manding) far more physician services than in the past (as indicated by data from the Ontario Health Insurance Plan [OHIP] database). Furthermore, although the authors point out that the type of services needed will not be the same as in the past, they base their calculations solely on population change rather than other inevitable shifts such as type of disease and the development of new technology (not to mention the likelihood of new challenges such as the recent outbreak of severe acute respiratory syndrome). Second, physicians too are changing. They are now opting for a more balanced lifestyle, which means they are no longer working 60 to 90 hours per week, are no longer seeing large numbers of patients each day and will not be practising medicine until the age of 70 or beyond.[3,4] Thus, we are seeing a rapidly growing demand for physician services at the same time as individual physicians are cutting back on hours of work.

We simply must not repeat the mistakes made by health care planners 12 years ago and must not base our policies on retrospective reports. The need for physicians and other health care providers will continue to escalate, and the time to prepare is now.

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Frank Denton and associates[1] found that population aging would have little effect on the required supply of physicians in the future, although a redistribution among medical disciplines would be needed. Although we agree that a "Chicken Little" approach must be avoided, we feel that some acknowledgement of population aging is needed in planning for future physician resources.[2]

First, we would like to raise a methodological concern. The analysis by Denton and associates[1] is based on current payments to fee-for-service physicians in Ontario, but it is doubtful that this is the most appropriate way to fund physician services for aging patients with multiple problems. Also, using historical data to project future needs is suspect; it implies that the way we do things now is optimal. In this case, it masks the changes that will be required in physicians' practices.

As the proportion of older adults in the population increases, the propor-

tion of people seeking care who are older adults will also increase. Already, one-third of deaths from ischemic heart disease among women occur in those over the age of 85.[3] Therefore, all physicians will be seeing more frail older adults with multiple active diseases and both functional and cognitive deficits. Such patients have better outcomes when cared for by a multidisciplinary team using the principles of comprehensive geriatric assessment.[4,5] For the most part, such teams are not present in hospitals or communities, and no plans are in place to establish them. Medical trainees receive little training in these principles, and there is no movement afoot to address this educational gap. Although organized medicine and national medical organizations are addressing future human resources needs, Task Force Two (a group studying physician human resources) has so far estimated only total future physician numbers,[6] and governments are not planning for the human resources required to care for an aging population. They need to plan for the development of teams of health care providers and must create incentives so that trainees choose careers in this area.

Will population aging affect the number of physicians required? As Denton and associates conclude,[1] possibly not, in the aggregate. Will physicians practising 10 years from now have the same patient populations as are seen today? No. The medical profession and government must realize that health care over the next few decades will focus on frail older adults and must put in place the personnel and systems to provide the care they will need.

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Frank Denton and associates[1] suggest that overall population growth is more important than the aging of the population in determining physician requirements, but 2 points seem to need further explanation.

First, the authors comment paren-