mands on specialist physicians. The group they mention — the oldest old — is growing rapidly, yet even if their numbers were to double or triple, they would have little impact on specialist services (although for some specialist groups, including geriatricians, the impact will be greater).

The issue is not the numbers of specialists but how specialist care is delivered. For example, how does Alberta manage with so many fewer specialists than Ontario or Quebec? Rather than being bewitched by numbers, we need to focus on what specialists do and ask what it is they really should be doing. What surgical or medical innovations might affect the need for particular specialists? These are difficult questions. But they need to be posed for all specialist groups.

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Health care needs versus health care wants

After reading the articles by Eva Ryten and colleagues, "The Class of 1989 and physician supply in Canada" (*CMAJ* 1998;158[6]:723-8) and "The Class of 1989 and post–MD training" (*CMAJ* 1998;158[6]:731-7), and the accompanying editorial, "New bottles, same old wine: right and wrong on physician supply," by Dr. Robert G. Evans (*CMAJ* 1998;158[6]:757-9), I have decided that neither Ryten and colleagues nor Evans is totally correct.

The most telling comment was from Evans: "It may in this new environment become possible to give more serious consideration to a wider range of ways to ensure that Canadians get the medical care they need." Unfortunately, he has forgotten that Canadians not only need medical care but want it. Whether they get what they want is different from whether they get what they need.

I suspect that Evans is discussing what people need, while Ryten and colleagues are dealing with what people want. I think this is also why you will find a huge discrepancy among various providers of medical services, as Ryten and colleagues suggest. If we provide only care that is sufficient for people's needs, we will no doubt become a 2-tier medical system: their wants will still have to be satisfied.

Personally, I have no problem with either system, but we have to be realistic and pragmatic about the wants of Canadians and not focus on what health economists or health care providers perceive those wants to be.

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[One of the authors responds:]

Dr. Rosenquist is puzzled by the striking difference between the conclusions we reached in our articles and the views expressed by Dr. Evans in his editorial. He speculates that these differences arise because my coauthors and I are concerned with the number of physicians required to satisfy patients' "wants," whereas Evans is concerned with meeting patients' "needs."

The conclusions we reached were based exclusively on the demographics of new physician supply, the demographics of the practising physician stock (age structure) and the projected population change in Canada. We concluded that Canada is educating far too few physicians.

I have always steered clear of discussing health care "needs" and "wants" because in the context of a fully publicly funded health care system this is a sterile debate. Almost the first lesson of economics is that if price is reduced, demand increases. Although all publicly provided health care must eventually be paid for through taxation, to the consumer of health care the price at the point of consumption is essentially zero.

When the price of a good is zero, demand will be unconstrained. No wonder health care budgets are regularly exceeded, and how easy it is to blame this on physicians for inducing demand merely to meet their income targets. Where there are no prices, any distinction between needs and wants is meaningless. That economists should advocate that the health care system be funded in such a way as to eliminate any incentives for sensible use of resources strikes me as bizarre. Rosenquist should ask the economists how they are going to ensure that, in the absence of price mechanisms of any kind, only health care "needs" are going to be met.

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Corrections

In the article "Reporting of gender-related information in clinical trials of drug therapy for myocardial infarction" (*CMAJ* 1998;159[4]:321-7), by Dr. Paula A. Rochon and colleagues, the affiliation information for coauthor Malcolm A. Binns was omitted. Mr. Binns is with the Rotman Research Institute, Baycrest Centre for Geriatric Care, Toronto, Ont.

In the article "Survivors of sexual abuse: clinical, lifestyle and reproductive consequences" (*CMAJ* 1998; 159[4]:329-34), by Drs. T. Kue Young and Alan Katz, an incorrect mathematical symbol was given in Table 1. For the number of sexual partners (lifetime), the first category should have been ≤ 5.