EDITORIAL

Out of country health care

Urologists reading the Globe and Mail Saturday January 28th may have thought that they had picked up a Urology journal. Back to back three quarter page articles in the first section described two cases of GU cancer. One man with a renal mass was faced with a 4 week wait for a CT scan, 'and a further 8 week wait' for surgery to have a suspected kidney cancer removed. He went to the Cleveland clinic for an immediate laparoscopic nephrectomy, at a cost of about $50,000. The Health Services Appeal and Review Board ordered the Ontario government to reimburse the patient in full.

The second case involved a patient with superficial bladder cancer who, faced with a cystectomy after the failure of conservative management, did his own research. This led him to the Netherlands for a combined intravesicle chemotherapy-hyperthermia treatment. The same Board has ordered the Ontario government to reimburse the patient fully for the treatment, based on the conclusion that the treatment is no longer experimental (the published data on this approach is limited to small phase 2 experiences; there is very little experience in BCG failures). The patient's tumor recurred after he returned to Canada and he has since had a cystectomy.

These reports evoked mixed emotions. The long wait times for cancer surgery in Canada represent a failure of our system. Most welcome the recent Supreme Court Chaoulli decision, which gives patients recourse from excessive delays in our monopsonistic system. Nonetheless, we may have deluded ourselves with excessively negative PR. Several provinces now post detailed information by hospital division on wait times on the web. This is a laudable initiative. The Cancer Care Ontario web site, **http://www.health.gov.on.ca/transformation/wait_times/wait_mn.html#**, is an eye opener. It indicates that in Ontario, the median wait time for surgery for prostate or bladder cancer is 21 days. At various Toronto hospitals, it varies between 17 and 28 days. This information (if accurate—a major qualifier) allows patients to make an informed choice. Perhaps, today, the first patient described above would be able to find a local urologist with an acceptable waiting list.

Reducing the wait for cancer surgery has become a national priority. The relatively short wait times in Ontario may represent an improvement, based on the provision of additional resources. However, in a resource constrained system such as ours, privileging certain disease states and treatments over others results in winners and losers, with the unrecognized diseases getting inadequate resources. Is it right that a patient with severe incontinence wait 6 months or a year for surgery so that another patient can get expedited access to a radical prostatectomy? Surely both are important.

Finally, there is the uncomfortable spectre of substantial tax dollars flowing out of Canada to US physicians and hospitals who, not facing the same resource constraints, are able to offer surgery with no waiting list at a cost three times higher than in this country. Similarly, funding a patient's expenses in Europe for an unproven intravesicle treatment (which ultimately proved unsuccessful) seems extraordinary when, for example, Interferon for BCG refractory bladder cancer is not funded in most of the country.

This issue of the journal contains a cornucopia of interesting articles. The study on sexual disorders in Canadians, based on interviews with more than 1000 men and women, is a major achievement. The conclusion that "Many middle aged and older adults in Canada report continued sexual interest and activity" is reassuring. The Radiation Oncology consensus document on bone loss in androgen deprivation is a call to action; the recommendations express a much more interventionalist approach to osteoporosis diagnosis and prophylaxis in men on ADT than is generally practiced.

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