EDITORIAL

The Price of Freedom is Eternal Vigilance!

One need only to review the circumstances surrounding the efforts by the last Federal government to present and have passed a new Medical Care Act, Bill C-3 (The Canada Health Act), to realise the truth and validity of the above maxim as it applies to Optometry.

Had Bill C-3 passed into law as it was first tabled in the House of Commons, it could have meant the death knell for Optometry as an autonomous health care discipline, not to mention the same fate for other health care disciplines. The Bill, in its initial format, could have led to the entrenchment of a medical monopoly in *all* aspects of health care.

It is often said that history tends to repeat itself. That is particularly true in this instance which is virtually a carbon copy of the situation in 1966 when the Medical Care Act was passed. Optometry, at that time, was presented with a proposed statute — after the fact, as it were. In 1966, changes that recognised optometric services were ultimately enacted as a part of the legislation.

In 1984, Optometry again was able to achieve recognition by presenting its case (again *after* the proposed legislation was first introduced) before the Standing Committee of the House of Commons on health care. The Committee voted unanimously in favour of our key proposal at its meeting on March 21, 1984. As is now public record, Bill C-3 received final reading in its amended form.

Optometrists in Canada owe a debt of gratitude to the members of the CAO President's Committee working on the CAO Brief for its tremendous expense of effort, time and energy.

The authors of the Canada Health Act's original text, advisors to the Minister of Health, are career public servants, a good number of whom are physicians or medically-oriented lay people. It is not surprising, therefore, that the proposed legislation was brought forward without any reference to professionals other than physicians as providers of services under the Act. It illustrates once again the urgency for the appointment of an *Optometric Consultant to the Minister of Health*, to ensure that Optometry's voice is heard during the actual drafting of the text of proposed legislation, thus avoiding the delays, controversies and expenses involved in preparing amendments. In fact, all health care occupations, particularly the five primary disciplines, should have a say in the preparation of such legislation.

Through a separate recommendation in CAO's Brief, the Minister of Health has been apprised of Optometry's policy on this matter of optometric participation in the preparation of new legislation dealing with health matters. Optometry, through its national and provincial Associations, must also give this particular recommendation priority in order to avoid future similar legislative "surprises". Such optometric consultants are required in not only the federal Department of Health and Welfare, but also in provincial Departments of Health and Social/Welfare Services.

Not only must this profession have a word in the preparation of proposed legislation, we must be assured that optometric services are available through the various agencies of both federal and provincial levels of government which provide health services. Optometry must be universally recognised by all departments and agencies whose present contradictory policies, in some cases, must be abolished.

In this same vein, the various levels of government should establish a uniform policy in the distribution of research grants and capital funding for new facilities. The present policy that all such grants must be channelled through the Medical Research Council needs to be changed so that other disciplines can more readily engage in research and development which is *not* copied on the medical model of health care. The makeup of the Council should have a more general representation to eliminate the medical domination. Its name could be changed to, for example, the Council for Research in Health Care, or some similar title, to more fully reflect the true purpose of its raison d'être.

In its fiscal arrangements with the provinces, the federal government should establish a policy that assures a just and equitable distribution of all funds for research and new facilities for the five primary health care disciplines. It is not always true, or even realistic to assume, that medicine is the only health care discipline with the abilities and personnel to conduct valid health research. In fact, what medicine often claims as its own work is actually the effort of such scientists as bio-chemists, chemists, physiologists, bio-engineers and pharmacists among others.

Such a policy would not be in contradiction of the primary aim of the Canada Health Act, namely health care that is universal, comparatively inexpensive and readily accessible. In fact, it would only enhance such objectives by assuring more equitable progress in all fields, avoiding a good deal of the ill will which arises from the seemingly arrogant

domination of health care by medicine. It could automatically provide for a minimum level of funding for all groups and, consequently, guarantee that the services offered would be more comprehensive.

These are some of the objectives that Optometry must embark upon. We cannot forget that the price of our present freedom is eternal vigilance and hard work!

GMB

LETTERS

Editor, CJO

In my opinion, there should be more involvement by our profession in meeting the needs of the geriatric population. Optometry should be more responsive to their demands, and I feel that we should be planning to have a larger segment of our patients coming from the elderly age group. There are, I feel, at least four areas with which we should deal:

Education Research: There are functional changes that occur as we age, with a higher incidence of disease. We should be educated and aware of the oculo-visual and systemic problems that can exist. Increased research into age-related visual changes should be pursued.

Diagnostic Drugs: For better disease detection, especially through small pupils and cloudy lenses, it is imperative that Optometry obtain the full use of diagnostic pharmaceutical agents as a help to not only the elderly, but to all optometric patients. I feel that, when set against the benefit of improved pathology detection, the risk is very low.

Low Vision: In Canada, most low vision patients still receive ophthalmological care only. We must expand the optometric role in low vision. Our profession has the unique skills that allow us to derive the maximum benefit from a patient's existing sight.

Accessibility: Optometrists should be planning their offices so they are accessible to the aged and/or non-ambulatory patient. When we renovate, or move, we should have their needs in mind. We should also not rule out institutional visits as a service to provide needed optometric care.

I believe that, if Optometry doesn't change to meet the demands of the elderly, especially if we don't acquire the full range of diagnostic drugs, then this ever-expanding segment of the population will seek medical eye care, to the detriment of Optometry as the primary vision care profession.

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