied to all General Practitioners have been damaging across the board, and have left General Practitioners in a very difficult position, and in many cases have left practices non-viable. Given the levels of deprivation in many rural areas these cuts are more damaging, as there is little private income coming into these practices to offset the losses arising from FEMPI.

One reduction under this process which is often overlooked was the removal of the special fee payable for discretionary medical cards in 2013. This payment reflected the extra workload which would be expected of patients granted a medical card on discretionary grounds. With the removal of this, and the increase in discretionary cards, there was an increase in workload with a contrasting decrease in resourcing. This cut alone involved the removal of approximately €10 million annually from General Practice (Reilly, 2013), and a significant number of these cards were for rural patients.

All of the above gives an indication of the challenges and difficulties faced by Rural Practice. The result of these cuts and actions has been failure to fill posts, emigrating doctors and large dissatisfaction and anger among GP's. Failure to take necessary action will lead to further vacancies, lack of investment in practice and ultimately will lead to many patients having to travel significant distances to see a GP.

The importance of appropriate action being taken is emphasised by a recent study showing the difference in results for patients suffering Cardiac Arrest in rural areas. (Masterson, et al., 2015)

While there is no simple solution to these problems, we have identified actions which should be taken to address these difficulties in the short, medium and longer term. Taking appropriate action will be beneficial to GP's and patients, and indeed will move work from secondary care to primary which is far most cost effective.

## Solutions for Rural Practice

The IMO has a Framework Agreement and Memorandum of Understanding with the HSE and Department of Health to negotiate on behalf of GP's and one of the priorities is the area of Rural Practice. The IMO following consultation with Rural Practitioners has identified a number of actions which will help address the issues of Rural Practice.

While the attracting and retention of GP's is a difficulty, if necessary steps were taken the fact that 60% of GP graduates when surveyed stated they wished to remain in Ireland shows that the situation can remedied (McCárthaigh, 2014). We should take all necessary actions to ensure that they remain in Ireland, and that they see a future here.

We will firstly set out the short term or immediate steps which need to be taken, and then move on to the medium and then to the long term solutions which should be put in place.

### Immediate steps to take

While all of the difficulties faced by Rural Practice are urgent and there is a need for a number of actions to take place, there are a couple of actions which should be prioritised. This should not to the detriment of work and planning being undertaken on the medium to longer term solutions set out below.

#### Rural Practice Allowance

The first action which should be taken is to clarify and widen the criteria for the Rural Practice Allowance. While there has been some initial action on this by the HSE, this only addresses some problems at the margins. The criteria were set out in 1972, and there has been very little change in the interim period.

We would propose a substantial change to how this allowance is applied and granted. Firstly the criteria which are applied should be more certain. The use of the Electoral District rather than the population of the actual village or centre should be ceased. This has reduced the number of persons entitled to the allowance, and is an artificial distinction which is not justifiable. All decisions on the allowance should be based in the village or centre going forward.

The next proposal is that the allowance should be attached to a practice, rather than to a doctor. This would reduce the uncertainty which occurs upon retirement, and would be a way to encourage new GP's to take over a practice. It would allow greater planning into the future, and would make the filling of posts less of a difficulty.

The final issue is to move to introduce a tiered allowance. Rather than the current positon, which has been slightly amended, where you either receive the allowance or don't we would seek the introduction of a sliding scale. Such a scale would operate to allow those doctors who fall just outside the criteria would receive a less allowance dependent on how far outside the criteria they fall. The breakdown of how we see this operating is set out in the below table:

Centre	Town within 3 miles	Fees and Allowances	Financial Allowance
500 population	1,500 or less	Full Fees and Allowances	100%
Greater than 500 but less than 750	2,000 or less	Full Fees and Allowances	75%
Greater than 750 but less than 1,000	2,500 or less	Full Fees and Allowances	50%

While the level of the allowance and associated payments is something which needs be reviewed as part of the FEMPI review, we are concerned here with the conditions surrounding the award of the allowance.

#### Patient Location Allowance

The removal of distance coding, as addressed earlier, is felt strongly by GP's in Rural Ireland. It provided a fair mechanism to reflect the area which a practice covered, and compensated those doctors who had a much dispersed patient population for the resultant costs.

We would propose a patient allowance be put in place, based on a similar rationale to that underpinning the distance code system, which would provide an additional capitation and out of hours payments for patients based on their distance from the premises. It should be possible to introduce a more simplified model than what was in place under the distance coding system, while achieving the same results.

The introduction of such an allowance would improve viability, make house calls both during normal hours and out of hours possible and lead to a reduction in the number of ambulance calls. It would also assist the Out of Hours co-operatives' who are under pressure in many Rural Areas. If they were paid appropriately for house calls out of hours, rather than being the same rate for all out of hour's calls, then this would ease the pressure on the operations. Additionally some rural doctors can find it difficult to enter such arrangements, but this step would help address this, as it would be viable for the co-operative to include such practices in their rota.

#### Practice Supports

To reflect the additional workload on General Practice, and to allow single handed practices to develop we would propose some changes to the practice support subsidies. While there may be a longer term issue here, there are a couple of steps which could be taken immediately to assist Rural Practitioners.

Firstly allowing GP's in rural areas to hire a second Nurse or Secretary if it is required. While it may not be viable for some practitioners to take on a partner they could potentially develop their practices and increase the services on offer to patients by increasing the complement of practice staff.

Secondly allowing single handed GP's to qualify for the practice manager subsidy. This is currently confined to partnerships and group practices, and allowing single handed GP's to benefit from this allowance would be sensible action. Having a practice manager can greatly contribute to the development and management of a practice, and can free the GP to spend more time doing clinical work and seeing patients, rather than having to take on the day to day management of the practice. Allowing single handed GP's to qualify for this allowance would allow more practices to take on a practice manager, and allow their practice to enjoy the benefits. It should also be borne in mind that a number of such practices employ a practice manager but are getting no support.

### Special Items of Service

A number of the Special items of services are simply not cost effective to perform. In Rural areas due to the lack of a local outpatients departments GP's have to provide these services at a loss, which is neither sustainable nor fair.

The particular items which we consider should be addressed as a priority are suturing, removal of foreign bodies, catherisations and ECG's. The fees for these services need to be substantially increased to reflect the cost and time involved. Such an increase would decrease attendance at secondary care as more of these procedures could be undertaken in General Practice. This would be better for the patients, and indeed for the HSE. Even at an increased rate it would be still be more economical to undertake this work in Primary Care, rather than in a Secondary Care setting.

### Medium Term Steps

The actions we are calling for here, while not as immediately urgent as what is considered above, are still crucial. These are still important actions which need to happen.

### Branch Surgeries

Many GP's are required to operate branch surgeries as part of their contract with the HSE. These are often in areas with very low populations which are not sustainable to operate from. While we appreciate the need for such communities to have access to a GP, for this to continue proper supports need to be put in place.

In most cases all that is provided is a free premises, but this does not reflect the time commitment, and indeed time away from the principle surgery which is involved. It can have a knock on effect in terms of staff costs as well.

To address this situation where a GP is required to operate a branch surgery there should be specific supports available to reflect the commitment involved.

### Minor Surgery

Many GP's wish to expand the services they offer, and would welcome the opportunity to use their abilities and skillset to the fullest extent. One area which would allow for this is minor surgery. This is particularly the case in areas with limited access to secondary care, where encouraging the development of more minor surgeries would be welcome.

This could be done by introducing further special items of service, which would be at a rate which would adequately compensate the GP for the time, cost and skill required to undertake these procedures. Similarly to the STC's it would be better for the patient and for the HSE for more of

these procedures to be undertaken in a Primary Care setting. It would be also be an application of the principal of money following the patient which has been cited as the future of the health service.

#### Co-Operatives and Out of Hours

The current requirement for GP's to provide 24/7 cover is neither sustainable nor desirable. Currently many GP's cannot afford to buy out their red-eye shifts, i.e. the nights shifts which are often between 8pm and 8am, and so are having to cover their own commitment. They then often have to work in their surgery the following day. This is not good for the patient or for the doctor.

There is a need to address the level of out of hours cover required and to standardise arrangements throughout the country to address shortfalls.

#### Leave

One of the most significant issues faced by Rural Practitioners is securing locum cover for periods of annual leave. In the case of long term sick leave if the GP is unable to get long term cover then this is covered by the HSE, and a similar solution should be considered for other types of leave. We would also seek a review of the types of supports available to allow more isolated GP's to undertake CME.

In conjunction with this there should be a review of the payments for periods of leave. The Locum payment under the GMS scheme is in no way adequate in proportion to the costs of locums at present.

#### Longer term solutions

While all of the above areas are more specific actions, and steps the longer term concerns more policy actions and steps which should be followed.

The actions listed above if taken would certainly make Rural Practice more sustainable and allow it to further develop, but this is a process we should look to continue into the future. In order to do so the provision of ring-fenced budgeting for Rural Practice is a necessity. This would allow for the continuous improvement of Rural Practices.

With the Government commitment towards Universal Primary Care, with the development of more chronic care there will need to be significant investment in General Practice and particularly in Rural Practice. This is not even considering investment and development of a greater IT infrastructure or bringing premises up to HIQA standards.

When this is combined with the demographic pressures and increasing health issues like obesity it is simply not realistic to proceed without the dedication of such resources.

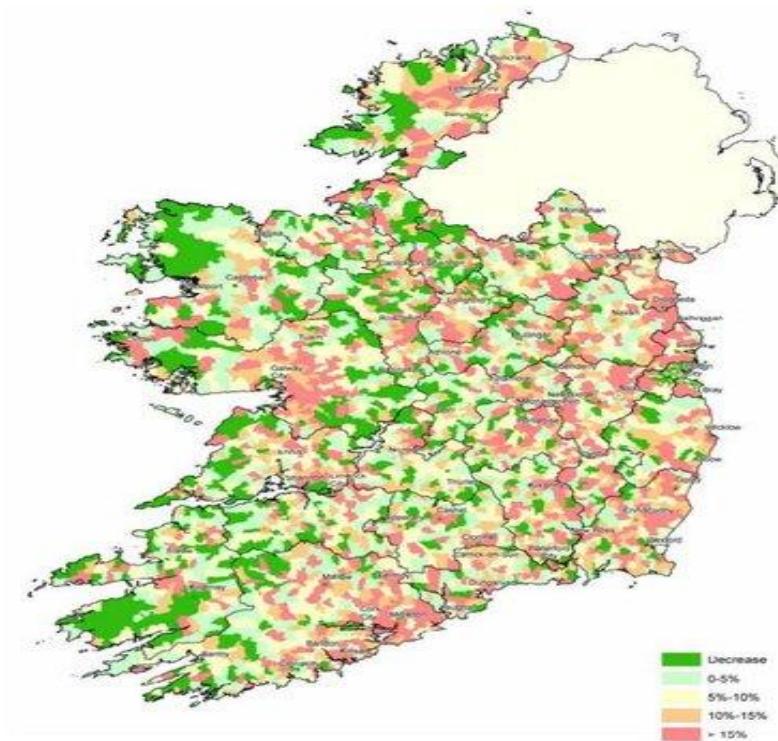
## Conclusion

In this paper we have identified a significant number of problems faced by rural practitioners, and outlined the factors which have left many practices in a perilous predicament.

While the situation is very serious, the IMO believes that by taking the actions which we have outlined that it can be improved. All parties are agreed that Rural Practice is a key part of the firmament of Rural Ireland, now it is time for action to be taken to ensure it survives into the future.

## Graphs and Illustrations

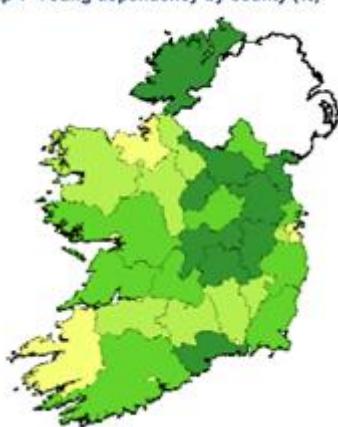
### Illustration 1



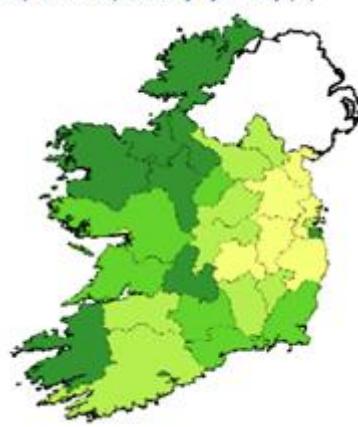
(CSO, 2011)

### Illustration 2

Map 1 Young dependency by county (%)



Map 2 Old dependency by county (%)



(CSO, 2011)

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