There seems to be a feeling on the ground that general practitioners (GPs) in the private sector are facing a lot of challenges these days. Judging by the feedback that SMA has received in recent times, this is evident from the verbal and written communications to the Association, and the online discussions in the SMA website's forum.

I have personally talked to GPs (or Family Physicians) who have painted a relatively gloomy picture on the future of general practice. What is perhaps troubling is that these GPs do not belong to a particular subset of the population, that is, I get these comments from young and old GPs, employer and employee GPs, experienced and inexperienced GPs, and others. Even more disturbing is the fact that some of the GPs owning or managing the larger group practices feel that general practice is going sour. Now, I do not think that this represents the universal opinion of all GPs in Singapore. I am not even convinced that the majority of GPs feel this way.

However, in my years of private sector practice, I have never seen such pessimism and diffidence in the profession.

So, what has gone wrong? Many GPs have cited the following issues: dwindling patient load, increased operating costs, reduced income, long working hours, unfair managed care schemes, demanding patients, and fear of litigation. These issues are not new – they have always been challenging GPs all these years. So, how do these factors become more prominent? Perhaps GPs with limited resources are drained?

THE COMPETITIVE LANDSCAPE

Competition has always been present in any business environment, not just the healthcare scene. Many private GPs view polyclinics as a major competitive factor. They think that the polyclinic is a major reason why they are suffering from dwindling patient loads and reduced incomes. And they feel that if not for the patient subsidy available in these polyclinics, their patient load would improve. Instinctively, such thinking may make sense but competitive forces are not static. It would be simplistic to assume that if less patients consult polyclinic doctors, things will be much better. I believe that market forces would cause a new competitive equilibrium to be achieved. Even if there is an outward shift of patients from the polyclinics, it does not mean this patient pool will be taken over by the existing private GPs.

The reason is obvious. Today, the primary care landscape is not determined by private GPs and polyclinics alone. Firstly, the Traditional Chinese Medicine (TCM) practitioners are an emerging force to reckon with. They are now licensed and recognised by the authorities; many undergo a formal training programme for certification; culturally, they are well-accepted. Secondly, the growing trend towards complementary medicine is evident. Many patients are now seeking alternative healthcare options, thus increasing the demand for services provided by TCM practitioners. This shift in patient preference further intensifies the competitive landscape in the primary care sector.

In conclusion, while the challenges faced by GPs in the private sector are real, it is important to recognise the evolving nature of competition in healthcare. By understanding the dynamics of the market and adapting to these changes, GPs can work towards maintaining and even improving their patient load. The key lies in continuing to provide high-quality care while also differentiating themselves from other providers, whether it be in terms of service quality, patient convenience, or cultural alignment. Through strategic planning and innovation, GPs can navigate the competitive landscape and ensure the sustainability of their practices.
MARKET SATURATION OF GENERAL PRACTICES

Table 1 shows the number of general practice clinics in recent years. It will be evident that the market is probably fairly saturated at this point in time as there has not been significant growth in the numbers in the last five years. This does not mean very few clinics were set up. It is probable that the number of new clinics approximates that of the number of clinics that have closed down, hence the stable trend shown.

Table 1: Number of General Practice Clinics, Year 2000-2004 (Source: Ministry of Health)

<table>
<thead>
<tr>
<th>Year</th>
<th>2000 (Jan)</th>
<th>2000 (Dec)</th>
<th>2001 (Jan)</th>
<th>2001 (Dec)</th>
<th>2002 (Jan)</th>
<th>2002 (Dec)</th>
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<th>2003 (Dec)</th>
<th>2004 (Jan)</th>
<th>2004 (Dec)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of GP</td>
<td>1285</td>
<td>1285</td>
<td>1294</td>
<td>1294</td>
<td>1294</td>
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SCOPE OF GENERAL PRACTICE

Some GPs share the view that the scope of general practice has narrowed over the years. Many examples relating to "external environment change" have been quoted and these are probably familiar to many practitioners. Paediatric vaccinations are commonly administered by schools and pharmacies nowadays. Antenatal care is not commonly practised by many GPs partly due to patient preferences and perhaps also due to medical-legal reasons. Easy access to Specialist care has meant that the GP and patient equality partly of refer to Specialists. For example, a patient may desire to see a Specialist early because of lack of both in the GP's skills and knowledge. In this country, the existing time to see a Specialist is relatively short compared to many developed countries. Hence, the patient may want an early second opinion, particularly if subsidised Specialist care is available. In another scenario, the GP may refer early because a managed care scheme does not compensate him adequately for expertise and extra time spent in minor surgery, complex medical problems, patient counseling, and so on. These examples reflect a development in the healthcare scene that has evolved due to multiple factors, and are probably beyond the control of the average GP.

One of the strategies that some GPs have adopted is to replace the core broad-based skills that are so valuable in the community can be better delivered with GPs grouping together. There are different models and arrangements to go about this. The fundamental consideration should be from the perspective of how patient care in the community can be better delivered with GPs grouping together. It GPs can organise themselves such that they provide cost-effective and quality care in the community, they will always remain relevant and viable.

With this consideration in mind, it appears that we should...
NEWS FROM SMA COUNCIL

1. ASIAN TSUNAMI MEDICAL RELIEF

It is heartening to see Members stepping forward overwhelmingly to render their services during the Tsunami disaster. Many have gone out with various groups to render their professional expertise and skills in the affected countries. Many have also responded in other ways even as they continue to practice back home in Singapore.

The SMA Council is glad to support the initiative by SMA Member Dr Eric Chiam, in mobilizing doctors to donate medicines and medical supplies for relief work in Sri Lanka, as identified by Sri Lanka High Commission. Appeals were via email and website announcements. SMA also donated 1180 Draeger masks and 1000 disposable surgical gowns. The Council deeply appreciates Dr Eric Chiam and Dr Lisa Chen for their efforts in mobilizing fellow practitioners and undertaking logistics. The Council would also like to thank all members/doctors who had responded to the appeal. (See page 7 for detailed report.)

Members were also informed of other avenues of medical relief - they could donate to the Medical Associations of Indonesia and Thailand through SMA, or make direct donations to Singapore Red Cross Society. The author wishes to thank the Licensing and Accreditation Unit (Ministry of Health) for making available the general practice clinic data quoted in the article.

2. MEETING OF 3 PROFESSIONAL BODIES

The Presidents of the 3 professional bodies (AM, CFPS and SMA) met on 11 February. It was agreed that they would henceforth meet regularly (thrice a year) to exchange views and promote closer collaboration and cooperation.

3. DEATH CERTIFICATION

Members who require clarification on the certifiable causes of death may refer to the following articles:


Acknowledgements

The author wishes to thank the Licensing and Accreditation Unit (Ministry of Health) for making available the general practice clinic data quoted in the article.