EDITORIAL

A Co-operative Attitude

There has always existed a close and sympathetic relationship between optometry and the ophthalmic industry. One could not exist without the other. The relationship has not always been ideal, but there has always existed a degree of mutual trust and respect which has benefitted both parties.

For the greater part, this relationship has been a business one but it has also nurtured many long-lasting personal friendships which motivate the individuals to support each other. The practitioner, by employing the technical services of the laboratories and distributors, helps keep these firms in business. The industry responds by subsidizing optometric functions and providing funds and materials for research, prizes and scholarships or outright donations to our teaching institutions. Advertising in the Canadian Journal of Optometry is another manner of contributing, by helping to make the publication financially viable.

No universal policy for making contributions exists and the decision depends on the administration of each firm. It is satisfying to note that the majority of optical firms do make some contribution, but there are a number who have no consistent policy. Most, if not all, will make indirect contributions by renting an exhibit booth at a congress or convention. This practice should be encouraged, not only for the camaraderie such meetings create, but also because it helps keep practitioners current in the developments in the industry. However, the profession should not abuse this aspect and should organize the programme such that exhibitors get full value for the money and the time they spend for such ventures.

Of greater importance to the future of the profession are contributions to more lasting projects such as bursaries and scholarships, grants for research and development of clinical practice, trust fund donations and capital grants to our teaching institutions. These contributions are usually of considerable monetary value. One could not reasonably expect all firms to contribute to all such projects. One firm may prefer grants for R & D; another, because of its services, may opt for bursaries or prizes; while still others would consider the trust fund more worthwhile.

A small annual contribution to the Canadian Optometric Education Trust Fund should actually be within the reach of most companies, and would be of real value to the profession. The COETF will strengthen the profession, indirectly benefitting the contributing companies. This, then, should be looked upon by the companies as an investment in *their* future too.

It is only fair that practitioners encourage and patronize those firms who have in the past and continue to commit a significant portion of their revenue to optometric projects. Similarly, practitioners would expect that firms heavily patronized by optometrists would manifest some responsibility in this matter, particularly those few firms who have not set any policy in this matter.

In all fairness to the contributing firms, practitioners should not let a few cents, or even dollars, deter them from patronizing these firms who by their contributions manifest loyalty and faith in optometry the profession.

GMB

GUEST EDITORIAL

The Canada Health Act — Perceptions from the Field

So now we have a new Canada Health Act — Bill C-3.

A lot of work has gone into the Act, on our behalf, by members of CAO and the national staff to ensure that Section 4(3) of the previous Medical Care Act was retained in some form.

The status quo, plus some, has been upheld.

The terminology of the section in question previously restricted the Act to the use of the term "medical practitioner" which meant that, for other health care practitioners to be included in Federal funding, they had to be "specified by the Governor in Council and, if the provincial law so provides, be deemed to be (providing) services rendered by a medical practitioner that are medically required." The new Act now entitles the provinces to include as insured services "similar or additional services rendered by other health care practitioners."

The provincial governments in nine out of ten

provinces have already recognized optometry's role as a primary health provider in their health insurance plans. So what happens next? In which direction should optometry and the other health professions be headed?

One of the stated objectives of the Canada Health Act is to "facilitate reasonable access to health services without undue financial or other barriers." Costs to both the federal and provincial governments are of major concern in the provision of health care. The system wants to reach *all* those in need regardless of economic situation, geographical location or level of care required. Universal accessibility is the goal.

By penalizing those provinces who allow extra-billing, over billing, hospital user fees, etc., the federal government hopes to remove the economic barriers which have reduced accessibility to the health care system and threaten to lead to the development of a two-tiered system of health care. But the future costs of the system need to be looked at now.

Our population is aging, and requires care. Technological change in medicine is a reality, and an expensive one. We do not solve these problems, however, by prohibiting extra-billing. A few specialists who extra-bill to augment their private incomes will be upset. But those hospital administrators trying to purchase much-needed equipment, and those individuals trying to find chronic care space for their elderly parents, will still be in distress. The cries from the hospitals, the health care practitioners and the public for increased funding from all levels of government will only grow louder.

The patient, as an individual, has changed as well. Patients are often called "health consumers" and their attitude toward the health care professions is not as passive as it once was. They are better educated and more knowledgeable than ever before and consumer associations now do reports on health care in much the same manner as they do on imported cars and humidifiers for the home.

A system in which only a limited number of highly qualified health care professionals are allowed to bill the health insurance program directly has to be expensive. At present, many services are being provided by, and therefore billed by over-qualified personnel. Not every health care need requires the training and expertise of a physician. The use of nurse practitioners as primary health providers in some remote communities, and in urban health centres, is an excellent example of a successful and viable alternative to our more widely accepted present system. And what of the areas in which a physician is not always the most appropriately qualified individual for the patient's needs? The role, for example, of the nutritionist and dietician in a prevention oriented system of education is not generally utilized at present. These individuals are generally found in institutions where a patient's first contact is through a physician and, frequently, it is after they have already developed specific medical problems.

Should we not be looking at these alternatives to our present physician dominated, healing oriented health care system as a means of trying to reduce our health care costs? The long term advantages of a prevention and health promotion approach to health care do not seem to be given any serious consideration. Our new Canada Health Act, which tries to give some direction to the approach of health care plans in the provinces, has not dealt with this concept at all and, in fact, a rather drastic shift in the attitude of both the public and the politicians would be required to bring it about. Counselling a famiy on nutrition, diet, stress management, etc., is certainly not as glamourous as performing triple bypass surgery, but it might be as much of a life saving exercise, and it certainly costs less.

Canada is one of the few Western countries which does not license mid-wives. Clinical psychologists in private practice are not covered by health insurance programs in many provinces. Nurse practitioners, nutritionists and dietitians have already been mentioned. Physiotherapists are another excluded group. The appropriate use of these health care practitioners is an option to be considered when trying to control our health care costs while still providing accessibility. If these groups, through their provincial associations, were to negotiate with the provincial governments for inclusion in the health insurance program, they could begin the shift of the health care system from its present, relatively exclusive status, to a more open system.

With a new multi-faceted health care system, we should be able to provide efficient, prevention oriented care at a reduced cost. The barriers to universal accessibility need not exist.

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Ottawa

"They Also Serve . . ."

In submitting a brief to the Government of Canada, protocol requires that the authors of the brief be present when it is submitted. This ensures that any questions coming from the government representatives can be directed straight to those identified as responsible for the submission.

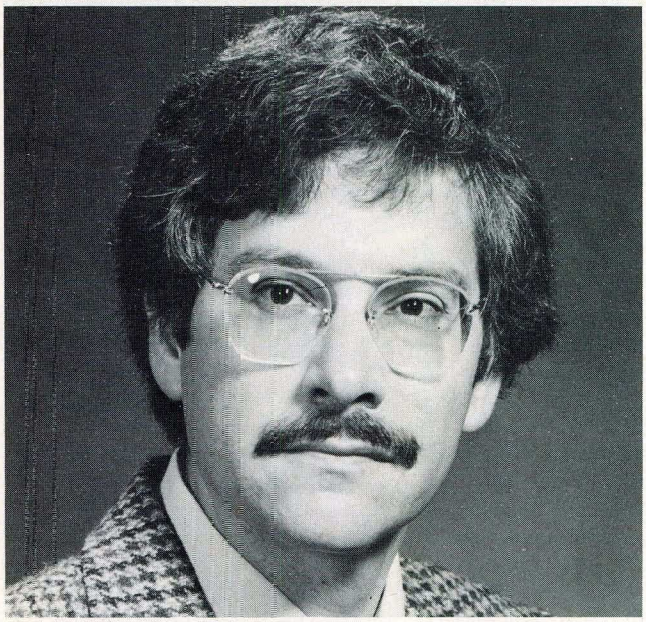
Readers of our March issue, with the full text of the C.A.O. Brief to the House of Commons Standing Committee on Health, Welfare and Social Affairs, will note that the authors of the brief are identified as Drs. des Groseilliers, Hansford, Brown, Woodruff and Mr. Lambert. There is another.

Dr. Hervé Landry, unfortunately, was due back in Moncton on the day the brief was slated for presentation to the Committee. As a result, he was omitted from the roll of authors of the brief because of the above protocol practice. It must be noted, however, that any appreciation to the above authors will have to include equal thanks to Dr. Landry who, with the others, logged the long hours of preparation, discussion, draft writing and re-writing of the final version of the brief. The result of their work speaks for itself — optometry and other non-medical health professions will continue to be assured of coverage under provincial health care schemes. We will not argue with those who point out that for optometry, nothing really was gained over what was in the 1966 Medical Care Act but, for a few dangerous moments, we were in danger of losing even that. To the above, and to all those members of the C.A.O. Political Action Group, goes a well-deserved round of thanks on behalf of this profession to which so many have dedicated themselves.

MJD

New Director for Waterloo's School of Optometry

Effective July 1, Professor Jacob G. Sivak will assume the position of Director of the School of Optometry, University of Waterloo, for a three-year term.



Dr. Sivak

Dr. Sivak has been a member of the university faculty since 1972, becoming a full professor in 1980. An active researcher throughout his years at Waterloo, Dr. Sivak has published numerous papers on the evolutionary development of the eye as an optical instrument, and on applied matters dealing with clinical methodology and instrumentation. He is a Fellow of the American Academy of Optometry.

His particular interest as regards the future of the School is in the application of new developments in science and technology to the clinical program.