GENERAL PRACTICE IN A DEVELOPING SOCIETY

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One of the chief differences between a developing society and a developed one lies in their economic standing, or the lack of it in the former. Another difference is in the disparity between the degrees of social sophistication of the peoples of the two societies. There are of course other points of difference, but these two by themselves can provide ample matter for the short discussion here.

If one considers the purely economic standpoint, Singapore can hardly be rated a developing society as we are now the world's 4th largest port and rapidly becoming the 3rd. The annual per capita income of our people is the 2nd highest in Asia, and the standard of living by and large is comparable to, if not actually superior, to that of the average Japanese.

In degree of social sophistication however, although we have rapidly urbanised and the impact of industrialisation is being felt, the traditional outlook of the East persists, none more so than in matters pertaining to medicine and health. The TV set may have made its way into our living rooms but the thought and philosophy of the West in many ways are not often evident.

So it must be that when one talks of a developing society in Singapore the term is relative not only in comparison with the regions around, but also within the context of the island and the people here.

PROBLEMS FACING THE GENERAL PRACTITIONERS IN SINGAPORE

There are over 1,200 doctors in Singapore, more than half of this are in general practice. The Government spends 11% of the National budget ($88 million or approximately £12 million) on health services. Outpatient services are provided free or at a nominal charge of 80 cents (2 shillings) to all those who care to ask. There is no national health insurance scheme.

The doctor-population ratio is 1: 1,800 but in point of fact this is actually much lower because nearly half the people seek native cures when ill and do not consult a doctor. This together with the ready availability of the Government outpatient services make life tough for the young General Practitioner setting out into practice.

TRAINING OF GENERAL PRACTITIONERS

With half the people oriented to traditional native cures, the General Practitioner in this form of developing society finds that he has to modify his western-trained outlook if he is to have empathy with his patients. He cannot decry age old beliefs in "heat", "wind", and the "cold" humours of traditional Chinese medicine, nor can he afford to neglect racial and cultural differences in the Muslim and the South Indian Tamil.

All this requires some knowledge of the background of the local people, and it is rather unfortunate that this has been wanting in the undergrad training at the University. There is now a move to attach students to General Practitioners, and the Ministry of Health has also come up with schemes to help train newly qualified doctors for general practice.

PERSONALISED MEDICAL CARE

The General Practitioner in his modern role is regarded as the primary physician who sees the patient first and decides on the line of management. To do this effectively there must be personalised medical care for the patient. This is difficult to provide with an outpatient type of medical service in that there is a lack of continuity due to the frequent change of staff in the O.P. Departments.

The ultimate aim of any socialist government must be to provide personalised medical care for its people from the womb to the tomb. In a developing society such as ours because of other commitments on the national budget this is not readily feasible.

We have however in Singapore a good general practice service which even now treats the sick at reasonable charges. Nowhere else in the world perhaps does it cost a patient so little to get well so fast.

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The Government should make the existing General Practitioner service a framework on which to provide better personalised care for the people. With the people fast reaching a fair degree of affluence there should be little need in the near future for free or heavily-subsidised medical outpatient treatment from the Government.

THE MINI-HOSPITAL

What should be developed should be the provision of district "cottage" hospitals, or the Mini-hospitals where the General Practitioner can look after his own cases. These mini-hospitals can care for 30 to 40 beds each and can be built for about $200,000 each (£30,000), a mere fraction of the cost of a General Hospital.

It costs the Government at present $35 a day (£5) to maintain a bed in the general hospital. For 40 beds in a general hospital the expenditure will come to $42,000, a month. A mini-hospital can be run at perhaps 1/3rd this cost. By way of comparison the yearly expenditure for a 50-bed convalescent Home for children in this country amounts to only $60,000.

Nearly half the cases in a general hospital can be safely cared for by their own General Practitioners in these mini-hospitals. If a sufficient number of these mini-hospitals are strategically located, the work-load of the General hospitals will be reduced and there will also be greater convenience to patients and relatives.

The mini-hospital seems to be the answer for developing societies where *priority* for personalised medical care is *high* and the *funds* readily available for medical projects are *low*.

WORK OF A NATIONAL MEDICAL ASSOCIATION

The work of a national medical association like the Singapore Medical Association is to see that the people of the country get the best available medical service, from either the public or the private sector.

This is possible only if the views of the Association are held in regard by the Government and those in authority.

A body like the Commonwealth Medical Association lending moral support to individual medical associations will establish the fact that doctors are not trade-unionists but professional men dedicated to the moral and physical well-being of their society.