# *Appointments—equating supply with demand*

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**SUMMARY.** A small increase in consulting time in one general practice has given pleasure to patients and helped to relax the receptionists.

## Introduction

Consultation rates vary widely, and it is assumed that they reflect differing consumer demand or divergent patterns of doctor-initiated recall. Beveridge thought that demand would ultimately fall as the population became healthier. Powell (1966) considered that the demand is limitless, and that waiting lists and delay are the only deterrent. In theory the total demand could be the same as the number of patients—assuming that each patient does not come more than once a day! The demand for appointments seems to grow and, being free of charge at the time, is also free of the normal economic factors determining supply and demand.

The supply of appointments is usually constant in general practice and variations are caused by demand and not by price. There is only one comparable commodity—water, where there is fixed rate irrespective of the amount used. The good and bad service is given at the same price. A capitation fee can no more distinguish between good and bad service than can a fee-per-item-of-service which governments have consistently rejected. An incentive can only be provided by either a variable price, which implies some kind of market for medical care, or by a salary and promotion structure. The present proper demand for medical audit will lead to the latter unless general practice is to be taken outside the framework of a service rendered free at the point of consumption. It is tempting to predict that it will end in a salaried service.

In many practices the appointment book is full and a " rationing by delay " system occurs. Demand is outside the doctor's control. The supply can be varied. We lack knowledge of the two parameters of the demand/supply equation. If we cannot entirely control the first we can at least try to assess it. We do control the supply and should try more sensibly to equate it with the true demand.

## Demand and supply

How should we assess true demand? If there were a limitless number of appointments available how many patients would appear requesting help? If the true demand proved to be much more than the present supply of appointments, then the experiment would have to be abandoned. If, on the other hand, a small extension or readjustment of surgery hours would contain the demand, it might be worth the effort of changing habit and routine. The extra work would produce a dividend of more contented patients and a less aggressive and tortured receptionist.

## Method

A list of 3,950 in 1971 produced 8,703 consultations (2·2 consultations per patient per year), but with 16 hours of consultation time per week there were only 8,000 appointments provided.

For an experimental four weeks I provided 22 surgery hours (220 appointments), but the attendance never exceeded 180. This seemed a realistic level of true demand, and I decided to supply this number of spaces in the book.

The consultation rate has risen fractionally from 2·20 in 1971 to 2·32 in 1973 when 3,604 patients produced 8,370 consultations and there were 9,000 appointment times available.

First, I expanded my surgery hours from four to 4½ hours per day. Next I had to arrange for all patients requesting a consultation to be seen within 24 hours.

## Discussion

The legitimate demands upon surgery time increase. Few doctors have consciously chosen their

surgery hours; instead have they been determined by the history of the practice. People complain that " it takes two to three days to get an appointment with my doctor."

It may be said that no great harm results; urgent cases are always seen, or local casualty departments are misused. However, doctor and receptionist undoubtedly suffer. The receptionist has the unpleasant job of rationing appointments, and trying to persuade patients that their problems are not urgent. In their customary role of ' buffer ' they have to persuade the doctor to see ' extras.' Time is wasted, tempers are frayed and the incoming telephone line is blocked. The surgery hours appropriate to a different epoc have been perpetuated without reference to consumer preference.

There is mounting public pressure for a true 24-hour service. What is against reacting to the increased demand by increasing the supply? It seems reasonable to organise a service whereby all those requesting it could be seen within 24 hours. Many doctors find that consulting sessions of more than two hours are physically exhausting. One friend described the first hour as " fun," the next half hour as " work," and the rest as " screaming-time". The rate of efficient work probably falls, and the level of patience and diagnostic acumen may fall similarly.

## New appointment times

I decided to reserve one hour in the afternoon for patients requesting to be seen that day. Simultaneously I decided that patients asking for " this day" attention should be directed to that surgery, thereby artificially maintaining gaps in the evening surgery for problems arising later in the day. Only by such a method does it seem possible to allow both previous bookings and reasonable access on the day. The pressure to attend at a slightly inconvenient time seemed a reasonable price to exact for " this day " attention. An urgent problem should demand slight self-sacrifice; a less urgent one could justifiably wait until the next day.

Enquiry revealed that 4½ hours of consulting time a day was necessary. This was arranged as follows:

(a) 08.30–10.00 hours

(b) 11.30–12.30 hours

(c) 14.30–15.30 hours

(d) 17.00–18.00 hours

All appointments are bookable in advance except the 14.30–15.30 session which is declared open at 08.30 each day. The 17.00–18.00 surgery correspondingly becomes closed until 15.30 when it is again open for patients needing attention that day.

## Conclusion

I have found this a practical way of working. The longest session occurs early in the day when I am freshest. I am able to leave the surgery early to do the new calls. Gone are the days of being kept in the building until 12 noon, with supposedly urgent house calls awaiting me. The rest of my visits and my other committments are fitted in as I come and go both to surgery and home. This is surely a proper priority and distribution of effort. A ready clientele is available for the late morning and early afternoon sessions—mothers and young children, elderly retired couples, and college students on vacation.

### REFERENCE

Powell, J. E. (1966). *Medicine and Politics.* London: Pitman.