EDITORIAL

DOCTORS: TOO MANY OR TOO FEW III

It has been previously argued in these columns that a statistic figure like the number of doctors per population is of little value in the estimation of medical needs, and it has been shown too that the expert body of W.H.O. has been in the space of ten years demonstrated to be quite wrong when it attempted to lay down the optimum requirement of doctors and medical personnel in a community. Contrary to the theory of supply and demand, the doctors are actually migrating from places where there is a lesser concentration of doctors to those areas where the concentration is greater! And this is so in the field of doctor movements both within the country and without. Thus doctors tend to concentrate in towns rather than rural areas, and in industrialised countries rather than underdeveloped ones, although they would by so doing be facing more competition theoretically, since they would be in an area with a higher doctor per population ratio. Whether economists, statisticians, and health planners like it or not, the fact is indisputable that a young British Consultant would want to be in Harley Street, a doctor in Singapore within a 2-mile radius of Raffles Square, and a Malaysian doctor in Kuala Lumpur, Penang, or Ipoh. These hard facts must tell us that for Britain, Singapore and even Malaysia, the needs of doctors is no longer dependent solely on figures of doctor to population like the mystic one of 1:2000. In fact in 1954, the Director of Medical Services for Singapore with a population doctor ratio of 1:2700 reported that "there is no acute shortage of doctors in Singapore" and 2 years later, the then Minister for Health indulged himself in acrimonious debates with local doctors by alleging that Singapore was in acute need of doctors!

However, if we accept that medical facilities do in fact contain an element of luxury which increases in importance as the society becomes affluent, then any estimation of doctor need of a community cannot be realistic or reliable, unless it takes into account the state of affluence of the society, the degree of health consciousness of the public, and the extent of hypochondriacal fears aided and abetted in some cases by popular magazines and occasionally by doctors even, dedicated to so-called prophylactic bodies which issue from time to time partially tested statements of causes of death and methods of prevention. Hence the doctor need of a community would be dependent on factors other than the simple and crude doctor to population ratio, and amongst these factors might be included the state of affluence of the individual, and the degree of health education in the modern sense in the community.

The doctor requirement is an important information to educators and nation planners, for basing on it, medical schools have been designed and built, hospitals have been modelled and erected, and finance has been earmarked and rechannelled. Unfortunately, as we know now, it is an information not easy to come by if we insist on reliability, as it is dependent on essential need, and demand of whims and taste. The need is easy to foresee, for it does not require a very intelligent man to say how much it will cost a country in terms of medical manpower and facilities to control infectious disease, provide environment regulators for the protection of health, and assist those in dire financial circumstances in medical necessities. The demand, however, is dependent on changing pattern of culture which would vary, and the trend in the last half-a-century has shown that the variation is always away from the spartan mode of life where pain and illness were regarded as things of no moment. In fact, analysis of the utilisation of doctors in individual cases would confirm almost invariably that the proportionate weighting of the latter factor tends to be greater than the former locally and in developed countries, and this disproportionate weighting increases with the improvement in education and wealth of a community. We are yet unable to estimate this bias with certainty, but experience in the last 15 years must teach us that we should no longer use the figure of doctor to population ratio seriously in our consideration of medical education programmes, and the provision of medical facilities.

This must mean that any pronouncement about student enrolment, medical cost, doctor number required, national health cost and manpower needs cannot be regarded seriously if it is based on doctor to population ratio alone. In fact, the gross underestimates of cost in the earlier years of British National Health Service

has been due in no small measure to the lack of appreciation that medical requirement is a variable one because, it has a demand factor dependent on personal whims and knowledge. But we need to have medical planning meanwhile, and if this ratio is not a dependable factor, then we must look elsewhere for guide lines. One simple solution would be for the community to consider what should be the fair recompense of a doctor taking into account his long and irregular hours of work, his long training and therefore a later start in earning life, and his needs in the way of a continuing education to remain efficient. In this manner, the potential medical expenditure of the community would easily yield us a figure of optimum doctor number which will meet the need and yet keep the doctors contented. Admittedly, this is by means an ultimate in the way of parameters of medical need, but it seems to be for the time being, a far more dependable and logical one than the traditional doctor to population ratio.

Gwee Ah Leng