By Dr Wong Chiang Yin, SMA President

What's Wrong with Earning $10,000 a Month?

On 6 August 2006, *The Straits Times* published an article titled "*Tough times for heartland docs*" by Nur Dianah Suhaimi which described the plight that many GPs are experiencing now. The article stated: "Doctors who used to take home between $20,000 and $30,000 a month say their earnings are now down to about $10,000. And that, they say, is not much money in return for working 12-hour days and six-day weeks, including public holidays. Others might only dream of making $10,000 a month."

So what is wrong with earning only $10,000 a month (no CPF from employer, no 13th month, no paid holidays)?

The fact is: nothing wrong with earning only $10,000 or even $8,000 or $6,000. Especially when more than half of Singapore earns less than $3,000 a month.

Having said that, we now live in a unipolar world of capitalism (with communist economic theory proven to be but impractical palaver) and there is also NOTHING WRONG with a person trying to maximise his income through legal means. And if not maximise, at least try to maintain his income. So while there is nothing wrong with earning $10,000, there is also nothing wrong with a doctor trying to try his very best to maintain his income or even increase it from $10,000 to $20,000 a month. The caveat being, in addition to employing legal means, as a doctor, he must also do so ethically.

The problem now is that GPs have been 'commoditised' as a result of oversupply competition by other care-givers. As *The Straits Times* article noted, it is not uncommon to find more than one GP clinic located in the same HDB block. The freely available and heavily subsidised polyclinic and restructured hospitals' specialist outpatient clinics take away work from the GPs. Even the large numbers of Traditional Chinese Medicine practitioners who have been trained in recent years and are being trained now will create competition for the GPs.

In the business world, commoditisation is the process that transforms the market for a unique, branded product into a market based on undifferentiated price competition. In other words, GP A is no different from GP B, GP C and so on to GP Z.

Commoditisation can be the desired outcome of an entity in the market, or it can be an unintentional outcome that no party actively sought to achieve. No one is immune to commoditisation, not even the much vaunted Sony. As recent as in June 2006, a *Fortune* magazine article by senior writer Marc Gunther discussed how commoditisation has been a challenge to Sony: "Almost as soon as Sony unveils a new device, cheap knockoffs are built in China." That is to say Sony products find it harder to be differentiated from the competing products since the latter erodes the value of the Sony brand.

It is natural for GPs to resist being commoditised. Some succeed. Recently I had lunch with a 72-year-old GP who by all accounts still runs a very busy practice. It is so successful that he must be one of the few GPs who see patients only on appointments and he has to limit his workload to about five patients an hour. He does not work nights and Sundays. I am told by some of his patients that his charges are reasonable. From my brief encounter with him over lunch, I found him to be a person of most pleasant temperament: he had an Osler-like quality of imperturbability and most of all, he had empathy. His patients

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love him and go back to him, notwithstanding his practice being in a part of town that does not have many residents anymore. He is not a commodity.

One way to resist commoditisation is to acquire new skills. The many courses and training programmes run by the College of Family Physicians Singapore go a long way in helping the GP resist becoming a commodity. Another example is the recent Acupuncture Course conducted by the Singapore Chinese Physicians Association Training College for medical practitioners – the course was very well received. Others go into non-therapeutic medical practice such as Aesthetic Medicine (granted, a few may actually be therapeutic, but 95% or more of aesthetic medicine patients really have no pathology to treat).

One or two will sadly go down the wrong path and end up on the wrong side of the Singapore Medical Council or the law while refusing to be commoditised.

Most simply just try to work harder and longer. And longer and harder. And it goes on and on. But like all things, this vicious cycle GPs are in cannot go on indefinitely. Something has got to give.

On the other hand, it is noteworthy that widespread attention has been paid to the shortage of clinician-scientists in Singapore. Massive efforts have been directed to address this shortage, ranging from import of foreign talent, increasing the list of recognised medical schools, giving out of increasing number of undergraduate and postgraduate scholarships, even to the building of a Graduate Medical School from scratch. This is because the country recognises the good these people can bring to the economy and to society as a whole. All this effort is good stuff.

However, when it comes to manpower planning, the medical profession is really a very heterogeneous group of people. The manpower planning issues relevant to, for example, the following groups: (a) Liver Transplant Surgeon, (b) Geriatricians, (c) GPs and (d) Clinician-Scientists are all interrelated yet different.

We worry if we have enough clinician-scientists, but do we worry if we have too many GPs? Do we look into GP manpower planning as rigorously as we look into MD-PhD manpower planning? Just to speculate: the good that every MD-PhD brings may well be offset by the five 'excess' GPs we have created as a by-effect of MD-PhD production – if we assume very optimistically that 10% of one cohort become MD-PhD, 40% become specialists and 50% become GPs.

The easy way out is to say, well, we do not have to do anything much, we just let these GPs compete freely and let market forces decide. But ultimately, while medical practice can be made more efficient and medical costs can be lowered by market forces and competition, healthcare and medical practice can NEVER be perfectly competitive and a completely efficient market. So there is some cost to over-production or under-employment of GPs and this cost has to be ultimately borne by society. So while we should let competition and market forces bring about lower prices, we should not kid ourselves that this can continue indefinitely or that the more GPs we have, the merrier. The pursuit of free market is not necessarily without costs, unfortunately.

So while we look systematically and vigorously into manpower planning for clinician-scientists, liver transplant surgeons and so on, we should also do the same for the GP. The number of GPs should not be as a result of a 'leftover effect' – that is, after we train all the specialists and researchers. What is left we assume will become GPs, and hopefully most of them will take up further training leading to the GDFM or MMed. And somehow, 'what is left' is the optimum number that we should have. As retired senior civil servant Mr Ngiam Tong Dow said so aptly, "The greatest danger is that we are flying on auto-pilot".[1]

Just like for clinician-scientists, we need a studied consensus on how many GPs we need and we also need to take concrete steps to facilitate the realisation of this consensus. While we live in a unipolar world of capitalism and free markets, some interference and planning is still needed sometimes. Was it not the old communist Deng Xiao Ping who said, "There is some degree of planning in capitalism just as there is some degree of market forces in socialism"?

It is all right to legally and ethically earn $10,000. And more if possible. The real question is not how much a GP should earn, but rather this: Should patients be mere commodities too? This is because when GPs become largely commoditised, can their patients be not far behind? ■

Reference:

1. The Straits Times, 28 September 2003.