EDITORIAL

II. DOCTORS: TOO MANY OR TOO FEW?

We have seen previously that the position of doctor requirement cannot be estimated on ratio of doctor to population as otherwise we would be hard put to explain how the doctor shortage has become more manifest in countries that have figures much better than the 1 to 2,000 proposed by W.H.O. technical committee, and in fact by insisting on such an estimation, we would be even more hard put to explain the brain drain of doctors from countries with a poorer ratio like India to those with a higher ratio like U.S.A. A closer scrutiny of the problem must show us that the medical need of a community has two components—the essential and the luxury; the essential one is vital to the survival and continued health of an individual or a community, but the luxury component is only to satisfy a demand which is often created on other premises. This is a situation that in fact applies to many other items essential to life. Hence the first 2,500 calories of food per adult per day would be essential, but the next calory after that would be luxury; and the first 25 gallons of arable water per head per day would be vital, but not the next amount.

Once we accept this distinction that the medical need of a community is only in part an essential item, then the problem of doctor number becomes simpler, for whereas there is a ceiling to essential need, there is no way to satisfy completely the demand for luxury, and in fact no method is reliable enough to estimate it. Hence it is a relatively simple matter to find out the amount of food that will keep off malnutrition and subnutrition, the amount of water that will supply the needs of essential drinking and personal hygiene, and even the number of doctors required to keep a community free of infectious diseases and supplied with treatment for emergencies. It is however, quite a different matter to estimate what the public will want in the way of water, food or doctors if they can have their way. The former is based on requirement which has an estimable physical basis, whereas the latter is entirely up to individual whims and fancy, that can be wanton, wasteful, and even irrational.

Hitherto, the demand has been regulated by the cost, which being individual, has a direct restraining influence, and hence in a society that is less affluent, there is less waste and wantoness as the demand for luxury aspect of service is kept down by the consumer himself. With the advent of a socialised society, the cost of a service quite frequently is removed from the individual to become a commitment of the state, and essential services like food, water, electricity, and medicine are readily accepted as the burden of a state, and are readily subsidised to be free or very much belowcost to the individual. The difficulty is, of course, that without imposing a ceiling on essential need, the demand soon extends to the luxury sector; and mounting cost, increasing shortage of personnel, progressive inadequacy of facilities become more and more evident as the expenditure increases, constituting what may be called the modern socialist paradox in that shortage becomes more obvious as the facilities are increased!

Of course, it may be argued, as in fact it has been, that the demand before the adoption of a welfare state policy, was being artificially dammed down by the cost to the individual, so that many people were actually consuming less than what would be the essential minimum in the ways of calories of food, gallons of water, and hours of doctoring. But this cannot be the true argument because so far there seems no limit to the increase in demand; and hence whilst a ratio of 1 doctor to 10,000 population was not regarded as acute shortage some 15 years ago, at present a doctor to under 500 population in U.S.A., Israel and U.S.S.R. is still inadequate enough to require brain drains, increased intake of undergraduates, and even compulsory posting of doctors!

It may be sobering to think in terms of a few hypothetical figures. Appendicectomy is generally regarded as an essential in appendicitis, but if the public were to persuade themselves into prophylactic appendicectomy, as in fact was done in some countries, then for Singapore alone, more than 50,000 appendicectomies would be needed each year. Similarly, electrocardiography is without doubt a necessity in cases of cardiac arrhythmia or myocardial infarction, but a public, health conscious enough, or more truly, hypochondrical enough to demand as a prophylactic a yearly E.C.G. over the age of 40 would mean an annual load of 10,000 cases. This would

apply to screening for preinvasive cervical cancer—an erroneous term, for what is detected is not cancer, as the popularly held concept of cancer is a painful, fatal, short surviving disease with little prospect of cure except in very early stages, and preinvasive cervical metaplasia is not painful, and more than half remains well after 10 years, and even the other half may show no true cancer after 10 years. This would seem to show that if we are catering for essential medical need, there may be a possibility of estimation of the requirement that is more accurate and realistic, but if we are catering for luxury too, then we would be courting serious difficulties when we attempt to forecast and plan ahead.

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