consider raising the topic of HIV with sexually active men and women in their practices.

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References

1. *Global Programme on AIDS. Report of the Meeting on Research Priorities Relating to Women and HIV/AIDS, Geneva, 19–20 November 1990*, World Health Organization, Geneva, 1991
2. The European Collaborative Study. Children born to women with HIV-1 infection: natural history and risk of transmission. *Lancet* 1991; 337: 253–260
3. Cassol SA, Lapointe N, Salas T et al: Diagnosis of vertical HIV-1 transmission using the polymerase chain reaction and dried blood spot specimens. *J Acquired Immune Defic Syndrome* 1991 (in press)

Canadian medicare: view from Utopia

Since moving to the United States some 4 years ago I have watched with incredulity, pity and exasperation the plight of Canada's medical profession under universal, government-sponsored medicare.

The draconian measures proposed in Quebec's Bill 120 (such as stiff penalties for MDs who don't practise as government deems fit) and the seemingly cosy accord between the Ontario Medical Association (OMA) and Ontario's New Democratic Party government have a common thread: Canadians' willingness to allow governments to exert inordinate control over their affairs. And that is what's causing Canadian medicare to unravel.

The lack of competitiveness in Canadian health care has led to rationing, waiting lists, shortages of equipment and scandalously low relative amounts expended on research and on technology. Lack of any kind of copayments or deductibles has led to abuses of the system both by users and by providers.

Canada's insistence on public administration as one of the tenets of medicare is surely the silliest example of enforced noncompetitiveness. Private insurers competing with government insurance would surely inject more life (and cash) into the system. The argument that such competitiveness flies in the face of an egalitarian concept of universal medicare is almost as absurd as Canada's insistence that there cannot or should not be two-tiered medicine and that real access to health care actually exists. Consider the predicament of a Newfoundlander who wants to undergo lithotripsy.

In all of this the poor Canadian physician has been truly squeezed. Between 1971 and 1985, after adjustment for inflation, Canadian physician fees decreased 18%, while those of US physicians rose 22%.[1] Yet Canada spends one-third per capita of the US figure for health care research and little more than 75% of the US figure for hospitals and construction.[2]

Even if Ontario physicians have been quietly lured into the provincial government's lions' cage, it may not be too late to rattle the cage or even to steal out of it. It will take a blueprint for a restructured medicare system that embraces at least limited competition, some form of copayment, increased funding for research and a collective willingness by Canadians to rely less on government.

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References

1. *Canadian Health Insurance: Lessons for the U.S. Report to the Chairman, Committee on Government House of Representatives*, US General Accounts Office, Washington, 1991: 5
2. Ibid: 29

[We are delighted that Mr. Woods has found Utopia in suburban Pennsylvania and that he hasn't become ill. — Ed.]

Cognitive impairment in the elderly

The recent correspondence between Graham Worrall and Drs. Louise Teitelbaum, M. Lynne Ginsburg and Robert W. Hopkins (*Can Med Assoc J* 1991; 145: 196, 198) concerning the prevalence of cognitive impairment in Canada serves as a good introduction to the Canadian Study of Health and Aging, currently under way in 18 centres across Canada. The study directly addresses the points raised in the correspondence.

The study will assess the prevalence of cognitive impairment, dementia and Alzheimer's-type dementia in people aged 65 years or more in all provinces of Canada, using representative samples drawn from community and institution populations. A screening instrument is being used in the community samples (total n = 9000). Those with positive results of screening, plus a random sample of others with negative results, receive an extensive clinical diagnostic work-up, including history-taking, physical examination, neurologic and neuropsychologic testing, and laboratory studies. People living in institutions (total n = 1250) proceed directly to the physical examination.

Embedded in the study design is a case-control study of risk factors for Alzheimer's-type dementia in which data will be collected via questionnaires to examine current etiologic hypotheses. In addition, a prospective risk factor survey, targeting those found