nothing of the lack of early intervention strategies for asymptomatic individuals. The Canadian medical establishment has not met its professional obligations to treat PLWAs/PLHIVs.

The use of the EDRP has made the struggle to get AIDS treatments a three-dimensional problem. Instead of becoming simpler, the situation has become more complex.

A. The federal government is not yet prepared to negotiate with multi-national pharmaceutical firms as a sovereign nation. It prefers to walk in the shadow of the United States Food and Drug Administration (FDA). This means that the Canadian release of new drugs is regulated by United States authorities.

B. The pharmaceutical firms are governed by their market interests, except where they have to meet FDA standards for safety and efficacy. Improving the life-chances of PLWAs takes a back seat to making profits. AZT cost US$10,000 per patient per year and alpha-interferon has recently been pegged at US$12,000 per year. Last year, Burroughs-Welcome, the producer of AZT, made the largest wind-fall profit in its history.

Nor are these corporations above using the AIDS crisis to put pressure on government to deregulate their industry. They hope that programs like "fast-tracking" the approval of drugs for AIDS will lead to lower standards of safety and efficacy in approving all new drug products.

C. And lastly, there is the problem of developing a backup system for doctors treating people with HIV infection. At the present time, the medical profession has failed to strike a common front in the fight against AIDS. Traditional methods and resources are not up to providing the necessary initiative and direction. Even the much touted Ontario Consensus Conference held last November has produced nothing in the way of a consensus on HIV treatment. Turf wars and personality conflicts abound. Different career-interests and levels of commitment on the part of physicians have left patients fending for themselves. Within Canada there is a virtual lack of any comprehensive system for the management of AIDS treatments.

Problems within the medical community are serious. For family doctors who are committed to treating people with HIV infection, the work is a money-losing venture. This is because PLWAs take more time, require more paperwork, and, because HIV infection is a complex disease, their treatment demands more study and analysis by doctors. The costs of these kinds of extra services, however, are not easily recoverable from OHIP. Moreover, to make AIDS treatments a special OHIP category for payment of services would immediately identify people with HIV disease. This raises serious problems of confidentiality and anonymity.

For AIDS ACTION NOW! the increasingly more complex problem of getting treatment for PLWAs/PLHIVs raises the question, "What is to be done?"

At present, we are in the process of evaluating the effectiveness of the new federal minister of health and welfare. To date, the government does not seem interested in taking a firm stand with multinational pharamaceutical firms. We are also waiting to see if the minister will reorganize the Federal Centre for AIDS so that its mandate will include providing treatment backup services to doctors and their patients as part of the new national AIDS strategy.

The struggle for DDI has produced the first confrontation with a multi-national pharmaceutical company. There is no reason to believe that this will be the last one either. Unfortunately, community-based organizations have little leverage when it comes to forcing these corporations to take account of the needs of PLWAs and people living with HIV infection. The development of new strategies and tactics will be required for the future.

Fortunately, the situation is not totally bleak. The money that AAN! has recently received from the Trillium Foundation (thanks to those of you who play the lotteries) to establish a treatment information exchange should be able to help provide treatment backup services to both doctors and patients.

These will include the publication of *TreatmentUpdate/TraitementSida* and brochures like *Treatment AIDS* and *Testing AIDS* in both English and French, and hopefully other languages. This grant will also provide money to begin the monitoring of people taking various treatments (including complementary therapies) with a view to seeing which ones appear to be most effective — a sort of community research initiative for Toronto. This kind of treatment information should be useful to both patients and doctors.

The Trillium money will also allow AAN! to set up meetings between doctors and PLWAs/PLWHIVs to discuss the latest developments in AIDS therapies. There is also talk (from the Vancouver PWA Society) of developing videotapes on HIV infection for doctors treating PLWAs and PLWHIVs, and of a computer-conferencing system for doctors (spearheaded by AAN!) to help with the exchange of treatment information. Lastly, there is the development and implementation of a treatment registry, part of AAN!'s seven-point policy paper, promised recently by the federal government.

It is not difficult to see that the problem of getting treatments for people with HIV disease is not over. In fact, the sitcation has expanded and become a good deal more complex in the year and a half of AAN!'s existence. Where do we go from here? That is something for us to decide together. What should be clear is that the problem of access to treatment has not been solved.

George Smith