gram to compensate living organ donors, as well as families of deceased donors. "They are doing a benefit to society and in truth, they're saving the government money."

Dr. Anthony Jevnikar, past president of the Canadian Society of Transplantation, Corinne Weernink, president of the Canadian Association of Transplantation, say the medical community has accepted the legitimacy of living donations from relatives or friends, and are generally agreed that such donors should be financially compensated for lost wages and other costs while convalescing. "I think anything that we can do to promote living donation and decrease hurdles would be a benefit," says Jevnikar.

But the ethical issues are far more nuanced in the case of so-called "live unrelated" donors, in part because of the 3-in-10 000 risk of death while on the operating table. It's problematic enough for a physician to reconcile that risk with his oath to "do no harm" when dealing with emotionally-related donors and recipients, let alone those who use the Internet to find each other, says Jevnikar, a professor of medicine and director of kidney transplantation at the London Health Sciences Centre.

The ambiguities have prompted others to explore solutions that use independent oversight to ensure no benefits are being transferred to the so-called altruistic donor, whether through direct financial payment or indirect measures such as educational endowments for other family members.

In Vancouver, Dr. David Landsberg, director of renal transplantation at St. Paul's Hospital, has launched a pilot project to study the long-term psychological impact of altruistic donation that will assess 10 anonymous donors over the next 18 months.

Landsberg argues that a truly altruistic donor should be willing to remain anonymous, and a truly anonymous donation would eliminate concerns about financial reward or coercion. "The only psychological benefit that would come would be knowing that you helped someone that needed it."

Another potential solution lies in directly coupling anonymous donation with financial incentives.

One school of ethical thought, exemplified by Manchester University law professor John Harris, contends it's wrong to deny people the right to do what they like with their bodies, including selling organs, says Dr. John Dossetor, a member of the Canadian Council on Donation and Transplantation, an advisory body to the nation's deputy health ministers.

Proponents of such a regime argue that creating a "monopolist market" (in which a government agency purchases organs from donors at fixed rates, and then distributes them according to need) eliminates the possibility of wealthy people buying their way off waiting lists, Dossetor adds. "That has some appeal." — *Wayne Kondro*, Ottawa

HEALTH ECONOMICS

Delisting chiropractic and physiotherapy: False saving?

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Delisting chiropractic services in BC and Ontario, and limiting community-based physiotherapy in BC, Alberta and Ontario are false economies, both professional associations claim.

The Ontario government hopes to save $100 million annually by delisting chiropractic services in December 2004 and another $100 million by cutting community-based physiotherapy this spring. Ontario plans to use the savings from delisting "less critical" services to boost cancer and cardiac care, and home- and long-term care.

Comstock

Delisting physiotherapy will "strain an already overburdened health system."

However, a report by Deloitte Consulting Services commissioned by the Ontario Chiropractic Association predicts a 7%–14% increase in the number of patients visiting emergency departments and a 1.3%–2.6% increase in visits to family physicians, as Ontarians try to avoid paying for a chiropractor.

Graydon Bridge, president of the Canadian Chiropractic Association, says Ontario's delisting will "actually cost as much as $200 million as patients are diverted to more expensive and possibly less effective options." Manitoba, Saskatchewan and Alberta provide partial funding for chiropractic services.

In BC, chiropractic and community-based physiotherapy were delisted in 2002 for all but the poorest 20% of residents. The savings of $130 million annually were funnelled into preminum assistance subsidies. But the Canadian Physiotherapy Association says delisting resulted in increased waiting times, a 28% decrease in patients accessing community-based care and reports of patients ending treatment prematurely.

Public funding for community physiotherapy services varies widely across Canada; most recently, Alberta limited funding to trauma or surgical patients.

The Canadian Physiotherapy Association says these actions will have a profound impact. "Without the early intervention and treatment provided by physiotherapists, many citizens will develop more significant health problems and cause additional strain on an already overburdened health system," says CEO Pamela Fralick. — *Jennifer Dales*, Ottawa