



19TH World Rural Health Conference

The Limerick Declaration on Rural Healthcare

2022

Introduction

The 19th World Rural Health Conference, hosted in rural Ireland and the University of Limerick, with over 650 participants coming from 40 countries and an additional 1,600 engaging online, has carefully considered how best rural communities can be empowered to improve their own health and the health of those around them. The conference has also considered the role of national health systems and all stakeholders, in keeping with the commitments made through the Sustainable Development Goals and the enjoyment of the highest attainable standard of health as one of the fundamental rights of every human being (1, 2). The conference was addressed by experts in rural health from all regions of the world and this conference declaration is in response to the “Blueprint for Rural Health”(3), the declaration from the 17th World Rural Health Conference in Bangladesh, which was designed to inform rural communities, academics, and policy makers about how to achieve the goal of delivering high quality health care in rural and remote areas most effectively. This statement is also in support of World Health Assembly resolution 72.2 on primary health care (4), which calls on all stakeholders to provide support to Member States in mobilizing human, technological, financial and information resources to help build strong and sustainable primary health care (PHC), as envisaged in the Declaration of Astana (5).

Guiding Principles based on “Blueprint for Rural Healthcare”

Globally, an estimated 2 billion people living in rural areas do not have adequate access to essential health services, which adversely affects health outcomes (6), and is a driving cause of health inequities experienced by rural populations. These inequities undermine human potential and national developmental trajectories, and are implicated in the weakening of national social cohesion (7). Rural communities also have important strengths and assets, which can play a key role in contributing to robust national health systems and inclusive

societies. The 19th World Rural Health Conference, its partners, and hosting organisations (Appendix 1) assert the right of rural communities to equitable access to healthcare:

- **Rural Healthcare Needs and Delivery**

Equitable access to rural healthcare should be based on the regular assessment of community needs, address all basic healthcare needs, and be based around a comprehensive, locally-based healthcare infrastructure linked to effective referral systems. Patient-centred care pathways should be co-designed with rural communities and enhanced, but not replaced, by technology. Attention must be given to understanding the supply-side and demand-side factors driving inequitable access, and addressing barriers to quality health services across the pathway.

- **Rural Workforce**

A sustainable Rural health workforce should as much as possible come from the local communities they serve and be incentivised, supported, mentored and valued throughout the career pathway. Social accountability should be a key underlying principle for higher educational institutions who should orientate their training, research, and service provision to populations living in rural and remote areas. The WHO guideline on health workforce development, attraction, recruitment and retention in rural and remote areas highlights the importance of interconnected, bundled and whole-of-society approaches to rural service delivery, tailored to the local context (8). This should be based on pillars of equity, diversity, and inclusion with gender as a key area of focus.

- **Advocacy and Policy**

Policy for rural health should include rural communities and rural organisations as key stakeholders and equal partners whose needs and views are sought and who participate in decision making as key informants about rural health. Government health policies, strategies, plans, programmes and financing modalities should be “rural proofed¹” to mitigate any deleterious effects of these in rural areas, particularly in the areas of social and environmental determinants of rural health. Governments should develop a unified policy to promote rural health, inclusive of rural proofing approaches at national, regional and local levels. This is in keeping with wider cross-sectoral approaches to rural development and revitalization of rural areas as essential for cohesive, equitable sustainable development (9). A successful and sustainable rural health sector requires inter-sectoral collaboration for the many dimensions of primary health care, including but not limited to investment in training and career pathways, hence creating a desirable workplace that healthcare workers will commit to for the longer term.

¹ Rural proofing is a term used to describe the systematic application of a rural lens to policies and other actions, to ensure that they are adequately accounting for the needs, contexts, and opportunities of rural areas.

- **Research for Rural Healthcare.**

The rural dimension often continues to be neglected in analyses of risk factors for ill-health, health status, and health system performance (10). Health research needs to be rural proofed with a designated percentage of funding ring fenced for this purpose. The media also have an important role in sharing research outcomes, to build national awareness of the issues facing rural communities and opportunities for greater national inclusion and societal wellbeing. Further research on the economic contribution of the health sector to rural and local development is also timely, given the economic multiplier effect of investments in the health sector (11, 12, 13).

Case Study: Irish Rural Healthcare

The participants recognise:

- That Ireland has one of the highest rural based populations in Europe – more than 1.6 million people, from a total population of 4.8 million(14). Irish rural practices have a higher proportion of older people, with more health needs, than other practices and face significant challenges in terms of geographical access and financial costs(15). Irish rural populations have already experienced the negative impact of loss of medical services followed by continuing depopulation; unless specifically managed, this phenomenon will only increase(16). It is crucial that issues of density and distribution of health workers are addressed in order to attain better health outcomes for rural communities.
- The absolute and relative number of rural Irish General Practitioners (GP) has been falling over the past twenty years (14). Those that remain are older than the national GP average. Key rural GP recruitment and retention difficulties include significant challenges in finding both short-term cover and long-term replacements, together with inadequate infrastructural support for often smaller list sizes(16).
- With the notable exception of the University of Limerick, Irish medical schools do not provide the internationally recognised gold standard for the promotion of generalism, namely Longitudinal Integrated Clerkships (LIC) in general practice(17).
- The significant potential for rural general practice nurses to both complement and support the work of GP's is not being realised. Significant barriers to achieving this coalesce around a lack of advanced practice nursing roles and the absence of a clear career pathway and funded educational opportunities(18).

- There is currently no Government target regarding the proportion of Irish medical graduates required in general practice to deliver ‘*Sláintecare*’ (Irish Government health policy)(19). Between the six Irish medical schools, the proportion of European Union (EU) graduates who apply for postgraduate general practice training places ranges from 25-55% (20). The reasons for this are unclear. *Sláintecare* is predicated on having a health service with a foundation in primary care where the right care is delivered to the right patient in the right place at the right time. This is a very sensible and also evidence-based founding principle, as we know that over 90% of healthcare contacts happen in the community and any healthcare system that has primary care as its foundation is more cost-effective and delivers better health outcomes for people.(21) However, this will not be achieved without recruiting and retaining a healthcare workforce, in our urban centres, but more critically outside our urban centres where they are most under threat.
- Increasingly, rural primary care providers in resettlement countries like Ireland are providing care to large refugee and migrant populations.
- There exists great opportunities to enhance the health system’s capacity to meet the needs of rural communities, in keeping with Government priorities for an inclusive Irish society, and to have the health sector contribute to economic growth in rural communities as part of a rural revitalization agenda. Rural proofing of Irish health policies can help ensure that they are aligned with rural needs and realities. This is called for in the EU Long Term Vision for Rural Areas (22) and is a forthcoming component of the Better Regulation Agenda, to assess the anticipated impact of major EU legislative initiatives on rural areas. This EU vision calls for Member States to consider implementing the rural proofing principle at national, regional and local level.

Congruent with current evidence(23) and best international practice(3, 24), the participants of the conference endorse the following recommendations:

Rural Healthcare Needs and Delivery

- A national health needs assessment of Rural Healthcare should be carried out and communities should be enabled and resourced to identify and address, and indeed solve, their local health care challenges.
- Rural services must provide first contact care which can be accessed within the community. Closure of rural healthcare services and practices or downgrading of such services to a “part time” basis must be avoided at all costs.
- The current focus on large urban based healthcare infrastructure development should be widened to include investment in rural healthcare infrastructure so as to ensure decent working conditions for rural health workers. This will include funding

to cover investment in innovative technological solutions to enhance but not replace the face-to-face service.

- This investment in rural healthcare infrastructure should be co-created with our rural communities protecting and enhancing local environments while addressing the social determinants of health.
- Essential rural and remote services such as dispensing of medication and house calls need to be specifically and properly funded and supported. Current funding mechanisms do not exist or are inadequate.
- There is a need for governmental initiatives to develop training and professional accreditation in interpreting to improve the availability of quality interpreting services for Irish primary care settings.
- To support community-based education programmes and the associated '*transformative learning*'(17), medical schools need to develop rural academic educational and research infrastructure closely aligned to the communities which they serve.

Rural Workforce

- We aim to build a diverse and inclusive workforce that is representative of the communities we wish to serve, underpinned by the principles of social accountability while being committed to gender equality and social justice.
- Building on established international examples, and rigorous research evidence, we recommend that a new undergraduate medical programme, dedicated to producing graduates who have the skills, attitudes and desire to work in rural and remote locations, is funded by the Irish Government.
- We need targeted admission policies to enrol students with a rural background in health worker education programmes.
- Under the principle of social accountability, all medical schools should develop, with appropriate funding, LIC's in general practice, with a particular focus on rural practice, and should include a curriculum consisting of a minimum of 25% of clinical placements based in the community setting.
- A specific rural curriculum and pathway should exist within GP training where Rural GP trainers/mentors should be recruited and retained, and exposure to rural practice should be maximised.
- On completion of GP training, an adequate number of postgraduate Rural General Practice fellowships funded by the National Doctors Training and Planning (NDTP) and the Health Service Executive (HSE) should form the next step of this Rural General Practice career pathway.
- Training at the medical school and postgraduate GP training levels should be based on curricula that include rural context and criteria for effective rural practice.
- Local HSE management, working with GP Network leads and GP principles should identify and offer support, guidance and mentoring in succession planning for retiring and pre-retiring GP principles on an ongoing basis.

- Challenges of solo practitioners should be recognized and supported through innovative solutions involving shared appointments, salaried posts, fellowship positions and creating partnerships and clusters.
- Guaranteed parental leave for practitioners and family friendly workplaces should be a minimum requirement for a rural healthcare practice.

Advocacy and Policy

- Under planned European legislation all government policy should involve rural stakeholders and will be mandated to undergo rural proofing.
- An All-Party Oireachtas Health Committee inquiry and report into Irish Rural Healthcare needs and services should be convened. This will provide a clear blueprint for the Irish Department of Health, the HSE and the Irish College of General Practitioners for Irish Rural Healthcare into the future.
- Development of a clear rural general practice career pathway (or '*pipeline*'). A target regarding the proportion of Irish medical graduates required in general practice to deliver '*Sláintecare*' should be set. The equivalent figure in the UK is 50%(25).
- We need to deploy a package of fiscally sustainable financial and non-financial incentives for health workers practising in rural and remote areas. The Rural Practice allowance is one such key support but access to it needs to be widened and it needs to be increased.
- To provide clinical, academic and advocacy leadership in Rural healthcare, Chairs of Rural General Practice should be funded within higher education institutions with, in addition, an ICGP Clinical Lead in Rural Healthcare .
- The Irish Department of Health and An Board Altranais should lead an inter-agency response to develop and support GP nursing career development and leadership which will lead to advanced practice nursing roles together with the provision of clear nursing career pathways.
- Different types of health workers for rural practice, such as advanced nurse practitioner and expanded paramedic roles, should be developed. These novel roles should meet the needs of communities based on people-centred service delivery models including enhanced scopes of practice.

Research for Rural Healthcare

- We must enable dynamic co-production of evidence on rural health between communities, health workers, academic researchers, policymakers (in health, rural development and other sectors) and civil society organizations by mainstreaming rural research activities.
- Community members need to be empowered to use their lived experiences and voices in research born out of these communities as key evidence in rural healthcare provision.

- We must identify, foster and develop rural research expertise directly within rural communities while encouraging and supporting innovative solutions to the challenges identified by communities themselves.
- We must make research skills accessible and available to rural communities and potential researchers through outreach and online programs developed and provided through partnerships with higher educational institutions and the Department of Rural and Community Development.
- This needs to be driven through ring fenced and proportional research funding accessible to communities and rural researchers building an equitable community of research practice.

Conclusion

All participants in this conference and the partner organisations commit to proactively adopting these principles and actions to strengthen the current Irish rural healthcare workforce; including our pandemic response, while creating novel opportunities for Rural Healthcare to serve our communities

Equal access to healthcare is a crucial marker of democracy. Hence we call on Governments, Policy makers, Academic institutions and communities globally, to commit to providing their rural dwellers with equitable access to healthcare which is properly resourced and fundamentally patient-centred in its design.

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Appendix 1. 19th World Rural Health Conference Partners, Collaborators and Hosting organisations

- The Irish College of General Practitioners
- University of Limerick, School of Medicine
- Rural, Island and Dispensing Doctors of Ireland
- World Organisation of family Doctors (WONCA)
- World Organisation of family Doctors (WONCA) Europe
- World health Organisation (WHO)
- WONCA Working Party on Rural health
- European Rural and Isolated Practitioners Association (EURIPA)
- National Centre for Rural and Remote Medicine (UK)
- St Andrews and Dundee Universities Scottish Graduate Entry Medical Programme (ScotGEM)
- Association of University Departments of General Practice in Ireland (AUDGPI)
- HRB Primary Care Clinical Trials Network Ireland
- WHO Collaborating Centre for Migrants' Involvement in Health Research
- Public and Patient Involvement Research Unit, University of Limerick,

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- Professor Bruce Chater, Chair WONCA Working Party on Rural health, Founding Chair of the Australian National Rural Health Alliance
- Dr Claire Collins, Director of Research, Irish College of General Practitioners
- Dr Jerry Cowley, Rural GP, Mulranny Co Mayo, Chairman, Rural Island and Dispensing Doctors of Ireland
- Dr Frank Fogarty, Rural GP, Clonmany Co Donegal, Rural Island and Dispensing Doctors of Ireland
- Professor Liam Glynn, Professor of General Practice, University of Limerick and Chair of the Organising Committee, 19th World Rural Health Conference
- Dr Peter Hayes, Senior Lecturer in General Practice, University of Limerick and Chair of the Scientific Committee, 19th World Rural Health Conference
- Professor Anne MacFarlane, Director, WHO Collaborating Centre for Migrants’ Involvement in Health Research and Public and Patient Involvement Research Unit
- Professor Andrew Murphy, Professor of General Practice, National University of Ireland, Galway
- Dr Patrick O Donnell, Clinical Fellow in Social Inclusion, University of Limerick and Co-Chair of the Student Committee, 19th World Rural Health Conference
- Professor Shelley Nowlan, Deputy National Rural Health Commissioner, Australian Government, Chief Nursing and Midwifery Officer, Queensland Health
- Dr Ferdinando Petrazzuoli, Chair Scientific Board, European Rural and Isolated Practitioners Association (EURIPA)
- Dr Diarmuid Quinlan, Medical Director, Irish College of General Practitioners
- Dr Robert Scully, Deputy Director ScotGEM, St Andrews and Dundee Universities.
- Professor Roger Strasser, Professor of Rural Health and Founding Dean Emeritus Northern Ontario School of Medicine (NOSM), Canada.
- Theadora Swift Koller, Department for Gender, Equity, Human Rights, Director General’s Office, WHO
- Dr. Shagun Tuli, University of Global Health Equity in Rwanda and Rural Ambassador to 19th World Rural Health Conference.
- Dr Victoria Sparrow-Downes, Memorial University of Newfoundland and Rural Ambassador to 19th World Rural Health Conference.
- Dr John Wynn Jones, Immediate Past President, WONCA Working Party on Rural health.

