



Message From The Chairperson

The business of Vital Statistics has changed significantly in the past five years, which is exemplified by the number and type of requests for linked health data received by provincial/territorial vital statistics programs. The importance of the Vital Statistics database to the development of the health information infrastructure, both at the provincial/territorial and the national levels, is being increasingly recognized by those making the requests. They include researchers in government departments, non-government organizations, and the private sector. The data is used for program planning and evaluation, medical research, public health surveillance, and health education and promotion.

In recent years, advances in technology have provided solutions to a number of the problems of collection, analysis, and dissemination of large volumes of data from numerous and varied sources. These improvements have facilitated the availability of more accurate, comparable, and timely information, and enabled linkages of multiple data banks to provide a detailed longitudinal profile of an individual's health. Today, technology enables us to link the health of populations to environmental problems that may arise in certain geographic areas, or to lifestyle choices, or to any other criteria which have been collected. It also permits the conducting of disease surveillance initiatives, which are essential for the detection of emerging health problems and the formulation of disease control strategies. The success of population-based health research is dependent, to a large extent, on the availability of valid and reliable data and an infrastructure to support it.

In spite of technological advances, we are still confronted by challenges, such as fragmentation of data, lack of uniformity, critical data gaps, and differences in coding systems leading to difficulties in making data comparisons. Although good information is a requirement in the health care field to support program and planning decisions, appropriate tools for displaying and manipulating data or human resources trained to use them effectively may not always be available, preventing relevant information from being easily used for specific purposes.

The adoption by Council of a set of data dictionaries for vital events will assist in standardizing definitions and ensuring data consistency on the provincial/territorial and national levels. Other initiatives, which are in various stages of exploration, include the adoption of unique identifiers, development of a standard format for transmission of electronic data, systems integration (such as hospital reporting systems), and electronic birth and death data collection.

In addition, a quality control program for data integrity is essential. Many of our systems now incorporate edit and query functions designed to ensure the integrity of demographic and other critical information being entered into the database. In the ongoing quest to improve the quality and relevance of the information, statistical tables must be carefully scrutinized to identify outliers (data points outside the norm), improbable trends, improper medical coding selections, and other variants.

In Canada, the situation where some vital statistics branches are reporting to departments other than Health could result in a reduction in the amount and quality of health data collected and analyzed, which would be a detriment to the national program. The recent invitational consultations sponsored by the Canadian Institute for Health Information (CIHI) in collaboration with Statistics Canada and the Minister of Health's Advisory Council on Health Infrastructure provided an opportunity for valuable input from directors of Vital Statistics programs. However, directors not reporting to Health may not have had the opportunity to participate in this initiative. Nevertheless, directors of vital statistics programs, regardless of reporting direction, must participate in initiatives to ensure that an adequate health information infrastructure is available to improve the health reporting system and, in turn, the health of the populations we serve. ♦

Alice Garner, Chairperson, Vital Statistics Council for Canada

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Telephone Services Reach World Class Standards

by Walter Bilyk
Office of the Registrar General, Ontario

Telephone service is one of the key functions of the Ontario Office of the Registrar General (ORG). As late as January 1997, the telephone services provided by the ORG were in a state of crisis. More than 90% of incoming callers received busy signals with an average of 9,000 busy signals every day. Additionally, a large number of callers abandoned their calls due to long wait times. Clients had limited alternatives to telephone services; these being by mail, averaging a four to six week turnaround time, or in-person at public counters available only in Toronto and Thunder Bay. Inevitably, complaints were received at the ORG, by senior management, and at the political level. To improve telephone services, the ministry's senior management approved the Telephone Service Improvement Project.

A number of steps were taken to establish a foundation for success for this project. These steps included establishing project teams, developing detailed project plans and forging intra-branch partnerships, establishing performance measures and standards,¹ direct communication with staff to ensure active participation, and training and development. Once this foundation was established for the project, the following steps were taken.

As part of the initial phase of the project, the ORG recruited internally, introduced staff rotation and a

compressed work week option, moved the telephones to a quieter location within the Branch, and provided specialized telephone training. Other steps included changes to the telephone call flow and script which increased by 100% the number of callers who served themselves. In the second phase, distributed call centre technology was implemented to share telephone equipment and routing procedures were modified to increase capacity to handle complex issues and unusual customer inquiries. Existing staff from another ministry branch in Toronto were trained to handle basic inquiry calls.

The Telephone Service Improvement Project resulted in a dramatic decrease in the number of busy signals, abandoned calls, and average wait time. Currently, 90% of calls are answered within two minutes (98% of all callers receive service). The improvements in telephone services are illustrated in *Table 1*.

The innovations and approaches used in the project are transferable to other public and private sector organizations that provide services to the public. The project uses collaborative partnerships, team co-operation, employee participation, and existing technical and human resources to achieve outstanding service improvements with minimal investment.

The resounding success of this project has resulted in a number of permanent changes, including:

Table 1: Telephone Service Improvements

Performance Standards	Before Project	After Project	Improvements
No. of Busy Signals (daily average)	9,190	20	99.8%
No. of Abandoned Calls (daily average)	210	42	80.0%
Average Wait Time (in minutes)	4.5	0.5	89.0%
% of Calls Answered in Two Minutes	23.0%	90.0%	67.0%
% of Clients Served	14.0%	98.0%	84.0%

significant improvements in provision of telephone services and access to service, increased productivity, improved staff morale, inclusion of telephone standards as part of management and staff performance contracts, on-going training; and daily monitoring of calls. Additionally, complaint letters have significantly decreased while letters of recognition and compliments have increased.

The Telephone Service Improvement Project proved to be an excellent example of utilizing people, processes, technology, service delivery, and partnerships to achieve customer service improvements, supporting the ORG's vision of providing timely, high quality services to the public and its stakeholders. ♦

¹ The ORG management conducted research to identify telephone services standards. This proved to be a key contributing factor for reaching world-class call centre standards. The standards are being considered for the development of government-wide telephone service standards. (Federal Consortium Benchmarking Study Report, February 1995, *Serving the American Public: Best Practices in Telephone Service*.)

Work Continues on ICD-10 Implementation

by Patricia Wood
Health Statistics Division, Statistics Canada

At a recent teleconference meeting, the Vital Statistics Council for Canada finalized January 2000 as the Canadian implementation date for the *International Statistical Classification of Diseases and Related Health Problems, 10th Revision* (ICD-10) for mortality classification.

Since 1920, Canadian cause of death data have been classified, tabulated, and published using the World Health Organization's (WHO) *International Classification of Diseases* (ICD). Use of this standard for mortality classification allows national and international comparability in the study of underlying cause of death. Historically, the ICD has been subject to dicennial revisions and the *International Classification of Diseases, 9th Revision* (ICD-9) has been in use in Canada since 1979. Designed to replace ICD-9, ICD-10 has improved scope, structure/presentation, specificity, currency, and compatibility with international reporting requirements.¹

In the late 1960s, the National Center for Health Statistics (NCHS) in the United States began to develop software to automate the mortality classification rules and guidelines presented in the ICD. The result of this effort is a software product, known as PC-MICAR/ACME, which automates the ICD-9 coding of causes of death information and the classification and selection of underlying cause of death. NCHS expects to have an ICD-10 version of PC-MICAR/ACME software available for January 1999 implementation in the United States.

In Canada, PC-MICAR/ACME software is used in the processing of cause of death data for eleven jurisdictions. The exception is Quebec where the implementation of automated mortality classification is pending the completion of the French language adaptation of the software, documentation, and instructional material.

At the request of Council, the Data Standards and Quality Committee developed an ICD-10 implementation plan. Several significant milestones have been met. In Ontario, the Office of the Registrar General has implemented PC-MICAR/ACME for the 1998 data year. The PC-MICAR/ACME Users' Group has been established and has had a teleconference meeting. Health Statistics Division has drafted bilingual ICD-10 stub files and abbreviated list stub files. Eighty percent of the terms in the PC-MICAR/ACME dictionary have been translated to French, including those designed to assign external cause codes.

Currently other tasks related to ICD-10 implementation are being addressed. Work continues on the French translation of the data entry portion of the mortality classification software and the instructional material. Testing of the French adaptation of PC-MICAR/ACME is expected to take place this summer with implementation in Quebec taking place for the 1999 data year. Health Statistics Division is collaborating with NCHS to develop ICD-10 training material designed to reorient trained mortality coders. Pilot training courses are to be scheduled this summer. The mortality data dictionary, including edits, are being revised for ICD-10. ♦

¹ Achieving Standardization in Diagnosis and Intervention Classification: Future Directions for Canada, CIHI, November, 1995.

Confidential Change of Name

by Andrew McBride
British Columbia Vital Statistics Agency

The Vital Statistics Council for Canada is presently giving consideration to the development of a legal change of name process that would enable a legal change of name on a confidential basis to facilitate a change in identity for persons in life threatening situations.

Vital Statistics organizations are responsible for the administration of name legislation in eleven of the twelve provinces and territories of Canada. The purpose of name legislation in Canada is to establish in law the rules associated with acceptable "legal" names and establish the requirements and process for legal changes of name.

Legal name changes are most often applied for in order to:

- ♦ align children's surnames with a new family surname when a new family is formed (e.g., change children's surnames to that of a step father);
- ♦ return to a pre-marital surname on the dissolution of a marriage (not required in most jurisdictions);
- ♦ Canadianize names;
- ♦ change a name as part of the adoption process; and,
- ♦ change a name as a matter of personal preference (does not apply in all jurisdictions).

The majority of legal changes of name are a matter of public record, and are usually advertised in the provincial or territorial gazette. This is done in order to make the fact of a person's legal change of name available to interested parties such as creditors and law enforcement agencies.

Recently, the need to change a person's identity in order to protect that person from a dangerous or life-threatening situation has been identified. This has been reflected by the implementation of the federal government's Witness Protection Program and the well publicized dangers that may be faced by persons fleeing spousal abuse situations. A legal change of name is recognized as a key element in changing a person's identity.

In order to facilitate a change of identity, there are two fundamental requirements for a legal change of name: first, such changes cannot be a matter of public record, and second, access to any records that

link a person's pre-change identity to the post-change identity must be severely restricted.

The process of legally changing a person's name to facilitate a change of identity has been referred to as a confidential change of name. The Vital Statistics Council for Canada, which has representatives from all twelve jurisdictions, has discussed the issue of confidential change of name since the Witness Protection Program was initially implemented in 1991. However, the Council could not address the confidential change of name issue at that time because only three member jurisdictions had the legal authority to process changes of name without publication and to seal the records. The Council identified a number of important questions which needed resolution before it could proceed:

- ♦ Who is qualified to determine when a confidential change of name should be done?
- ♦ What are the conflicts with current legislation, and what are the issues related to amending the legislation?
- ♦ How could the confidential change of name practices be standardized where some participants are not Vital Statistics organizations and therefore not members of the Council?
- ♦ What are the issues related to security of inter-jurisdictional transfer of highly sensitive personal information?
- ♦ To what extent would Vital Statistics personnel and program participants be exposed to personal risk as a result of this program?

The issue of confidential change of name re-emerged for more serious consideration following the proclamation of the federal *Witness Protection Program Act* in June 1996. In addition, the establishment of contact between a number of provincial/territorial Vital Statistics organizations and various stakeholder groups has served to raise awareness of this issue. The Council invited two of the major stakeholders to make a presentation at its meeting in June, 1997, following which the Council established a Confidential Change of Name Committee. The chair of this committee is the Deputy Registrar General of Ontario and its members are representatives from the Yukon, Prince Edward Island, and British Columbia.

The mandate of the new committee is to:

- ♦ develop and recommend a standard definition of "confidential change of name";
- ♦ develop and recommend standard eligibility criteria (for use on an interim basis) for provincial

- and territorial Vital Statistics departments;
- ♦ identify stakeholders in the confidential change of name process and develop an effective mechanism for communicating with these stakeholders;
- ♦ recommend a standardized format for communicating confidential change of name information between jurisdictions;
- ♦ develop and recommend standard policy to facilitate confidential change of name on an interim basis;
- ♦ develop and recommend legislative changes, standard policies and processes respecting confidential changes of name, and model legislative language; and,
- ♦ prepare a report on the committee's work and to present its recommendations at the Council meeting in June 1998.

As of March 1998, many items in the Committee's mandate have been addressed and the committee will deliver its report as scheduled at the Council meeting between June 29 and July 3, 1998. The committee is also planning to meet with representatives of some of the major stakeholder groups at that time. ♦

Causes of Death: How the Sexes Differ

*Claudio Perez**
Health Statistics Division, Statistics Canada

In the ongoing comparison of sexes for health and longevity, men are speeding ahead of women – to their graves! While the overall pattern of age at death is similar for males and females, rising and falling similarly over the life cycle, death rates are predominately higher for males. This difference is greatest in late adolescence. The 1993 death statistics for Canada reveal that the male-to-female ratio of death rates at 15-19 years of age was 2.3, after which it steadily declined to 1.4 at the 65 years of age and over category.

Conditions originating in the perinatal period were the leading cause of death under age 1 for both sexes, although the death rate due to this cause was 33% higher for boys than girls. The predominant causes of death for children 1-9 years of age were motor vehicle accident deaths, cancer, and congenital anomalies, with similar death rates for boys and girls.

With the onset of adolescence, differences in the statistics for boys and girls become more distinct. At ages 10-14 years, external causes of death accounted for 54% of deaths among boys but only for 45% among girls (with corresponding death rates of 11.8 among boys and 6.9 among girls per 100,000). At ages 15-19, the all-cause mortality rate for boys was well over twice as high as the rate for girls, mostly due to much higher rates of motor vehicle accident deaths and suicides.

At ages 20-44 years, the large differences in mortality between the sexes persisted. The 1993 death rates for men and women were 151.2 and 67.2 deaths per 100,000, respectively. The three leading causes of death for men in this age category were suicides, motor vehicle accidents, and HIV/AIDS, together accounting for 45% of deaths. HIV/AIDS accounted for much of the difference between all-cause male and female death rates. For women in this age group, the three leading causes of death were motor vehicle accidents, breast cancer, and suicides, together accounting for one-third of all deaths. In this age group, the breast cancer death rate contributed to women's overall cancer death rate, which surpassed the overall rate for men (23.8 vs. 17.5 deaths per 100,000). This excess in the death rate for women, compared to men, was exceptional.

In middle age, at 45-64 years of age, the differences between the death rates for the sexes start to diminish. The leading broad cause of death for both sexes was cancer, followed by diseases of the circulatory system. For people 65 years or over, men and women shared the leading broad causes of death, namely, diseases of the circulatory system, followed by cancer. For men and women, the leading specific cause of death in this age group was ischaemic heart disease.

Even when the two sexes shared the most common causes of death, the cause-specific death rates for males were almost always higher. The results of this difference can be seen in a life expectancy for men that falls short of that for women by six years (74.9 years for men and 81.0 years for women). Given that socioeconomic and behavioural factors account for much of the excess in premature death in males, public health interventions focused on young adult men will most likely result in the most gains in longevity. ♦

* This summary was from "Causes of Death: How the Sexes Differ," by Kathryn Wilkins, which appeared in Statistics Canada's journal *Health Reports*, 1995; 7 (2): 33-43. To order reprints or to subscribe to *Health Reports* (catalogue no. 82-003), call 1-800-267-6677 (toll free in Canada) or Fax (613) 951-1584.

ON A TYPICAL DAY IN BRITISH COLUMBIA IN 1997

122 LIVE BIRTHS OCCURRED IN THE PROVINCE TO B.C. RESIDENTS:

- 62 males and 60 females were born
- 57 live births involved maternal complications
- 40 babies had perinatal complications
- 25 were cesarean deliveries
- 8 were pre-term
- 6 were low birth weight babies
- 6 were born to teenage mothers
- 3 were multiple births
- 9 home births every 10 days
- 9 stillbirths every 10 days

60 MARRIAGES WERE SOLEMNIZED IN B.C.:

- 33 were civil ceremonies and 27 were performed by religious representatives
- 37 marriages were to couples where both parties were marrying for the first time
- 2 marriages every 10 days were to couples where both parties were teenagers

75 DEATHS OCCURRED IN THE PROVINCE TO B.C. RESIDENTS:

- 40 males and 35 females died
- 27 deaths were due to diseases of the circulatory system including:
 - 19 deaths from heart diseases
 - 6 deaths from cerebrovascular diseases
- 20 deaths were due to cancer including:
 - 5 lung cancer
 - 2 colorectal cancer
 - 2 breast cancer
 - 1 prostate cancer
- 15 deaths were attributable to tobacco smoking
- 8 deaths were due to diseases of the respiratory system including:
 - 4 deaths from pneumonia / influenza
 - 3 deaths from chronic lung disease
- 6 deaths resulted from accidents and violence including:
 - 1 suicide
 - 1 motor vehicle traffic accident fatality
 - 2 homicides every 10 days
- 5 deaths were alcohol-related, 1 directly and 4 indirectly due to alcohol
- 1 death was drug-induced
- 2 deaths were due to diabetes
- 2 deaths were due to Alzheimer's disease and senile dementias
- 3 deaths every 10 days were from AIDS / HIV infections
- 6 infant deaths every 10 days

Source: *British Columbia Vital Statistics Agency*

ANNOUNCEMENT

Vital Statistics Council for Canada – Presentations by Organizations

The annual meeting of the Vital Statistics Council for Canada is being held at the Lord Elgin Hotel, Ottawa, Ontario, from June 29th to July 3rd, 1998.

Throughout the year, the Vital Statistics Council for Canada receives requests from individuals representing various organizations across Canada who wish to make a presentation to the Council in order to either share information or to make a specific request of the Council.

The Council welcomes these requests. However, in order to manage the growing number of requests being made each year, the Council has agreed to adopt some general guidelines regarding the submission of these requests.

The presentation being made must be within the mandate of the Vital Statistics Council for Canada. Upon the initial request, the organization must provide the Council with an outline of the presentation that will be made as well as a short biography of the individual(s) making the presentation. Depending on the type of presentation, the Council may request that the organization address specific questions or items within their presentation so that the Council can provide constructive feedback to the organization after the presentation. A copy of the more detailed presentation must also be submitted once it is prepared. This information will be shared with Council members prior to the annual meeting.

So that the Council has sufficient time to consider a request from an organization to do a presentation, the Council should receive the request no later than April 30th of each year. Once approved, the Council will place the individual(s) representing the organization on the agenda of the annual meeting, which is normally held sometime in June. The presentation will be limited to 30 minutes including questions from the audience. Obtaining the required equipment or props for the presentation will be the responsibility of the organization or the individual making the presentation.

Organizations who wish to make a presentation to the Council, or who would like to receive further information about the process, should address their requests to:

Secretariat
Vital Statistics Council for Canada
c/o Health Statistics Division
Statistics Canada
18th Floor, R.H. Coats Building
Ottawa, Ontario
K1A 0T6

If appropriate, the individual(s) representing the organization may be asked to contribute an article to *Vital News*, the newsletter of the Vital Statistics Council for Canada, regarding their presentation.

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