

The possible effects of transport on a rural practice: a retrospective survey

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HOME visiting in North America occupies a much smaller proportion of the general practitioner's time than it does in this country—possibly only one or two visits each day. In this country, both under the National Health Service and in private practice, the surgery consultation–visit ratio is rarely greater than five to one and is quite commonly two to one. In rural practices this figure is as a rule even nearer to parity, and this is usually thought to be geographical in origin. For example, in this practice in 1965 the surgery–visit ratio was one to one.

This paper gives the results of a retrospective survey of the surgery consultations and visits for all patients of this practice for the whole in 1968, to determine what differences, if any, were the result of factors such as distance from the surgery, availability of private or public transport, the nearness of other practitioner's surgeries and the availability of bus services. A purely subjective retrospective opinion was also made concerning each visit as to whether the patient could have attended the surgery if transport had been available—either a private car or a vehicle supplied by the local authority, and these figures were also correlated with the place of residence and with the availability of private transport.

This is a dispensing rural practice with the surgery premises attached to the house situated eight to ten miles from each of nine other surgery premises in the district. The only bus service is from the market town eight miles away, so that often visits have to be made because absence of transport makes it impossible for patients to attend the surgery.

In this type of rural area it is possible to delineate what are known in political circles as spheres of influence and the patient's homes have been placed into the category of the 'sphere of influence' of this practice or of some other practice; this appears in the

TABLE I
PLACE OF CONSULTATIONS IN RELATION TO DISTANCE FROM SURGERY

	<i>Number of patients</i>	<i>Total consultation rate</i>	<i>Surgery consultation rate</i>	<i>Visiting rate</i>	<i>Surgery/visit consultation ratio</i>	<i>Possible L.A. transport ratio</i>	<i>Corrected visiting rate</i>	<i>Possible visits saved</i>
Within 1 mile	356	5 (1,780)	3.8 (1,371)	1.2 (398)	77	27 (108)	.9	.3
1–4 miles	491	4.5 (2,251)	1.8 (932)	2.7 (1,319)	41	64 (856)	.9	1.8
Over 4 miles	184	4.1 (756)	1.6 (303)	2.5 (453)	40	40 (298)	1.5	1.0
Total	1,031	4.7 (4,787)	2.5 (2,606)	2.2 (2,170)	54	60 (1,262)	0.9	1.3

tables as over four miles; this is a subjective division but there is no reason why it should invalidate the findings of this survey.

Table I. The surgery-visit consultation ratio for the practice in 1968 was 2.5-2.2. If transport had been available for all those whom it was considered applicable, the ratio would have become 3.8-0.9, a theoretical saving of 1.3 visits per patient per annum. Those patients living within one mile of the surgery could save 0.3 visits if transport was available, but some of these patients who require observation and medical attention have an aversion to attending a surgery under any circumstances.

Table II. The lowest consulting rate in all of the groups studied is given by those patients with a car who live from one to four miles from the surgery, although even here a possible of 0.6 visits might have been avoided if there had been official transport. The amount of visiting which the rural practitioner undertakes for what are basically social reasons

TABLE II
PLACE OF CONSULTATION IN RELATION TO POSSESSION OF A CAR AND DISTANCE FROM THE SURGERY

Cars	Number of patients	Total consultation rate	Surgery consultation rate	Visiting rate	Surgery/visit consultation ratio	Possible L.A. transport ratio	Corrected visiting rate	Possible visits saved
1-4 miles	264	3.8 (1,084)	2.2 (670)	1.6 (414)	61	42 (177)	1.0	.6
4+ miles	89	4.1 (370)	2.5 (223)	1.6 (147)	60	54 (80)	.7	.9
No cars								
1-4 miles	227	5.0 (1,146)	1.1 (263)	3.9 (883)	22	72 (637)	1.2	2.7
4+ miles	94	4.4 (417)	.8 (80)	3.6 (337)	19	64 (218)	1.2	2.4

TABLE III
PLACE OF CONSULTATION IN RELATION TO AVAILABILITY OF PUBLIC TRANSPORT

Bus routes	Number of patients	Total consultation rate	Surgery consultation rate	Visiting rate	Surgery/visit consultation ratio	Possible L.A. transport ratio	Corrected visiting rate	Possible visits saved
To Norham	196	5.1 (989)	1.8 (350)	3.3 (639)	35	60 (394)	1.3	2.0
Else-where	378	4.4 (1,699)	1.6 (637)	2.8 (1,062)	37	62 (668)	1.0	1.8
None to Norham	478	4.4 (2,100)	1.9 (928)	2.5 (1,172)	44	50 (588)	1.25	1.25
None else-where	309	4.5 (1,348)	2 (625)	2.5 (759)	45	62 (483)	.9	1.6

is illustrated by the figures for the possible visits which could be saved if transport was provided for those with no cars.

Table III. Rather unexpectedly, these figures suggest that those patients who are remote from any bus services have a lower visiting ratio than those who have the benefit of a bus service to some surgery or other, while those patients who live on a bus route to the village show up worst of all. Possibly those who live in more remote places are more reluctant to request a visit because of isolation from a telephone as well as from a surgery.

The saving of 1.0 visits per annum to patients living more than four miles from the surgery and who therefore could be considered to be living outside of my 'sphere of influence' leads to a more medico-political conclusion; if transport were to be provided out of public funds to bring patients to the surgery, it might be difficult to persuade the holders of the public purse of the propriety of doing this from other doctor's areas. There is no doubt that these figures do show that in a rural area such as this, a considerable saving of doctor driving time could be made so that more doctor patient time might result.

Assuming that on average the time to complete a visit is twice that required for a surgery consultation, it can be shown that this practice could provide medical care for another 160 patients in the same number of hours as at present, if transport was available to bring patients to the surgery.

Summary

A retrospective study in a rural practice is presented which demonstrates the possible increased time available for consultations if transport was available to bring patients to the surgery.

Looking ahead: the future maternity services of Bristol. JOSEPH SLUGLETT, O.B.E., M.D. *British medico-chirurgical journal.* 1970. 85, 9.

"Any plans for the future must take into account a number of factors of which the most important is the increasing demand by mothers for institutional delivery whether in specialist or general-practitioner maternity hospitals. In 1967 only 16 per cent of live births took place at home while by 1968 this had dropped to 11 per cent and it is reasonable to assume that this figure will be further reduced in the future. This is a trend which many feel should be encouraged, there is no place for domiciliary delivery in a well-equipped town like Bristol. . . .

"Until quite recently most general practitioners thought that, as far as their cases were concerned, special general-practitioner maternity hospitals would suffice but there is increasing realization that this is not the answer nowadays. They would feel much happier if they could conduct their deliveries in a well-equipped maternity hospital where all facilities would be immediately available in case of emergency. Further, if all mothers are to benefit from the modern approach to labour as described by O'Driscoll (1969) and his colleagues in Dublin, this can only be done in a maternity hospital."

REFERENCE

O'Driscoll, K., Jackson, R. J. A., and Gallagher, J. T. (1969). *British Medical Journal.* 2, 477.