12 Wishes of a GP for the New Year

Every year about this time, I would ask my two kids for their New Year resolutions or wishes. It is interesting to hear what they say, because the things that they want ultimately reflect on the state of their inner selves. Last year, my younger son said he wanted a Microsoft Xbox. (For you oldies out there, that is a gaming console.) The daughter said she wanted to do well in her 'O' Levels. Whew. At least there is one kid with a brain like mine, I thought.[1]

This year, it dawned upon me that really, I need to ask myself the same question too. After all, there is a kid in all of us and we can still dream. ("Hope" is too realistic a word for these nigh-miracles.)

And also to show the kids who wrote December issue's "The 12 Wishes of Junior Doctors for Christmas" that hey, old coots like GPs have problems too. If you think your problems are going to end when you cease to be a "junior doctor", think again.

1 INCREASE POLYCLINIC CHARGES.

Just one buck upwards is also good. Think about it – the chief reason why there is a genocide of GPs out here is that we cannot compete with the great polyclinics. With hefty subsidies, they are cheaper and better. If they raise one dollar in their consultation fee, we can do likewise. We can correspondingly move one dollar up for every patient. That is easily $10,000 a year in earnings per GP, folks!

The minority 15% to 20% market share of the polyclinics often afforded as an excuse that the polyclinic does not impact on the entire primary care scene does not do justice to the overall effect polyclinic pricing has on the healthcare market. It is like the lone SPC petrol kiosk next to Coronation Plaza giving 10% discount has an effect on all petrol kiosks in Bukit Timah Road and Dunearn Road. Whether Esso, Shell or Caltex, the rest have to give discounts too! You do not need a PhD in economics to figure this out.

2 SCRAP NIGHT POLYCLINICS.

An elaboration of Wish #1. It used to be busy people have to see GPs because they cannot afford to wait in the polyclinics in the daytime. Now they can avail themselves to polyclinic subsidies and services in the night as well. Well, it is like if your GP practice does not die from cancer, they will make sure you get a bolus potassium to finish the job.

3 SHARE FUNDING FOR SHARED CARE.

There is a lot of talk about shared care. To us poor folks in the trenches, shared care is tantamount to "I share with you my patients, and I also share with you my earnings." But, it is never quid pro quo. Whenever I refer, the patient is lost to the hospital system. Forever. When do the hospitals share their patients with us? Sharing is one-way more than ever. And even if the public hospitals did want to share with us, the patients do not want to be weaned off the nutritious diet of subsidies that are available only in the public hospitals and polyclinics. "I not stupid" and because "money no enough" are still the best bets in subsidised healthcare.

4 SHARE SAVINGS.

We hear a lot about public hospitals doing bulk purchasing to save costs. How about passing some of the savings to us in the gutters by selling us stuff bulk-bought at low prices? Are we not fit to share even the crumbs under thy table, sire?

5 LOWER HDB RENTS.

Of course, this one is a perennial favourite, and to be fair to HDB (Housing Development Board), rents have come down. Let us hope they do not raise the rent at the first sight of a pick-up in the economic climate. The truth is, while sales at shopping malls and crowds at restaurants point to an economy bottoming out, the GP world still looks like it has been battered by the perfect storm.

And so, we can still hope that rents will fall further.

6 RANK HMOS.

The state of HMOs (Health Management Organisations) here is plainly pretty pathetic. The recent survey published in the *SMA News* illustrates this. It is almost like the construction industry, where the main contractors do not pay the sub-contractors, and the sub-contractors in turn do not pay the small-job contractors who bear most of the cost. The smallest guy in the food chain dies first. The small-job and sub-contractor in healthcare is us – the GP. (*see illustration on the right*)

We have CASE (Consumers Association of Singapore) to represent the consumer and SIAS (Securities Investors Association of Singapore) to defend the rights of the small investor. How about the SMA or the CFPS (College of Family Physicians Singapore) doing something to represent the

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Footnote:

1. *In case you are wondering, I want the Xbox of course!*

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GPs' interests against the might of the HMOs? I hope we can form an industry watchdog to oversee and rank HMOs.

7 AUDIT SOME GP CHAINS WHO QUOTE $1 OR $2 CONSULTATION FEES.

The SMA has guidelines for pricing of drugs and consultation fees. However, these guidelines have been vitiated by clowns out there who continually quote $1 or $2 consultation fees to their corporate clients. Of course, this act of deception is also well received by fools on the other side of the fence who feel that $1 or $2 consultation is still possible when a cone of *kacang putih* costs $1 as well. It is literally peanuts! As we all know, the $1 or $2 charge is not possible unless accompanied by overcharging in other areas, usually in the medicines part of the bill. We should get a non-partisan body like SMA and CASE to audit these clowns. Also, we should get the Singapore Human Resources Institute to educate the clueless in their midst – "There is *REALLY* no free lunch, dude." Ipsa loquitur, if the polyclinic charges $8 consultation with subsidies, how can any GP practice quote less than $8?

8 REPLACE URINE HCG TEST FOR FOREIGN WORKERS WITH BLOOD HCG TEST.

Every time I perform a foreign maid check-up, I feel a knot in my stomach. There is always a chance that I would miss a pregnancy and be invited to drink tea with SMC (Singapore Medical Council). I still do the check-ups because I need the money and do not want to offend the family who hired the foreign maid (also known as my real patients). But really, with lab tests becoming cheaper and cheaper, it is time we junked the urine HCG test and go for the much more reliable blood HCG instead. It is still the same venepuncture anyway – no pain, more gain.

9 COME CLEAN: ACCESSIBILITY, AFFORDABILITY AND QUALITY – SOMETHING HAS GOTTA GIVE.

Healthcare is always a trade-off between accessibility, affordability and quality. So far, we have maintained that primary healthcare is accessible and affordable to all. And indeed the system is so – but, at the expense of quality. The problem was eloquently described by another co-sufferer last month "General practice – going the way of the dodo bird" (Dr Wong Sin Hee, *SMA News*, December 2004).

But quality does not only suffer at the GP level. The GP does not treat what he can (or rather the patient is unwilling to pay the GP for services the latter can render albeit without subsidies) and transfers the patient upwards – to the hospitals. Consequently, the hospitals suffer from crowding and overwork, and hence, quality suffers there as well. Because we want to keep primary care affordable and accessible, quality suffers in the ENTIRE healthcare system.

But no one wants to raise this to the people in the street. What they do not know cannot hurt them, as long as the patient knows he only needs to pay the GP $20 for flu and

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$8 for consultation at the polyclinic. Affordability is the sacred cow while quality gets slaughtered, chopped and minced to bits.

10 FORGET TRAINING AND MORE TRAINING. SOMEONE PLEASE PAY FOR PREVENTION AND HOLISTIC CARE THAT WE ARE (ALREADY) TRAINED TO DO.

The CFPS has proposed a new training programme to be implemented for GPs, and the awarding of the GDFM (Graduate Diploma for Family Medicine) to these GPs who complete the programme. I personally know of GPs with M.Med (FM) (Master of Medicine in Family Medicine) who are dying out there. Surely it cannot be that they have lack of training since the M.Med is superior to the GDFM. I hope the powers-that-be get in touch with reality. Even if we equip the GPs with MD or PhDs, GP quality will still languish. This is because with prices for GP services artificially depressed, and patients not educated or convinced to pay for holistic care, health promotion and disease prevention, we are training for futility.

Let us face it. There are some congenital misfits in our midst who like to make a quick buck out of anti-aging, MLM (multi-level marketing), sleeping pills and cough mixtures. But the recent spate of discoveries of doctors participating in unethical practices is also a consequence of the fact that there is not enough real and paid work to go around for everyone. Do you think a reasonable GP would like to take part in MLM if he gets 70 patients a day with real problems, or if the patient will pay him for health education? Some guys are just forced by circumstances to venture into the grey zone, while yes, I also recognise that a few just want to be there.

More training will just produce a more over-trained GP, but a GP still short of real or paying work. To paraphrase Bill Clinton: "It's the payment, stupid."

11 ALLOW GPS TO REFER PATIENTS TO SUBSIDISED SERVICES.

Patients of GPs have been kept out of subsidised hospital services. Only public hospital A&E departments and polyclinics are given the gatekeeper role to subsidised services in the public hospitals. (Okay, the faceless guy drafting replies to the press will tell you that the patient referred by the GP can still be a subsidised hospital patient after seeing the medical social worker and if the patient qualifies to be downgraded, but heck, the truth is, no sane person would choose this route – they just head for the polyclinic.) But really, are these gatekeepers doing their jobs, and why should they?

I spoke to a polyclinic doctor recently. He tells me in no uncertain terms that he will refer a patient to the subsidised specialist outpatient clinic and/or give a MC at the drop of a hat. The reasons for referring are simple. Firstly, that makes the patient happy and so he would not complain. Secondly, that also gets the patient out of the consultation room in the fastest possible time, which allows him to see the next patient quickly to clear the crowds and make more people happy. Thirdly, by seeing more patients quickly, he generates more subsidies and revenue for the polyclinic, and that means more bonus for himself at the end of the year. There is no upside to refusing to give a referral. In fact, he may run the risk of generating a complaint from the patient, and in turn he has to draft a long medical report to his boss, who in turn will give an apologetic reply to the patient when none was indicated, all in the name of maintaining a good "service quality" statistic for the polyclinic. The very notion of gatekeeping means some will get past the gate and some will be kept outside. How can the gatekeeper do his job when there is no one to defend or protect the gatekeeper when he keeps someone outside the gate?

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However, with the onset of means testing, maybe it is time to allow GPs to refer to subsidised services as well. Work in the hospitals as such may not increase with means testing, and at least it will lighten the load in the polyclinics. It should also cut out the folks who go there just to get a referral. Personally, I have asked a few patients of mine to go to the polyclinics just to get a referral to the subsidised specialist outpatient clinic. And if a *goondu* like me can figure that out, I am sure there are many more GPs who can figure out the same thing too.

12 TOLONG! TOLONG! WILL SOMEONE PLEASE SPEAK OUT FOR THE GP PLEASE?!?!

While the GP holocaust continues, what is happening? SMA continues to speak for the "entire profession" and champion issues on ethics and professionalism. It does not pay much attention to the plight of the GPs, except for the occasional article in the *SMA News*, which at least, I must say, is a decent start. The CFPS has cloistered itself with the cloak of academia. So who speaks for the GP dying from lack of work, low prices and long working hours (that is, non-academic issues)? Who is the Voice that will speak on bread and butter issues that keep us alive even before we continue to drone on about ethics, professionalism and academic development?

The GPs need a real voice. One that states the issues clearly, passionately, and if necessary, bluntly as well. And make that my Real Wish for this New Year. ■