



Pacific NorthWest  
Economic Region

## Pacific Northwest Economic Region: Health Care Working Group



**“When Health is absent – wisdom cannot reveal itself, art cannot manifest, strength cannot fight, wealth becomes useless, and intelligence cannot be applied”**  
– Herophilus, (335 BC to 280 BC – Greek Physician – The Father of Anatomy).

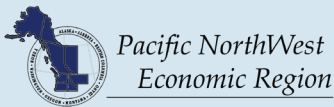
### **Humor**

**Doctor:** Does it hurt when you do this?

**Patient:** Yes

**Doctor:** Well, don't do that

This newsletter supported by:



### **Message from PNWER Health Care Working Group Co-chairs**

This is the first PNWER Health Care Working Group newsletter. We hope to highlight activities and programs in the Pacific Northwest Region along with some helpful statistics and information sources. We welcome thoughts on how this newsletter might serve the public and private sector members in highlighting important work they have underway and outlining some of the challenges we need to address. If there are some 'best practice' examples please pass them on.

We plan to develop an ongoing program of health care forums to share innovative approaches through the coming year and welcome regional partners who might wish to host events in our partner regions. The challenges facing the health system are too complex to be solved in isolation. We have much to learn from one another – across borders and also bringing together ideas and innovation from both the public and private sectors.

Health is not only a major contributor to wealth, increased wealth is also a major contributor to enhanced health. We want to have the healthiest workers in the PNWER region and also the healthiest health industries. Technological innovation is often seen as a significant cost-driver and a threat to sustainability and affordability of the health system. In fact technological advances could well be the solution to ongoing sustainability of the system. We need new ways to deliver services to a growing and aging population using the scarce time available to an increasingly aging health workforce. We hope the PNWER region can serve as an example of fresh new ideas and a model for North America of individual, population and economic health! Please provide any ideas on how the newsletter might be useful through the PNWER office or directly to John Sproule, (Editor, PNWER newsletter) at [jsproule@ihe.ca](mailto:jsproule@ihe.ca). Have a healthy and productive 2009 meeting!

**John Sproule**, Senior Policy Director,  
Institute of Health Economics. Co-chair,  
Health Care Working Group

**Julie French**, State Representative,  
Montana, District 36, Co-Chair PNWER  
Health Care Working Group

### **Some Healthy Meeting Tips**

To begin we want to make sure that all PNWER delegates follow some useful healthy tips for meetings.

- **Everything in moderation:** Make sure to sample all the wonderful BC food and beverages – but make sure to do so in moderation. Avoid that third helping and lessen food intake later in the evening. Have fun visiting with colleagues but make sure to grab enough shut-eye to stay alert and contribute in the next day.
- **Choose healthy food choices:** Eat a variety of foods, choose lower-fat foods, choose whole grain and enriched breads, try dark green and orange vegetables and orange fruit more often. Chips, chocolate bars, and soft drinks? – do you need to ask?
- **Grab some exercise:** Try walking down the stairs from your room or getting off a few floors earlier. Encourage your chair of the session to have a stand-up stretch break. Join the Health Care Working Group Policy Walk on Tuesday at 3:00. If you are planning a 45 minute meeting with a colleague – why not do it while taking a leisurely walk?
- **Be positive in outlook:** It is known that a smiling face reduces stress for both the person smiling and the person receiving it. So attack the work of the conference with a smile. Let's get a lot of work done – but reduce unnecessary anxiety and stress.

Check out BC's Healthy Meeting Place: **ACT NOW!** – <http://www.actnowbc.ca> and take the Healthy Living Pledge. Remember – Every Move is a Good Move!

## A Profile of the PNWER Region

### Some Health Stats

These are just a few statistics comparing the various jurisdictions in the PNWER Region. We will be developing a more comprehensive PNWER Health Care Report for publication in the Fall of 2008. We have focused on a few public health measures. Of key concern is the high level of obesity.

Sources: US State healthfacts: [www.statehealthfacts.org](http://www.statehealthfacts.org); Canada and provinces: [www.cihi.ca](http://www.cihi.ca); Check out IHE in Your Pocket for some health statistics comparing Canadian provinces and countries: [www.ihe.ca](http://www.ihe.ca)

### We are an overweight region

British Columbia is the only jurisdiction without a majority of residents over weight!

Percentage of population either overweight or obese – 2007  
(Defined as Adult (18+) with a Body Mass Index over 25)

Washington	62.1%
Oregon	62.0%
Idaho	63.1%
Alaska	65.1%
Montana	62.4%
British Columbia	41.2%
Alberta	50.8%
Yukon	50.8%

Note: In the United States, the obesity rate among adults is the highest in the OECD (Organization of Economic Cooperation and Development) countries, followed by Mexico and the United Kingdom. Canada is lower but there is cause for significant concern!. The time lag between the onset of obesity and increases in related chronic diseases (such as diabetes, cardiovascular diseases and asthma) suggest that the rise in obesity that has occurred in the United States and other OECD countries will have substantial implications for future incidence of health problems and related spending

### Regular Flu Shots for Seniors

The United States is generally better at ensuring that elderly residents receive regular flu shots. (the best performer is the Yukon)

Percent of Adults (aged 65 and over) who had a flu shot in the last year

Washington	71.7 %
Oregon	72.9%
Idaho	68.9%
Alaska	63.7%
Montana	72.8%
Alberta	63.0%
British Columbia	61.0%
Yukon	75.0%

## Humor

### The Evolution of Medicine:

#### I have a headache ...

2000 BC - Eat this root

1000 AD - That root is infected. Say this prayer.

1850 AD - That prayer is superstition. Drink this potion.

1940 AD - That potion is snake oil. Swallow this pill.

1985 AD - That pill is ineffective. take this antibiotic.

2007 AD - That antibiotic is not natural. .... Eat this root.

### Regular PAP smears

The United States partners generally perform better at ensuring women have regular PAP smears.

(Percent having test within that last three years (US 2005, Canada 2006)

Alaska	87.0%
Washington	84.0%
Oregon	83.4%
Montana	82.1%
Idaho	68.9%
British Columbia	72.6%
Alberta	76.6%
Yukon	79.2%

### Breast Cancer Incidence Rate (BCIR) (per 100,000 women)

Breast Cancer Death Rate (BCDR) (per 100,000 women) –  
(American 2004, Canadian, 2004)

Alaska	132.1 (BCIR)	18.7 (BCDR)
Washington	136.6 (BCIR)	23.3 (BCDR)
Oregon	128.9 (BCIR)	24.1 (BCDR)
Montana	122.7 (BCIR)	24.3 (BCDR)
Idaho	118.7 (BCIR)	21.9 (BCDR)
British Columbia	92 (BCIR)	21.0 (BCDR)
Alberta	103.6 (BCIR)	20.5 (BCDR)
Yukon	95.4 (BCIR)	21.3 (BCDR)

## REGIONAL HEALTH ALLIANCE: COOPERATION FOR IMPROVED HEALTH.

Notwithstanding that SARS and the threat of an influenza pandemic have largely provided the impetus for current "high visibility" cross border public health initiatives, ongoing day to day collaboration has and continues to take place at the local/county level. The PNWER region is a model for the rest of the continent in collaboration and cooperation. We hope to take additional steps at the 2008 summit to build on that cooperation. Disease transmission knows no borders. In today's global economy, an infectious disease can be carried anywhere in the world in a matter of hours. Unlike other extreme events, infectious disease outbreaks and bioterrorist attacks tend to be invisible and their effects are likely to spread among the population before they are identified. It is essential to the safety and security of the United States and Canada that public health entities have the capability to rapidly detect and track outbreaks in order to stop them and reduce their impact. In addition this framework and cooperation can provide opportunities for addressing other health problems such as chronic illness.

### The Pacific North West Border Health Alliance

is intended to institutionalize the current informal working groups to ensure sustainability of the ongoing health collaborations. It is intended that the new alliance will replicate the Pacific North West Economic Region (PNWER) and support cooperation on public health, infectious disease and chronic illness.



## PNWER Profile: Medical Technology supporting High Performance.



Chris Jarvis

Chris Jarvis has never let his Type 1 diabetes slow him down. A world-class athlete, he has competed on the Canadian National Rowing Team for four years, winning two World Cup Gold Medals in 2007 and a Gold Medal at the Pan Am Games. While Chris remains focused on winning more gold medals for Canada, he also tracks another even more important personal goal. Chris works every day to keep his blood sugar levels in balance.

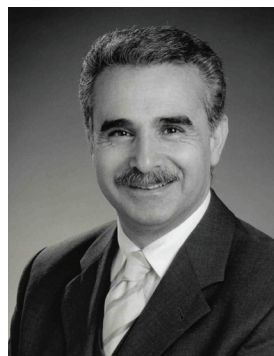
When he was 14, Chris was diagnosed with type 1 diabetes. His pancreas does not produce insulin, the hormone responsible for ensuring his body's energy needs are met. In the past, Chris relied on carefully planned injections of insulin by needle, accompanied by intermittent blood glucose testing (by pricking a finger and testing a small drop of

blood) to monitor his glucose levels. Today, with the help of an integrated insulin pump and continuous glucose monitoring system, Chris is free from the rigid meal, exercise and sleep schedules required by injection therapy.

The system displays glucose values every five minutes and alerts patients when glucose levels become too high or too low. This enables patients to discover how diet, exercise, medication and lifestyle affect their blood sugar control. "I am thrilled knowing that better control is possible," says Chris. "It gives me a sense of confidence knowing exactly what's happening inside my body." Although Chris represents someone who does not let diabetes stand in the way of his dreams, unfortunately it is a disease that affects many Canadians and this number is increasing every day.

People living with diabetes incur medical costs that are two to three times higher than those without diabetes, with potential for these individuals to face direct costs for medication and supplies ranging from \$1,000 to \$15,000 a year.<sup>1</sup> It is evident that cost-effective treatments and technologies for people living with diabetes are needed to reduce the costs to society. One technology is the one used by Chris – the insulin pump – which allows patients to free themselves from the inconvenience of multiple daily injections, giving them more flexibility and freedom in their lives and reducing the risks of long term complications. Many new technologies to support self-care are in store for tomorrow. Such examples are highlighted with our next profile:

<sup>1</sup> Canadian Diabetes Association. www.diabetes.ca. April 23rd, 2008



Dr. Karim Qayumi

## PNWER Profile: High Tech produces High Touch

How can a patient have a multitude of complaints, be examined, tested and undergo numerous surgical interventions without setting foot in a doctor's office? It's easy if you're **CyberPatient**, an interactive multimedia web-based teaching tool created by Surgery Professor **Karim Qayumi**. When Dr. Karim Qayumi arrived in Canada in 1983 after fleeing Soviet-occupied Afghanistan

with his wife and young son, he and his wife practically lived at the local library for 6 months teaching themselves English. Then he rolled up his sleeves and visited the University of British Columbia. Today Qayumi, a professor of cardiovascular and thoracic surgery at UBC, is prime mover behind the creation of a high-tech **Centre of Surgical Excellence and Innovation (CESEI)** at the Vancouver Coastal Health Authority. [www.cesei.org](http://www.cesei.org).

At CESEI there are a variety of sophisticated patient simulators: <http://www.cesei.org/simulators.php> which deliver the experience of treating a patient in true-to-life scenarios. The ultra sophisticated and highly versatile 'dummies' blink, speak and breathe. They have a heartbeat and a pulse, and accurately mirror human responses to procedures. It gives students "dry lab" experience with new technologies, while at the same time educating residents and boosting BC's rapidly developing telemedicine initiatives. A "smart classroom" is connected to the hospital's trauma unit, emergency department and operating rooms. "I can communicate with my students in the whole province," he says. "Our emphasis is on high tech to facilitate our educational goals." CESEI also has the goal to promote and implement new telemedicine technology in the delivery of healthcare through enhanced use of tele-consultation, tele-diagnosis, tele-surgery and tele-robotics. The future of telehealth and tele-diagnosis is an important one not only for improved health benefits but also for economic development. The PNWER Health Care working group plans to broaden activities in this important area: A couple of important websites for interest are below:

### Telehealth for the future – Check out:

**Continua Health Alliance:** Main Office – located in Beaverton, Oregon. <http://www.continuaalliance.org/home>. was launched in June of 2006 to address the lifestyle, health and demographic trends contributing to the skyrocketing costs of healthcare. It was established to find methods to address the rise of chronic health conditions due to the rapid aging of the population and the need to shift healthcare from traditional institutional settings to impacting consumers' everyday lives, particularly in the home.

**CAST: The Center for Aging Services Technologies** is leading the charge to expedite the development, evaluation and adoption of **emerging technologies** that can improve the aging experience. Barriers include cross-state (and border) licensure opportunities for nurses and physicians to gain the benefit of opportunities in telehealth, wellness monitoring and remote care management. There are significant policy issues that need to be addressed along with significant opportunities. <http://www.agingtech.org>



## Canada and the United States: Perhaps neither is “The Best Health Systems in the World”:

Why Not the Best?: (ref: Commonwealth Fund) Once upon a time, it was taken as an article of faith among most Americans that the U.S. health care system was simply the best in the world. A similar view was held in Canada. We have the best health care system in the world! – we would both claim. Yet growing evidence indicates the systems fall short – especially given the high level of resources we commit to health care.

Check out States in Action at [www.commonwealthfund.org](http://www.commonwealthfund.org) – along with the *Commission on a High Performance Health System*. It highlights significant issues and lessons from around the world.

A key challenge for the United States is ensuring universal affordable coverage. However while Canada does provide universal access to coverage for physician and hospital coverage it shares similar challenges to the US States. Quality of care is highly variable and delivered by a system that is too often poorly coordinated, driving up costs, and putting patients at risk. Our health systems need to focus on improving health outcomes for people over the course of their lives, as they move from place to place and from one site of care to another.

### What Works?

**Big Challenge is Determining What Works?:** Solutions to some of our most pressing health problems hinge on the ability to identify which diagnostic, treatment, and prevention services work best for various patients and circumstances. Doing so could control costs and improve outcomes. In many other countries outside the United States clinical and economic assessments of medications or medical therapies are required as a prerequisite to inform coverage decisions. The review processes differ in terms of levels of transparency, whether the decisions are mandatory or advisory, and whether results are subject to appeal but they are very useful approaches and are quickly spreading throughout health systems.

**Leaders in Health Evidence Development – PNWER Region:** The PNWER Health Care Working Group is planning to build on the expertise we possess in the region and share the work through development of a Health Evidence Network. (Initially beginning as an inventory of existing programs and perhaps building on some early priorities). Just to mention a few:

**Oregon – Drug Effectiveness Review Project (DERP):** DERP is a collaboration of public and private organizations, including thirteen states, that have joined together to provide systematic evidence-based reviews of the comparative effectiveness and safety of drugs in many widely used drug classes and to apply the findings to inform public policy and related activities. The Canadian Agency for Drugs and Technologies in Health ([cadth.ca](http://www.cadth.ca)) is a member. <http://www.ohsu.edu/drugeffectiveness/index.htm>

**Washington – Pharmaceutical Outcomes Research & Policy Program.** This program at the University of Washington conduct research on the effects and uses of pharmaceuticals in human populations. It disseminates timely information regarding pharmaceutical outcomes research and policies to government, the pharmaceutical industry, health care providers and the general public. It serves as a major centre and resource for public and industry sponsored research, consultation and training partnerships. <http://depts.washington.edu/porpp/>

**Alberta – The Institute of Health Economics (IHE)** [www.ihe.ca](http://www.ihe.ca) in Edmonton Alberta, is a non-profit organization committed to producing, gathering, and disseminating health research findings from the fields of health economics, health policy, health technology assessment and comparative effectiveness to improve the delivery of health care and support a sustainable health

system. The IHE is a unique partnership of government, academia, and industry representatives committed to bringing innovative thinking and relevant research to support health policy and practice. It operates as the secretariat for Health Technology Assessment International [www.htai.org](http://www.htai.org) and is a Technical member of the World Health Organization Health Evidence Network. <http://www.euro.who.int/hen>



### Some National Examples

**Canada – The Canadian Agency for Drugs and Technologies in Health (CADTH)** is an independent, not-for-profit agency funded by Canadian federal, provincial, and territorial governments to provide credible, impartial advice and evidence-based information about the effectiveness of drugs and other health technologies to Canadian health care decision makers. <http://cadth.ca/>

**United Kingdom – The National Institute for Health and Clinical Excellence (NICE)** <http://www.nice.org.uk/> is the independent organization responsible for providing national guidance on the promotion of good health and the prevention and treatment of ill health in the United Kingdom. It provides guidance on the use of new and existing medicines, treatments and procedures and clinical practice guidance on the appropriate treatment and care of people with specific diseases and conditions within the National Health Service.

### Good ideas: Paying for what works

**Value-Based Benefit Design:** Cost sharing plays a critical role in defining the health care benefit. To balance the demands for access to medical interventions with pressures to constrain costs, levels of cost sharing must be set in a manner that achieves appropriate clinical and financial outcomes. Using an alternative approach, Value-Based Insurance Design, patient contributions are based on the potential for clinical benefit, taking into consideration the patient's clinical condition. ActiveHealth Management (ActiveHealth®) announced the publication of a study early in 2008 designed to determine the medication compliance impact of selectively lowering co-pays for certain classes of drugs used in the treatment of chronic medical conditions. The study results showed a significant increase in compliance with four of five drug classes studied. ActiveHealth's patented clinical decision support technology, CareEngine® System, reviewed data for two large employer groups and identified clinically appropriate members in the group that would benefit from reduced co-pays for the five drug classes. The study, available in Health Affairs, is believed to be the first rigorous, controlled trial of a concept called value-based insurance design (VBID). (study published in January 10, 2008, Health Affairs). Organizations such as Aetna have been examining novel approaches to increase compliance for medications helpful in addressing chronic illness.

### For information or ideas on newsletter topics, contact:

Pacific Northwest Economic Region  
Brandon Harddenbrook,  
Deputy Director  
World Trade Center West  
2200 Alaskan Way, Suite 460  
Seattle, WA 98121  
Phone: (206) 443-7723  
Fax: (206) 443-7703  
[brandon@pnwer.org](mailto:brandon@pnwer.org)

PNWER Health Care Working Group  
John Sproule, Co-chair  
c/o Institutue of Health Economics  
1200, 10405 Jasper Avenue,  
Edmonton, Alberta Canada T5J 3N4  
Phone: (780) 862-1905  
[jsroule@ihe.ca](mailto:jsroule@ihe.ca)  
[www.ihe.ca](http://www.ihe.ca)