By Dr Wong Chiang Yin, SMA President

The Better Doctor

20 YEARS AGO

20 years ago, in 1987, I stumbled out of my army camp as a private in training to attend the Medicine Interview held in the three seminar rooms outside level two of the Medical Library. I was assigned to Team B, chaired by the late Professor of Medicine, Chan Heng Leong.

One of the more memorable exchanges during the interview was this:

"What do you read in your free time?"

"*Scientific American*."

"Are you saying that because you think we like people who read *Scientific American*?"

"No. I actually read that because I like it. I also read *MAD* magazine."

I then promptly fished out my copy of *Scientific American* and *MAD* magazine and showed the panel.

Another memorable question was: "There will be too many doctors when you graduate. In fact, there are probably already too many doctors now. What would you do after you graduate from medical school, if you find that you are unable to get a job that would allow you to practise medicine?"

I replied: "If you are really a bad doctor, you may not get a job even in good times. But then again, even in bad times, there is always a job for the better doctor."

I guess that was not really a bad answer for me; maybe it *was* a bad answer for the medical profession, because since then, the profession has been stuck with me.

A FOREIGN DOCTOR CONVERT

Recently, a senior (local) doctor working in the polyclinic commented to me over dinner that she felt the relevant authorities were treating NTS (non-traditional source) doctors unfairly. She felt that the NTS doctors were up against changing goal-posts. (NTS doctors are doctors with basic degrees from universities which were not registrable with SMC). These doctors were "promised a lot" when they were recruited and now with changing policies, it appears they would be asked to leave, when their current temporary SMC registration expires, after they have settled down here with their families. It appears that they were told that they would be given conditional registration if they obtained the GDFM, but now the bar has been raised to the M.Med.

I do not know if there was any truth to these allegations by her but nonetheless, I was surprised at this remark from her because I remember a few years ago, she was complaining to me about the quality of NTS doctors and the intense supervision they required. Well, it appears that her opinion of NTS doctors has changed quite a bit. According to her, the quality of the first NTS batch of doctors was patchy. The current ones were good – they realise the "precarious" position they are in with regard to their SMC registration and they work hard and make the extra effort to be good polyclinic doctors.

I then said if they were good, then they should have no problems passing either the GDFM or the M.Med. To this she replied: "You know, they may be good doctors, but they are not drilled like us since young to pass exams. Our M.Med exam is not easy to pass unless you are exam-oriented." I will not argue with her on this. She was a far better student than me in medical school. But this incident does illustrate how a previous cynic of having foreign doctors here has been persuaded to believe that they are good for our healthcare system.

Recently, the Minister for Health announced his intention to bring in more foreign doctors. This has drawn reactions from quite a few local doctors, GPs and specialists alike. Several have written to SMA and asked us what SMA is doing to protect the local doctors' livelihoods. One private sector cardiologist called me as if the world has ended for him.

AVOIDING CHARACTER ASSASSINATION

My own personal belief is this: If SMA is not protectionist, then appearing protectionist when you believe otherwise is hypocritical. If SMA is protectionist, then in Singapore's context, appearing protectionist may be the worst way to actually forward the protectionist cause. In other words, appearing protectionist may be the worst way forward whether SMA is protectionist or not. Because once you are labelled successfully as protectionist, you can be pretty sure that whatever you say afterward will not be taken very seriously. To be labelled as protectionist is to be successfully character-assassinated.

For the record, the current SMA council is not protectionist. Having said that, protecting local doctors' livelihood is different from being protectionist. For example, the local legal profession

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is actually facing a decreasing number of litigators despite more law graduates and now has to think of a way of making lives for litigators more bearable and litigation a more palatable career option.

The same thinking can be applied to the local GP scene where while there is no decrease in numbers, there are certainly more and more GPs turning to non-traditional areas of GP work to supplement their income.

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MORE DOCTORS – WHO PAYS?

The Minister for Health has also been reported to be saying that he wants to double the number of doctors in hospitals, from having one doctor for every two beds to one doctor per bed.

What are the possible outcomes if doctors were indeed to be doubled in our hospitals?

Let us assume an extreme scenario whereby despite the increase in doctors, the foreign patient load does not increase and all the additional doctors see only the same number of local patients. That would mean that each doctor has double the amount of time per patient. That is a good thing for the patient. Unfortunately, the downstream effects in extreme situations would be:

a) the pay of each doctor is halved, or
b) each local patient pays double the amount he would have previously paid for the same amount of physician services, or
c) supplier induced demand sets in and the doctor doubles the amount of physician services needed by one patient.

I do not believe for a moment that the relationship between doctors' income and number of doctors is linear: that doubling number of doctors will lead to each doctor earning only half of what he used to. The likely scenario is that all of the above will occur to some limited extent (that is, decrease in doctor's pay, increase in healthcare inflation and supplier induced demand), unless a large part of the capacity generated by these additional foreign doctors will be used by foreign patients, which is unlikely. Foreigners will take up some of the additional capacity but domestic consumption will still take up the majority of the increase in capacity afforded by foreign doctors.

That leaves us to ask – *who pays* for the new services provided by these doctors to the local population? The quick answer is Singapore will pay because another country is certainly not paying for the health services consumed by us. And how will this be paid? Simply put, the bill has to be either paid for by the government (more taxes?) or the people in one way or the other. Singapore has traditionally adopted the policy that the people should take responsibility for their health and therefore for most of the healthcare costs incurred. Hence in Singapore, Government Health Expenditure (GHE) only takes up about 1/3 of Total Health Expenditure (THE). This can be seen in Table 1 where Singapore is compared to developed countries and our neighbours. Singapore's GHE is only 36.1% of THE and this is low when compared to other developed countries and some neighbouring countries as well. In the absence of a means test, one can argue that accessibility of healthcare to the poor will be compromised if this percentage drops further. Even in free-market USA, where 1/6 of the population does not have access to healthcare except at emergency departments, the government takes up a higher proportion of THE (at 44.6%). If Singapore goes any lower than 36.1% (and without a means test), it will probably have to contend with the poor having problems availing themselves to healthcare, similar to countries such as India, China, Indonesia and Vietnam with a low GHE as a percentage of THE. In fact, in all likelihood, the government's share of THE in Singapore may actually increase if the trend seen in other developed countries is anything for us to go by, especially so when we do not have a means test to direct and focus GHE toward the poor and needy.

Singapore's percentage of GDP spent on healthcare is also on the low side when compared to other developed countries. With an aging population and rising expectations, this figure will have to likewise go up to levels of most other developed countries (that is, between 7% to 10%).

In other words, the new capacity created by an influx of foreign doctors (should this influx take place at all) will not be only at the expense of local doctors' income but will have to be funded at least commensurately by an increase in GHE and THE as well.

Looking at the table, Singapore's Physician per 1,000 Population is indeed low by developed country standards. The point to be made here is that the shortage of doctors in Singapore is *selective and there is a mal-distribution of workload between the public and private sectors which exacerbates the effects of shortage*. We certainly do not need more GPs, obstetricians and so on. And if we pay renal physicians and geriatricians a whole lot less than some popular surgical disciplines or what these same specialists can get in the private sector, then we will never get enough local doctors specialising in renal medicine or geriatrics, and even if we do get more of them, we cannot get them to stay in the public sector where most of the work is done.

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Table 1: Selected Countries and, THE as Percentage of GDP, GHE as Percentage of THE and Physician Density

Country	THE as % of GDP (2003)[1]:	GHE as % of THE (2003)[1]	Physician Per 1,000 population
Australia	9.5	67.5	2.47 (2001)[2]
Canada	9.9	69.9	2.14 (2003)[2]
China	5.6	36.2	1.06 (2001)[2]
France	10.1	76.3	3.37 (2004)[2]
Germany	11.1	78.2	3.37 (2003)[2]
India	4.8	24.8	0.60 (2005)[2]
Ireland	7.3	78.9	2.79 (2004)[2]
Japan	7.9	81.0	1.98 (2002)[2]
Netherlands	9.8	62.4	3.15 (2003)[2]
New Zealand	8.1	78.3	2.37 (2001)[2]
South Korea	5.6	49.4	1.57 (2003)[2]
Switzerland	11.5	58.5	3.61 (2002)[2]
UK	8.0	85.7	2.30 (1997)[2]
USA	15.2	44.6	2.56 (2000)[2]
Singapore	**4.5**	**36.1**	**1.56 (2005)[3]**
Indonesia	3.1	35.9	0.13 (2003)[2]
Malaysia	3.8	58.1	0.73 (2003)[4]
Thailand	3.3	61.6	0.37 (2000)[2]
Vietnam	5.4	27.8	0.58 (2003)[4]

NO COMPROMISE IN STANDARDS

Another point to be made really is why would foreigners want to come here? As history has shown, it is very difficult to convince top clinical talent to come to Singapore. The proviso here being we need to be clear about what constitutes top talent. Our notions and definitions of talent must never be allowed to be compromised for the sake of making up the numbers (for example, to make up one doctor per inpatient). The standards expected of foreign doctors must be at least as high as those expected of the local doctors, if not higher. A level playing field is the basic requirement for local and foreign doctors to have a good chance of co-existing harmoniously.

It is commonly known that at least half the graduates of famous schools in China and India such as Peking Union Medical College and All-India are offered jobs in the West before or soon after they graduate. Will there be any significant numbers from these top schools left for Singapore? And once good foreign doctors are allowed into Singapore, we also need to address the equally important issues of objectively assessing these doctors and to get them to leave Singapore if they are found to be wanting.

We can learn from the experiences of other sectors such as banking and the corporate world and so on, where foreigners are free to work here and also have been made to leave quickly when found wanting. Exit management – getting the unsatisfactory ones out – is as important as getting them in, that is, recruitment.

STEPS FORWARD

In summary, I would like to add that while allowing more foreign doctors into Singapore may seem ominous to some of us in the profession, I take the view that it is not only just the doctor's livelihood that is at stake. At stake are also the equally important issues of health inflation, supplier induced demand etc and the overall competitiveness and efficiency of our healthcare services. The current macro-equilibrium between accessibility, affordability and quality can go either way with more foreign doctors. It is not a risk-free policy or path to take. So frankly, there are other people who should (and I hope would) be worrying about this more than doctors.

The problem for the SMA is that at the micro-level (that is, the individual level), there will be doctors who will feel the negative effects of the winds of change. It is our duty as the national medical association to go out and help prevent this or at least prepare them for this. To this end, the SMA Private Practice Committee will be running a series of seminars and courses to help our members. For a start, we will restart our seminar on "Starting Private Practice". This was a seminar that was very popular a few years back. We also develop further courses that we think will help the private sector doctors to optimise their practices financially and operationally.

20 years later today, I still believe that there will always be a job for the better doctor. And a reasonably well-paying one too. ■

References:

1. ***2003 Statistics from WHO website: www.3.who.int/whosis/core, (accessed 29 January 2007)***
2. ***Year statistic obtained given in parenthesis***
3. ***http://www.moh.gov.sg/corp/publications/statistics/manpower.do, (accessed 29 January 2007)***
4. ***http://www.wpro.who.int/NR/rdonlyres/135A09A2-E83E-4CB3-B771-3C5529DB878B/0/annextable2005.pdf***

Editor's note: In response to several members' request for an English translation of the last President's Forum in January, Dr Wong Chiang Yin has made an English translation. However, due to shortage of space, we will not print the article in hard copy. The online PDF copy is available at http://www.sma.org.sg/sma_news/sma_newsmainpges/3901main.html