[Jill Strachan, of the Canadian Institute for Health Information, responds:]

The Canadian Institute for Health Information (CIHI) maintains 2 databases on physicians in Canada. The Southam Medical Database contains information on the supply of physicians in Canada and includes physicians who are engaged in clinical and nonclinical practice (e.g., teaching, research and administration). The second database is the National Physician Database, which contains information on Canadian physicians and their activity levels. Information derived from both of these databases can play a role in physician resource planning.

The Southam Medical Database is useful for this purpose because it allows for the identification of supply, distribution and migration trends at both provincial and national levels for all physicians, not just those engaged in clinical practice. This database has been validated,[1] and the counts by province and specialty are consistent with those of other national databases such as the Canadian Medical Association Masterfile, counts provided by the Royal College of Physicians and Surgeons of Canada and the IMS Canada Database. All specialty allocations are based on the physicians' most recent certified specialty. This database does identify physicians who are retired and semi-retired, and these records were excluded from the data provided for the study by Dr. Roos and colleagues.

Dr. Hugenholtz is correct in stating that the information derived from this database should be interpreted with caution when it is used for physician resource planning in relation to clinical practice, because it does not take into consideration whether the physician is engaged in clinical practice and if so, his or her associated type and level of activity. The National Physician Database would have been a better source for the study by Roos and colleagues, since it is based on physician claims data provided by the provincial medical insurance plans. However, timely data from this database were not available when the study was undertaken.

Jill Strachan
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Reference

1. Southam Medical Database: quality assurance review. Ottawa: Canadian Institute for Health Information; 1996.

[One of the authors responds:]

We compared the counts of different specialists provided by the CIHI with counts of Manitoba specialists using both billing data and lists of practitioners provided by the Manitoba Medical Association and others. We also compared counts of practitioners with full-time equivalent estimates derived from billing data and other sources. In other words, we carefully constructed Dr. Hugenholtz's requested measure of clinical activity and paid close attention to the issues that concern Dr. Nazerali and associates. We found that the CIHI data (over the 6 years examined) underestimated by 2% the number of specialists in the province, although for some of the smaller specialties the discrepancies were larger. The physician counts tended to overestimate specialist clinical activity (as judged by full-time equivalents) by 11%; the percentage varied across specialist groups. Therefore, for our purposes, the database seemed adequate.

We share Dr. Donen's frustration at being unable to include approximately 25% of specialists in our analyses, but Canadian data collection for anesthetists, radiologists, pathologists and other hospital-based specialists is particularly poor and we could not include them. Similarly, individual subspecialists (e.g., geriatricians and geropsychiatrists) are not well served by our existing data systems.

We also agree that it is difficult at this juncture to predict the future. There are many factors in addition to the decrease in class sizes that influence specialty numbers, including the closing of the US border to Canadian specialists.

Given the figures quoted by Donen, it would appear that, had we included anesthesiology in our analysis, this specialty would have had an annualized growth in the range of 1%, lower than most of the surgical groups except general surgeons (Table 1 of our article). This would have translated to a slower-than-predicted growth to keep pace with population change (Table 3 of our article). Yet the number of specialists is the wrong indicator on which to focus; many other issues warrant attention. In the case of anesthesiology, for instance, there are no certified or noncertified specialist anesthetists practising in Manitoba's rural south, and the number of rural family practice anesthetists decreased sharply over the period 1986–1996. Despite the appearance of a critical shortage of these specialists, residents of the rural south undergo more surgery than other Manitobans.

We take no issue with the observation of Nazerali and associates that our assumption about the provision of adequate levels of service to the elderly in 1986 needs validation. Likewise, any assumption that current levels are correct must also be validated. Our work clearly supports the contention that physician numbers are the wrong matter about which to worry, which is 1 of the 2 main points we tried to make. However, Nazerali and associates seem to have missed our second main point: the aging of the population per se places few de-

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.

G.E. Rosenquist, MD
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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.

Eva Ryten
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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.