

NUNAVUT REPORT ON

COMPARABLE HEALTH INDICATORS

2004



DEPARTMENT OF HEALTH AND SOCIAL SERVICES

GOVERNMENT OF NUNAVUT





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## Message from the Minister of Health and Social Services:

It is my pleasure to release Nunavut's second report on Health and Health System Performance.

In September 2000, the *First Ministers' Meeting Communiqué on Health* directed Health Ministers to collaborate on the development of a comprehensive framework using jointly agreed upon comparable indicators reporting on health status, health outcomes and quality of service.

I am proud to say that the government of Nunavut has been committed to regular public reporting and released its first report in September 2002. Since then, further work has been undertaken, following the February 2003 First Ministers' Accord on Health Care Renewal to develop new indicators to measure progress on achieving the reforms set out in the accord, and meet the objectives of timely access, quality, sustainability and health status and wellness.

Nunavummiut expect that a report like this helps make their government more accountable and they deserve to know how Nunavut compares to the rest of Canada.

On behalf on the Premier and our legislatives colleagues, I would like to thank all of Nunavut's health professionals for their vital and much appreciated work.

Sincerely,

A handwritten signature in black ink that reads "Levinia Brown". The signature is written in a cursive, flowing style.

**Levinia Brown**

Minister, Department of Health and Social Services  
November 30<sup>th</sup> 2004

## **Management's Responsibility for the Nunavut Report on Comparable Indicators 2004.**

The Department of Health and Social Services of the Government of Nunavut is responsible for the integrity of the Nunavut Report on Comparable Indicators 2004. The responsibility of the Department includes maintaining systems and controls to ensure that information is objective, complete and accurate in accordance with the reporting requirements approved by the Conference of Deputy Ministers of Health.

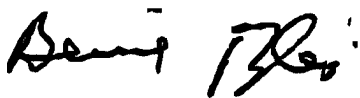
To the best of our knowledge, this information is reliable and free from error, however, we are also aware that health indicator data needs to be improved especially when considering a small population like we have in Nunavut.

In preparing this report, the Department relied on information provide by external parties as indicated in the report. The Departments responsibility for information provided by external parties is limited to being reasonably confident that it is free of significant misrepresentation.

The health indicators in the report comply with the definitions, technical specifications and standards of presentation approved by the Conference of Deputy Ministers of Health. The report states and properly describes any departures from what was approved.

The Auditor General of Canada's Audit Opinion is the result of applying the standards for assurance engagement set by the Canadian Institute for Chartered Accountants to the report and the auditor's report follows.

Sincerely,



**Bernie Blais**

Deputy Minister, Department of Health and Social Services  
November 30<sup>th</sup> 2004



# Exclusions

**We have not reported on the following indicators because Nunavut was not included in the applicable surveys.**

1a-PC	Difficulty obtaining routine or on-going health services during regular daytime hours*
1b-PC	Difficulty obtaining routine or on-going health services during evenings or weekends*
2a-PC	Difficulty obtaining health information or advice during regular daytime hours*
2b-PC	Difficulty obtaining health information or advice during evenings or weekends*
2c-PC	Difficulty obtaining health information or advice at night*
3a-PC	Difficulty obtaining immediate care during regular daytime hours*
3b-PC	Difficulty obtaining immediate care during evenings or weekends*
3c-PC	Difficulty obtaining immediate care at night*
4-PC	Proportion of the population that reports having a regular family doctor
20a-OI	Median wait times for surgery
20b-OI	Distribution of wait times for surgery
21a-OI	Median wait time for specialist physician visits
21b-OI	Distribution of wait times for specialist physician visits
33a-DM	Median wait time for diagnostic services*
33b-DM	Distribution of wait times for diagnostic services*
37a-HLT	Health adjusted life expectancy (HALE) for overall population*
37b-HLT	Health adjusted life expectancy (HALE) by socio-economic status*

**We have not reported on the following indicators because tele-health services are not available in Nunavut**

9-PC	Patient satisfaction with telephone health line or tele-health services*
10-PC	Patient perceived quality of telephone health line or tele-health services
11-PC	Proportion of the population reporting contact with a telephone health line or tele-health service

**We have not reported on the following indicators because data is not available or there were data quality issues**

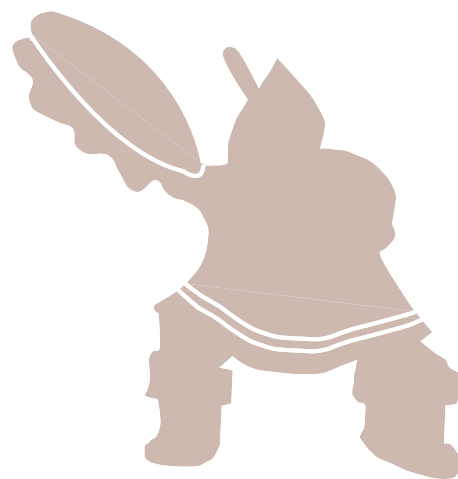
14-PC	Proportion of women aged 50-69 obtaining mammography in the past two years
17a-OI	Median wait time for cardiac bypass surgery
17b-OI	Distribution of wait times for cardiac bypass surgery
18a-OI	Median wait time for hip replacement surgery
18b-OI	Distribution of wait times for hip replacement surgery
19a-OI	Median wait time for knee replacement surgery
19b-OI	Distribution of wait times for knee replacement surgery
22-OI	Readmission rate for acute myocardial infarction (AMI)
23-OI	Readmission rate for pneumonia
24-OI	30-day in-hospital acute myocardial infarction (AMI) mortality rate
25-OI	30-day in-hospital stroke mortality rate
26-OI	365-day survival rate for acute myocardial infarction (AMI)
27-OI	180-day survival rate for stroke
30-DR	Prescription drug spending as a percentage of income*
31a-DM	Median wait time for radiation therapy for prostate cancer
31b-DM	Distribution of wait times for radiation therapy for prostate cancer
32a-DM	Median wait time for radiation therapy for breast cancer
32b-DM	Distribution of wait times for radiation therapy for breast cancer

36b-HLT	Life expectancy by socioeconomic status
41-HLT	Mortality rate for prostate cancer
46-HLT	Five-year relative survival rate for lung cancer
47-HLT	Five-year survival rate for prostate cancer
48-HLT	Five-year survival rate for breast cancer
49-HLT	Five-year survival rate for colorectal cancer
64-HLT	Exposure to second-hand tobacco smoke rate
69-HLT	Immunization for influenza, aged 65 plus ("Flu Shot")*
70-HLT	Prevalence of Depression

**Data on the following indicators will not be made available in this report, but are available from the CIHI web-site at [www.cihi.ca/comparable-indicators](http://www.cihi.ca/comparable-indicators)**

6-PC	Patient perceived quality of overall health care services
8-PC	Patient perceived quality of community-based care
29-OI	Patient perceived quality of hospital care
35-HR	Patient perceived quality of physician care
50-HLT	Incidence rate for lung cancer
52-HLT	Incidence rate for breast cancer
51-HLT	Incidence rate for prostate cancer
53-HLT	Incidence rate for colorectal cancer

\* featured indicators



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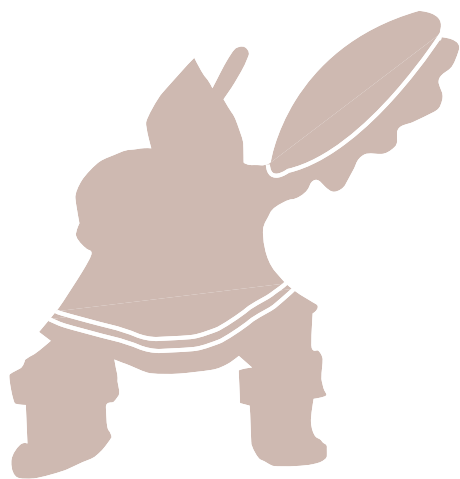
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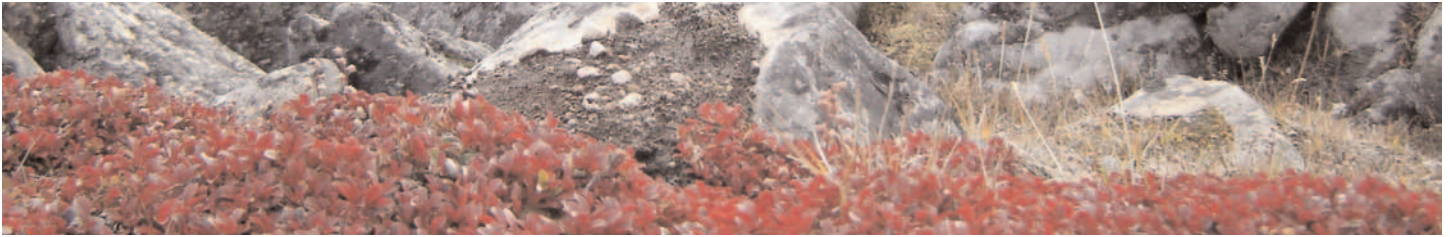
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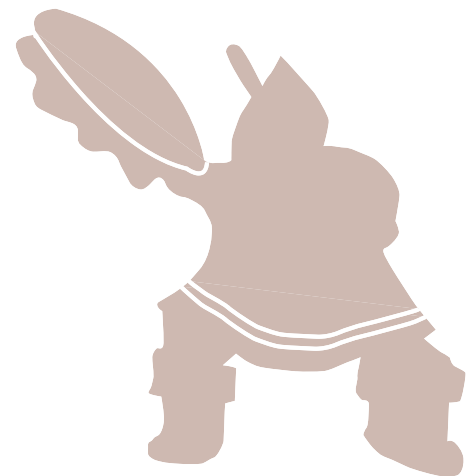


## Introduction

In September 2002, 13 provinces and territories, as well as the federal government, released their jurisdictional comparable indicators reports. This marked the first time that health ministries from all jurisdictions, were concurrently reporting to their constituents on a set of 67 jointly agreed indicators addressing health status, health outcomes and quality of service.

The February 2003 *First Ministers' Accord on Health Care Renewal* directed Health Ministers to develop further indicators to supplement the work undertaken pursuant to the September 2000 Communiqué. Based on the requirements set out in the 2000 Communiqué and the 2003 Health Accord, input from a range of stakeholders and experts, consultation with other Federal, Provincial and Territorial groups and the general public, the Advisory Committee for Governance and Accountability (ACGA) recommended to the Conference of Deputy Ministers a total of 70 indicators (86 sub-indicators). Eighteen indicators (26 sub-indicators) were required to be featured in the 2004 reports, while the remaining 52 indicators (60 sub-indicators) minimally will be made available on a common website.

The ACGA has also initiated additional work related to the development of performance indicators for reporting in the long-term (beyond 2004). Considerations for long-term development include both concepts and specific indicators that require further development.

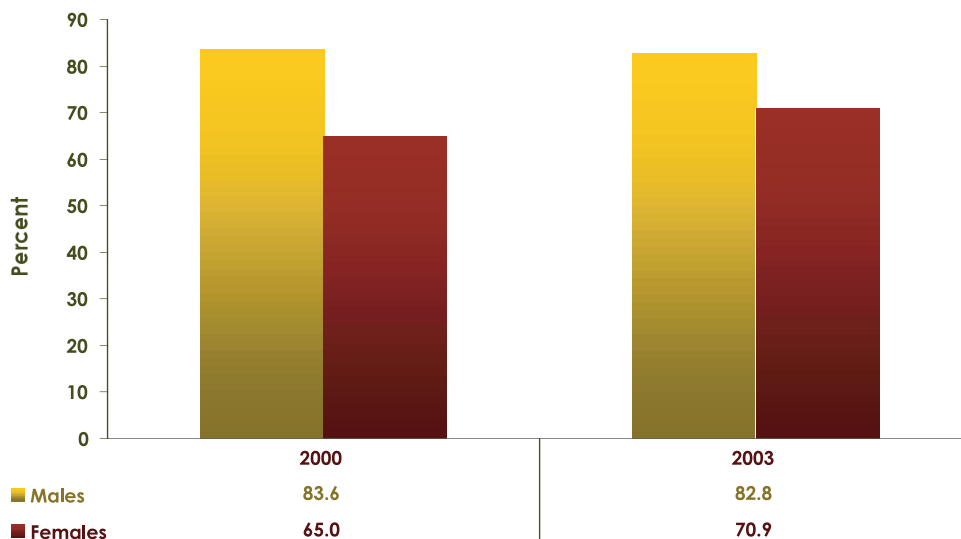


# Primary Health Care (PC)

## Indicator 5: Patient Satisfaction with Overall Health Care Services

**Figure 5-PC-1**

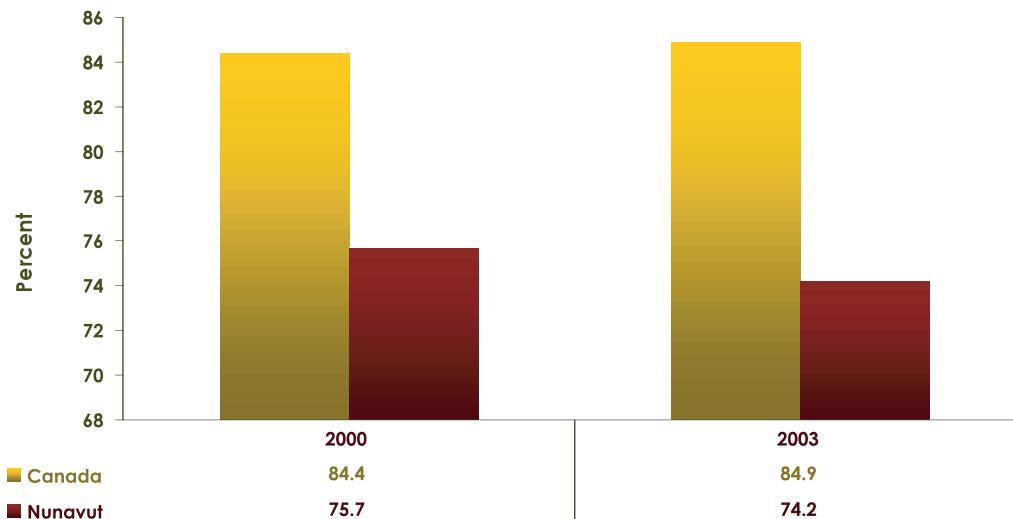
Percentage of population aged 15 and over very or somewhat satisfied with the way overall health care services were provided (age-standardized), males vs. females, Nunavut, 2000 and 2003



Source: Statistics Canada, Canadian Community Health Survey, 2000/01 and 2003  
See notes 1, 6, and 8.

**Figure 5-PC-2**

Percentage of population aged 15 and over very or somewhat satisfied with the way overall health care services were provided (age-standardized), Canada and Nunavut, 2000 and 2003



Source: Statistics Canada, Canadian Community Health Survey, 2000/01 and 2003  
See notes 1, 6, and 8.

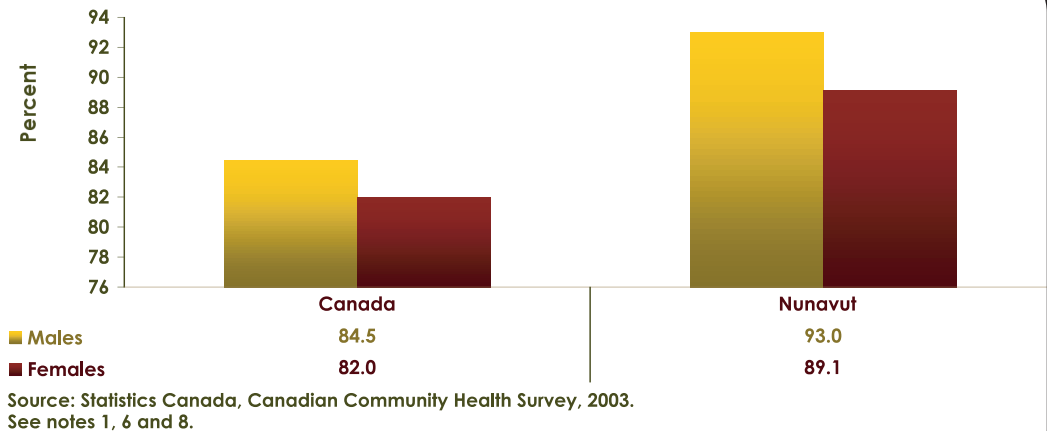
Patient satisfaction with the way that overall health care services were provided measures satisfaction with the method that the service was provided (i.e. the language skills of service providers, good hospital food, etc.), rather than overall satisfaction with overall health care services.

In 2003, approximately 74% of respondents in Nunavut were satisfied with the way overall health care services were provided. Patient satisfaction in Nunavut was approximately 11% lower than it is in the rest of Canada.

## Indicator 7: Patient Satisfaction with Community-based Care

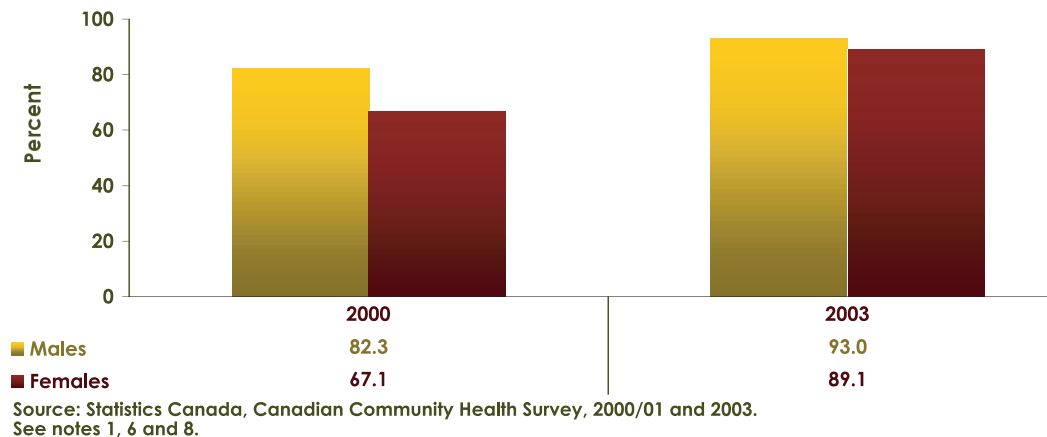
**Figure 7-PC-1**

Percentage of population aged 15 and over very or somewhat satisfied with the way community-based care was provided (age-standardized), males vs. females, Canada and Nunavut, 2003



**Figure 7-PC-2**

Percentage of population aged 15 and over very or somewhat satisfied with the way community-based care was provided (age-standardized), males vs. females, Nunavut, 2000 and 2003



Primary care in Nunavut is mostly provided by Community Health Nurses in Community Health Centres. Approximately 82%<sup>1</sup> of Nunavummiut are seen by a Community Health Nurse for their initial diagnosis and in 2003, over 90% of Nunavummiut reported being satisfied with community-based care. Physicians travel regularly to the communities to follow up on patients.

<sup>1</sup>Nunavut Health and Social Services. Community Health Reporting System Fiscal Year 2002/03 Review. In Press.

# Indicator 12: Hospitalization Rate for Ambulatory Care Sensitive Conditions

**Figure 12-PC-1**

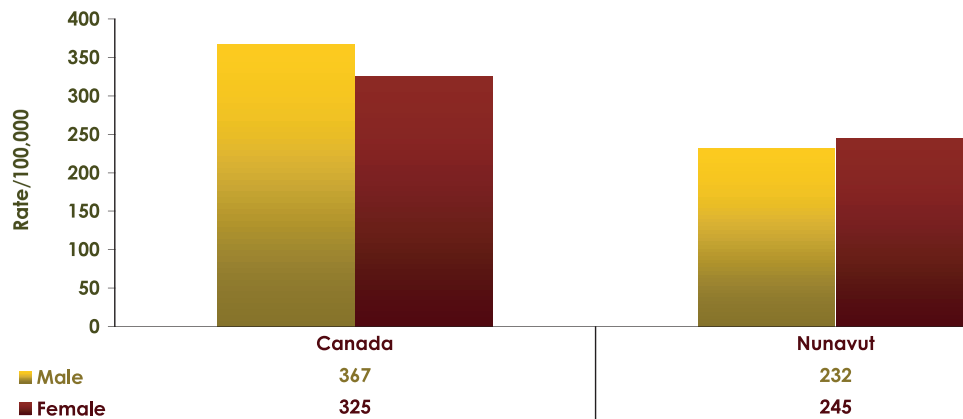
Hospitalization rate per 100,000 for ambulatory care sensitive conditions (age-standardized), Nunavut, 1999/00 to 2001/02



Source: CIHI, Hospital Morbidity Database, Census, Statistics Canada, ISQ. See notes 1, 12 and 15.

**Figure 12-PC-2**

Hospitalization rate per 100,000 for ambulatory care sensitive conditions (age-standardized), males vs. females, Canada and Nunavut, 2001/02



Source: CIHI, Hospital Morbidity Database, Census, Statistics Canada, ISQ. See notes 1, 12 and 15.

Hospitalization rates for conditions which may often be cared for in the community are one indicator of appropriate access to community-based care. These are long term health conditions which can often be managed with timely and effective treatment in the community, without hospitalization. These conditions include diabetes, asthma, alcohol and drug dependence and abuse, neurosis, depression, and hypertensive disease. Although preventative care, primary care, and community-based management of these conditions will not eliminate all hospitalizations, such steps could prevent many of them<sup>2,3</sup>.

<sup>2</sup>Anderson, G.M. (1996). Common conditions considered sensitive to ambulatory care. In V. Goel, J.I. Williams, G.M. Anderson, P. Blackstien-Hirsch, C. Fooks & C.D. Naylor (eds.), *Patterns of Health Care in Ontario. The ICES practice atlas (2nd edition)*. Ottawa, ON: Canadian Medical Association. P. 104-110.

<sup>3</sup>Manitoba Centre for Health Policy and Evaluation (MCHPE). Ambulatory Care Sensitive (ACS) Conditions. [http://www.umaniitoba.ca/centres/mchpe/concept/dict/ACS\\_conditions.htm](http://www.umaniitoba.ca/centres/mchpe/concept/dict/ACS_conditions.htm).

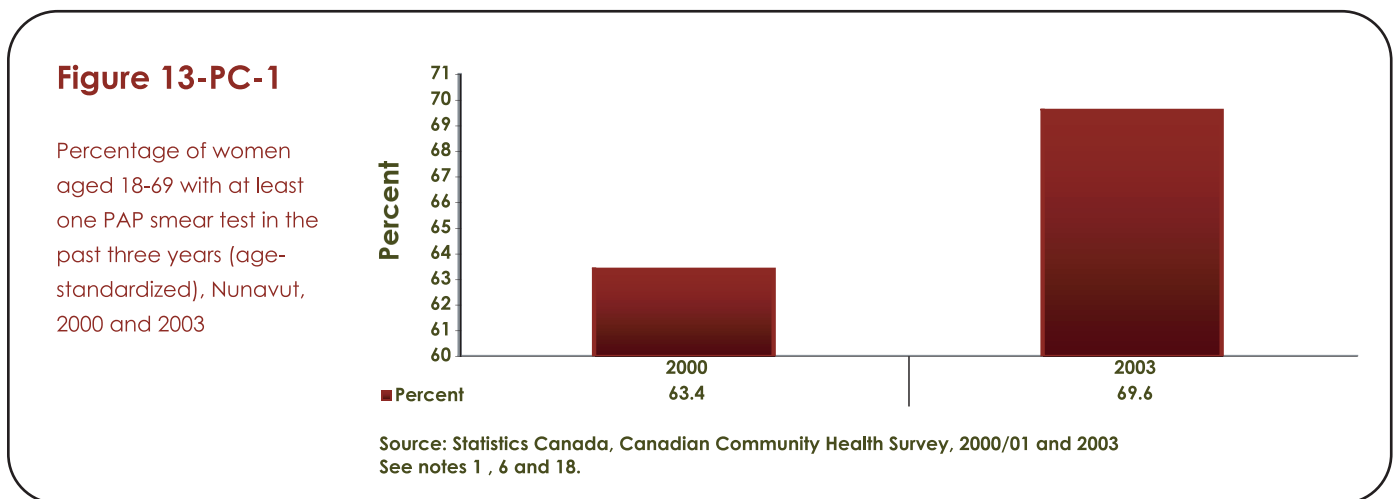


Health care professionals generally believe that managing these conditions before a patient requires hospitalization improves the patient's health, contributes to better overall community health status, and often saves money because community-based care usually costs less than hospitalization<sup>2,4</sup>.

The rate of ambulatory care sensitive conditions is much lower in Nunavut than it is in the rest of Canada. Ostensibly, this indicates that adequate preventative care and management within the community are available and accessible. The standard of practice in community health centers includes a chronic disease clinic. Aspects of these clinics include regular surveillance, counseling and support for patients and their families, treatment and interventions. These all would serve to minimize the number of ACSC hospitalizations.

Low rates may also reflect low prevalence of these ambulatory care sensitive conditions among Nunavummiut. According to a recent survey, self-reported rates of asthma, hypertension and diabetes are all lower in Nunavut than in the rest of Canada<sup>5,6,7</sup>.

## Indicator 13: Proportion of Female Population Aged 18-69 with at Least One PAP Smear Test in the Past Three Years



PAP smear tests detect pre-malignant lesions of cancer of the cervix. This allows time for intervention that avoids progressive, fatal disease.

In Nunavut, the number of women who reported having received a PAP smear test in the past three years has increased by 6% between 2001 and 2003. Most Community Health Centres set "Well Woman" appointments for each woman in the community, when she is due for her PAP test. Appointment cards are delivered to the women. Scheduling appointments automatically takes the burden of remembering off of the woman and in doing so increases the number of women being screened. Also, Nunavut has introduced standard testing of PAP smears using liquid cytology, which gives more accurate results than previous methods<sup>8</sup>.

<sup>4</sup>Billings, J. Anderson, G.M. & Newman, L.S. (1996, Fall). Recent findings on preventable hospitalizations. *Health Affairs*, 15(3), p. 239-249.

<sup>5</sup>Statistics Canada, CANSIM table 105-0201. Asthma, by age group and sex, household population aged 12 and over, Canada, provinces, territories, health regions (June 2003 boundaries) and peer groups, every 2 years. Canadian Community Health Survey, cycle 2.1, 2003.

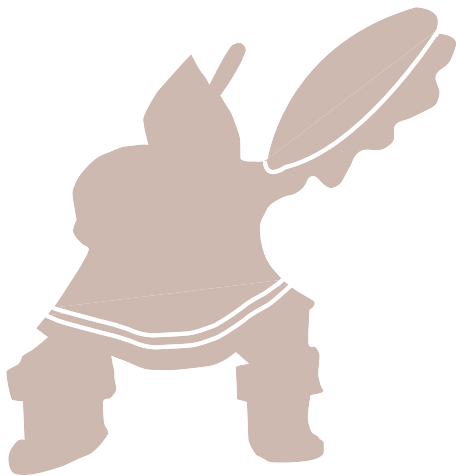
<sup>6</sup>Statistics Canada, CANSIM table 105-0210. High blood pressure, by age group and sex, household population aged 12 and over, Canada, provinces, territories, health regions (June 2003 boundaries) and peer groups, every 2 years. Canadian Community Health Survey, cycle 2.1, 2003.

<sup>7</sup>Statistics Canada, CANSIM table 105-0211. Diabetes, by age group and sex, household population aged 12 and over, Canada, provinces, territories, health regions (June 2003 boundaries) and peer groups, every 2 years. Canadian Community Health Survey, cycle 2.1, 2003.

<sup>8</sup>McCrorry DC, Matchar DB, Bastian L. et al. Evaluation of Cervical Cytology. Evidence Report/Technology Assessment No. 5. AHCPR Publication No. 99-E010. Agency for Health Care Policy and Research, U.S. Department of Health and Human Services, Rockville, MD, February 1999.

The Society of Gynecologic Oncologists of Canada recommends that all women age 18 and over who are sexually active receive PAP smears. Initially, the woman should receive two smears one year apart and if these smears are satisfactory then the woman should be retested every three years until the age of 69<sup>9</sup>.

The department recognizes the importance of primary prevention. Public Health activities focus on prevention by advising against high risk behaviours through the promotion of safer sex. The department also plans to do more education to inform people about the importance of having yearly PAPs as part of a secondary prevention strategy to detect pre-malignant lesions before cancer of the cervix develops.



<sup>9</sup>Society of Gynecologic Oncologists of Canada. *Programmatic Guidelines for Screening for Cancer of the Cervix in Canada*. 1998.

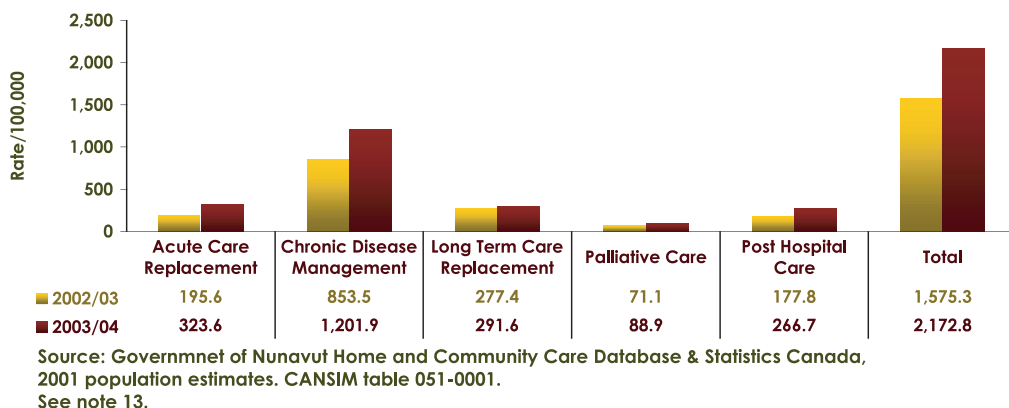
# Home Care (HC)

## Indicator 15: Home Care Clients per 100,000 population, all ages

Nunavut receives funding for its Home Care program from the First Nations and Inuit Health Branch (FNIHB) of Health Canada. The goal of the First Nations and Inuit Home and Community Care program is to provide basic community care services that are comprehensive, culturally sensitive, effective and equitable to that of other Canadians and which respond to the unique health and social needs of First Nations and Inuit. The home care program enables people with disabilities, chronic or acute illness and the elderly to receive the care they need to stay in their home communities.

**Figure 15-HC-1**

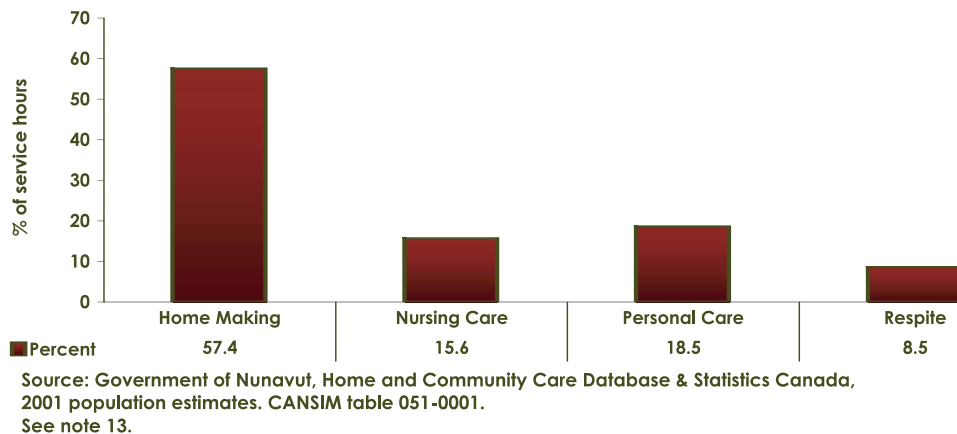
Home care clients by client type, rate per 100,000, Nunavut, 2002/03 and 2003/04, all ages



Patients are assessed and assigned to one of five client management categories. These categories are: Acute Care Replacement, Chronic Disease Management, Long Term Care Replacement, Palliative Care, and Post Hospital Care. In the 2003/04 fiscal year, the majority, 55%, of home care clients in Nunavut were referred for chronic disease management. Client numbers increased from 2002/03 to 2003/04 fiscal years in all client care categories.

**Figure 15-HC-2**

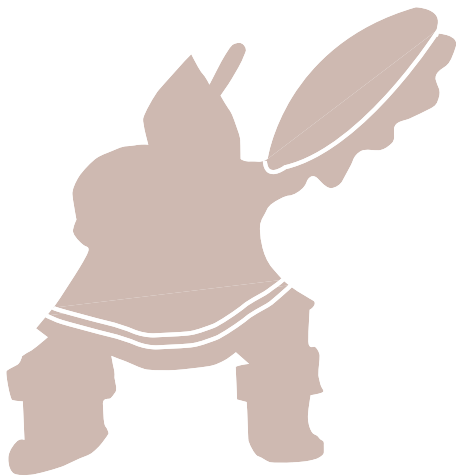
Home care services, percent of total service hours, Nunavut 2002/03, all ages, clients aged 60 and over



Home making services accounted for 57% of services provided to patients over 60 years of age. Home making involves duties such as washing dishes, picking up groceries and making beds. "Assisted-living" facilities are very limited in Nunavut and provision of these home making services enable the elderly to remain in their homes close to their families.

## **Indicator 16: Home care clients per 100,000 population, aged 75 plus**

In fiscal year 2002/2003, 106 clients aged 75 and over received home care services, representing 63,855 clients per 100,000 population.

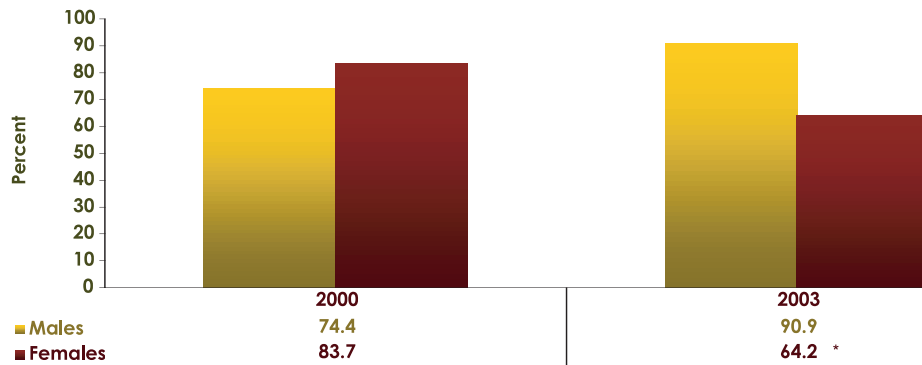


# Other Programs and Services (OI)

## Indicator 28: Patient Satisfaction with Hospital Care

**Figure 28-OI-1**

Patient, aged 15 and over very or somewhat satisfied with the way hospital care was provided (age-standardized), males vs. females, Nunavut, 2000 and 2003



Source: Statistics Canada, Canadian Community Health Survey, 2000/01 and 2003. See notes 1, 6, 8 and 18.  
\* C.V. is between 16.6% and 33.3% -- use with caution

Patient satisfaction with the way that hospital care was provided measures satisfaction with the method that the service was provided (i.e. services in the patient's own language, good hospital food, etc.), rather than overall satisfaction with overall health care services. Respondents were asked about their most recent hospital visit within the previous year.

There is only one hospital in the territory and people from the 24 other communities have to leave their families and communities to get hospital care. Often, they may have to leave the territory for hospitalization.

Plans are underway to have 2 additional hospitals in Rankin Inlet and Cambridge Bay, thus reducing the number of patients having to go out-of-territory for hospitalization.



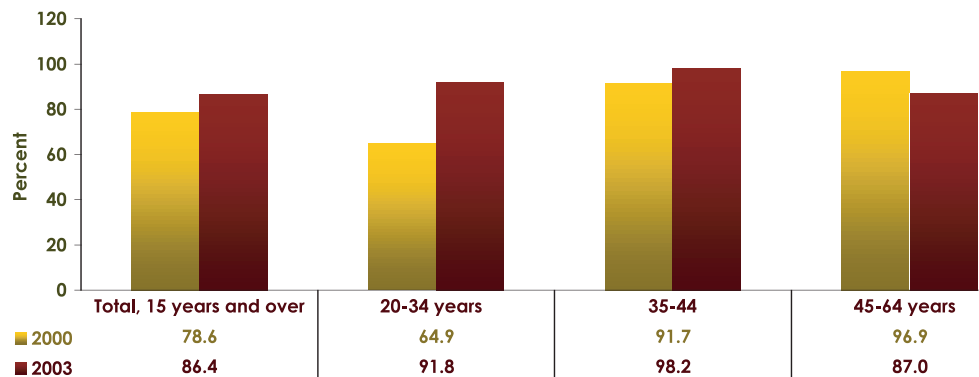


# Human Resources

## Indicator 34: Patient Satisfaction with Physician Care

**Figure 34-HR-1**

Percentage of population aged 15 and over very or somewhat satisfied with the way physician care was provided, received by age, Nunavut, 2000 and 2003



Source: Statistics Canada, Canadian Community Health Survey, 2000/01 and 2003.  
Data suppressed for 65+ age group due to large C.V. See notes 6 and 8.

Patient satisfaction indicators are based on the respondent's most recent visit to a physician.

On average in 2000 and 2003, 83% of Nunavummiut reported that they were satisfied with the physician care that they received. The level of satisfaction was generally equally reflected across all age groups.

In Nunavut, patients get to see a physician for primary care in only two communities, Iqaluit and Pond Inlet. In the other communities patients are seen by a physician for follow-up care only after they are referred by a nurse. There are some new initiatives for connecting patients to physicians by tele-health, but this is not used as yet for primary care.

In 2000, there were 22 physicians per 100,000 population in Nunavut, compared to 95 per 100,000 in the rest of Canada<sup>10</sup>. Nunavut, like the rest of Canada is faced with challenges recruiting and retaining physicians.

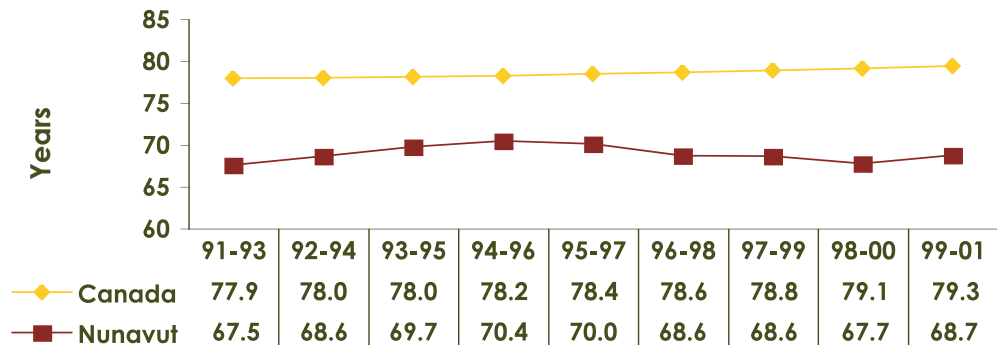
<sup>10</sup>Canadian Institute for Health Information. *Health Care in Canada*. 2003.

# Healthy Canadians (HLT)

## Indicator 36a: Life Expectancy for Overall Population

**Figure 36a-HLT-1**

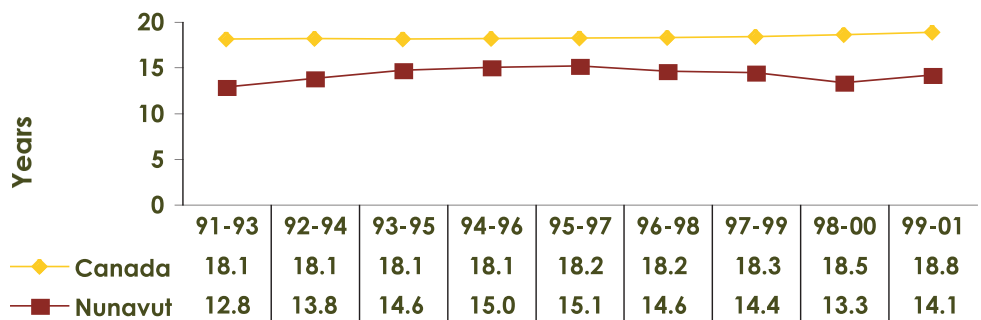
Life expectancy in years at birth, Canada and Nunavut, 1991-2001



Source: Statistics Canada, Vital Statistics files, Birth and Death Databases and Demography Division (population estimates); ISQ  
Three-year rolling averages used. See note 2 and 10.

**Figure 36a-HLT-2**

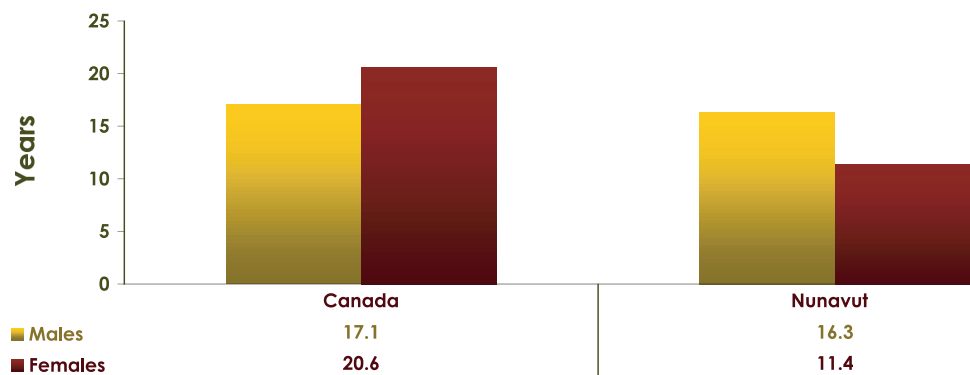
Life expectancy in years at age 65, Canada and Nunavut, 1991-2001



Source: Statistics Canada, Vital Statistics files, Birth and Death Databases (2000/2001) and Demography Division (population estimates); ISQ.  
Three-year rolling averages used. See note 2 and 10.

**Figure 36a-HLT-3**

Life expectancy in years at age 65, males vs. females, Canada and Nunavut, 2001



Source: Statistics Canada, Vital Statistics files, Birth and Death Databases and Demography Division (population estimates); ISQ. See note 10

Life expectancy at birth for Nunavummiut is ten years lower than that of other Canadians.

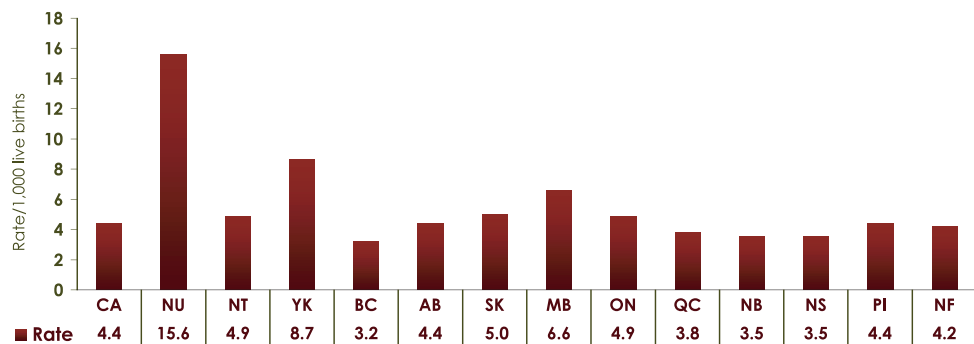
Life expectancy provides a picture of a population's overall health as well as the quality of healthcare people receive when they are ill: a healthy population that has access to quality healthcare is likely to have a longer life expectancy. It should be noted that life expectancy is an indicator of the quantity rather than quality of life. Increases in life expectancy that are associated with increased prevalence of serious debilitating disease may not be valued in the same way as an increase in life expectancy where the added years are lived in good health.

The prevention of illness is a fundamental component of life expectancy. Nunavut has introduced a number of programs to prevent illness including the Tobacco Reduction Strategy and the "Healthy Living Plan". There are also Public Health clinics such as "Well Woman", "Well Man", "Well Child" and "Chronic Disease" offered in each community where measures to prevent illness such as immunizations, as well as individual monitoring and counseling are done for communicable and chronic diseases, prenatal and infant care.

## Indicator 38: Infant Mortality

**Figure 38-HLT-1**

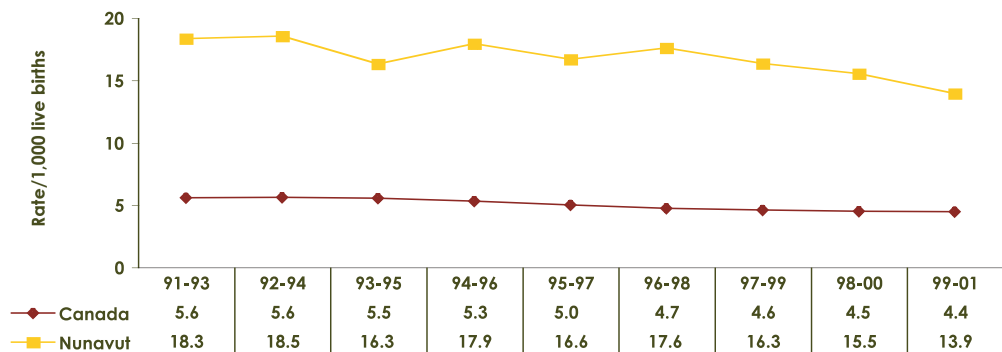
Infant mortality rate per 1,000 live births (birth weight 500g or more), Canada, 2001



Source: Statistics Canada, Vital Statistics, Births and Deaths Databases, ISQ. See note 3 and 16.

**Figure 38-HLT-2**

Infant mortality rate per 1,000 live births (birth weight 500g or more), Canada and Nunavut, 1991-2001



Source: Statistics Canada, Vital Statistics, Births and Deaths Databases; ISQ. Three-year rolling averages used. See notes 2, 3 and 16.

This indicator is the number of infants who die in the first year of life, expressed as a rate (per 1,000 live births) for each year.

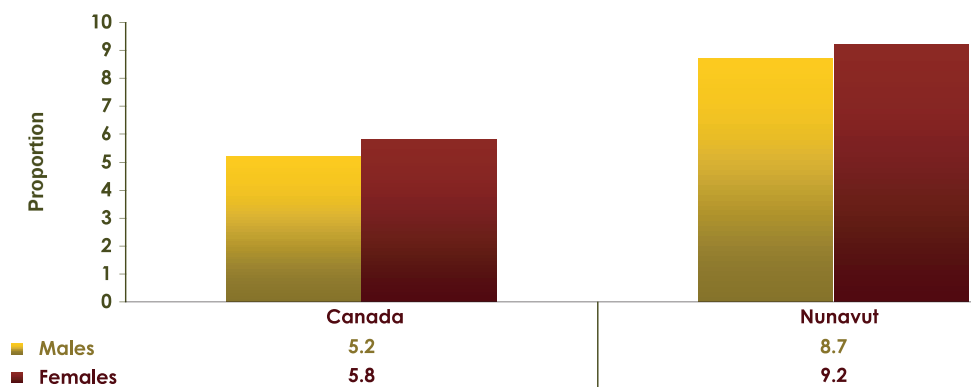
Infant mortality is a long-established measure of child health. This indicator reflects the health status and health care provision of a population, the effectiveness of preventive care, and the attention paid to maternal care and child health. One of the principle risk factors associated with infant mortality in Canada is low birth weight. Pre-term births account for approximately 75-85% of all perinatal deaths in Canada<sup>11</sup>. Low socioeconomic status is another factor that is associated with high rates of infant mortality.

In 2001, Nunavut's infant mortality rate of 15.6 per 1,000 live births was approximately three times higher than it was for Canada. The rate of infant deaths in Nunavut has been on a steady decline since they have been recorded in 1991. The decline is presumed to be a reflection of increased early and regular prenatal care, obstetrical care during labour and delivery, as well as postpartum care and maternal education.

## Indicator 39: Low Birth Weight

**Figure 39-HLT-1**

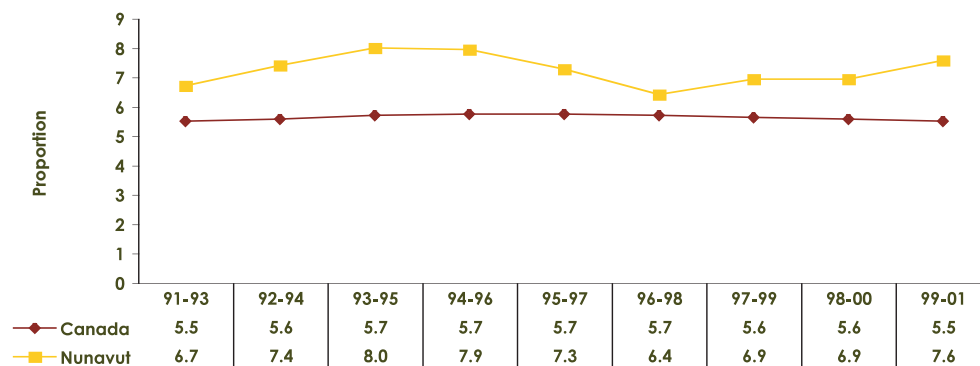
Proportion of low birth weight infants (500 to 2,500g), males vs. females, Canada and Nunavut, 2001



Source: Statistics Canada, Vital Statistics, Birth Database; ISQ. See note 4, and 16.

**Figure 39-HLT-2**

Proportion of low birth weight infants (500g to 2,500g), Canada and Nunavut, 1991-2001

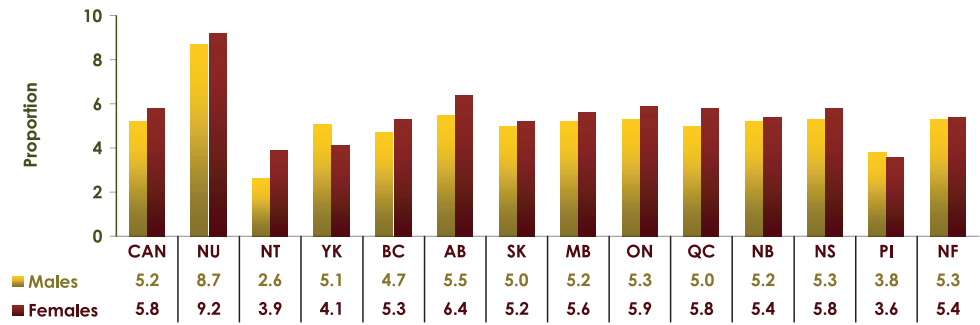


Source: Statistics Canada, Vital Statistics, Birth database; ISQ. Three-year rolling averages used, see notes 2, 4 and 16.

<sup>11</sup>Health Canada. Canadian Perinatal Health Report, 2000. p. 53.

**Figure 39-HLT-3**

Proportion of low birth weight infants (500g to 2,500g), males vs. females, Canada, 2001



Source: Statistics Canada, Vital Statistics, Birth database, ISQ.  
See note 4 and 16.

Low birth weight is expressed as a percentage, and is defined as the proportion of live births (birth weight known) with a birth weight less than 2,500 grams and at least 500 grams.

Low birth weight (less than 2,500 grams but more than 500 grams) is an indicator of newborn babies' general health, and a key determinant of infant mortality and morbidity. Low birth weight babies are at a greater risk of dying during the first year of life. They are also at risk of suffering from certain disabilities, such as mental retardation, visual and respiratory problems and learning disabilities<sup>12</sup>.

Generally, healthy women are more likely to have healthy birth weight babies. Women who smoke during pregnancy or have poor nutrition and consequent low gestational weight gain or low pre-pregnancy body mass index are more likely to have low birth weight babies. Low birth weight is also associated with social factors, such as exposure to environmental tobacco smoke and economic circumstances.

In 2001, Nunavut reported approximately 9% of low birth weight births, about 3% higher than the national average.

The department is offering access to early and regular prenatal care and appropriate level of obstetric care during labour, birth, and the early postpartum period in order to ensure more favourable birth weight outcomes. It also has directed tobacco control activities at pregnant women.

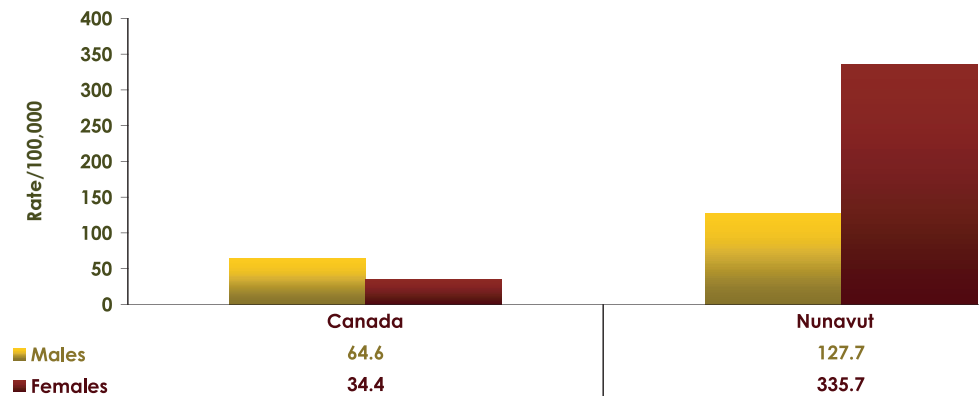
<sup>12</sup>Newburn-Cook, C.V. White, D. Svenson, Lawrence, Demianczuk, N. N. Bott, N. and Edwards, J. Where and to what extent is prevention of low birth weight possible? *Western Journal of Nursing Research*, 2002, 24 (8), 887-904.



## Indicator 40: Mortality Rate for Lung Cancer

**Figure 40-HLT-1**

Lung cancer mortality rate per 100,000 (age-standardized), males vs. females, Canada and Nunavut, 2001

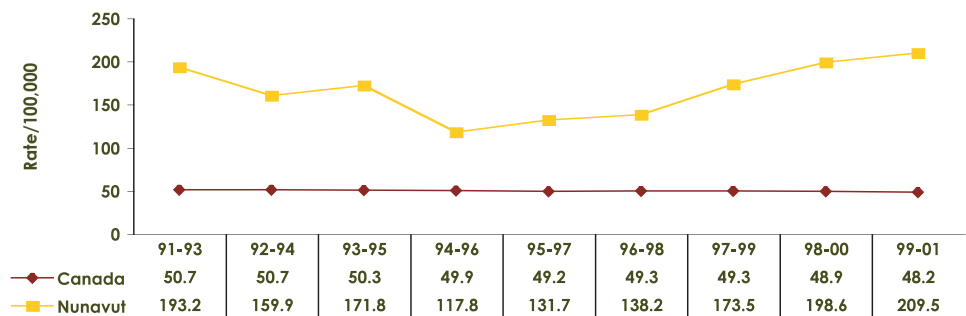


Source: Statistics Canada, Vital Statistics and Demography Division; ISQ. See notes 1, 5 and 11.

In Nunavut, the rate of lung cancer mortality in females was much higher than that of males, and nearly ten times higher than that of Canadian women. While the trend has been that women in Nunavut do have a higher lung cancer mortality rate, 2001 had an exceptionally high female mortality rate.

**Figure 40-HLT-2**

Lung cancer mortality rate per 100,000 (age-standardized), Canada and Nunavut, 1991-2001



Source: Statistics Canada, Vital Statistics and Demography Division; ISQ. Three-year rolling averages used. See notes 1, 2, 5 and 11.

The rate of lung cancer mortality is much higher in Nunavut than it is in the rest of Canada. Lung cancer mortality rates have been increasing since 1996 and appear to be on the rise in Nunavut.

The major risk factor for developing lung cancer is tobacco smoking. It has been estimated that 65% of Nunavummiut smoke – a rate higher than anywhere else in Canada<sup>13</sup>. Several extensive tobacco control initiatives are currently underway in Nunavut. They are aimed at prevention, harm reduction, cessation and protection. These initiatives will particularly target youth and pregnant women.

The department's biggest achievement to date is the passage of Bill 33, the Tobacco Control Act. This bill aims at reducing the amount of environmental tobacco smoke that Nunavummiut are exposed to, as well as to prohibit the sale of tobacco to minors. It has received national recognition as the most progressive act in Canada.

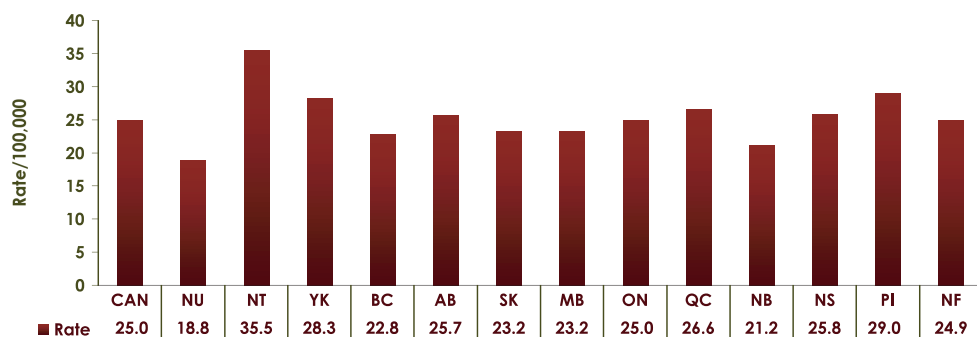
<sup>12</sup>Newburn-Cook, C.V. White, D. Svenson, Lawrence, Demianczuk, N. N. Bott, N. and Edwards, J. Where and to what extent is prevention of low birth weight possible? *Western Journal of Nursing Research*, 2002, 24 (8), 887-904.

<sup>13</sup>Statistics Canada. CANSIM table 105-0227. Smoking status, by age group and sex, household population aged 12 and over, Canada, provinces, territories, health regions (June 2003 boundaries) and peer groups, every 2 years. *Canadian Community Health Survey, cycle 2.1, 2003*.

## Indicator 42: Mortality Rate for Breast Cancer

**Figure 42-HLT-1**

Breast cancer mortality rate per 100,000 (age-standardized), females, Canada, 2001



Source: Statistics Canada, Vital Statistics Demography Division; ISQ.  
See notes 1 and 5.

The mortality rate for breast cancer appears lower in Nunavut than in every other province in Canada, however this difference was not statistically significant. There is evidence that breast feeding might have a protective effect against breast cancer<sup>14</sup>. The department actively encourages women to breast feed infants.

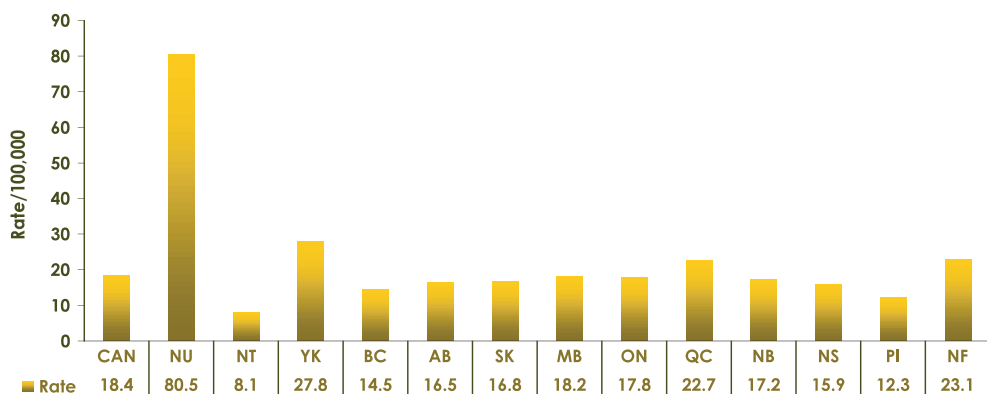
A mammography screening program is not currently available to Nunavut women. Women who wish to have screening mammography are assisted to book such tests when they are in the south on personal or business travel. The department does not pay for such travel. However, the cost of the screening mammogram itself is covered. Diagnostic mammograms and all associated travel costs are fully covered under the policy. If a physician, nurse, or the woman herself finds a breast lump, or if there is breast discharge or pain, etc. then a mammogram may be ordered as part of the investigation to help determine the nature of the lump. Women are also instructed on how to do breast self-examinations by nurses and physicians.

Cancer is treated outside of Nunavut. Being alone in strange city, surrounded by a strange language and culture can be stressful to patients. Kivalliq region has been successful in providing chemotherapy in Rankin Inlet to a resident from that region.

## Indicator 43: Mortality Rates for Colorectal Cancer

**Figure 43-HLT-1**

Colorectal cancer mortality rate per 100,000 (age-standardized), Canada, 2001



Source: Statistics Canada, Vital Statistics and Demography Division; ISQ.  
See notes 1 and 5.

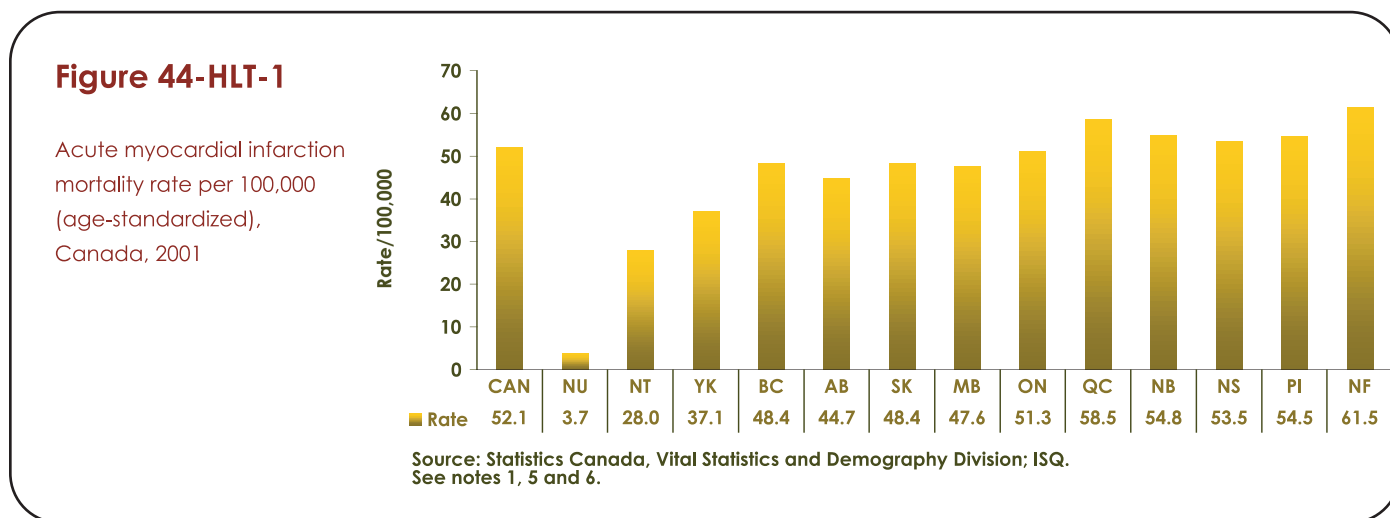
<sup>14</sup>Lipworth, Loren, Bailey L. Renee, and Dimitrios Trichopoulos. History of Breast-Feeding in Relation to Breast Cancer Risk: a Review of the Epidemiologic Literature. JNCI 4:92. 302-312. February 2000.

The rate of colorectal cancer mortality is much higher in Nunavut than it is in the rest of Canada. However, it should be noted that rates of colorectal cancer in 2001 were unusually high.

The department concentrates its efforts on a primary prevention strategy, i.e. preventing the cancers by educating Nunavummiut about proper nutrition, active living and the dangers of smoking. Although there is not a screening program for colorectal cancer, screening tests for occult blood are available at the community level.

Proper nutrition and diet are thought to have a protective effect against colorectal cancer. Programming is in place to promote a balance between traditional and modern diets. The presence of a nutritionist in the department and federal funding for projects that are delivered locally will continue to increase awareness, especially in the younger population.

## Indicator 44: Mortality Rate for Acute Myocardial Infarction



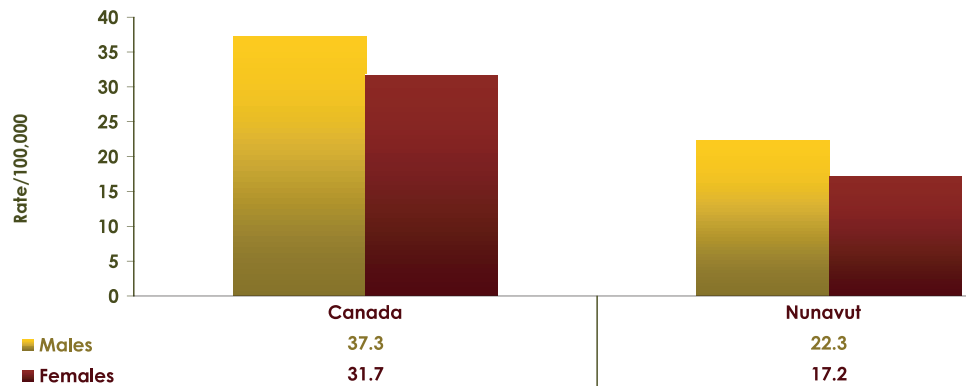
In Nunavut, the mortality rate for acute myocardial infarctions (AMIs) was low in 2001. That year, the Canadian rate was more than 14 times higher than Nunavut's. Over the last 10 years, Nunavut has had a lower rate of AMI mortality than the rest of Canada on average (see note 11). This could change as Nunavummiut adopt a more western lifestyle, so it is important to have preventative measures in place.

Primary prevention efforts for AMI are focused on promoting a healthy lifestyle – diet, exercise, and not smoking. In addition, blood pressure is routinely taken at both well man and well woman clinics in the territory. Since, family history is considered as a non modifiable factor linked to the development of heart disease, a healthy lifestyle remains the major focus in terms of preventing death from AMI.

## Indicator 45: Mortality Rate for Stroke

**Figure 45-HLT-1**

Stroke mortality rate per 100,000 (age-standardized), males vs. females, Canada and Nunavut, 2001



Source: Statistics Canada, Vital Statistics and Demography Division; ISQ. See notes 1, 5 and 11.

The mortality rate for stroke appears lower in Nunavut than in the rest of Canada, but this difference is not statistically significant. In 2001, the rate was 22.3 for males and 17.2 for females, while in Canada the rates were 37.3 for males and 31.7 for females.

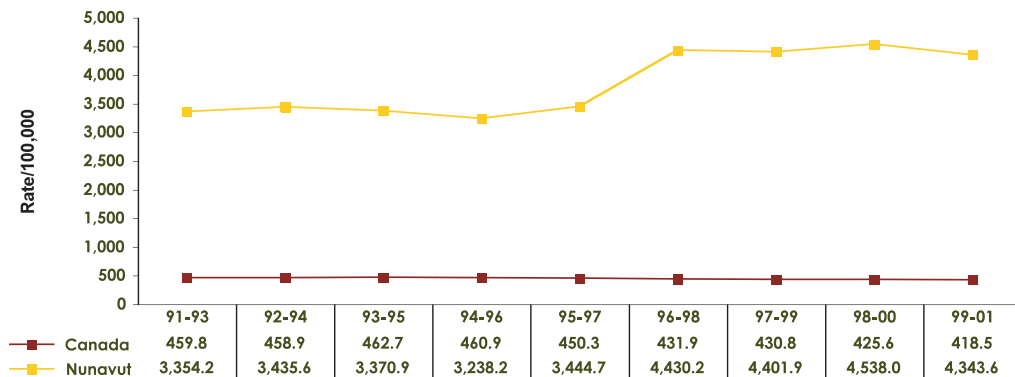
As with other cardiovascular diseases smoking, high blood pressure, obesity, and low level of physical activity are considered important risk factors for stroke.

Primary prevention efforts for stroke are focused on promoting a healthy lifestyle.

## Indicator 54: Potential Years of Life Lost Due to Suicide

**Figure 54-HLT-1**

PYLL due to suicide, rate per 100,000, Nunavut and Canada, 1991-2001



Source: Statistics Canada, Vital Statistics, Death Database and Demography Division (population estimates); ISQ.

Three-year rolling averages used. See notes 2, 5, 10 and 11





## Indicator 56-Incidence rate for invasive meningococcal disease

There was one new case of invasive meningococcal disease reported in 2002, which resulted in a rate 7.6 per 100,000<sup>15,16</sup>.

Invasive meningococcal disease can cause an acute fatal illness and some strains have caused outbreaks and epidemics. While there are good measures to treat the illness and limit the spread of the disease, many jurisdictions in Canada have moved to vaccination as a preventive measure. Nunavut is initiating such a program because while the disease incidence has been low, crowded housing and potential delays to treatment could result in substantial morbidity and mortality in an unvaccinated population.

## Indicator 57-Incidence Rate for measles

There were no new cases of measles reported in Nunavut in 2002<sup>17</sup>. The success of our vaccination campaigns means that Nunavut is playing its part in the global strategy to eliminate measles as we have previously with smallpox and polio.

The Pan-American Health Organization adopted the goal of measles elimination by 2000; it is the only public health goal that has been adopted by all Canadian provinces and territories. Two doses of measles vaccine are required for complete protection; the first dose is given at 12 months and the second dose prior to school entry, at either 18 months or 4-6 years of age. In the absence of global eradication, achieving measles elimination requires ongoing, enhanced surveillance and continued *high immunization coverage* rates.

## Indicator 58-Incidence Rate for Haemophilus influenzae b (Hib) invasive disease

There were 2 cases of invasive Haemophilus influenzae b diagnosed in Nunavut in 2002 which resulted in a rate of 57.8 per 100,000<sup>15,18</sup>. Vaccination against the disease was begun in Nunavut in 1988.

Hib was the most common cause of bacterial meningitis and a leading cause of other serious invasive infections in children prior to the introduction of Hib vaccines. Vaccine preventable cases are now rare. Four doses of the vaccine are given in combination with diphtheria, pertussis, tetanus, and polio before the age of 2 years.

## Indicator 59-Incidence Rate for Tuberculosis

TB is an important public health problem that has become more prominent in recent years. Incidence is linked to high-risk groups such as recent immigrants, aboriginal communities and people co-infected with HIV. Multiple drug resistance is also emerging in Canada.

<sup>15</sup>Health Canada. Notifiable Diseases Reporting and Enhanced Surveillance System, 2002.

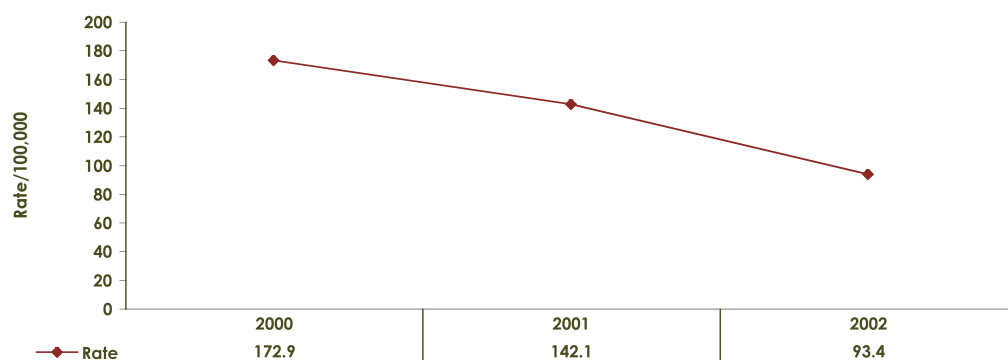
<sup>16</sup>Statistics Canada. CANSIM table 051-0001. Estimates of population by sex and age group, Canada, provinces and territories, 2002.

<sup>17</sup>Health Canada. Notifiable Diseases Reporting and Enhanced Surveillance System, and Enhanced Measles Surveillance System, 2002.

<sup>18</sup>Statistics Canada. CANSIM table 051-0001. Estimates of population by sex and age group, Canada, provinces and territories, 2002.

### Figure 59-HLT-1

Tuberculosis, Incidence rate per 100,000, Nunavut, 1999 to 2002\*



Source: Health Canada, Canadian Tuberculosis Reporting System, \*New and relapsed cases.

Although the incidence rate of Tuberculosis in Nunavut remains higher than the Canadian average (5.2)<sup>19</sup>, it has decreased steadily over three years.

Initiatives in TB elimination and control include a school-screening program in grades kindergarten, six and nine. Additionally, regional coordinators have been assigned to each of Nunavut's three regions. Nunavut practices Direct Observed Therapy (DOT) not only with active cases but also in the treatment of latent TB infection.

## Indicator 60-Incidence rate for Verotoxigenic E. coli

There was one case of Verotoxigenic E. coli reported in Nunavut in 2002, resulting in a rate of 3.5 per 100,000<sup>20,21</sup>.

The incidence of Verotoxigenic E. coli may be considered an approximate indicator of food-borne illness. It also has implications for water-borne disease issues. E. coli 0157 is included in the category of Verotoxigenic E. coli (VTEC), accounting for more than 90% of cases. There is an intent that all jurisdictions should report VTEC in the future. Verotoxigenic E. coli can cause severe bloody diarrhea, hemolytic anemia, kidney failure and death.

Nunavummiut are especially vulnerable to this disease because so much food is consumed uncooked. Long transportation times or improper storage at any point in the transport chain can encourage the growth of the disease causing bacteria.

## Indicator 61-Incidence Rate for Chlamydia

This is a common sexually transmitted infection (STI) which may result in pelvic inflammatory disease, female infertility and ectopic pregnancy. The higher incidence rates relative to other STIs means that Chlamydia incidence is a more sensitive indicator of change in risk behaviours and can therefore better reflect the effectiveness of primary and secondary prevention. High risk behaviour, i.e. unprotected sex, can result in other STIs such as gonorrhoea, syphilis, HIV, hepatitis B and unwanted pregnancy.

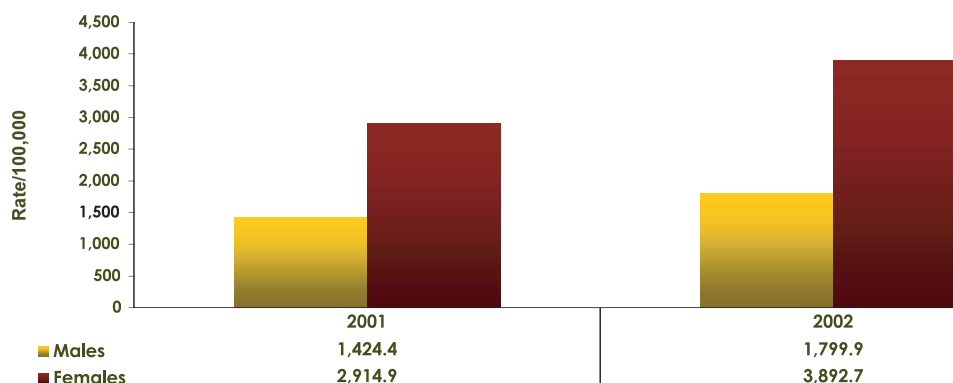
<sup>19</sup>Health Canada, Canadian Tuberculosis Reporting System.

<sup>20</sup>Health Canada. Notifiable Diseases Reporting and Enhanced Surveillance System, 2002.

<sup>21</sup>Statistics Canada. CANSIM table 051-0001. Estimates of population by sex and age group, Canada, provinces and territories, 2002.

**Figure 61-HLT-1**

Chlamydia, crude Incidence by gender, Nunavut, 2001 and 2002

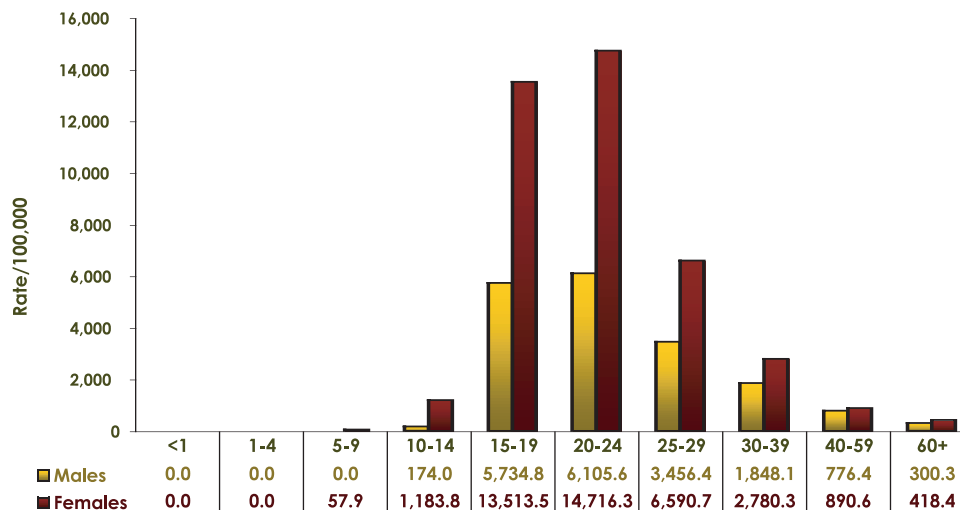


Source: Nunavut Communicable Disease Registry. Population/denominator: Statistics Canada, CANSIM table 051-001

Chlamydia is Nunavut's most commonly reported communicable disease. High rates in 2002 highlight the importance of and our need to improve our health promotion (promoting, abstinence, mutual monogamy and barrier protection) and health protection activities (treatment and contact tracing).

**Figure 61-HLT-2**

Incidence rate per 100,000 of chlamydia by age, males vs. females, Nunavut 2002



Source: Nunavut Communicable Disease Registry. Population/denominator: Statistics Canada, CANSIM table 051-001, 2002

The 15-24 age group is the most at risk of being infected with Chlamydia. The rates between men and women should be approximately equal, but it is likely that women are diagnosed more often because they are more likely to seek medical attention than are men. Also, the rates are likely to be a significant underestimate of disease in both men and women since infection often does not cause symptoms. Even so these figures indicate approximately 1 in 10 in these age groups are infected each year.

Screening for Chlamydia is routinely carried out in "Well Woman", "Well Man" and "Prenatal" clinics.

## Indicator 62-HLT Rate of Newly reported HIV cases

Nunavut has had no reported cases of HIV infections from 1995 to 2001<sup>22</sup>. This has changed. Most infections are sexually transmitted. This can be considered an indicator of high-risk sexual behaviours. The number of new HIV diagnoses is a function of both HIV incidence and HIV testing patterns.

<sup>22</sup>Nunavut Department of Health and Social Services. Report on Comparable Health Indicators for Nunavut and Canada. September 2002.

Less than 5 new cases of HIV were reported in 2002 and 2003 combined<sup>23</sup>. These reports represent only those cases which were diagnosed in Nunavut and reported to the Department of Health and Social Services. Anonymous tests are also not represented.

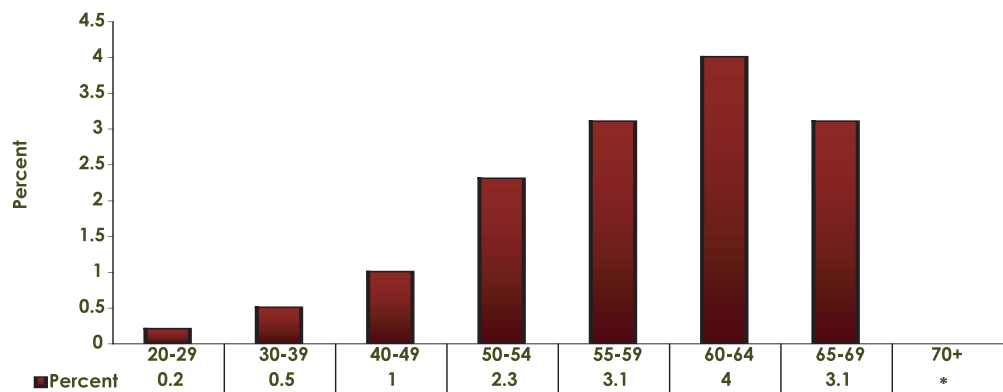
## Indicator 63: Prevalence of Diabetes

Diabetes is a chronic disease in which the body cannot regulate the amount of sugar in the body. It often leads to long-term complications including heart disease, stroke, kidney failure, limb amputation, and blindness, and can contribute to premature death.

The prevalence of diabetes is the number of individuals in the population with the disease at a specific point in time and it gives an idea of the importance or burden of this disease at a given time. This measure is widely used in public health monitoring and planning. Prevalence data, however, should not be used for trend analysis. It has been estimated that approximately 5% of all Canadians were affected by diabetes in 1998/99, thereby generating direct costs related to physician and hospital care, prescription drugs, and other costs borne by individuals, as well as indirect costs including premature death or disability<sup>24</sup>.

**Figure 63-HLT-1**

Crude prevalence (percent) of diabetes by age, Nunavut, 1999/2000

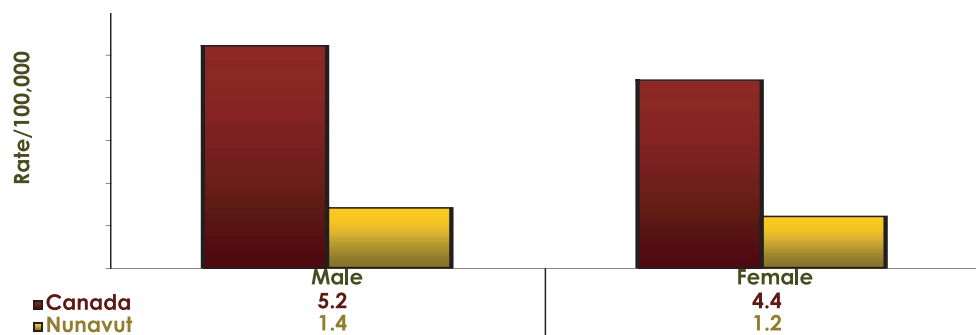


Source: National Diabetes Surveillance System  
\* Age 70+ data suppressed due to confidentiality. See note 17.

The majority of diabetes cases in Nunavut range in age from 40 to 69. Diabetes is a chronic disease so if there is increased incidence in a younger population, the burden on the health care system is greater because they have to be managed for a longer overall period of time.

**Figure 63-HLT-2**

Diabetes, age-standardized prevalence by sex, persons aged 20 and older, Nunavut, 1999/2000\*



Source: National Diabetes Surveillance System  
\*By Fiscal Year (April 1 - March 31). See note 1 and 17.

<sup>23</sup>Health Canada, HIV and AIDS in Canada. Surveillance Report to December 31 2003, Surveillance and Risk Assessment division, Centre for Infectious Diseases Prevention and Control, Health Canada, 2003.

<sup>24</sup>Health Canada, Centre for Chronic Disease Prevention and Control, Population and Public Health Branch. Diabetes in Canada. Second Edition. 2002.

In 1999/00, 1.3% of Nunavummiut had had diabetes compared to 4.8% nationally (readers should interpret this data with caution, see note 17). Note that prevalence reflects the cases accumulated at a single point in time.

Overweight, obese and physically inactive people are considered at risk for developing diabetes. In 2003, over 28% (crude rates) of Nunavummiut were overweight and 20% (crude rate) were obese<sup>25</sup>. Nearly 60% (crude rates) of Nunavut residents were physically inactive<sup>26</sup>. Smoking is considered a risk factor for complications of diabetes. In 2003, nearly 65% Nunavummiut (age 12+ years) were smokers compared to 23% of Canadians (crude rates)<sup>27</sup>.

Nunavut's ADI community-based diabetes prevention programs saw more than 6300<sup>28</sup> participants in 2003-04.

Nutrition and Dental Services ran a 'Drop the Pop' campaign during Nutrition and Dental Months (March/April 2004) to encourage kids to 'drop the pop' and pick up water, milk, 100% fruit juices instead. Over 2000 children participated in the Drop the Pop activities<sup>29</sup>.

Ten health care professionals from Nunavut participated in a Diabetes Educator Course, and returned to their communities to share knowledge with colleagues.

In 2003/04 the Aboriginal Diabetes Initiative (ADI) funded an environmental scan of current diabetes resources and services in Nunavut, comparing the situation here with the national standards for diabetes training and education. In 2004/05 work will continue on this e-scan to develop a diabetes prevention and management strategy that will be tailored to Nunavut.

## Indicator 65: Self-Reported Health

**Figure 65-HLT-1**

Percentage of population aged 12 and older for variable self-rated health (age-standardized), Canada vs. Nunavut 2003



Source: Statistics Canada, Canadian Community Health Survey. See notes 1 and 6.  
\* C.V. is between 16.6% and 33.3% -- use with caution.

Self-reported health is a general indicator of the overall health status of individuals aged 12 and older and it is a more subjective measure of how an individual feels about her/his own health. Besides an overall assessment of health status, this measure of health status provides important information on disease conditions that other measures may miss: incipient disease, disease severity, some aspects of positive health status, physiologic/psychological reserve, social and mental functions<sup>30</sup>.

<sup>25</sup>Statistics Canada, CANSIM table 105-0209. Body mass index by age group and sex, household population aged 18 and over excluding pregnant women, Canada, provinces, territories, health regions (June 2003 boundaries) and peer groups, every 2 years. Canadian Community Health Survey, Cycle 2.1, 2003.

<sup>26</sup>Statistics Canada, CANSIM table 105-0233. Leisure-time physical activity, by age group and sex, household population aged 12 and over, Canada, provinces, territories, health regions (June 2003 boundaries) and peer groups, every 2 years. Canadian Community Health Survey, Cycle 2.1, 2003.

<sup>27</sup>Statistics Canada, CANSIM table 105-0227. Smoking status, by age group and sex, household population aged 12 and over, Canada, provinces, territories, health regions

<sup>28</sup>Nunavut Department of Health and Social Services. 2003/2004 Community Wellness Annual Report.

<sup>29</sup>Pulaarvik Kablu Friendship Centre. Drop the Pop, Nutrition and Dental Month 2004, Final Report.

<sup>30</sup>Statistics Canada. How Healthy are Canadians? Statistical Report on the Health of Canadians, ACPH, 1999, Health Reports, Vol. 11, No. 3

A number of key factors that typically affect the assessment of an individual health status are age, education, income<sup>31</sup>. Health generally deteriorates with age and older people may perceive their health status as less excellent or good. People in higher income groups mostly characterize their health as excellent or very good as increased income may lead to increased investments in health. Similarly, education determines income, which is strongly correlated with self-rated health.

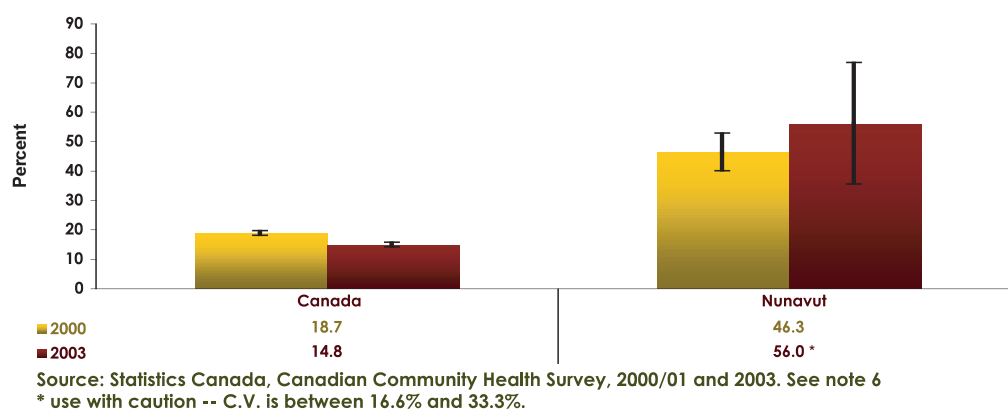
About 50% of Nunavummiut consider themselves to be in excellent or very good health.

## Indicator 66-Teenage Smoking Rates: Proportion Teenage Smokers

Smoking tobacco is a known risk factor of many forms of cancers, heart disease, respiratory disorders and infections, as well as a host of other medical conditions. Health Canada estimates that smoking is responsible for more than 45,000 deaths per year<sup>32</sup>. Because of the addictive nature of nicotine, youth smoking is of particular concern. It is estimated that approximately eight out of every 10 people who try smoking become habitual smokers<sup>32</sup>.

**Figure 66a-HLT-1**

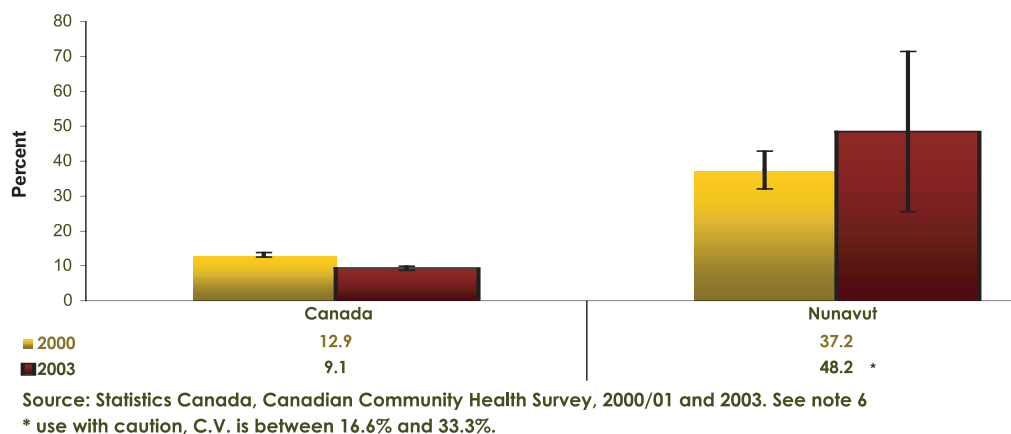
Percentage of population aged 12-19 who are current daily or occasional smokers, Canada and Nunavut, 2000 and 2003



This indicator is the proportion of those aged 12-19 who report current smoking (i.e. both daily and occasional smokers). It includes those members of the population aged 12 to 19 (inclusive) who are daily smokers.

**Figure 66b-HLT-2**

Percentage of population aged 12-19 who are daily smokers, Canada and Nunavut, 2000 and 2003



<sup>31</sup>Chevalier, S., Choiniere, R., Ferland, M. Et. Al. Community Health Indicators: Definitions and Interpretations. 1995: Canadian Institute for Health Information.

<sup>32</sup>Health Canada. The Scoop on Smoking – Health Canada for Youth. <http://www.hc-sc.gc.ca/hecs-sesc/tobacco/youth/scoop.html>.



Almost three times more teenagers in Nunavut smoke compared to the rest of Canada. This comparison is statistically significant.

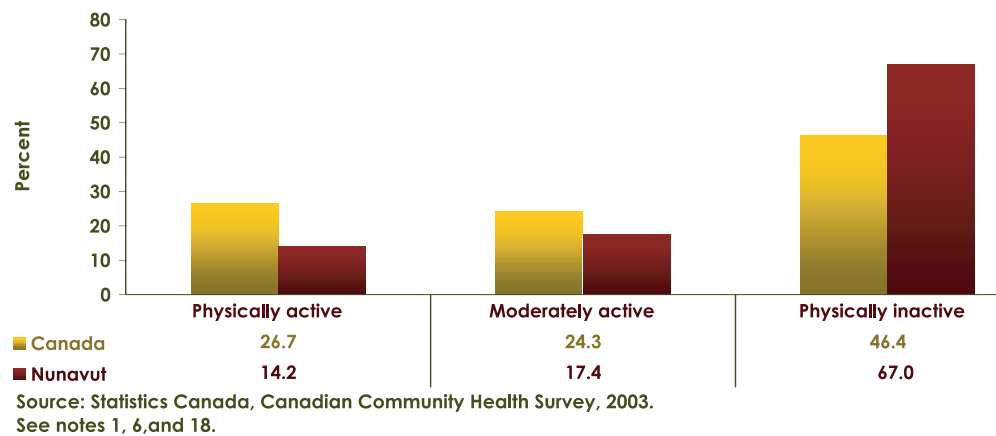
Nunavut's bill 33, recognized for being the most progressive tobacco control act in Canada, is aimed at tougher measures related to prohibition of tobacco sales to minors.

One of the department's initiatives aimed at reducing smoking in youth is the "Minister's Youth Action Team on Tobacco" (MYATT). MYATT is a group of 19 Inuit youth between the ages of 14 and 19 from across Nunavut. They meet regularly to advise the Minister and the department on how to tailor tobacco control initiatives to youth at risk. The team also helps to develop creative new tobacco cessation, prevention, and education program ideas as well as helping to implement programs at the community level.

## Indicator 67: Physical Activity

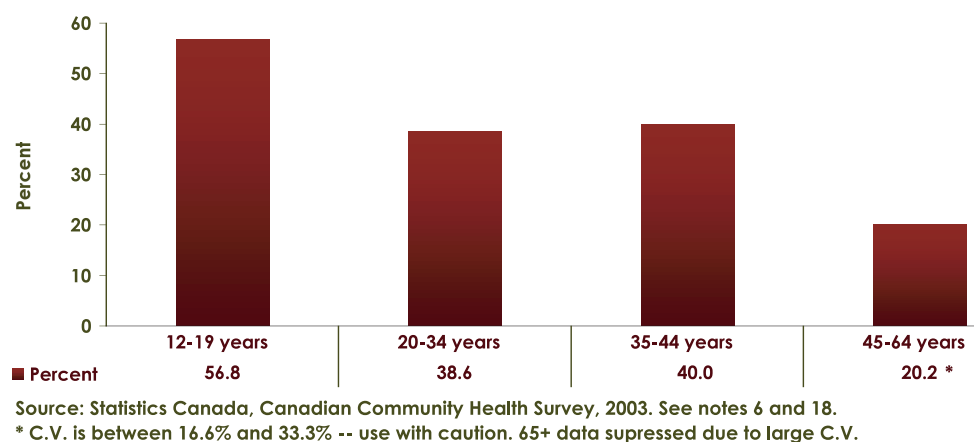
**Figure 67-HLT-1**

Percentage of population aged 12 and over for variable self-reported physical activity (age-standardized), Canada or Nunavut, 2003



**Figure 67-HLT-2**

Percentage of population aged 12 and over reporting active or moderately active, by age, Nunavut, 2003



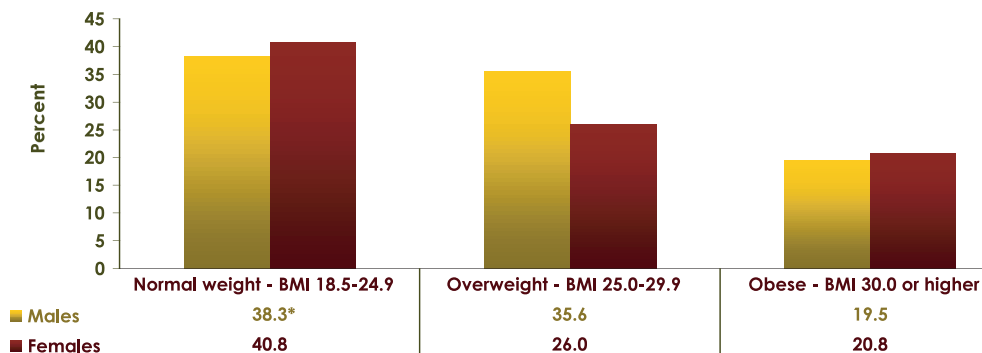
Overall, 67% of Nunavummiut reported being physically inactive. The lowest rates of physical activity were reported in those aged 45 and over.

The department is currently working on a “Healthy Living Strategy” that is a collaborative multi-disciplinary effort between the departments of health, education and recreation, to increase awareness and opportunity for healthy lifestyle choices.

## Indicator 68: Body Mass Index

**Figure 68-HLT-1**

Percentage of population aged 18 and over, for variable body mass index (age-standardized), males vs. females, Nunavut, 2003



Source: Statistics Canada, Canadian Community health Survey, 2003. See notes 1, 6, 7 and 18.  
\* C.V. is between 16.6% and 33.3% -- use with caution.

BMI is based on self-reported height and weight, and calculated for persons 18 years of age and over, excluding pregnant women. Due to different rates of growth for individuals under 18 years of age, the standard BMI is not considered a suitable indicator for this group. BMI is calculated as weight (in kilograms) divided by height (in metres) squared. BMI is expressed as the percentage of adults who report a body mass index in specified categories, ranging from underweight to obese.

The Canadian Guidelines for Body Weight Classification in Adults outlines a weight classification system that can be used to identify weight-related health risks in populations, and in individuals in Canada aged 18 and over<sup>33</sup>. Some evidence suggests that obesity is prevalent among Inuit in Canada, but the association between the actual health risk and obesity for Inuit is not well defined<sup>33</sup>. Still, these guidelines are, in general, appropriate for all ethnic groups in Canada, and are currently the best measure of risk available to use as part of a comprehensive health assessment<sup>33</sup>.

A larger proportion of Canadians have become overweight or obese over the past two decades, which results in considerable physical and economic costs<sup>34</sup>. Obesity has been identified as a major risk factor contributing to a number of chronic illnesses such as diabetes and heart disease<sup>34</sup>.

Health promotion initiatives that address healthy nutrition and active lifestyles, as well as encourage healthy environments, are important components of achieving healthy weight.

In Nunavut, only 40% of the population reported having a normal BMI (18.5 to 24.9).

<sup>33</sup>Health Canada, Canadian Guidelines for Body Weight Classification in Adults. 2002.

<sup>34</sup>Raine, Kim D. Overweight and Obesity in Canada: A Population Health Perspective. August 2004.

## Notes:

1. Rates have been standardized according to the 1991 Canadian population. Age standardization eliminates the impact of differing age distributions, either over time, or between regions. This enables comparisons to be made regardless of spatial or temporal differences in age distribution.
2. A rolling average combines data over multiple years (in this case three years) of observation in order to limit wide fluctuations in data which often occur in small populations.
3. Births to mothers not resident in Canada, and infant deaths to non-residents of Canada are excluded. Infants born outside of the province/territory of residence of their mothers or infants who die outside the province/territory of their mother are included in the rates for the mother's province/territory of residence.
4. Rates exclude births with unknown birth weight; births to mothers not resident in Canada. Infants born outside of the province/territory of residence of their mothers are included in the rates for the mother's province/territory of residence.
5. Rates exclude deaths of non-residents of Canada.
6. Persons living on First Nations Reserves and on Crown lands, residents of institutions, full-time members of Canadian Armed Forces, and residents of certain remote regions are excluded from the sample.
7. Rate excludes everyone less than 18 years of age, pregnant women and persons measuring less than 914 cm or greater than 210.8 cm in height.
8. Persons less than 15 years of age are excluded.
9. Patients not treated as inpatients in acute care hospitals (e.g., those seen only in an emergency department or chronic care institution).
10. Non-residents of Canada are excluded from the deaths and population estimates used for life tables.
11. From 1979 to 1999 the underlying cause of death was coded using ICD-9; beginning with 2000, the underlying cause of death was coded using ICD-10, thus introducing discontinuity to the trend data for the following: lung cancer (2% decrease), unintentional injuries, suicide, AMI (2.7% decrease), cerebrovascular disease (6.9% increase).
12. A re-abstraction study designed to examine the consistency of coding for this indicator yielded a 10.8% discrepancy rate overall. The discrepancy rates reported here represent an overall average and cannot be directly attributed to individual facilities, provinces or territories. This means that while the overall rate includes results from a number of jurisdictions, the rate for a particular subgroup of the population ( e.g. a specific region or jurisdiction) may differ to some degree from the overall rate and therefore caution should be used when making comparisons across subgroups.
13. Clients that were only assessed but did not receive any additional services were excluded.
14. Some data produced for the September 2002 Comparable Health Indicators Reports may have changed due to updated provincial and territorial numbers therefore data tables provided for the November 2004 Comparable Health Indicators Reports, replaces all previous data tables.
15. Population estimates and not the total number of admissions are used as the denominator.
16. There are some concerns with comparability of this indicator in specific jurisdictions due to missing birth registrations or data quality problems.
17. Readers should be cautious when interpreting these data:
  - three types of diabetes are included in the database: Type I, Type II, and gestational diabetes;
  - a baseline error rate of 20 to 25% exists in the published (1999/2000) data;

## Notes continued...

this level of error is accepted by Health Canada and by those national experts identified by Health Canada

- since 1997-98, these data have been accumulating false positives. For the data published here this may not have a significant impact. Health Canada plans to work to reduce these errors so that by the time they publish the 2001-02 data, this accumulation will not become significant; and
- this “baseline error rate” is likely to vary by age and sex groups

18. One should be careful in the interpretation of the changes over time for this indicator because the change in mode of collection may be one of the factors influencing changes. The discrepancy rates reported here represent an overall average and cannot be directly attributed to individual facilities, provinces or territories. This means that while the overall rate includes results from a number of jurisdictions, the rate for a particular subgroup of the population (e.g a specific region or jurisdiction) may differ to some degree from the overall rate and therefore caution should be used making comparisons across subgroups.

