Rural general practice

TO many visitors and residents, country life is attractive. Rural areas look nice; the pace of life is slower than in towns and cities; outdoor recreation can be relaxing and invigorating and there may be a feeling of safety away from crime-ridden urban areas. Visitors to the countryside, like holiday makers elsewhere, may have rose-tinted memories of pleasant vacations.

Do such commonly held perceptions reflect the reality of life for the people who live and work in small towns, villages, hamlets and scattered communities? Approximately one fifth of England's population lives in rural areas,[1] but how much do we know about the health needs and provision for the rural population in the United Kingdom? What proportion of rural dwellers are socioeconomically deprived? What are their particular health needs? What are the implications of increasing drug abuse and crime in rural areas?[2] Is there a danger of underfunding of rural health care as limited National Health Service resources are channelled towards deprived inner city areas? Given the lack of information about health needs, utilization and costs in rural areas, the answer is that we do not know.

When attempting to gather information, the first difficulty encountered is the lack of agreement on a definition of rurality. Rural areas and rural practices in Surrey or Kent are very different from those in the Scottish highlands or English Lake District. Definitions of rurality include population density or sparsity, land use (including agriculture), remoteness from urban centres, and subjective perception of rurality. Although an urban electoral ward may be sufficiently homogeneous for socioeconomic definition, one must analyse much smaller areas, such as postcode areas or even individual households, to reach valid conclusions about wealth and deprivation in scattered rural areas.

Unfortunately, indices usually used to quantify deprivation and health, such as those of Jarman or Townsend,[3-5] are inappropriate in a rural context where, for example, cultural origin is not usually an important issue. In many country areas retired people and temporary residents become the ethnic minorities with different health care needs. Car ownership, another socioeconomic indicator, may be a luxury for urban residents but a necessity in the country, more so since the demise of rural public transport.

What do we know about rural health? First, in general, mortality rates[6,7] and children's birth weights and heights[8] are better in rural than in urban areas. But, just as socioeconomic disadvantage adversely affects health in towns, so it does in the country.[9] Residents of remoter areas have higher mortality rates than those who live in more accessible rural areas.[10]

Apart from obvious rural health problems such as zoonoses and agricultural accidents, certain other conditions are more prevalent in the country. Suicide rates are higher among men in the rural Scottish highlands than in the urban centres[11] and people are more likely to die from road traffic accidents in rural areas.[12,13]

Accessibility to health services affects the way in which they are used. Thus, data which refer to consultation rates may be misleading in areas where health care is relatively inaccessible to patients. Those whose homes are distant from medical services under-report both acute and chronic illness[14] and may delay consulting about serious disease, such as colorectal cancer.[15] General practitioner consultation rates, hospital outpatient attendance rates and inpatient admissions all decline with both distance to the doctors' surgery and to hospitals.[14,16] This negative effect of distance on utilization of medical services is particularly true for women, elderly people and those in lower social classes.[14,16] Teenagers without public transport may find it difficult to seek confidential advice about, for example, contraception, pregnancy and drugs.

Travel costs, including the cost of time spent travelling, are greater when patients have to travel further to the surgery, hospital or maternity unit. It is difficult to quantify such indirect costs of health care, but they are important to patients.

Trends towards group practice and closure of branch surgeries[17] and smaller maternity units mean that services become more centralized and less accessible to patients. If this trend continues, the disadvantages for rural patients, particularly those in remote areas, may well get worse.

The content of rural general practice is different from that of urban practice. Rural general practitioners are more likely to deal with acute medical and obstetric emergencies, sudden deaths, road accidents and other traumas than general practitioners in areas where patients can call for an ambulance or go directly to hospital in an emergency.

Rural health workers too have their own problems. General practitioners may find it difficult to attend postgraduate educational meetings and are less likely to attend than their urban colleagues.[18] Innovative solutions to the problem of access to educational activities for rural doctors include practitioner groups in doctors' surgeries and peripatetic meetings such as those of the Montgomeryshire Medical Society. Nevertheless, doctors in smaller, isolated practices will inevitably have less freedom to attend meetings of all sorts than colleagues with more partners or access to out-of-hours rotas or deputizing services.

There is an urgent need for information about health needs, accessibility, provision and deprivation in rural areas.[19] The Centre for Health Services Research in Newcastle, on behalf of Northumberland and Cumbria Family Health Services Authorities has already embarked upon an important study of equity and resources in primary health care in rural areas. The RCGP's newly formed rural practice task group proposes to commission a further UK–wide study of rural deprivation, rural health and access to and availability of primary care services. Without accurate information from research studies such as these, solutions are likely to remain elusive. Readers are invited to contribute to the debate by writing to the RCGP rural practice task group about their experiences of rural primary health care, to help seek solutions and to disseminate ideas.

JIM COX

General practitioner, Caldbeck, Cumbria and Chairman, RCGP rural practice task group

References

1. Fennel J. *Health care in rural England.* Cirencester: Action with Communities in Rural England, 1992.
2. Cocker S. Drugs: a new kind of rural pursuit. *Independent on Sunday* 1994; 6 March: 12.
3. Jarman B. Identification of underprivileged areas. *BMJ* 1983; **286:** 1705-1709.
4. Townsend P, Philimore P, Beattie A. *Health and deprivation: inequality in the north.* London: Croom Helm, 1988.
5. Hutchinson A, Foy C, Sandhu B. Comparison of two scores for allocating resources to doctors in deprived areas. *BMJ* 1989; **299:** 1142-1144.
6. Office of Population Censuses and Surveys. *Area mortality: decennial supplement 1969-73, England and Wales.* London: HMSO, 1981.

7. Office of Population Censuses and Surveys. *Mortality and geography: a review in the mid 1980s, England and Wales.* London: HMSO, 1989.
8. Reading R, Raybould S, Jarvis S. Deprivation, low birth weight, and children's height: a comparison between rural and urban areas. *BMJ* 1993; **307:** 1458-1462.
9. Phillimore P, Reading R. A rural advantage? Urban–rural health differences in northern England. *J Pub Health Med* 1992; **14:** 290-299.
10. Bentham CG. Mortality rates in the more rural areas of England and Wales. *Area* 1984; **16:** 219-226.
11. Crombie IK. Suicide among men in the highlands of Scotland. *BMJ* 1991; **302:** 761-762.
12. Bentham G. Proximity to hospital and mortality from motor vehicle accidents. *Soc Sci Med* 1986; **23:** 1021-1026.
13. Daly KE, Thomas PR. Trauma deaths in the south west Thames region. *Injury* 1992; **23:** 393-396.
14. Haynes RG, Bentham CG. The effects of accessibility on general practitioner consultations, outpatient attendances and inpatient admissions in Norfolk, England. *Soc Sci Med* 1982; **16:** 561-569.
15. Launoy G, Le Coutour X, Gignoux M, *et al.* Influence of rural environment on diagnosis, treatment, and prognosis of rectal cancer. *J Epidemiol Community Health* 1992; **46:** 365-367.
16. Parkin D. Distance as an influence on demand in general practice. *J Epidemiol Community Health* 1979; **33:** 96-99.
17. Cartwright A, Anderson R. *General practice revisited.* London: Tavistock, 1981.
18. Murray TS, Dyker GS, Kelly MH, *et al.* Demographic characteristics of general practitioners attending educational meetings. *Br J Gen Pract* 1993; **43:** 467-469.
19. Watt IS, Franks AJ, Sheldon TA. Rural health and health care. *BMJ* 1993; **306:** 1358-1359.

Address for correspondence

Dr J Cox, RCGP rural practice task group, Royal College of General Practitioners, 14 Princes Gate, Hyde Park, London SW7 1PU.

INFORMATION FOR AUTHORS AND READERS

Papers submitted for publication should not have been published before or be currently submitted to any other journal. They should be typed, on one side of the paper only, in double spacing and with generous margins. A4 is the preferred paper size. The first page should contain the title only. To assist in sending out papers blind to referees, the name(s) of author(s) (maximum of eight), degrees, position, town of residence, address for correspondence and acknowledgements should be on a sheet separate from the main text.

Original articles should normally be no longer than 2500 words, arranged in the usual order of summary, introduction, method, results, discussion and references. Letters to the editor should be brief — 400 words maximum — and should be typed in double spacing

Illustrations should be used only when data cannot be expressed clearly in any other way. Graphs and other line drawings need not be submitted as finished artwork — rough drawings are sufficient, provided they are clear and adequately annotated.

Metric units, SI units and the 24-hour clock are preferred. Numerals up to nine should be spelt, 10 and over as figures. One decimal place should be given for percentages where baselines are 100 or greater. Use the approved names of drugs, though proprietary names may follow in brackets. Avoid abbreviations.

References should be in the Vancouver style as used in the *Journal.* Their accuracy must be checked before submission. The figures, tables, legends and references should be on separate sheets of paper. If a questionnaire has been used in the study, a copy of it should be enclosed.

Three copies of each article should be submitted and the author should keep a copy. One copy will be returned if the paper is rejected. Rejected manuscipts will be thrown away after three years. Two copies of revised articles are sufficient. A covering letter should make it clear that the final manuscript has been seen and approved by all the authors.

All articles and letters are subject to editing.

Papers are refereed before a decision is made.

Published keywords are produced using the *GP-LIT thesaurus.*

More detailed instructions are published annually in the January issue.

Correspondence and enquiries
All correspondence should be addressed to: The Editor, British Journal of General Practice, Royal College of General Practitioners, 12 Queen Street, Edinburgh EH2 1JE. Telephone (office hours; 24 hour answering service): 031-225 7629. Fax (24 hours): 031-220 6750.

Copyright
Authors of all articles assign copyright to the *Journal.* However, authors may use minor parts (up to 15%) of their own work after publication without seeking written permission provided they acknowledge the original source. The *Journal* would, however, be grateful to receive notice of when and where such material has been reproduced. Authors may not reproduce substantial parts of their own material without written consent. However, requests to reproduce material are welcomed and consent is usually given. Individuals may photocopy articles for educational purposes without obtaining permission up to a maximum of 25 copies in total over any period of time. Permission should be sought from the editor to reproduce an article for any other purpose.

Advertising enquiries
Display and classified advertising enquiries should be addressed to: Advertising Sales Executive, Royal College of General Practitioners, 14 Princes Gate, Hyde Park, London SW7 1PU. Telephone: 071-581 3232. Fax: 071-225 3047.

Circulation and subscriptions
The *British Journal of General Practice* is published monthly and is circulated to all Fellows, Members and Associates of the Royal College of General Practitioners, and to private subscribers. The 1994 subscription is £110 post free (£125 outside the European Community, £16.50 airmail supplement). Non-members' subscription enquiries should be made to: Bailey Management Services, 127 Sandgate Road, Folkestone, Kent CT20 2BL. Telephone: 0303-850501. Members' enquiries should be made to: The Royal College of General Practitioners, 14 Princes Gate, Hyde Park, London SW7 1PU. Telephone: 071-581 3232.

Notice to readers
Opinions expressed in the *British Journal of General Practice* and the supplements should not be taken to represent the policy of the Royal College of General Practitioners unless this is specifically stated.

RCGP Connection
Correspondence concerning the news magazine, *RCGP Connection,* should be addressed to: RCGP Connection Editor, Royal College of General Practitioners, 14 Princes Gate, Hyde Park, London SW7 1PU. Telephone: 071-581 3232.