not respond to requests for comment.)

Fears of conscription have arisen before as provincial governments grapple with physician shortages or introduce new emergency legislation and pandemic plans. As in Ontario, questions about compensation, indemnity and insurance have followed.

In Quebec 4 years ago, physicians raised concerns about Bill 114, which would have required all Quebec doctors with recent ED experience to provide ED coverage in the event of a staffing shortage. The proposed legislation was drafted in response to a shortage of emergency department doctors. Although the Bill did not become law, later efforts to manage Quebec physicians met equal protest. When Quebec released details of its pandemic plans in mid-March, the plan called for the "voluntary" assistance of retired medical professionals to cover any shortages.

Conscription fears also arose in Alberta last December when Calgary's Medical Officer of Health, Dr. Brent Friesen, released his Pandemic Influenza Response Plan for the Calgary Health Region.

As Friesen explained to *CMAJ*, the province's power to conscript is not new, stemming from amendments to Alberta's 2002 Public Health Act. The Act allows the Medical Officer of Health to conscript individuals to meet emergency needs.

"If you look at most emergency legislation across the country, it's written in such a fashion as to allow organizations to conscript people that they require," says Friesen. "But again, it is done as a last resort."

Despite news headlines, current discussions with Alberta's health care professionals about emergency and pandemic issues are not focused on conscription, but instead around ensuring health care workers have training to serve in whatever capacity they are needed, as well as on indemnity and compensation concerns.

The obligation, says Friesen, is "to make sure that we've got it laid out well in advance in terms of the measures we're going to have in place to protect people if we are asking them to undertake these works and do these things for the benefit of society as a whole."

With health care clearly under provincial jurisdiction, these debates have been focused at the provincial and local levels. However, in a catastrophic national emergency, doctors could be forced to serve under the federal Emergencies Act, which in 1988 replaced the old War Measures Act. Such an order can only be invoked at the request of a province if there is no other existing legislation, provincial or otherwise, that could be used to manage a situation. — Pauline Comeau, Ottawa

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Apples, oranges and wait times: CIHI report

Published at www.cmaj.ca on Mar. 22, 2006.

The first major effort to compile comparable nationwide data on health services wait times suggests that skyrocketing demand in the so-called priority areas of cancer, heart, diagnostic imaging, joint replacements and sight restoration hasn't appreciably lengthened the time it takes to get treatment.

But Canadian Institute for Health Information (CIHI) officials are quick to caution that conclusions drawn from its recent report, *Waiting for Health Care in Canada: What We Know and What We Don't Know* are suspect because of data collection and methodological issues.

"We do not have a comprehensive, cross-Canada picture," said CIHI Chair Graham Scott, at a Mar. 7 press conference. "But our expectation is that there will be better, more comparable data in the future."

CIHI President Glenda Yeates says the data are highly variable because of factors ranging from physician practice patterns, referral procedures and things like "what type of care you need, whose list you are on and where you are waiting, how processes of care and wait lists are managed and special factors related to individual patients or conditions."

"There is no average person or average wait," Yeates says.

This is the first time comprehensive wait time data has been compiled, and without a valid reference point it's impossible to conclude whether the situation is improving, Scott said in an interview. "But the one thing we can do is show that there's been a huge increase in volume and the wait times don't seem to have gotten worse, so if there's a positive message, I suppose that's positive."

Scott stressed the need for more standardization of the way wait times are measured across Canada. "In the vast majority of the country, wait times are controlled by individual physicians.

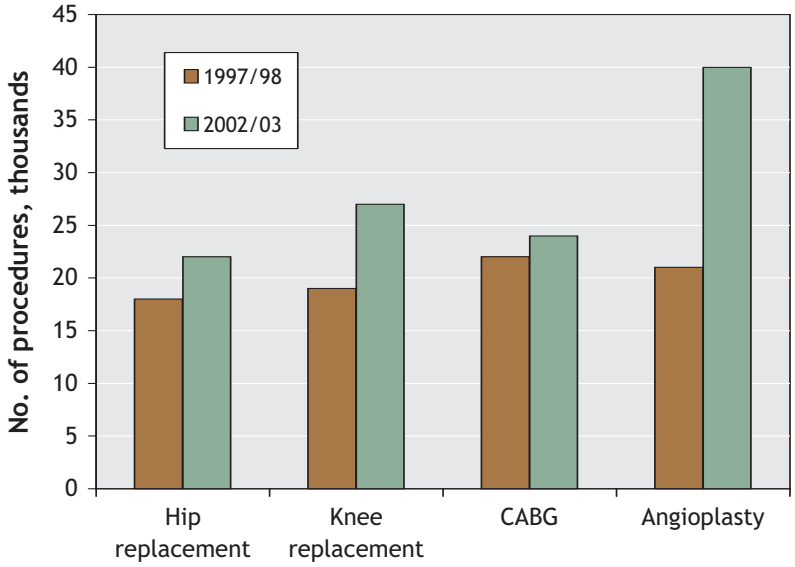

Fig. 1: Five-year increase in numbers for 4 procedures. Note: CABG = Coronary artery bypass graft.

So until the system and the physicians cooperate and pull that all together, which they've done in some places like the Alberta Bone and Joint Institute, and so on, it's very hard to begin to measure some of these things, let alone how each one of those physicians measures it."

The report indicates explosive demand for services, including a 51% increase (by 22 000 cases) between 1998–2003 in the number of cardiac bypass surgeries and angioplasties; a 30% hike (up 11 340) in knee and hip replacements; and a 32% increase (62 000 cases) in cataract surgeries (Fig. 1).

Overall, the report projects roughly half of all patients wait less than 30 days for non-emergency surgery, with hip and knee replacements taking much longer, typically 3 months. Roughly 10% of all patients wait at least 6 months for treatment.

The report also indicates that queues to see a specialist are typically long. In the case of hip and knee replacement patients, often 30% of the overall wait time is spent waiting for the initial visit with an orthopedic surgeon.

Mike McBane, executive director of the Canadian Health Coalition, a pro-medicare lobby, expressed concern that the focus on wait times is deflecting attention from needed systemic changes.

"We're getting a partial picture of less and less," McBane said. "We're going backwards. Instead of moving to reform the system, moving to prevention, moving to home care, we're going back to fixation on a few high tech procedures of acute care. But what about the whole system?" — Wayne Kondro, Ottawa

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Wait-list weary Canadians seek treatment abroad

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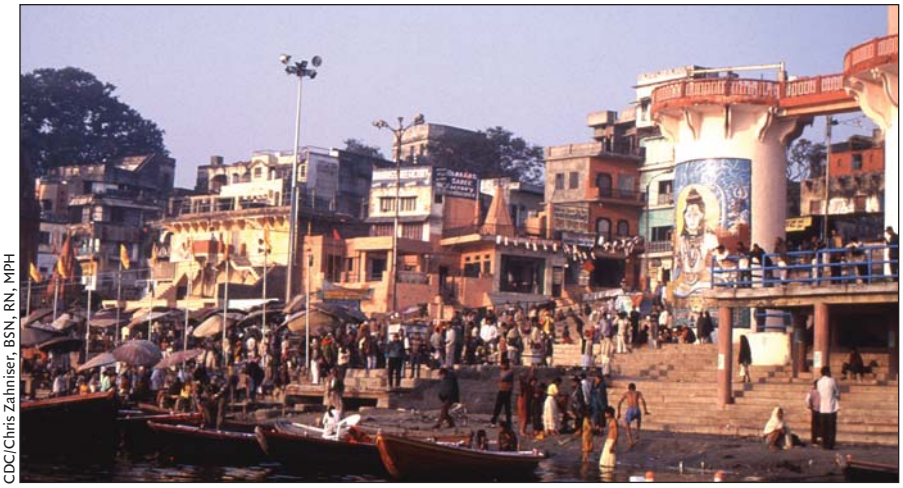
A Canadian company that arranges cardiac, orthopedic and cosmetic surgery in India, France and other countries says wait lists at home are driving Canadians' demand for its services.



CDC/Chris Zahniser, BSN, RN, MPH

Medical tourism is increasingly popular in India and other countries, where BC companies are arranging surgeries along with sightseeing for Canadian patients.

MedSolution.com has fielded 2500 inquiries from Canadians interested in private cardiac and joint replacement surgery since it began operating in late 2005, says John Knox, spokesman for the Burnaby, BC-based company.

So-called "medical tourism" is a well-established industry in Asia and the UK, but companies promoting it in Canada are relatively new. No statistics on the total number of patients are available.

At press time, MedSolution was in the process of sending 6 US patients to its partner hospitals in India and France for surgery, Knox said. About the same number of Canadian patients were undergoing medical assessments to qualify them for the service.

The companies hook patients up with a hospital and surgeon, arrange for their family doctors to send records and consult with the surgeons overseas, make travel arrangements and book hospital admissions.

India has become a destination of choice because treatment is less expensive than in the US and doctors are often Western-trained, says Knox.

Getting a hip replacement, for example, costs about US$40 000 in the US, but US$15 000 in France and US$6000 in India, Knox says. The company also hopes to expand its partner institutions to hospitals in Malaysia and Costa Rica, among other countries.

Although there is no guarantee that Canadians who have the surgeries performed out of country will be reimbursed by provincial health insurance plans, that is not a major obstacle for MedSolution's clients, says Knox.

"Waiting lists are so out of control in this country, many patients are willing to pay anything to obtain swift access to the services they need," he says. "It's our job to help them find a hospital in a country that suits their personal preferences and their budget."

In one well-publicized case in Alberta, the province reimbursed Aruna Thurairajan of Calgary for the $3000 she spent having spinal surgery performed in India. The flight cost her an additional $2000.

"I wasn't even wait-listed" in Canada, says Thurairajan. "I had to beg the surgeons [here] to give me an x-ray and an MRI."

She does not regret her trip and has referred other patients to India, she says. "It's as good as the best hospitals in the US."

Other medical tourism companies in BC, such as Timely Medical Alternatives, arrange surgeries at hospitals in states bordering Canadian provinces. That Vancouver-based company is compensated by the US hospitals for finding Canadian patients.

The company has chosen not to send patients farther afield because of the risk of complications involved for patients flying more than 5000 miles, says Rick Baker, a principal with the private company. — Laura Eggertson, *CMAJ*

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