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-

thetically that between 1970 and 2000 the requirements for physicians in Canada increased by 72%, whereas supply increased by 116%. However, the overwhelming experience of those of us working in the profession is that large segments of the population can no longer find a family doctor; furthermore, getting patients to specialists in a timely manner is often so difficult as to approach futility. This jarring discoordination renders the article's future projections difficult to evaluate and merits an explanation. Could the reason be increasing medical capabilities, technology or demand, or might the cause be less inhuman physician lifestyles?

Second, Denton and associates[1] report that although use of physicians' services generally increases with patient age, it declines as elderly patients become very old, except in general practice, where use continues to increase even to the oldest age group. Perhaps the explanation is that GPs caring for very elderly patients do so in relative isolation, with these patients receiving less aggressive management. If so, is this appropriate? Or does it represent an adaptation to scarce resources, not only of human resources but also things such as diagnostic equipment, operating room time, even ground transportation?

There's a thesis topic here for somebody!

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The provision of and need for services for elderly patients are underestimated by Frank Denton and associates[1] in their analysis of the effect of population aging on future physician requirements. In their Fig. 1, pediatrics is identified as a separate physician category, but geriatrics is not, even though the roles of geriatricians and the Regional Geriatric Programs (RGPs) of Ontario were recognized by the province's ministry of health in 1988.[2]

In addition, many of the medical services provided to frail elderly patients are not captured by OHIP. Comprehensive geriatric assessments performed by geriatricians (or by team members with case conferences involving geriatricians) in the 5 RGPs are funded by alternative payment plans, not OHIP.

Of patients 75 years of age or older, 14% to 27% are frail and could benefit from a comprehensive geriatric assessment.[3] However, the RGPs of Ontario saw only about 1% of this group in 2001/02. By 2030, the proportion of the population in this age group will have grown by more than 94%.[4,5]

Unfortunately, the supply of physicians with geriatric training is not keeping up with this projected demand. For example, in Canada in 2000/01, only 7 people entered a training program in geriatric medicine,[6] and only rarely do family physicians train in care of the elderly.

Planning by medical schools alone will not address the low numbers of physicians with geriatric training. Governments need to establish and implement policies to correct the existing and increasing shortfall of health care professionals able to assess and treat frail elderly patients.

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**[The authors respond:]**

There is a misunderstanding common to all 4 sets of comments. The issue we addressed is how population change will affect future requirements for physician services — that issue, and that issue alone. To that end, we abstracted from (held constant) all other factors that might affect requirements.

One of our principal findings was that "overall requirements for physicians *in consequence of population change alone* are almost certain to increase by less in the future than in the past"[1] (italics in original). We also noted that a variety of factors would affect future requirements, but to investigate the effects of population change with any precision, it is necessary to abstract from these other factors, important as they may be.

Raymond Dawes says we "postulate that because population increases are now lessening, the future need for physicians will increase to a lesser extent than in the past." However, we did not and would not draw such a conclusion. It would be unwarranted on the sole basis of our analysis of population effects, with utilization rates held constant.

We agree with Chris MacKnight and David Hogan that fee-for-service may not be "the most appropriate way to fund physician services for aging patients with multiple problems." However, as we noted,[1] fee-for-service practices accounted for almost all physician services in Ontario,[2] and the data available to us (for 1995/96) on what services were provided to patients of different ages and sexes related to such practices. MacKnight and Hogan also feel that "using historical