Health Canada

2013-14

Departmental Performance Report

The Honourable Rona Ambrose, PC., M.P.
Minister of Health

Catalogue No. H1-9/6-2014E-PDF
ISSN 2368-3554
Pub. 140261

This document is available on the Treasury Board of Canada Secretariat website at http://www.tbs-sct.gc.ca[i]

This document is available in alternative formats upon request.

Table of Contents

Foreword

Departmental Performance Reports (DPRs) are part of the Estimates family of documents. Estimates documents support appropriation acts, which specify the amounts and broad purposes for which funds can be spent by the government. The Estimates document family has three parts.

Part I (Government Expenditure Plan) provides an overview of federal spending.

Part II (Main Estimates) lists the financial resources required by individual departments, agencies and Crown corporations for the upcoming fiscal year.

Part III (Departmental Expenditure Plans) consists of two documents. Reports on Plans and Priorities (RPPs) are expenditure plans for each appropriated department and agency (excluding Crown corporations). They describe departmental priorities, strategic outcomes, programs, expected results and associated resource requirements, covering a three-year period beginning with the year indicated in the title of the report. DPRs are individual department and agency accounts of actual performance, for the most recently completed fiscal year, against the plans, priorities and expected results set out in their respective RPPs. DPRs inform parliamentarians and Canadians of the results achieved by government organizations for Canadians.

Additionally, Supplementary Estimates documents present information on spending requirements that were either not sufficiently developed in time for inclusion in the Main Estimates, or were subsequently refined to account for developments in particular programs and services.

The financial information in DPRs is drawn directly from authorities presented in the Main Estimates and the planned spending information in RPPs. The financial information in DPRs is also consistent with information in the Public Accounts of Canada. The Public Accounts of Canada include the Government of Canada Consolidated Statement of Financial Position, the Consolidated Statement of Operations and Accumulated Deficit, the Consolidated Statement of Change in Net Debt, and the Consolidated Statement of Cash Flow, as well as details of financial operations segregated by ministerial portfolio for a given fiscal year. For the DPR, two types of financial information are drawn from the Public Accounts of Canada: authorities available for use by an appropriated organization for the fiscal year, and authorities used for that same fiscal year. The latter corresponds to actual spending as presented in the DPR.

The Treasury Board *Policy on Management, Resources and Results Structures* further strengthens the alignment of the performance information presented in DPRs, other Estimates documents and the Public Accounts of Canada. The policy establishes the Program Alignment Architecture (PAA) of appropriated organizations as the structure against which financial and non-financial performance information is provided for Estimates and parliamentary reporting. The same reporting structure applies irrespective of whether the organization is reporting in the Main Estimates, the RPP, the DPR or the Public Accounts of Canada.

A number of changes have been made to DPRs for 2013−14 to better support decisions on appropriations. Where applicable, DPRs now provide financial, human resources and performance information in Section II at the lowest level of the organization’s PAA.

In addition, the DPR's format and terminology have been revised to provide greater clarity, consistency and a strengthened emphasis on Estimates and Public Accounts information. As well, departmental reporting on the Federal Sustainable Development Strategy (FSDS) has been consolidated into a new supplementary information table posted on departmental websites. This new table brings together all of the components of the Departmental Sustainable Development Strategy formerly presented in DPRs and on departmental websites, including reporting on the Greening of Government Operations and Strategic Environmental Assessments. Section III of the report provides a link to the new table on the organization's website. Finally, definitions of terminology are now provided in an appendix.

Minister's Message

I am pleased to present Health Canada's *2013–14 Departmental Performance Report*, which outlines Health Canada's actions this past year to strengthen the health care system and help Canadians maintain and improve their health.

Health Canada continues to be a leader in ***promoting health system innovation*** **to improve** health care quality for Canadians. We continued to advance cancer control and treatment through the Canadian Partnership against Cancer and took action to improve palliative care by helping front-line caregivers get the skills and knowledge they need to provide quality end-of-life care to patients and their families that they deserve.

Health Canada made great strides this past year in ***modernizing legislation and regulations*** to better protect the health and safety of Canadian families. We introduced Vanessa's Law, new patient safety legislation that gives us new powers to remove unsafe drugs from store shelves and to collect information about potentially dangerous drugs. The proposed law complements our actions to make drug labels and safety information easier to read and understand. We have also been working more closely with our United States counterparts to improve patient safety and reduce red tape around regulatory decisions.

Canadians have told us they need access to the right information to make well-informed decisions concerning their health and that of their families. At Health Canada, we are listening. We have ***made transparent, innovative and accessible information for Canadians a priority***. Health Canada is providing more information to Canadians than ever before so that they can see for themselves how and why decisions are made. We have also strengthened our commitment to engage with Canadians. Consultations with parents and stakeholders on nutrition labels have allowed us to better understand what kind of information is most important to Canadians and how we can make labels more meaningful and useful.

Health Canada is committed to improving the health of Canada's ***First Nations and Inuit*** people. We have continued to implement the historic *British Columbia Tripartite Framework Agreement on First Nations Health Governance.* Now British Columbia First Nations have responsibility for their own health and can incorporate their cultural knowledge, beliefs and values into the design and planning of their health programs and services.

These are only some of the highlights from this past year. As Minister of Health, I am very proud of Health Canada's accomplishments in 2013-14. They demonstrate our continued commitment to help Canadians maintain and improve their health.

The Honourable Rona Ambrose, PC., M.P.
Minister of Health

Section I: Organizational Expenditure Overview

Organizational Profile

Appropriate Minister: The Honourable Rona Ambrose, PC., M.P.

Institutional Head: George Da Pont

Ministerial Portfolio: Health

Enabling Instrument(s): *Canada Health Act* [ii], *Assisted Human Reproduction Act* [iii], *Canada Consumer Product Safety Act* [iv], *Canadian Environmental Protection Act* [v], *Controlled Drugs and Substances Act* [vi], *Food and Drugs Act* [vii], *Tobacco Act* [viii], *Hazardous Products Act* [ix], *Hazardous Materials Information Review Act* [x], *Department of Health Act* [xi], *Radiation Emitting Devices Act* [xii], *Pesticide Residue Compensation Act* [xiii], *Pest Control Products Act* [xiv].

List of Acts and Regulations [xv]

Year of Incorporation / Commencement: 1913

Other: Canadian Food Inspection Agency joined the Health Portfolio in October 2013.

Organizational Context

Raison d'être

Health Canada plays various roles that help Canadians to maintain and improve their health and contribute to strengthening Canada's record as a country with one of the healthiest populations in the world.

The Minister of Health is responsible for this organization.

Responsibilities

First, as a **regulator**, Health Canada is responsible for the regulatory regimes governing the safety of products including food, pharmaceuticals, medical devices, natural health products, consumer products, chemicals, radiation emitting devices, cosmetics and pesticides. It also regulates tobacco products and controlled substances, public health on aircraft, ships and other passenger conveyances, and helps manage the health risks posed by environmental factors such as air, water, radiation and contaminants.

The Department is also a **service-provider**. For First Nations and Inuit, Health Canada supports: basic primary care services in remote and isolated communities and public health programs including communicable disease control (outside the Territories); home and community care; and, community-based health programs focusing on children and youth, mental health and addictions. The Department also provides a limited range of medically-necessary, health-related goods and services to eligible First Nations and Inuit that are not otherwise provided through other public programs or private insurance plans.

Health Canada is a **catalyst for innovation, a funder and an information provider** in Canada's health system. It works closely with provincial and territorial governments to develop national approaches to health system issues, and promotes the pan-Canadian adoption of best practices. It administers the *Canada Health Act*, which embodies national principles to ensure a universal and equitable, publicly-funded health care system. It provides policy support for the federal government's Canada Health Transfer to provinces and territories, and provides funding through grants and contributions to various organizations to help meet overall health system objectives. The Department draws on leading-edge science and policy research to generate and share knowledge and information to support decision-making by Canadians, the development and implementation of regulations and standards, and health innovation.

Strategic Outcomes and Program Alignment Architecture (PAA)

1 **Strategic Outcome:** A health system responsive to the needs of Canadians
- 1.1 **Program:** Canadian Health System Policy
  - 1.1.1 **Sub-Program:** Health System Priorities
  - 1.1.2 **Sub-Program:** *Canada Health Act* Administration
- 1.2 **Program:** Specialized Health Services
- 1.3 **Program:** Official Language Minority Community Development

2 **Strategic Outcome:** Health risks and benefits associated with food, products, substances, and environmental factors are appropriately managed and communicated to Canadians
- 2.1 **Program:** Health Products
  - 2.1.1 **Sub-Program:** Pharmaceutical Drugs
  - 2.1.2 **Sub-Program:** Biologics & Radiopharmaceuticals
  - 2.1.3 **Sub-Program:** Medical Devices
  - 2.1.4 **Sub-Program:** Natural Health Products
- 2.2 **Program:** Food Safety and Nutrition
  - 2.2.1 **Sub-Program:** Food and Nutrition Safety
  - 2.2.2 **Sub-Program:** Nutrition Policy and Promotion
- 2.3 **Program:** Environmental Risks to Health
  - 2.3.1 **Sub-Program:** Climate Change and Health
  - 2.3.2 **Sub-Program:** Air Quality
  - 2.3.3 **Sub-Program:** Water Quality
  - 2.3.4 **Sub-Program:** Health Impacts of Chemicals
- 2.4 **Program:** Consumer Product and Workplace Chemical Safety
  - 2.4.1 **Sub-Program:** Consumer Product Safety
  - 2.4.2 **Sub-Program:** Workplace Chemical Safety
- 2.5 **Program:** Substance Use and Abuse
  - 2.5.1 **Sub-Program:** Tobacco
  - 2.5.2 **Sub-Program:** Controlled Substances
- 2.6 **Program:** Radiation Protection
  - 2.6.1 **Sub-Program:** Environmental Radiation Monitoring and Protection
  - 2.6.2 **Sub-Program:** Radiation Emitting Devices
  - 2.6.3 **Sub-Program:** Dosimetry Services
- 2.7 **Program:** Pesticides

3 **Strategic Outcome:** First Nations and Inuit communities and individuals receive health services and benefits that are responsive to their needs so as to improve their health status
- 3.1 **Program:** First Nations and Inuit Primary Health Care
  - 3.1.1 **Sub-Program:** First Nations and Inuit Health Promotion and Disease Prevention
    - 3.1.1.1 **Sub-Sub Program:** Healthy Child Development
    - 3.1.1.2 **Sub-Sub Program:** Mental Wellness
    - 3.1.1.3 **Sub-Sub Program:** Healthy Living
  - 3.1.2 **Sub-Program:** First Nations and Inuit Public Health Protection
    - 3.1.2.1 **Sub-Sub Program:** Communicable Disease Control and Management
    - 3.1.2.2 **Sub-Sub Program:** Environmental Public Health
  - 3.1.3 **Sub-Program:** First Nations and Inuit Primary Care

- **3.1.3.1 Sub-Sub Program:** Clinical and Client Care
- **3.1.3.2 Sub-Sub Program:** Home and Community Care

3.2 Program: Supplementary Health Benefits for First Nations and Inuit

3.3 Program: Health Infrastructure Support for First Nations and Inuit

- **3.3.1 Sub-Program:** First Nations and Inuit Health System Capacity
  - **3.3.1.1 Sub-Sub Program:** Health Planning and Quality Management
  - **3.3.1.2 Sub-Sub Program:** Health Human Resources
  - **3.3.1.3 Sub-Sub Program:** Health Facilities
- **3.3.2 Sub-Program:** First Nations and Inuit Health System Transformation
  - **3.3.2.1 Sub-Sub Program:** Systems Integration
  - **3.3.2.2 Sub-Sub Program:** e-Health Infostructure
  - **3.3.2.3 Sub-Sub Program:** Nursing Innovation
- **3.3.3 Sub-Program:** Tripartite Health Governance

Internal Services

- **Sub IS:** Governance and Management Support
  - **Sub-Sub IS:** Management and Oversight Services
  - **Sub-Sub IS:** Communications Services
  - **Sub-Sub IS:** Legal Services
- **Sub IS:** Resource Management Services
  - **Sub-Sub IS:** Human Resources Management Services
  - **Sub-Sub IS:** Financial Management Services
  - **Sub-Sub IS:** Information Management Services
  - **Sub-Sub IS:** Information Technology Services
  - **Sub-Sub IS:** Other Administrative Services
- **Sub IS:** Asset Management Services
  - **Sub-Sub IS:** Real Property Services
  - **Sub-Sub IS:** Materiel Services
  - **Sub-Sub IS:** Acquisition Services

Organizational Priorities

Organizational Priorities

Priority	Type[1]	Strategic Outcome(s) [and/or] Programs
Priority I – Promote Health System Innovation	Ongoing	SO1 1.1 Canadian Health System Policy

Summary of Progress

Health system innovation is vital to responding to the health needs of Canadians. Although health care delivery is primarily under provincial/territorial jurisdiction, the federal government has an ongoing role in providing financial support for provincial and territorial health insurance plans, maintaining the core principles of the *Canada Health Act* (CHA), and supporting health care innovation and collaboration across jurisdictions.

Health Canada's $19.7 million funding for the Health Care Policy Contribution Program supported several initiatives related to health human resources, integration of internationally educated health professionals, and health care system innovation, including:

- Seven provincial and territorial agreements for the Family Medicine Residencies Initiative worth $39.5 million over six years to support the provinces and territories in providing family medicine residency positions and advanced training in rural and remote areas across the country.
- Twelve provincial, territorial and non-governmental organizations (NGOs) agreements funded at a total of $9.6 million, to advance the assessment, training and integration of internationally education health professionals across Canada.
- An agreement with the Institute for Safe Medication Practices Canada for the Canadian Medication Incident Prevention and Reporting System project to analyze and reduce the risk of harmful medication incidents. In 2013-14, $1.6 million was allocated to this project.

Health Canada supported innovations that improve health care quality and increase health system sustainability. The Department:

- Supported the Minister to engage the public and stakeholders on opportunities and challenges for Canada's health care system through speeches, roundtables, and outreach, pursued discussions with the provinces and territories on health care innovation, and took steps towards the creation of a ministerial advisory panel on innovation.
- Provided $79.3 million in funding to support the Canadian Institute for Health Information (CIHI) to develop an interactive website to help Canadians understand how well their health care system is performing according to 15 performance indicators - province by province, region by region, and in some instances, hospital by hospital.
- Provided $107.2 million in financial support to Canada Health Infoway to advance electronic health systems, as important components of innovation in health care.
- Provided $48.5 million in funding to support the Canadian Partnership against Cancer (CPAC) which has accelerated uptake of new knowledge and coordinated approaches to advance cancer control in Canada.
- Provided $3 million to support the Pallium Foundation of Canada to equip more front-line health care providers with palliative care skills and knowledge.

1. Type is defined as follows: previously committed to—committed to in the first or second fiscal year prior to the subject year of the report; ongoing—committed to at least three fiscal years prior to the subject year of the report; and new—newly committed to in the reporting year of the RPP or the DPR. If another type that is specific to the Department is introduced, an explanation of its meaning must be provided.

- Provided $14.6 million in funding and worked with the Mental Health Commission of Canada, other levels of government, NGOs, health professionals, communities and individuals to promote mental health system innovation in alignment with “Changing Directions, Changing Lives”, Canada’s national mental health strategy.
- Funded $6.7 million to the Brain Canada Foundation to create the Canada Brain Research Fund (CBRF) that supports Canadian neuroscience research to advance knowledge and treatment of brain diseases and mental disorders.
- Funded $16.4 million to the Canadian Agency for Drugs and Technologies in Health to inform health care decision-makers about the effectiveness and efficiency of health technologies.
- Enhanced collaboration with the Organization of Economic Co-operation and Development Health Committee in the development and implementation of its program, as it relates to health care system priorities in Canada and sharing of best practices.
- Funded $7.8 million to the Canadian Patient Safety Institute to accelerate the pace of improvement in patient safety.
- Provided guidance to the Canadian Foundation for Healthcare Improvement as it developed and launched its Spreading Healthcare Innovations Initiative.
- Provided $6 million in funding and guidance to the Health Council of Canada to maintain value-added tools, such as the Innovation Portal which highlights best practices in the health care system.

Health Canada coordinated its approach to health systems research, consulted across the Health Portfolio and academia, and strengthened in-house research capacity focused on health care system trends and impacts. The Department:

- Analyzed the emerging landscape of health care technology policy to identify potential areas for collaboration.
- Launched a series of projects, such as a Social Health Insurance project to contribute to the evidence base on home care and facility-based long-term care needs and costs in Canada; and a project to understand further the role of non-drug health technologies as a health system cost driver.
- Led an assessment of federally supported health data in collaboration with Statistics Canada, the Public Health Agency of Canada (PHAC) and the CIHI, identifying deficiencies in existing health data and key opportunities for improvement. This is the first step in developing a strategy to improve the health information available to health policy makers, program planners, and Canadians.

Priority	Type	Strategic Outcome(s) [and/or] Programs
Priority II – Modernize Health Protection Legislation and Programs	Ongoing	SO2 2.1 Health Products 2.2 Food Safety and Nutrition 2.3 Environmental Risks to Health 2.4 Consumer Product and Workplace Chemical Safety 2.5 Substance Use and Abuse 2.6 Radiation Protection 2.7 Pesticides

Summary of Progress

Health Canada regulates consumer products, food, pharmaceuticals, biologics, medical devices, natural health products, chemicals, radiation emitting devices, cosmetics, and pesticides. As well, Health Canada helps to manage the risks posed by environmental factors, and the health implications of air quality, water quality, radiation, and environmental contaminants. To manage rapid technological change, the advent of products that blur traditional definitions, and to incorporate innovative components, Health Canada continued to modernize its regulatory programs.

In 2013-14, 12 regulations were approved or amended by the Minister. The Department continued to advance the transformation of regulatory frameworks for food and health products into an aligned regulatory system that contributes directly to the safety of Canadians. Some significant initiatives were:

- Schedule F to the *Food and Drug Regulations*[xvi] is a list of drugs that require a prescription for human and veterinary use in Canada. This Schedule was repealed and replaced with the Prescription Drug List, a web-based list that is maintained administratively. Previously a regulatory amendment was required to add or remove a drug to Schedule F. As the new Prescription Drug List is not in the *Food and Drug Regulations*, updates can be done administratively. This non-regulatory approach to maintaining the List, makes it easier to update, resulting in operational efficiencies for Health Canada.
- A regulatory proposal to amend the *Food and Drug Regulations* was published in Canada Gazette Part I, respecting the labelling requirements for mechanically tenderized beef which would include safe cooking instructions in order to prevent foodborne illnesses.
- Launched the Plain Language Labelling Initiative to improve the safe use of drugs by making drug labels and safety information easier to read and understand including Revisions to Part III (Patient Medication Information) of the Product Monograph Guidance Document for Industry.
- New *Blood Regulations*[xvii] formalized Canada's internationally recognized best practices for safety requirements with respect to blood that is collected for transfusion or for use in the manufacture of a drug for human use.

Health Canada enhanced regulatory review and decision-making by building information technology infrastructure, such as the Common Electronic Submissions Gateway, which accepts a variety of electronic regulatory transactions. As of March 31, 2014, over 60% of the regulatory information managed by Health Products and Food Branch is electronic.

Health Canada continued to implement the *Canada Consumer Product Safety Act* (CCPSA), including:

- Increasing outreach activities.
- Increasing strategic monitoring and surveillance, which included the implementation of a transparent and evidence-based approach to the prioritization of reported incidents and the assessment of risks related to product hazards.

- Re-focusing compliance and enforcement activities at a facility level.
- Establishing a surveillance protocol for recalls.
- Implementing the Administrative Monetary Penalties (*Consumer Product Regulations*[xviii]), so that Health Canada has a flexible and responsive enforcement approach for dealing with specific incidences of non-compliance.

Health Canada and Canadian Border Services jointly launched a pilot to provide commercial traders with a single window to submit electronically all information required to comply with customs and other government regulations with the United States (U.S.) and European Union.

Health Canada hosted the 2nd North American Summit on Consumer Product Safety in September 2013, and achieved agreement on a new workplan of cooperation between Canada, the U.S. and Mexico, and conducted joint outreach and liaison activities with the U.S. Consumer Product Safety Commission and Mexico's Procuraduria Federal del Consumidor.

Health Canada undertook a series of initiatives to renew the regime for Medical Marijuana and implement the new *Marihuana[2] for Medical Purposes Regulations*[xix] (MMPR), which came into force in June 2013.

Health Canada developed with other North American and international regulators and industry partners, a scientific framework to better assess the potential risk of pesticides to pollinators, resulting in new best practices for managing treated seed.

Health Canada continued to further integrate and make consistent use of foreign regulatory information. Initiatives included:

- Participating in the International Conference on Harmonisation of Technical Requirements for Registration of Pharmaceuticals for Human Use.
- Collaborating on the Review of Generic Drugs with the Australian Therapeutic Goods Administration (TGA), the Heads of Agencies Consortium, Singapore's Health Sciences Authority and Swissmedic.
- Participating in the International Generic Drug Regulators Pilot focusing on active substance master files, biowaivers and work-sharing models.
- Working on the Asia Pacific Economic Cooperation Regulatory Harmonization Steering Committee promoting greater regulatory convergence and capacity building related to medical products.
- Co-hosting the Pan American Network for Drug Regulatory Harmonization Conference with the Pan American Health Organization.
- Participating in international standard committees for the development of standards and guidelines related to consumer products.
- Collaborating with U.S. regulatory counterparts to reduce regulatory burden for health products, and to align regulatory approaches for workplace chemicals.
- Using joint reviews to facilitate same time access to new pesticide technology for Canadian growers. For example, of six agricultural use active ingredients received, three of the registrants opted for global joint reviews in collaboration with international partners.

[2] While the Government of Canada has reverted to the original spelling of marijuana with a "j", the regulations are spelled with an "h" (i.e. marihuana) and can therefore not be changed.

Priority	Type	Strategic Outcome(s) [and/or] Programs
Priority III – Strengthen First Nations and Inuit Health Programming	Ongoing	SO3 3.1 First Nations and Inuit Primary Health Care 3.2 Supplementary Health Benefits for First Nations and Inuit 3.3 Health Infrastructure Support for First Nations and Inuit Internal Services (CFOB – IM/IT)

Summary of Progress

Health Canada worked with First Nations, Inuit, other federal departments and provincial and territorial partners to improve health outcomes, strengthen access to quality health services and support greater control of the health system by First Nations and Inuit.

Health Canada supported ongoing health system improvement through community capacity development. It developed health human resource solutions in collaboration with partners and stakeholders, with a focus on culturally relevant community-based care. This included health education bursaries/scholarships and internship/summer student work opportunities, and training for community based health care workers.

The Department invested in programs such as eHealth infrastructure to deliver modern primary and public health care services to geographically remote communities, making it possible for health care professionals to consult and collaborate with specialized health professionals, and increase their knowledge and skills through distance education.

Health Canada collaborated with provinces, territories, and First Nations and Inuit communities to enhance public health services. The Department worked on a national approach to address the high rates of blood-borne and sexually-transmitted infections in First Nations living on-reserve, with a particular focus on HIV/AIDS; developed the Monitoring and Performance Framework for tuberculosis programs as part of the early implementation of Health Canada's Strategy Against Tuberculosis for First Nations On-Reserve; completed a four-year Immunization Social Marketing Campaign; and assisted First Nations communities in enhancing their capacity to monitor drinking water quality by working closely with targeted communities.

Health Canada completed the implementation of the British Columbia (B.C.) Tripartite Framework Agreement on First Nations Health Governance realigning resources significantly within this strategic outcome (see Strategic Outcome III). In October 2013, the First Nations Health Authority (FNHA) assumed responsibility for the design and delivery of health programs previously provided by Health Canada's First Nations and Inuit Health Pacific Region.

Health Canada invested in programs relating to First Nations and Inuit mental wellness to improve the quality and availability of comprehensive mental health and addictions services. The Department, in partnership with key stakeholders, supported the development of the First Nations Mental Wellness Continuum Framework. This collaborative work involves a comprehensive mapping of existing mental health and addictions programming, including those focused on First Nations suicide prevention. Work also continued with the Inuit Tapiriit Kanatami and regions on a plan for development of an Inuit-specific mental wellness continuum approach.

Health Canada and Aboriginal Affairs and Northern Development Canada (AANDC) began to simplify and standardize policies, procedures and the management of transfer payments. For example, Health Canada and AANDC developed joint recipient audits and recipient audit protocols; established a single federal standardized financial reporting package, including audited consolidated financial statements for common recipients; and, developed a common management control framework and

default management approach.

Health Canada continued to fund supplementary health benefits to eligible First Nations and Inuit. As part of ongoing efforts to increase efficiencies, Health Canada centralized the administration of dental benefits in Ottawa, and worked to improve turnaround times for dental benefit approvals. In addition, as part of its prescription drug abuse (PDA) strategy, delisted or restricted opioids and other drugs subject to misuse, increased access to non-opioid medications, provided access to opioid addiction treatment where appropriate, and enhanced the Prescription Monitoring Program.

Priority	Type	Strategic Outcome(s) [and/or] Programs
Priority IV – Modernize communication to support transparent, innovative, and accessible information for Canadians	Ongoing	Internal Services (CPAB)

Summary of Progress

Canadians expect seamless access to the information they need to take action on their health and safety. Health Canada is committed to engaging Canadians so that its policies, programs, and services reflect citizen priorities and perspectives, and to using the internet and new technological tools to make information easily accessible.

Health Canada increased transparency and engagement with Canadians and stakeholders through innovative communication tools and approaches such as posting drug safety reviews, and using social media and web 2.0 tools to complement nutrition labelling consultations. In addition, Health Canada successfully developed and launched the Regulatory Transparency and Openness Framework and Action Plan and contributed to the Government of Canada's Open Government Initiative.

Health Canada is committed to developing innovative web-based communications solutions, products and tools. As part of the Government of Canada's Web Renewal Action Plan, Health Canada ensured all of its 35,000 web pages were made accessible so that all Canadians can get the information they need online. Health Canada also ensured that the Healthy Canadians website, which brings together all Government of Canada health-related information, is compliant with current web standards.

Health Canada worked to develop stronger capabilities to engage citizens in two-way, interactive communication that spreads across social media communities. This provides increasingly more integrated advice from a whole health portfolio perspective supporting the communications priorities and directions of the Minister of Health. To reach Canadians in relevant ways, the Healthy Canadians social media campaign expanded its social media platforms to include Pinterest, Twitter and YouTube in addition to its popular Facebook page which has over 35,700 fans.

Health Canada finalized the Consultation and Stakeholder Information Management System launch, complete with a training and communication strategy. This system will provide a single-window for stakeholder and citizen engagement and allow the department to improve its consultations. Health Canada also delivered a training workshop internally and to external stakeholders on the Consumer Product Safety Pilot Project.

Priority	Type	Strategic Outcome(s) [and/or] Programs
Priority V – Build a stronger, more adaptable organization, through strategic investments and business transformation	Ongoing	Internal Services (CSB – HR; CFOB – Finance, IM/IT, Real Property)

Summary of Progress

Health Canada continued to focus on the harmonization of internal services with the PHAC to provide streamlined, innovative service of high quality, and less cost to Canadians. Through the Shared Services Partnership, a Policy Harmonization Framework was developed outlining how internal service areas should proceed during the transition to a common set of policies and approaches.

Health Canada successfully delivered a major transformation initiative known as Procure to Pay (P2P). This initiative revolutionized the transactional environment for accounting and procurement by creating a single, integrated shared services platform serving both Health Canada and PHAC. P2P achieved the following objectives: re-engineered through enabling technology, the end-to-end accounting and procurement transaction processes for Health Canada and PHAC, operated by Health Canada as a shared service; eliminated “paper signatures” where possible and moved to a paperless environment, with integrated workflow and electronic approvals; consolidated 14 regional accounting sites into two national hubs; and regrouped the multiple and dispersed Health Canada and PHAC procurement teams across Canada into a more centralized, shared services procurement organization. The P2P initiative is yielding benefits in terms of efficiency and effectiveness and strengthened financial practices through the standardization of end to end business processes and the implementation of automated data validation and controls enhancing audit readiness.

An opening balanced audit was successfully conducted, which satisfies a past RPP commitment to ensure Health Canada is in the position to conduct a controls reliant audit of its financial statements, should it be called upon to do so.

Work on an integrated HR service delivery model saw the completion of the Common Human Resources Business Process project. Designed to streamline and standardize Human Resources processes, the project also enables process efficiencies, clearly defines people management roles and responsibilities and drives strategic decision-making in all areas of HR business. Health Canada also completed several horizontal initiatives including the implementation of the Employee Performance Management initiative, the government-wide Pay Consolidation project and Regional Operations Alignment.

An Application Portfolio Management Framework was developed to define the process for creating an evolving Health Canada/PHAC IT applications inventory, and an initial assessment of all applications completed.

Through the implementation of the National Accommodation Strategy, Health Canada delivered a number of office modernization projects nationwide for both Health Canada and PHAC. Several of these projects surpassed government timelines, allowing the Department to realize $4.3 million in savings in March 2014, a year ahead of schedule. The optimization of departmental office space has allowed consolidation of client groups and the divestiture of rentable lease spaces at targeted locations in the National Capital Region.

The regional projects completed in support of the B.C. Tripartite Framework Agreement were key to accommodating the transfer of federal health programs to the First Nations Health Authority.

Risk Analysis

The following table describes the key risks identified by Health Canada as having the highest likelihood and impact on program delivery in 2013-14 and examples of how the Department responded to those risks.

Key Risks

Risk	Risk Response Strategy	Link to Program Alignment Architecture
Risks exist with design and reform of regulatory systems to ensure effectiveness and sustainability	• Continued to implement the Regulatory Roadmap. • Continued to implement international regulatory best practices. • Worked collaboratively with international partners to effectively harmonize regulatory processes where appropriate.	SO2
Risks exist with health services delivery innovation, regional transformation and linkages to local health delivery systems	• Aligned program/service delivery with provincial systems. • Continued to align grants and contributions programs with AANDC. • Continued to implement health outcome data collection tools. • Developed new indicators to measure progress. • Enhanced business planning processes for First Nations and Inuit.	SO3
Risks exist with the ability to deliver relevant, effective and timely communications and engagements with stakeholders, clients, and the public	• Continued to implement Open Government Strategy with a focus to improve public access to health and safety information online. • Developed a corporate consultation and stakeholder information management and reporting system. • Developed a risk-based, fast-track communication and approval process. • Developed media relations and regional outreach approaches. • Worked to build an accessible, relevant, end-user oriented web presence.	SO1 SO2 SO3 Internal Services

Risk	Risk Response Strategy	Link to Program Alignment Architecture
	• Developed and launched the Regulatory Transparency and Openness Framework and Action Plan.	
Risks exist with implementing innovations in grants and contributions delivery to Canadians	• Continued to implement harmonized common risk management and reporting requirements for grants and contributions. • Standardized grants and contributions management. • Enhanced use of multi-departmental agreements including horizontal terms and conditions. • Developed shared accountability requirements. • Adopted innovative evaluation techniques. • Continued to transform and harmonize financial and grants and contributions systems with AANDC.	SO1 SO2 SO3 Internal Services

Risk Narrative

Effective risk management practices equipped Health Canada to respond proactively to change and uncertainty by using risk-based approaches and information to enable more effective decision-making throughout the organization. In 2013-14, the Department made significant improvements in the way it manages its corporate risks. The 2013-14 Corporate Risk Profile renewal process focused on greater senior management involvement, as well as on developing more robust risk responses.

Internal and external pressures had the potential to impact the Department as it delivered its programs and services, such as: new therapies and medications; scientific and technological change; unpredictable global economic conditions; unforeseen potential health crises; changing lifestyles and demographics; and the aging work population. These pressures were taken into account during the risk identification and voting exercise. The risks and risk responses identified above were also listed in the RPP, and served to inform prioritization, decision-making, and resource allocation, with a focus on strategic outcomes and long-term priorities.

Health Canada managed its key risks in a variety of ways. For example, in order to ensure regulatory and policy consistency with international partners, Health Canada continued to coordinate with its international counterparts and share best practices to effectively align regulatory processes. The Department remained flexible in adapting to changes to the regulatory environment and lessons learned throughout 2013-14.

Additionally, Health Canada continued to take steps to effectively manage risks around greater alignment and integration of First Nations and Inuit health care with provincial health systems and local health delivery organizations. As the Department moves forward with the implementation of its transformation agenda, its actions will reflect lessons learned, including: the continued importance of maintaining an effective relationship with our partners and stakeholders; early engagement on key issues and priorities; and, recognizing the inherent challenges with applying a nationally-based solution to a regional issue.

Finally, Canadians increasingly expected to communicate with Health Canada and receive up-to-date health information through the internet and other social media. Health Canada continued to provide timely and evidence-based health and safety information to meet public, client, and stakeholder expectations.

Actual Expenditures

Budgetary Financial Resources (dollars)

2013-14 (Main Estimates)	2013-14 Planned Spending	2013-14 Total Authorities Available for Use	2013-14 Actual Spending (authorities used)	Difference (actual minus planned)
3,292,207,430	3,301,143,553	3,947,321,110	3,828,179,497	527,035,944

Note: The variance of $527.0 million includes an increase of $646.2 million between planned spending and total authorities, which is offset by a decrease of $119.1 between total authorities and actual spending.

The increase of $646.2 million is mainly due to the receipt of in-year funding through Supplementary Estimates and from the Department's operating budget carry forward that was allocated to fund strategic investments in IM/IT and Real Property. The total authorities were also supplemented by payments required by collective agreements, statutory items, and the reimbursement of paylist expenditures.

The $119.1 variance is mainly related to lower than projected demand for Non-Insured Health Benefits, cost savings made in the Non-Insured Health Benefits (NIHB) Pharmacy benefit, as well as a portion of the operating budget that was carried forward to support strategic investments in 2014-15.

Human Resources (Full-time Equivalents [FTEs])

2013-14 Planned[3]	2013-14 Actual	2013-14 Difference (actual minus planned)
9,375	9,160	-215

Note: The variance in FTE utilization is mainly the result of savings achieved sooner than expected from simplifying and streamlining operations while maintaining or enhancing services to Canadians.

Budgetary Performance Summary for Strategic Outcomes and Programs (dollars)

Strategic Outcomes, Programs and Internal Services	2013-14 Main Estimates	2013-14 Planned Spending	2014-15 Planned Spending	2015-16 Planned Spending	2013-14 Total Authorities Available for Use	2013-14 Actual Spending (authorities used)	2012-13 Actual Spending (authorities used)	2011-12 Actual Spending (authorities used)
Strategic Outcome 1: A health system responsive to the needs of Canadians								
1.1 Canadian Health System Policy	294,238,083	296,189,883	244,186,030	238,002,805	375,031,600	353,877,280	405,697,982	371,307,898
1.2 Specialized Health Services	21,939,744	21,939,744	18,728,166	18,840,212	17,981,606	16,475,781	19,926,803	22,342,044
1.3 Official Language Minority Community Development	23,752,874	23,752,874	37,527,825	37,527,598	26,252,493	25,830,789	39,011,188	38,954,051

[3] While the total planned FTE amount is accurate, a realignment of planned FTEs at a lower level is needed to reflect current business requirements.

Strategic Outcomes, Programs and Internal Services	2013-14 Main Estimates	2013-14 Planned Spending	2014-15 Planned Spending	2015-16 Planned Spending	2013-14 Total Authorities Available for Use	2013-14 Actual Spending (authorities used)	2012-13 Actual Spending (authorities used)	2011-12 Actual Spending (authorities used)
Sub-Total	339,930,701	341,882,501	300,442,021	294,370,615	419,265,699	396,183,850	464,635,973	432,603,993
Strategic Outcome 2: Health risks and benefits associated with food, products, substances, and environmental factors are appropriately managed and communicated to Canadians								
2.1 Health Products	156,037,552	156,763,818	152,060,884	149,855,419	179,564,906	179,564,797	164,654,898	177,232,253
2.2 Food Safety and Nutrition	51,402,965	54,154,918	59,175,139	59,092,172	71,238,986	71,238,491	69,655,161	67,876,527
2.3 Environmental Risks to Health	109,816,852	109,816,852	102,849,859	99,641,612	107,621,366	101,141,190	103,655,546	105,098,576
2.4 Consumer Product and Workplace Chemical Safety	30,713,667	31,439,933	37,725,014	37,287,118	36,455,580	35,535,627	28,148,044	27,660,103
2.5 Substance Use and Abuse	84,926,070	85,652,336	82,748,939	82,311,043	88,593,095	88,591,578	115,533,278	123,029,291
2.6 Radiation Protection	14,963,096	15,689,362	20,522,668	20,565,167	21,421,594	21,420,658	15,303,974	14,034,921
2.7 Pesticides	40,442,256	41,168,522	40,651,125	40,214,339	47,823,266	46,299,835	42,148,137	46,821,505
Sub-Total	488,302,458	494,685,741	495,733,628	488,966,870	552,718,793	543,792,176	539,099,038	561,753,176
Strategic Outcome 3: First Nations and Inuit communities and individuals receive health services and benefits that are responsive to their needs so as to improve their health status								
3.1 First Nations and Inuit Primary Health Care	954,094,539	954,094,539	853,702,552	772,090,493	931,062,884	927,125,272	945,580,413	949,048,229
3.2 Supplementary Health Benefits for First Nations and Inuit	1,017,260,925	1,017,260,925	1,133,324,859	1,084,380,043	1,113,116,336	1,071,034,484	1,140,213,493	1,111,497,049
3.3 Health Infrastructure Support for First Nations and Inuit	231,648,633	231,648,633	604,177,779	612,878,547	525,566,179	525,066,806	356,715,000	351,559,090
Sub-Total	2,203,004,097	2,203,004,097	2,591,205,190	2,469,349,083	2,569,745,399	2,523,226,562	2,442,508,906	2,412,104,368
Internal Services								
Sub-Total	260,970,174	261,571,214	271,531,249	264,293,347	405,591,219	364,976,909	374,914,169	379,838,149
Total								
	3,292,207,430	**3,301,143,553**	**3,658,912,088**	**3,516,979,915**	**3,947,321,110**	**3,828,179,497**	**3,821,158,086**	**3,786,299,686**

At the outset of the 2013-14 fiscal year, Health Canada's planned spending was $3,301.1 million. Primarily through Main Estimates and Supplementary Estimates, Health Canada was allocated total authorities of $3,947.3 million. Actual Health Canada spending was $3,828.2 million.

The $8.9 million increase from Main Estimates to planned spending in 2013-14 is due to funding: for the Mood Disorders Society of Canada; to streamline government import regulations and border processes for commercial trade; and to continue enhancing the ability to prevent, detect and respond to food-borne illness outbreaks.

The $646.2 million increase from planned spending to total authorities in 2013-14 is mainly due to funding received for: the support of First Nations and Inuit Health Programs and Services; the support of the implementation of the British Columbia (B.C.) Tripartite Framework Agreement for the transfer to the First Nations Health Authority; the departmental operating budget carry forward; collective agreements; statutory items; and reimbursement of paylist expenditures.

The $119.1 million difference between total authorities and actual spending in 2013-14 is mainly the result of NIHB expenditures being lower due to lesser than expected client uptake by new eligible client populations (i.e. those registered under the provisions of the *Gender Equity in Indian Registration Act*[xx], or those who became eligible for NIHB as a result of the creation of the Qalipu Mi'kmaq Band). There was significant cost avoidance in the NIHB Pharmacy benefit resulting from greater usage of lower cost generic drugs. Also, a portion of the Department's operating budget was carried forward to support strategic investments in 2014-15.

Alignment of Spending With the Whole of Government Framework

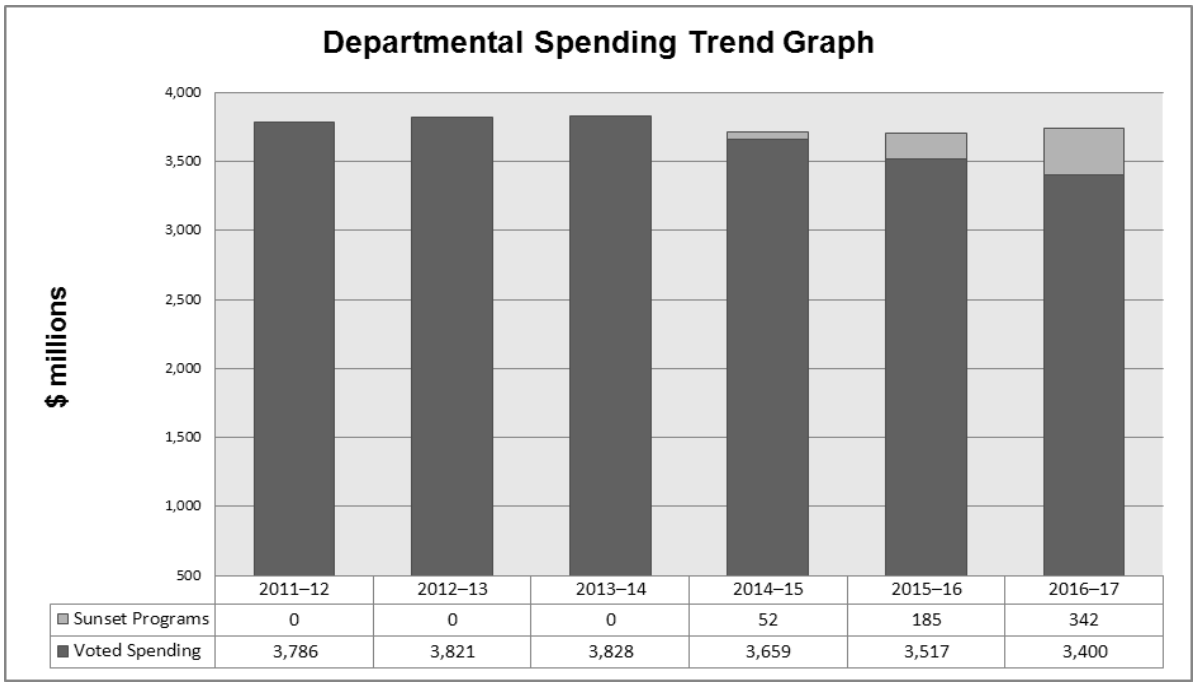
Alignment of 2013-14 Actual Spending With the Whole-of-Government-Framework[xxi] (dollars)

Strategic Outcome	Program	Spending Area	Government of Canada Outcome	2013-14 Actual Spending
SO 1 A health system responsive to the needs of Canadians	1.1 Canadian Health System Policy	Social Affairs	Healthy Canadians	353,877,280
	1.2 Specialized Health Services	Social Affairs	Healthy Canadians	16,475,781
	1.3 Official Language Minority Community Development	Social Affairs	Healthy Canadians	25,830,789
SO 2 Health risks and benefits associated with food, products, substances, and environmental factors are appropriately managed and communicated to Canadians	2.1 Health Products	Social Affairs	Healthy Canadians	179,564,797
	2.2 Food Safety and Nutrition	Social Affairs	Healthy Canadians	71,238,491
	2.3 Environmental Risks to Health	Social Affairs	Healthy Canadians	101,141,190
	2.4 Consumer Product and Workplace Chemical Safety	Social Affairs	Healthy Canadians	35,535,627
	2.5 Substance Use and Abuse	Social Affairs	Healthy Canadians	88,591,578
	2.6 Radiation Protection	Social Affairs	Healthy Canadians	21,420,658
	2.7 Pesticides	Social Affairs	Healthy Canadians	46,299,835
SO 3 First Nations and Inuit communities and individuals receive health services and benefits that are responsive to their needs so as to improve their health status	3.1 First Nations and Inuit Primary Health Care	Social Affairs	Healthy Canadians	927,125,272
	3.2 Supplementary Health Benefits for First Nations and Inuit	Social Affairs	Healthy Canadians	1,071,034,484
	3.3 Health Infrastructure Support for First Nations and Inuit	Social Affairs	Healthy Canadians	525,066,806

Total Spending by Spending Area (dollars)

Spending Area	Total Planned Spending	Total Actual Spending
Economic Affairs		
Social Affairs	3,039,572,339	3,463,202,588
International Affairs		
Government Affairs		

Departmental Spending Trend



Note: The additions to planned voted spending reflect estimated renewals of certain sunsetting programs, which are under further review and consideration by the government. The reduction of planned spending from previous years is mainly due to continued savings, and the exclusion of in-year Treasury Board Votes and statutory funding.

In 2013-14, Health Canada spent $3,828.2 million to meet expected program activity results and contribute to the achievement of departmental strategic outcomes. The figure above illustrates Health Canada's spending trend from 2011-12 to 2016-17.

For the 2011-12 to 2013-14 period, voted spending represents total authorities used as shown in the Public Accounts of Canada.

For the 2014-15 to 2016-17 period, voted spending corresponds to planned spending which excludes in-year funding from Supplementary Estimates, statutory funding, and carry forward adjustments.

Estimates by Vote

For information on Health Canada's organizational Votes and statutory expenditures, consult the *Public Accounts of Canada 2014*[xxii] on the Public Works and Government Services Canada website.

Section II: Analysis of Programs by Strategic Outcomes

Strategic Outcome 1: A health system responsive to the needs of Canadians

Program 1.1: *Canadian Health System Policy*

Description

The Canadian Health System Policy program provides strategic policy advice, research, and analysis to support decision-making on health care system issues, as well as program support to provinces and territories, partners, and stakeholders on health care system priorities.

Mindful of equity, sustainability, and affordability Health Canada collaborates and targets its efforts in order to support improvements to the health care system such as improved access, quality, and integration of health care services.

Through the management of grants and contributions agreements with key pan-Canadian health partners, the Canadian Health System Policy program contributes to priority health issues requiring national leadership and strong partnership.

The program objective is to support innovative health care policy and programs to help Canadians maintain and improve their health.

Budgetary Financial Resources (dollars)

2013-14 Main Estimates	2013-14 Planned Spending	2013-14 Total Authorities Available for Use	2013-14 Actual Spending (authorities used)	2013-14 Difference (actual minus planned)
294,238,083	296,189,883	375,031,600	353,877,280	57,687,397

Note: The variance of $57.7 million includes an increase of $78.8 million between planned spending and total authorities, mainly due to statutory grant funding for electronic health information communication technologies. This is offset by a decrease of $21.2 million between total authorities and actual spending, mainly due to surpluses in the Canada Brain Research Fund (CBRF) and the Health Care Policy Program, as well as internal reallocations of funding between programs.

Human Resources (Full-Time Equivalents [FTEs])

2013-14 Planned	2013-14 Actual	2013-14 Difference (actual minus planned)
267	126	-141

Note: The variance in FTE utilization is mainly due to a reduction in staff as a result of savings achieved through simplifying and streamlining operations and the transfer of various programs to Public Health Agency of Canada (PHAC) including the responsibility for services related to emergency management and international affairs as part of the Health Portfolio Shared Services Partnership. Reductions in FTEs were achieved through attrition and voluntary departures.

Performance Results

Expected Results	Performance Indicators	Targets	Actual Results
Acts as a catalyst to address current and emerging health issues and priorities.	# of actions taken (e.g., grant and contribution signed) to respond to current and emergent issues.	6 by March 31, 2014	6

Performance Analysis and Lessons Learned

Health Canada successfully advanced health care innovation as an area of policy priority, building interest and generating connections in the health care community and other sectors. Health Canada managed new and existing funding agreements that advanced priority health issues, including the following funding:

- $6.5 million over three years for McMaster University in support of innovative approaches to team based care, health care performance solutions and integration of electronic records.
- $3 million for a Pallium Foundation of Canada initiative to equip more front-line health care providers with the skills and knowledge needed to provide quality palliative care in a range of settings for people with life-threatening conditions.
- $1.6 million for the Canadian Medication and Incident Reporting and Prevention System project, through the Health Care Policy Contribution Program, to generate evidence on medication incidents in order to improve patient safety.
- $5 million for the first year of a five-year agreement for the Canadian Blood Services (CBS) to work on blood research and development.
- $14.6 million for the Mental Health Commission of Canada and $1.6 million for the Mood Disorders Society of Canada in support of mental health research, policy development and collaboration with provinces and territories to improve mental health in Canada.
- $6.7 million to support the CBRF, which is managed by Brain Canada, an organization dedicated to advancing cutting-edge brain research.
- $3.43 million to CBS in the final year of the Organ and Tissue Donation and Transplantation (OTDT) program agreement.

In 2013-14, the Deputy Minister approved an evaluation of Canadian Blood Services Grants and Contributions Programs 2008-2009 to 2012-13[xxiii].

Sub-Program 1.1.1: *Health System Priorities*

Description

Through the Health System Priorities program, Health Canada works closely with provincial and territorial governments, domestic and international organizations, health care providers, and other stakeholders to develop and implement innovative approaches, improve accountability, and responses to meet the health priorities and health services needs of Canadians. Key activities include increasing the supply of health professionals, timely access to quality health care services, and accelerating the development and implementation of electronic health technologies.

The program also manages grants and contributions agreements on a number of health care priorities, such as Canada Health Infoway (Infoway), the Canadian Institute for Health Information, Mental Health Commission of Canada, and the Canadian Partnership against Cancer, to support health care services for all Canadians.

The program objective is to ensure that Canadians have access to quality and cost-effective health care services.

Budgetary Financial Resources (dollars)

2013-14 Planned Spending	2013-14 Actual Spending	2013-14 Difference (actual minus planned)
294,442,000	352,078,271	57,636,271

Note: The variance between planned and actual spending is due to the inclusion of statutory grant funding for electronic health information communication technologies, offset by a surplus in the contribution agreement to establish the CBRF.

Human Resources (FTEs)

2013-14 Planned	2013-14 Actual	2013-14 Difference (actual minus planned)
252	111	-141

Note: The variance in FTE utilization is mainly due to a reduction in staff as a result of savings achieved through simplifying and streamlining operations and the transfer of various programs to the PHAC including responsibility for services related to emergency management and international affairs as part of the Health Portfolio Shared Services Partnership. Reductions in FTEs were achieved through attrition and voluntary departures.

Performance Results

Expected Results	Performance Indicators	Targets	Actual Results
Improved and maintained strategic	# and type of new/ maintained and/or	10 by March 31, 2014	62

Expected Results	Performance Indicators	Targets	Actual Results
partnerships with key national P/T regional partners (e.g., through funding such as grants and contributions) to advance health system priorities.	improved collaborative working arrangements and/or agreements between Government of Canada, provinces/ territories and stakeholders to advance health system renewal.		

Performance Analysis and Lessons Learned

In 2013-14, Health Canada planned to complete 10 new funding and collaborative working agreements but was able to establish 62 agreements with partners. The number of agreements completed was higher than anticipated due to renewal of time limited funding agreements and extensions of on-going and annual initiatives. Collaboration was strengthened through funding and close working relationships with a variety of partners including provinces, territories, academic institutions, and non-governmental organizations (NGOs).

Health Canada continued its work with (Infoway) to advance innovation in the health system by collaborating with partners to support the implementation of electronic records and related technologies. As of March 2014, Infoway has supported the enrolment of more than 16,000 clinicians in jurisdictional programs for physician office systems. Additional information is available in Infoway's Annual Report[xxiv].

The Canadian Partnership against Cancer (CPAC) is receiving funding of $241 million over five years ending in 2017. CPAC has advanced cancer control in Canada, yielding health system improvements including enhanced development and implementation of knowledge, best practices and guidelines.

Health Canada funding to the Canadian Institute for Health Information (CIHI) supported the development and launch of an interactive website to help Canadians understand how well their health care system is performing according to 15 performance indicators. CIHI also released the *Mental Health and Addictions Data and Information Guide* to help individuals and health care organizations access mental health and addictions information.

Health Canada continued to invest in mental health through funding for the Mood Disorders Society of Canada, which established the Canadian Depression Research and Intervention Network. The Network launched three Depression Hubs in March 2014 to advance research on depression and post-traumatic stress disorder.

The Brain Canada Foundation will receive funding of up to $100 million over six years ending in 2017, for the creation of the CBRF to advance knowledge and treatment of brain diseases and mental disorders. For example in April 2013, five teams were awarded funding of $1.5 million each over three years, as a part of the W. Garfield Weston Foundation-Brain Canada Multi-Investigator Research Initiative.

In 2013-14, the Deputy Minister approved the following evaluations: Health Care Policy Contribution Program[xxv]; Health Information Initiative 2007-08 to 2011-12[xxvi]; Synthesis Evaluation of Transfer Payments to Pan-Canadian Organizations 2008-09 to 2012-13[xxvii]; and, Health Canada's Transfer Payment to the Rick Hansen Foundation 2007-08 to 2012-13[xxviii].

Sub-Program 1.1.2: *Canada Health Act Administration*

Description

The administration of the *Canada Health Act* (CHA) involves monitoring a broad range of sources to assess the compliance of provincial and territorial health insurance plans with the criteria and conditions of the Act, working in partnership with provincial and territorial governments to investigate and resolve concerns which may arise, providing policy advice and informing the Minister of possible non-compliance with the Act, recommending appropriate action when required, and reporting to Parliament on the administration of the Act.

The program objective is to facilitate reasonable access to insured health care services without financial or other barriers.

Budgetary Financial Resources (dollars)

2013-14 Planned Spending	2013-14 Actual Spending	2013-14 Difference (actual minus planned)
1,747,883	1,799,009	51,126

Note: The variance between planned and actual spending is mainly due to paylist requirements[4].

Human Resources (FTEs)

2013-14 Planned	2013-14 Actual	2013-14 Difference (actual minus planned)
15	15	0

Performance Results

Expected Results	Performance Indicators	Targets	Actual Results
Provincial and territorial compliance with the requirements of the CHA.	% of CHA compliance issues concluded.	100 by March 31, 2014	67

[4] Paylist Requirements include funds for parental benefits, severance pay and vacation credits payable upon termination of employment with the Public Service.

Performance Analysis and Lessons Learned

In order to administer the Canada Health Act (CHA), Health Canada works collaboratively with the provinces and territories to investigate and resolve compliance issues and pursue activities that encourage compliance with the Act. In instances where a CHA issue has been identified but remain unresolved after initial enquiries, Division officials ask the jurisdiction in question to investigate the matter and report back. During 2013-14, nine compliance issues were addressed, with six being concluded (i.e. 67%). Three are still under review. These issues were identified late in the fiscal year and investigations and ensuing resolution, if required, often take more than 12 months to complete. For the most part, compliance issues arise from additional patient charges imposed by providers of insured health services (e.g., hospitals, clinics and physicians). In some instances other program criteria, such as comprehensiveness, portability and accessibility, are involved.

In line with the Canadian Health System program objective, the aim of the CHA is to facilitate reasonable access to medically necessary hospital and physician services for all Canadians. The Act sets out the criteria and conditions provinces and territories must comply with to receive the full amount of the Canada Health Transfer they are entitled to during a given fiscal year.

CHA compliance issues that are considered for the purpose of this reporting exercise are those that were raised or resolved during the reporting period, as well as ongoing issues that resulted in the application of deductions to Canada Health Transfer payments to a province or territory. Issues are considered concluded once a province or territory has made a commitment to take action to correct the compliance issue.

The responsibility for ensuring that providers of insured services operate in compliance with the requirements of the Act rests with the provinces and territories. Health Canada does not have jurisdiction over providers of insured services, nor does it have formal investigative powers to collect information on various practices that may be inconsistent with the requirements of the Act. As a result, federal officials must work collaboratively with their provincial and territorial counterparts to investigate and resolve compliance issues. Compliance investigations are complex and often sensitive in terms of privacy. They often require extensive fact-finding research and negotiations between government officials and providers of services.

Program 1.2: *Specialized Health Services*

Description

The Specialized Health Services program supports the Government of Canada’s obligation to protect the health and safety of its employees and the health of visiting dignitaries.

Health Canada delivers counselling, organizational development and critical incident support services to federal government departments through a network of contracted mental health professionals and also provides immediate response to employees following traumatic incidents in the workplace.

Health Canada delivers medical services to federal public servants who may be exposed to specific health risks due to their type of work. By providing occupational and psycho-social health services to federal public servants, Health Canada pro-actively contributes to reducing the number of work days lost to illness across the federal government.

Health Canada also arranges for the provision of health services for Internationally Protected Persons (IPP) who have come to Canada for international events, such as meetings or official visits by government leaders or the Royal Family. An IPP is a representative of a State, usually Heads of State and/or Government, members of the Royal Family, or officials of an international organization of an inter-governmental character.

The program objective is to ensure continuity of services and the occupational health of federal public servants who can deliver results to Canadians in all circumstances and to arrange health services for IPPs.

Budgetary Financial Resources (dollars)

2013-14 Main Estimates	2013-14 Planned Spending	2013-14 Total Authorities Available for Use	2013-14 Actual Spending (authorities used)	2013-14 Difference (actual minus planned)
21,939,744	21,939,744	17,981,606	16,475,781	-5,463,963

Note: The variance of $5.5 million between planned spending and actual spending is mainly due to reallocations of funding to other programs, and a lower than expected demand for psychologist and mental health service providers for the Employee Assistance Program and related services, which resulted in lower than anticipated spending.

Human Resources (Full-Time Equivalents [FTEs])

2013-14 Planned	2013-14 Actual	2013-14 Difference (actual minus planned)
288	185	-103

Note: The variance in FTE utilization is mainly due to a refocused service delivery mandate and restructuring of operations. Reductions in FTEs were achieved through attrition and voluntary departures. The reduced FTEs resulted in greater efficiencies from the realignment of the Public Service Occupational Health Program (PSOHP).

Performance Results

Expected Results	Performance Indicators	Targets	Actual Results
Federal employees are able to manage their psycho-social issues during and immediately following, stressful or traumatic events.	% of psycho-social cases that are closed within 8 Employee Assistance Program sessions.	70 by March 31, 2014	94.8
Reduced absenteeism in the workplace for employees who access Employee Assistance Services (EAS).	% reduction in absenteeism in the 30 days that follow an employee's last Employee Assistance	25 by March 25, 2014	43.5

Expected Results	Performance Indicators	Targets	Actual Results
	Program session versus the 30 days prior.		
IPP have access to health services and medical treatment they might require when they are in Canada for regular visits or to participate in major International events.	% of cases examined in which support provided was rated as acceptable or strong (client assessment).	100 by March 31, 2014	100

Performance Analysis and Lessons Learned

Health Canada continued to provide occupational health and psycho-social support to public servants to ensure continuity of service to Canadians. Overall, the program met the targets of the PSOHP, EAS and the IPP program.

Health Canada saw an increase in Health Evaluations and Communicable Disease Services in comparison to 2012-13. A client feedback survey conducted on PSOHP services received a high response rate and indicated a 92% satisfaction rate with services provided. In addition, Health Canada, in partnership with the Department of Foreign Affairs, Trade and Development, launched a pilot to streamline health evaluations for public servants and those selected for non-hardship overseas posts, and initial results are positive.

Health Canada negotiated additional Interdepartmental Letters of Agreements (Employee Assistance Program service contracts) with Correctional Services Canada Quebec and Ontario Regions, Atlantic Canada Opportunities Agency, Enterprise Cape Breton Corporation and the Military Police Complaints Committee. In addition, EAS received its third consecutive accreditation via the Council on Accreditation (COA). COA accreditation signifies the highest level of service quality and organizational performance in the EAS industry.

EAS experienced significant growth in business volume in the 2012-13 because of workforce adjustments in the federal public service. Estimated revenue projections for 2013-14 were lower than the previous year due to the expected decrease in the number of service requests. The revenue for 2013-14 was $12.2 million, approximately a 4% reduction from the previous year. Health Canada managed this situation effectively since the decrease in revenue resulted in a decrease in operational costs.

Health Canada developed 128 health contingency plans for IPP and their families visiting Canada in 2013-14.

Program 1.3: *Official Language Minority Community Development*

Description

The Official Language Minority Community Development program involves the administration of Health Canada's responsibilities under Section 41 of the *Official Languages Act*[xxix]. This Act commits the federal government to enhancing the vitality of Official Language Minority Communities (OLMC) and fostering the full recognition and use of English and French in Canadian society.

This program includes: consulting with Canada's OLMC on a regular basis; supporting and enabling the delivery of contribution programs and services for OLMC; reporting to Parliament and Canadians on Health Canada's achievements under Section 41; and, coordinating Health Canada's activities and awareness in engaging and responding to the health needs of OLMC.

The program objectives are to improve access to health services in the OLMC and to increase the use of both official languages in the provision of health care services.

Budgetary Financial Resources (dollars)

2013-14 Main Estimates	2013-14 Planned Spending	2013-14 Total Authorities Available for Use	2013-14 Actual Spending (authorities used)	2013-14 Difference (actual minus planned)
23,752,874	23,752,874	26,252,493	25,830,789	2,077,915

Note: The variance of $2.1 million between planned spending and actual spending is mainly due to an increase of funding received through Supplementary Estimates to promote official languages and enhance the vitality of official-language minority communities under the Roadmap for Canada's Linguistic Duality.

Human Resources (Full-Time Equivalents [FTEs])

2013-14 Planned	2013-14 Actual	2013-14 Difference (actual minus planned)
10	7	-3

Note: The variance in FTE utilization is the result of simplifying and streamlining operations to focus on core activities related to access to health care in the minority languages of Canadians.

Performance Results

Expected Results	Performance Indicators	Targets	Actual Results
OLMC have access to health care services in the official language of their choice.	# of health professionals who have successfully completed training programs (funded by Health Canada).	1,900 by March 31, 2014	2,318
	% of program trained health professionals who are retained.	86 by March 31, 2014	86

Performance Analysis and Lessons Learned

The Official Languages Health Contribution Program (OLHCP) supports health projects focusing on access to health care in official language minority communities. Treasury Board renewed the OLHCP for a five-year period on November 28, 2013. During 2013-14, there were 29 active contribution agreements in place, of which 15 were one-year extensions of prior ongoing commitments while Health Canada awaited program renewal approval. Funding for recipients of the program totalled $24.9 million and recipients received payments in a timely manner.

In 2013-14, Health Canada implemented actions to respond to an evaluation of its previous program by engaging stakeholders nationwide to propose new approaches for improving the availability of bilingual health human resources. An open call for proposals, which closed on January 31, 2014, yielded 96 project proposals in response to the challenge of engaging human resources initiatives in regions where official languages minority communities and their supporting institutions are less concentrated.

In 2013-14, the Deputy Minister approved the evaluation of the Official Languages Health Contribution Program 2008-12[xxx].

Strategic Outcome 2: Health risks and benefits associated with food, products, substances, and environmental factors are appropriately managed and communicated to Canadians

Program 2.1: *Health Products*

Description

The *Department of Health Act*, and the *Food and Drugs Act* and Regulations provide the authority for Health Canada to develop, maintain, and implement a regulatory framework associated with a broad range of health products that affect the everyday lives of Canadians, including pharmaceutical drugs, biologics and radiopharmaceuticals, medical devices, and natural health products.

Health Canada verifies that the regulatory requirements for the safety, quality, and efficacy of health products are met through risk assessments, including monitoring and surveillance, compliance, and enforcement activities.

In addition, Health Canada provides evidence-based, authoritative information to Canadians and key stakeholders, including health professionals such as physicians, pharmacists and natural health practitioners, to enable them to make informed decisions.

The program objective is for Canadians to have access to health products that are safe, effective, and of high quality.

Budgetary Financial Resources (dollars)

2013-14 Main Estimates	2013-14 Planned Spending	2013-14 Total Authorities Available for Use	2013-14 Actual Spending (authorities used)	2013-14 Difference (actual minus planned)
156,037,552	156,763,818	179,564,906	179,564,797	22,800,979

Note: The variance of $22.8 million between planned spending and total authorities as well as actual spending is mainly due to paylist requirements (please refer to footnote 4 for explanation of paylist requirements), collective agreement increases, and reallocations of funding from other programs to the Natural Health Product program.

Human Resources (Full-Time Equivalents [FTEs])

2013-14 Planned	2013-14 Actual	2013-14 Difference (actual minus planned)
2,130	1,867	-263

Note: The variance in FTE utilization is mainly due to lower than projected demand for regulatory reviews in 2013-14 and the resulting realignment of staffing to match workload.

Performance Results

Expected Results	Performance Indicators	Targets	Actual Results
Health products available to Canadians on the Canadian market are safe and effective.	% of regulated parties that are deemed to be in compliance with the *Food and Drugs Act* and its associated Regulations through the Inspection Programs.	95 by March 31, 2014	98

Performance Analysis and Lessons Learned

Health Canada is responsible for compliance and enforcement of legislation and regulations related to the safe production, distribution and/or use of drugs, biologics, medical devices and natural health products. Domestic inspections are conducted for Drug, Medical Device and Blood Tissues Organs and Xenografts establishments, but not for Natural Health Product establishments at this time.

Health Canada continued to modernize health product frameworks to achieve an efficient, sustainable and transparent regulatory system. Highlights include:

- Proposed new patient safety legislation, known as the *Protecting Canadians from Unsafe Drugs Act*[xxxi] (Vanessa's Law), which enables the Government of Canada to require mandatory adverse drug reaction reporting for health care institutions, to recall unsafe products, and to compel drug companies to revise labels to clearly reflect health risk information and do further testing on a product when issues are identified with certain at-risk populations such as children. Health Canada consulted with patients, health care providers and industry on the issues addressed by this new legislation.
- Health Canada published *Regulations Amending Certain Regulations Concerning Prescription Drugs*[xxxii]. These amendments repealed Schedule F and replaced it with the Prescription Drug List, a web-based list of drugs that require a prescription for human and veterinary use. They also provide the scientific criteria the Minister must consider in maintaining the Prescription Drug List. Previously a regulatory amendment was required to add or remove a drug to Schedule F. As the new Prescription Drug List is not in the *Food and Drug Regulations*, updates can be done administratively. This non-regulatory approach to maintaining the List, makes it easier to update, resulting in operational efficiencies for Health Canada. The amendments came into effect on December 19, 2013. Since that time, drugs have been added to the Prescription Drug List and removed to become non-prescription products in a timely, transparent manner using significantly fewer resources than were required to update Schedule F.
- The Department continued policy development, including further consultation on a proposed dedicated regulatory framework for veterinary drugs, including discussions at the Canadian Animal Health Products Regulatory Advisory Committee.

International Cooperation

- Health Canada and the U.S. Food and Drug Administration (FDA) cooperated on a draft Labelling Standard for Non-prescription Oral Adult Antihistamine. It is ready for posting in tandem with the FDA.
- Health Canada and the Australian Therapeutic Goods Administration (TGA) prepared two draft Labelling Standards (Non-prescription Topical Nasal Decongestants and Non-prescription Oral Adult Expectorant Cough and Cold).

Openness and Transparency

- The Clinical Trials Database provided the public with a listing of specific information relating to Phases I, II and III clinical trials in patients involving human pharmaceutical and biological drugs. Canadians can access the database to determine if a clinical trial has met the regulatory requirements or if there is a clinical trial that might be relevant to their medical condition.
- The Summary Basis of Decision database documents explain why Health Canada authorized drugs containing new active substances for sale in Canada.
- The Annual Inspection Report, available on the Health Canada website, provides aggregate information on inspections conducted against regulatory standards.

Sub-Program 2.1.1: *Pharmaceutical Drugs*

Description

The *Food and Drug Regulations* provide the regulatory framework to develop, maintain and implement the Pharmaceutical Drugs program, which includes pharmaceutical drugs for human and animal use, including prescription and non-prescription drugs, disinfectants, and sanitizers with disinfectant claims.

Health Canada verifies that regulatory requirements for the safety, quality, and efficacy of pharmaceutical drugs are met through risk assessments, including monitoring and surveillance, compliance, and enforcement activities.

In addition, the program provides information to Canadians and key stakeholders, including health professionals, such as physicians and pharmacists, to enable them to make informed decisions about the use of pharmaceutical drugs.

The program objective is for Canadians to have access to pharmaceutical drugs that are safe, effective, and of high quality.

Budgetary Financial Resources (dollars)

2013-14 Planned Spending	2013-14 Actual Spending	2013-14 Difference (actual minus planned)
64,208,997	75,722,583	11,513,586

Note: The variance between planned and actual spending is mainly due to paylist requirements (please refer to footnote 4 for explanation of paylist requirements) and collective agreement increases.

Human Resources (FTEs)

2013-14 Planned	2013-14 Actual	2013-14 Difference (actual minus planned)
1,122	898	-224

Note: The variance in FTE utilization is mainly due to lower than projected demand for regulatory reviews in 2013-14 and the resulting realignment of staffing to match workload.

Performance Results

Expected Results	Performance Indicators	Targets	Actual Results
The Pharmaceutical drugs industry understands regulatory requirements.	% of pharmaceutical product submissions that meet regulatory requirements.	80 by March 31, 2014	76

Performance Analysis and Lessons Learned

The review backlog for generics had been increasing since 2008-09 as submission volumes grew much faster than anticipated, due to patent protection that had ended for a record number of ‘blockbuster’ drugs. As a result the generics market in Canada and elsewhere became more attractive, and the number of generic companies operating in Canada increased. These forces resulted in a 104% growth in the volume of generic drug submissions received in TPD in a 5-year period from FY 2007-08 to 2011-12. The backlog grew rapidly from FY 2009-10 to its peak of 203 submissions in backlog in March 2012, and the effort to eliminate the backlog took almost two additional years. On November 28, 2013 the backlog in generic drug submissions was eliminated, and there are currently no generic drug submissions in backlog.

To eliminate the backlog, a three-pronged approach was used to improve review capacity and increase the number of monthly review decisions. These included 1) process improvements; 2) a small sustainable increase to human resources; and 3) use of foreign submission reviews through the Foreign Review Pilot Project. The decision-making capacity increased to a point where the number of decisions per month was greater than the rate of incoming submissions, while ensuring the safety, quality and efficacy of the generic drug approvals.

In 2013-14, 76% of the pharmaceutical drug submissions received were compliant with regulatory requirements. To improve the quality of submissions received, Health Canada will deliver a presentation entitled *Improve the Quality of Submissions* to the innovator drug industry

at the Canadian Association of Professionals in Regulatory Affairs Education Day and to the research development community. The focus of these presentations will be on regulatory administrative improvements for innovator drug submissions. A similar presentation will be prepared and presented to the generic drug industry at a workshop.

International Cooperation

Health Canada continued to make more efficient, consistent and systematic use and integration of foreign regulatory information. Health Canada collaborated with its U.S. regulatory counterparts to reduce the regulatory burden for health products, and move closer to an automated environment for the exchange, review and management of information supporting the process for health product reviews in initiatives such as:

- The International Conference on Harmonization of Technical Requirements for Registration of Pharmaceuticals for Human Use, which involves collaborative development, adoption and implementation of the International Conference on Harmonization guidelines.
- The International Collaboration in the Review of Generic Drugs involved a series of integrated initiatives that define a new and more efficient way of reviewing generic drugs. Initiatives included: The Regulatory Cooperation Initiative with the Australian TGA; Heads of Agencies Consortium with the Australian TGA, Singapore's Health Sciences Authority and Swissmedic; and the International Generic Drug Regulators Pilot, which continues to promote global collaboration in generic drug regulation, with a focus on active substance master files, biowaivers and work-sharing models.
- The Asia Pacific Economic Cooperation Regulatory Harmonization Steering Committee, chaired by Health Canada continued to make progress in promoting greater regulatory convergence and capacity building, focused on multi-regional clinical trials, supply chain integrity, biotherapeutics, cellular therapies, good review practices, pharmacovigilance and combination products.
- The Veterinary Drug Parallel Submission Review to provide concurrent availability of drugs to end users through FDA and Health Canada. Collaboration on seven pilot simultaneous reviews, which together cover all technical sections of submissions, resulted in one submission approved at the same time. Industry interest remains high, as work continued towards an evergreen simultaneous review mechanism.

In 2013-14, the Deputy Minister approved the following evaluations: Veterinary Drugs Program 1999-2012[xxxiii] and the Human Drugs Program 1999-2000 to 2011-12[xxxiv].

Sub-Program 2.1.2: *Biologics and Radiopharmaceuticals*

Description

The *Food and Drug Regulations*, *Safety of Human Cells, Tissues and Organs for Transplantation Regulations*[xxxv], and the *Processing and Distribution of Semen for Assisted Conception Regulations*[xxxvi] provide the regulatory framework to develop, maintain, and

implement the Biologics and Radiopharmaceuticals program, which includes blood and blood products, viral and bacterial vaccines, gene therapy products, tissues, organs, and xenografts, which are manufactured in Canada or elsewhere.

Health Canada verifies that regulatory requirements for the safety, quality, and efficacy of biologics and radiopharmaceuticals are met through risk assessments, including monitoring and surveillance, compliance, and enforcement activities.

In addition, the program provides information to Canadians and key stakeholders, including health professionals such as physicians and pharmacists, to enable them to make informed decisions about the use of biologics and radiopharmaceuticals.

The program objective is for Canadians to have access to biologics and radiopharmaceuticals that are safe, effective, and of high quality.

Budgetary Financial Resources (dollars)

2013-14 Planned Spending	2013-14 Actual Spending	2013-14 Difference (actual minus planned)
55,601,252	60,290,186	4,688,934

Note: The variance between planned and actual spending is mainly due to paylist requirements (please refer to footnote 4 for explanation of paylist requirements) and collective agreement increases.

Human Resources (FTEs)

2013-14 Planned	2013-14 Actual	2013-14 Difference (actual minus planned)
500	445	-55

Note: The variance in FTE utilization is mainly due to lower than projected demand for regulatory reviews in 2013-14 and the resulting realignment of staffing to match workload.

Performance Results

Expected Results	Performance Indicators	Targets	Actual Results
The Biologics, Radiopharmaceutical and Genetic Therapies industry understands regulatory requirements.	% of biologic and radiopharmaceutical product submissions that meet regulatory requirements.	80 by March 31, 2014	85

Performance Analysis and Lessons Learned

In 2013-14, 85% of biologic and radiopharmaceutical product submissions received were compliant with regulatory requirements, and Health Canada continues to work with stakeholders to improve this compliance rating.

New *Blood Regulations* formalized Canada's internationally recognized best practices for safety requirements with respect to blood that is collected for transfusion or for use in the manufacture of a drug for human use.

International Cooperation

Health Canada continues to strive for increased efficiency and consistency with the use of foreign regulatory education, and international collaboration and cooperation. Initiatives include:

- Increasing the regulatory convergence and exchange of domestic and international best practices, policies and protocols related to the regulation of vaccines, with a focus on HIV/AIDS vaccines through a variety of international forums and conferences.
- Improving regulatory readiness and strengthening the capacity of regulatory authorities in low-middle income countries in the area of vaccine products and clinical trials by training international counterparts and the establishment of an African mentorship program.

Openness and Transparency

As part of the commitment to create an environment that supports greater transparency from industry, Health Canada met with the Nuclear Medicine Alliance, BIOTECanada, and held a Radiopharmaceutical Workshop. At the meeting with BIOTECanada, Health Canada presented on the progress of several ongoing regulatory initiatives such as legislative and regulatory modernization, orphan drugs regulatory framework, stem cell therapy, lot release program, and plant molecular farming.

At the meeting with the Nuclear Medicine Alliance, Health Canada discussed the development of guidance documents for radiopharmaceuticals and for positron-emitting radiopharmaceuticals used in basic research.

The Department also held a Radiopharmaceutical Workshop, which provided an excellent opportunity for Health Canada to engage and educate over 75 stakeholders from the radiopharmaceutical community and to enhance transparency on government-wide initiatives related to the regulatory oversight of radiopharmaceutical products.

As part of our transparency initiatives to make information available to Canadians and stakeholders about how Health Canada makes its decisions, regulatory research laboratory information and scientist profiles were posted on Science.gc.ca[xxxvii].

In 2013-14, the Deputy Minister approved evaluation of the Canadian Blood Services Grant and Contribution Programs 2008-09 to 2012-13[xxxviii].

Sub-Program 2.1.3: *Medical Devices*

Description

The *Medical Devices Regulations*[xxxix] provide the regulatory framework to develop, maintain, and implement the Medical Devices program, which includes medical devices used in the treatment, mitigation, diagnosis, or prevention of a disease or an abnormal physical condition in humans.

Health Canada verifies that regulatory requirements for the safety, quality, and efficacy of medical devices are met through risk assessments, including monitoring and surveillance, compliance, and enforcement activities.

In addition, the program provides information to Canadians and key stakeholders, including health professionals, such as physicians and pharmacists, to enable them to make informed decisions about the use of medical devices.

The program objective is for Canadians to have access to medical devices that are safe, effective, and of high quality.

Budgetary Financial Resources (dollars)

2013-14 Planned Spending	2013-14 Actual Spending	2013-14 Difference (actual minus planned)
13,840,412	16,141,169	2,300,757

Note: The variance between planned and actual spending is mainly due to paylist requirements (please refer to footnote 4 for explanation of paylist requirements) and collective agreement increases.

Human Resources (FTEs)

2013-14 Planned	2013-14 Actual	2013-14 Difference (actual minus planned)
301	281	-20

Note: The variance in FTE utilization is mainly due to lower than projected demand for regulatory reviews in 2013-14 and the resulting realignment of staffing to match workload.

Performance Results

Expected Results	Performance Indicators	Targets	Actual Results
The Medical Devices industry understands regulatory requirements.	% of applications (Class III and IV*) that meet regulatory requirements. *(Classes I and II present very low health and safety risk to Canadians).	80 by March 31, 2014	49

Performance Analysis and Lessons Learned

In 2013-14, 49% of the medical devices applications received were compliant with the regulatory requirements, below the target of 80%. Health Canada is implementing and updating several strategies to increase industry understanding of its regulatory requirements. Currently, policy work is underway to ensure that only prescribed format applications are accepted for review. Format restrictions will require that manufacturers consider and include required regulatory information prior to application. It is anticipated that increased application quality requirements will require heightened regulatory awareness among manufacturers.

Additionally, webinars and industry workshops/regulatory training sessions will be delivered to increase awareness.

International Cooperation

The Medical Devices Single Audit Program (MDSAP) Pilot is expected to result in a stronger, more efficient and internationally consistent program that at the same time will reduce overall regulatory burden to manufacturers and promote innovation and trade. Health Canada was key in the development of all required documents for the pilot to be launched: Auditing Organization recognition criteria; Auditing Organization competency requirements; Audit Model Process and Companion Document; Audit Report Template; MDSAP quality management system (process and procedures); and, Assessment strategy for the recognition of Auditing Organization.

In January 2014, the participating regulatory authorities under the MDSAP Pilot (Health Canada, Australia, Brazil and the U.S.) used the newly created documents/process/systems to assess the applications that have been submitted by the Auditing Organizations for this program.

The documents/processes/systems are evolving during the pilot and continuous improvements and changes will be made to them, as they are being used by the participating regulatory authorities and the auditing organizations.

Health Canada is a member of the International Medical Device Regulators Forum, which continued international medical device regulatory harmonization and convergence through its six Working Groups. The Forum approved the publication of four documents used in the launch of the MDSAP pilot, and a guidance document that describes how a global Unique Device Identification (UDI) System should work. Health Canada will use the principles outlined in the UDI document to develop guidance for manufacturers on the implementation of a UDI system for medical devices in Canada.

In 2013-14, the Deputy Minister approved an evaluation of the Medical Devices Program 1999-2000 to 2011-12[xl].

Sub-Program 2.1.4: *Natural Health Products*

Description

The *Natural Health Product Regulations*[xli] provide the regulatory framework to develop, maintain and implement the Natural Health Products program, which includes herbal remedies, homeopathic medicines, vitamins, minerals, traditional medicines, probiotics, amino acids, and essential fatty acids.

Health Canada verifies that regulatory requirements for the safety, quality, and efficacy of natural health products are met through risk assessments, including monitoring and surveillance, compliance, and enforcement activities.

In addition, the program provides information to Canadians and key stakeholders, including health professionals such as pharmacists, traditional Chinese medicine practitioners, herbalists and naturopathic doctors, to enable them to make informed decisions about the use of natural health products.

The program objective is for Canadians to have access to natural health products that are safe, effective, and of high quality.

Budgetary Financial Resources (dollars)

2013-14 Planned Spending	2013-14 Actual Spending	2013-14 Difference (actual minus planned)
23,113,157	27,410,859	4,297,702

Note: The variance between planned and actual spending is mainly due to paylist requirements (please refer to footnote 4 for explanation of paylist requirements), collective agreement increases, and reallocations of funding from other programs to the Natural Health Product program.

Human Resources (FTEs)

2013-14 Planned	2013-14 Actual	2013-14 Difference (actual minus planned)
207	243	36

Note: The variance in FTE utilization is mainly due to temporary staffing to respond to the higher than projected demand by manufacturers for regulatory reviews under the Natural Health Products program.

Performance Results

Expected Results	Performance Indicators	Targets	Actual Results
The Natural Health Products industry understands regulatory requirements.	% of natural health product submissions that meet regulatory requirements.	80 by March 31, 2014	94

Performance Analysis and Lessons Learned

As a measure of industry applicants' understanding of regulatory requirements, 94% of natural health product submissions reviewed resulted in a new or amended product licence. The performance result is a direct reflection of the Department's collaborative approach to licensing. By maintaining open lines of communication with applicants, the Department helps industry understand and comply with regulatory requirements; as a result, 10,166 natural health products were licensed or amended during the fiscal year.

Health Canada continued to modernize oversight of natural health products to achieve an efficient, sustainable and transparent regulatory system. Highlights include:

- Consulting on and implementing a new approach for a three-class system for product authorization, and site authorization.
- In July 2013, the responsibility for review of non-prescription drugs and disinfectants was transferred to the Natural Health Products sub-program from the Pharmaceutical Drugs sub-program to facilitate greater alignment of product authorization functions for both Natural Health Products and non-prescription drugs.
- Operational alignment for Natural Health Products and non-prescription drugs continues to be analyzed, leveraging the best practices of both functional areas.

International Cooperation

Health Canada continued to harmonize regulatory oversight by partnering with other international regulators of health products industries. Health Canada continued to make more efficient, consistent and systematic use and integration of foreign regulatory information. As part of the Regulatory Cooperation Council, Health Canada collaborated with its U.S. regulatory counterparts to reduce regulatory burden for health products, and to move closer to an automated environment for the exchange, review and management of information supporting the health product review process in initiatives such as:

- U.S. - Regulatory Cooperation Council (Interfaces, data alignment).
- Australia - Regulatory Cooperation Initiative, International Regulatory Cooperation for Herbal Medicines (Interfaces, data alignment).
- European Union - Germany and European Medicines Agency relations.

Openness and Transparency

Health Canada continued to publish an activity calendar (Natural Health Products Directorate six month calendar of activities: January to June 2014 website[xlii]) that presents an overview of anticipated review activities, publications, workshops and meetings, including new or updated product monographs.

Program 2.2: *Food Safety and Nutrition*

Description

The *Department of Health Act* and the *Food and Drugs Act* provide the authority for Health Canada to develop, maintain, and implement a regulatory framework associated with the safety and nutritional quality of food. Food safety standards are enforced by the Canadian Food Inspection Agency.

Health Canada develops and promotes evidence-based, national healthy eating policies and standards for Canadians and key stakeholders, including NGOs, health professionals, and industry associations to enable all stakeholders to make informed decisions about food and nutrition safety as well as healthy eating.

The program objectives are to manage risks to the health and safety of Canadians associated with food and its consumption, and to inform Canadians of the benefits of healthy eating.

Budgetary Financial Resources (dollars)

2013-14 Main Estimates	2013-14 Planned Spending	2013-14 Total Authorities Available for Use	2013-14 Actual Spending (authorities used)	2013-14 Difference (actual minus planned)
51,402,965	54,154,918	71,238,986	71,238,491	17,083,573

Note: The variance of $17.1 million between planned spending and total authorities as well as actual spending is mainly due to additional funding received through Supplementary Estimates to continue enhancing the ability to prevent, detect and respond to food-borne illness outbreaks, reallocations of funding from other programs, paylist requirements (please refer to footnote 4 for explanation of paylist requirements), and collective agreement increases.

Human Resources (Full-Time Equivalents [FTEs])

2013-14 Planned	2013-14 Actual	2013-14 Difference (actual minus planned)
563	513	-50

Note: The variance in FTE utilization is mainly due to the savings achieved from simplifying and streamlining operations while maintaining services to Canadians. Reductions in FTEs were achieved through attrition and voluntary departures.

Performance Results

Expected Results	Performance Indicators	Targets	Actual Results
Foodborne illness, outbreaks and food safety incidents are effectively prevented and managed.	% of the time that Canada maintains a ranking amongst the top 5 jurisdictions internationally in responding effectively to food safety recalls.	100 by March 31, 2014	*

Expected Results	Performance Indicators	Targets	Actual Results
	(Note: The Food Safety Performance World Ranking initiative is designed to help identify relative strengths and weaknesses in Canada's food safety performance by comparing across 16 countries).		
Canadians make informed eating decisions.	% of Canadians who consult Health Canada's healthy eating information (e.g., Canada's Food Guide) to inform their decisions.	40 by March 31, 2015	40.7

* This external survey was not carried out in 2013-14. Canada still ranks amongst the top 5 jurisdictions internationally responding effectively to food safety recalls based on the 2010 Charlebois report.

Performance Analysis and Lessons Learned

The ranking survey is biennial, and there is no new data to report this year.

The program is on track to meet the 2015 target to have Canadians making informed decisions based on Health Canada's healthy eating information. Actions included work related to nutrition risks and enhanced risk management measures for priority hazards of food safety and contaminants in food.

Openness and Transparency

Health Canada developed and posted consumer friendly nutrition information and tools to help Canadians make informed food choices. A focus has been placed on helping Canadians better understand how to make healthy eating choices and use the Nutrition Facts table that is found on most pre-packaged food. Existing web content provides useful and targeted information for consumers, educators, health professionals.

Health Canada developed a multifaceted consultation plan to guide the Government's 2013 Speech from the Throne commitment to consult with Canadian parents on ways to improve nutritional information on food labels.

Sub-Program 2.2.1: *Food and Nutrition Safety*

Description

The *Food and Drug Regulations* provide the regulatory framework to develop, maintain, and implement the Food and Nutrition Safety program.

The program is the federal health authority responsible for establishing standards, policies, and regulations pertaining to food and nutrition safety; as well as for conducting reviews and for assessing the safety of food ingredients, veterinary drugs for food producing animals, food processes, and final foods. The program conducts risk assessments pertaining to the chemical, microbiological, and nutritional safety of foods. In addition, the program plans and implements food and nutrition safety surveillance and research initiatives in support of the Department's food standard setting mandate.

The program objective is to inform Canadians to enable them to make informed decisions about food and nutrition safety.

Budgetary Financial Resources (dollars)

2013-14 Planned Spending	2013-14 Actual Spending	2013-14 Difference (actual minus planned)
50,253,761	61,655,265	11,401,504

Note: The variance between planned and actual spending is mainly due to paylist requirements (please refer to footnote 4 for explanation of paylist requirements), collective agreements increases, and increases in program requirements.

Human Resources (FTEs)

2013-14 Planned	2013-14 Actual	2013-14 Difference (actual minus planned)
516	469	-47

Note: The variance in FTE utilization is mainly due to the savings achieved from simplifying and streamlining operations while maintaining services to Canadians. Reductions in FTEs were achieved through attrition and voluntary departures.

Performance Results

Expected Results	Performance Indicators	Targets	Actual Results
Effective response to emerging food and nutrition safety incidents including foodborne illness outbreaks.	% of health risk assessments provided to the Canadian Food Inspection Agency within standard timelines to manage food safety incidents.	90 by March 31, 2014	100

Performance Analysis and Lessons Learned

High risk Health Risk Assessments were responded to in less than eight hours on a 24/7 basis, contributing to the Government of Canada's ability to prevent, detect and respond to outbreaks of Foodborne Illnesses.

International Cooperation

The Department continued to lead and leverage national and international food standards development and risk management standards by effectively contributing in the international food standard setting process under the Codex Alimentarius Commission (Codex). Canada led the international Codex Committee on Nutrition and Foods for Special Dietary Uses work to revise the Codex General Principles for the Addition of Essential Nutrients to Foods in order to reflect the latest scientific evidence and current global market trends, while ensuring rational and safe addition of essential nutrients to foods.

As part of Canada's involvement in the Asia-Pacific Economic Cooperation's Food Safety Cooperation Forum, the Department promoted greater alignment in the regulatory approach for addressing the presence of food allergens in food products.
Openness and Transparency

The Department:

- Enhanced the transparency of scientific and regulatory food and nutrition safety decision-making processes by the consistent publication of scientific evidence for food regulatory decisions.
- Continued communication and engagement with stakeholders on key risk management, policy and regulatory decisions.
- Provided important advice and issued guidance to industry on the implementation of enhanced controls for foodborne pathogens such as E.coli O157 and S. Enteritidis.
- Participated in the Partnership for Consumer Food Safety Education by promoting the "Be Food Safe" campaign, which developed new education materials for consumers in an effort to reduce foodborne disease outbreaks in Canada. Health Canada contributed to the development of a "Be Food Safe" hamburger insert to be used by meat association members to educate consumers on the importance of cooking hamburgers to the appropriate internal temperature by encouraging the use of a digital food thermometer.

Health Canada undertook a broad range of consultations with industry, consumer and health stakeholders on food regulatory modernisation under the *Food and Drugs Act*, focussed on the openness, transparency and predictability of mandatory food pre-market activities through engagement and the publication of pre-market decisions. Activities continued to improve pre-market mandatory review activities for food additives, infant formula and novel foods, and improvements to the pre-market review programs for processing aids, food packaging material and incidental additives. These included process improvements and necessary updates to the dated food additive regulatory framework.

In 2013-14, the Deputy Minister approved the following evaluations: Food Safety and Nutrition Quality Program 1999-2000 to 2011-12[xliii] and Summative Evaluation of the Bovine Spongiform Encephalopathy (BSE) I and II Initiatives[xliv].

Sub-Program 2.2.2: *Nutrition Policy and Promotion*

Description

The *Department of Health Act* provides the authority to develop, maintain and implement the Nutrition Policy and Promotion program.

The program develops, implements, and promotes evidence-based nutrition policies and standards, and undertakes surveillance and monitoring activities. It anticipates and responds to public health issues associated with nutrition and contributes to broader national and international strategies.

In addition, the program promotes initiatives that target both intermediaries and consumers to increase knowledge, understanding, and action on healthy eating. The program works collaboratively with other federal departments/agencies and provincial/territorial governments, and engages stakeholders such as non-government organizations, health professionals, and industry associations to support a coordinated approach to nutrition issues.

The program objective is to promote healthy eating choices by Canadians.

Budgetary Financial Resources (dollars)

2013-14 Planned Spending	2013-14 Actual Spending	2013-14 Difference (actual minus planned)
3,901,157	9,583,226	5,682,069

Note: The variance between planned and actual spending is mainly due to paylist requirements (please refer to footnote 4 for explanation of paylist requirements), collective agreement increases, and increased requirements in the Healthy Eating campaign.

Human Resources (FTEs)

2013-14 Planned	2013-14 Actual	2013-14 Difference (actual minus planned)
47	44	-3

Note: The variance in FTE utilization is mainly due to the savings achieved from simplifying and streamlining operations while maintaining services to Canadians. Reductions in FTEs were achieved through attrition and voluntary departures.

Performance Results

Expected Results	Performance Indicators	Targets	Actual Results
Stakeholders integrate information on nutrition and healthy eating.	% of targeted stakeholders who integrate Health Canada healthy eating knowledge products, policies, and/or education materials into their own strategies,	80 by March 31, 2014	89

Expected Results	Performance Indicators	Targets	Actual Results
	policies, programs and initiatives that reach Canadians.		

Performance Analysis and Lessons Learned

The factors identified for achieving 89% integration of Health Canada's healthy eating information were the credibility of dietary recommendations based on scientific evidence, the inclusion of different patterns and styles of eating, as well as aspects beyond nutrition such as physical activity that encourage overall health and vitality.

Health Canada continued to undertake activities to keep its dietary guidance relevant, up-to-date and based on the most recent scientific evidence. Highlights include:

- Revision of the Nutrition for Healthy Term Infants (NHTI) recommendations for infant nutrition from six to 24 months that provide health professionals with evidence-informed guidance. Health professionals are encouraged to use NHTI to develop practical feeding guidelines for use by parents and caregivers and to promote the communication of accurate and consistent messages.
- The Outcome Assessment of Canada's Food Guide report provided information on who is using Canada's Food Guide (and related products); the level of awareness, knowledge and acceptance of the Guide by stakeholders and consumers; and the main facilitators and barriers to achieving increased integration of the Guide within policies, messaging and nutrition education across Canada.
- Website launched to facilitate nomination of nutrients for potential review to ensure Dietary Reference Intake values are based on most recent evidence.

Health Canada also continued to work with partners and stakeholders on Phase 3 of the Healthy Eating Awareness and Education Initiative, which focused on food skills, the set of skills necessary to provide and prepare safe, nutritious, and culturally acceptable meals for all members of one's household. This included establishing partnerships and collaborating with stakeholders from various organizations, such as the Retail Council of Canada, the Canadian Federation of Independent Grocers, and the Heart and Stroke Foundation, to develop tools and resources (such as implementing the food skills recipes project). This will promote clear and consistent messaging to help Canadians make informed food choices.

International Cooperation

Health Canada also provided nutrition policy expertise to support Canada's engagement in the development of international health strategies, action plans and monitoring frameworks. Recent examples are related to the prevention of chronic diseases and the promotion of health among mothers and children such as the World Health Organization's (WHO) *Global Action Plan for the Prevention of Control of Non-communicable Diseases 2013-2020* and related initiatives, Pan American Health Organization's *Strategy* and *Plan of Action for the Prevention and Control of*

Noncommunicable Diseases and the WHO *Comprehensive Implementation Plan on Maternal, Infant and Young Child Nutrition*.

Program 2.3: *Environmental Risks to Health*

Description

The *Canadian Environmental Protection Act*[xlv] (CEPA) and the *Department of Health Act* provide the authorities for the Environmental Risks to Health program to assess and manage the health risks associated with climate change, air quality, drinking water quality, and chemical substances. This program activity links closely with Health Canada's Health Products, Food Safety and Nutrition, Consumer Product Safety and Pesticides program activities, as the *Food and Drugs Act*, the *Pest Control Products Act*, and the *Canada Consumer Product Safety Act* (CCPSA) provide the authority to manage the health risks associated with chemical substances in products in the purview of these program activities.

Key activities include: risk assessment and management as well as research and bio-monitoring of chemical substances; provision of technical support for chemical emergencies that require a coordinated federal response; development of guidelines on indoor and outdoor air quality; development and dissemination of water quality guidelines; and, supporting the implementation of Heat Alert and Response Systems (HARS) in Canadian communities.

The program objective is to protect the health of Canadians through the assessment and management of health risks associated with chemical substances and to provide expert advice and guidelines to partners on the health impacts of environmental factors such as air and water contaminants and a changing climate.

Budgetary Financial Resources (dollars)

2013-14 Main Estimates	2013-14 Planned Spending	2013-14 Total Authorities Available for Use	2013-14 Actual Spending (authorities used)	2013-14 Difference (actual minus planned)
109,816,852	109,816,852	107,621,366	101,141,190	-8,675,662

Note: The variance of $8.7 million between planned spending and actual spending is mainly due to a reprofile of funding for the retrofit of the Sir Frederick Banting Research Centre to 2014-15, and the transfer of the Travelling Public Program to PHAC.

Human Resources (Full-Time Equivalents [FTEs])

2013-14 Planned	2013-14 Actual	2013-14 Difference (actual minus planned)
801	639	-162

Note: The variance in FTE utilization is largely attributed to program hiring delays and departures without backfills. In addition, 36 FTEs from the Travelling Public Program were transferred to PHAC.

Performance Results

Expected Results	Performance Indicators	Targets	Actual Results
Canadians, institutions and government partners have the guidance and tools they need to respond to potential and actual environmental risks associated with health.	% of planned guidance materials completed.	100 by March 31, 2014	93
	% of substances assessed to be harmful to human health for which at least one risk management instrument was developed within mandated timeframes, by category of substance (new and existing).	100 by March 31, 2014	96

Performance Analysis and Lessons Learned

Health Canada continued to protect the health of Canadians through the assessment and management of health risks associated with chemical substances and by providing expert advice and guidelines to partners on the health impacts of environmental factors such as air and water contaminants and a changing climate.

Specifically, Health Canada continued to implement the Chemicals Management Plan (CMP). Good progress was made towards the goal of assessing 1,500 remaining priority existing substances for environmental and health risks. Over 1,400 substance assessments were published or concluded at the various stages of the CEPA process. In addition, 12 of 13 Challenge and Legacy substances met the mandated timeframe of publication of proposed risk management instruments within 24 months following publication of final risk assessments, and publication of final risk management instruments within 18 months following publication of proposed risk management instruments. This involved the publication of five risk management instruments. A delay for one of the substances was incurred to address a stakeholder concern. Publication of a risk management instrument for this one substance is scheduled for 2014-15. Nine new substances manufactured or imported into Canada assessed to be harmful to health also had control measures developed within mandated timeframes.

In 2013-14, Health Canada also conducted health risk assessments, health benefit analysis, research and outreach in support of the development of Residential Indoor Air Quality guidelines, regulations to reduce emissions from transportation, more stringent health-based Canadian Ambient Air Quality Standards (CAAQS) for particulate matter and ozone, and increased coverage and awareness of the Air Quality Health Index (AQHI). Health Canada also protected the health of Canadians by developing health-based drinking water guidelines. In summary, 93% of planned guidelines were completed. The finalization of one air health risk assessment was not completed due to the complexity of the analysis required. Health Canada also completed 73 public outreach activities across Canada.

In addition, to minimize the health risks of extreme heat related to climate change, Health Canada shifted efforts from supporting the development of community-based HARS in at-risk communities, to the development of provincial-level systems, such as the system in Manitoba.

In 2013-14, the Deputy Minister approved an evaluation of the Action Plan to Protect Human Health from Environmental Contaminants 2008-09 to 2012-13[xlvi] (horizontal initiative led by Health Canada).

Sub-Program 2.3.1: *Climate Change and Health*

Description

The Climate Change and Health program supports actions to minimize the impact of climate change on the health of Canadians under the federal Clean Air Agenda.

A key activity in the delivery of this program is the Heat Resiliency Project, which aims to inform and advise public health agencies and Canadians on adaptation strategies to respond to extreme heat events.

This includes: development of community-based HARS; development and dissemination of training tools; guidelines, and strategies for health professionals; collaboration with key stakeholders and partners to assess and reduce vulnerabilities to extreme heat; and scientific research on health impacts of extreme heat to support evidence-based decision-making.

The program objective is to help Canadians adapt to a changing climate through measures intended to manage potential risks to their health associated with extreme heat events.

Budgetary Financial Resources (dollars)

2013-14 Planned Spending	2013-14 Actual Spending	2013-14 Difference (actual minus planned)
1,472,903	1,851,527	378,624

Note: The variance between planned and actual spending is mainly due to the reporting of actual costs that had been previously planned under Health Impacts of Chemicals.

Human Resources (FTEs)

2013-14 Planned	2013-14 Actual	2013-14 Difference (actual minus planned)
10	12	2

Note: The variance in FTE utilization is mainly due to the reporting of actual costs that had been previously planned under Health Impacts of Chemicals.

Performance Results

Expected Results	Performance Indicators	Targets	Actual Results
Use of knowledge on impacts of climate	# of Canadian communities with HARS.	12 by March 31, 2016	12

Expected Results	Performance Indicators	Targets	Actual Results
change on health and adaptation measures by Canadian communities.			

Performance Analysis and Lessons Learned

Extreme heat poses a growing risk to the health and well-being of Canadians, as climate change is expected to produce heat events with greater intensity, frequency and duration. By implementing appropriate preparation measures such as effective HARS, the health risks of extreme heat can be minimized. In 2013-14, Health Canada shifted efforts from supporting the development of community-based HARS in at-risk communities, to the development of provincial-level systems, such as the system in Manitoba.

Existing community-level partnerships in Ontario have been merged under a new initiative to establish a province-wide consistent approach to HARS. Establishing a provincial system in Alberta is also underway, with a pilot project being launched during summer 2014, and expected to be operational by 2016. The shift to provincially-based HARS has resulted in the development of HARS in 12 communities in 2013-14, ahead of schedule in relation to the target of 12 communities by 2015-16.

Enhancing community resiliency to extreme heat involves participation of all levels of government and the public. Collaborative processes between federal, provincial and local governments, involving a wide range of stakeholders have been the key to developing HARS, as well as providing technical advice to public health and health professionals.

Sub-Program 2.3.2: *Air Quality*

Description

The Air Quality program assesses the health risks of indoor and outdoor pollutants, and develops guidelines and standards under the CEPA. These efforts support the Government of Canada's Clean Air Agenda.

The program provides health-based science and policy advice that supports actions by all levels of government to improve air quality and health of Canadians. Key activities include: leading the development of health-based air quality standards and guidelines for indoor and outdoor air; determining the health benefits of proposed actions to reduce air pollution; conducting research on the levels of exposure and health effects of indoor and outdoor air pollutants to inform the development of standards, guidelines, regulations and other actions; and, implementing the AQHI in partnership with Environment Canada.

The program objective is to manage potential risks to the health of Canadians associated with air quality.

Budgetary Financial Resources (dollars)

2013-14 Planned Spending	2013-14 Actual Spending	2013-14 Difference (actual minus planned)
20,999,573	17,503,254	-3,496,319

Note: The variance between planned and actual spending is mainly due to lower than anticipated lab maintenance costs as well as delays in contracting.

Human Resources (FTEs)

2013-14 Planned	2013-14 Actual	2013-14 Difference (actual minus planned)
103	103	0

Performance Results

Expected Results	Performance Indicators	Targets	Actual Results
Actions by all levels of government and government partners to reduce Canadians' exposure to air pollutants incorporate Health Canada air-health advice and guidance	% of planned federal actions to promote reduction of air pollutant emissions and to protect health.	100 by March 31, 2014	100
	% of Canadians with access to the AQHI.	85 by March 31, 2015	63
All levels of government have access to scientific information on the impacts of air quality on health.	% of targeted knowledge transfer activities accomplished.	95 by March 31, 2014	100

Performance Analysis and Lessons Learned

Health Canada continued to promote reductions in air pollutant emissions and help protect the health of Canadians. For example, a key milestone in the implementation of the national Air Quality Management System was achieved in 2013-14 as new, more stringent, health-based CAAQS for particulate matter and ozone were established under the CEPA. Health Canada co-led the development of these new standards, guided by the findings of the Canadian Smog Science Assessment completed by Health Canada and Environment Canada in 2011.

Health Canada also completed a number of health risk assessments for key outdoor air contaminants, including carbon monoxide, coarse particulate matter and, sulphur dioxide and, indoor contaminants including nitrogen dioxide and certain volatile organic compounds. Significant progress was made on additional assessments, including diesel fuel and nitrogen dioxide, although these are behind schedule due to the complexities of the analyses. A generic

industrial sector assessment methodology and rapid screening techniques were also developed, that will improve the efficiency of carrying out health assessments in the future.

A number of research studies concluded that increases in air pollution level affect health endpoints, including diabetes and birth outcomes. Continued publication of study results in credible scientific journals ensures that Health Canada science contributes to the body of knowledge on the impacts of air quality on health. The ongoing roll out of the AQHI across Canada and other public outreach products improved the ability of Canadians to manage and reduce their exposure to air pollutants on a day-to-day basis. The increase in percentage reach of the AQHI continues to grow to meet the revised target of 80% for fiscal year 2014-15. The AQHI is now available to approximately 63% of Canadians in 10 provinces and one territory and 79 locations.

Successful implementation of the air program requires collaboration among all levels of government, NGOs and industry. The early and continued engagement of stakeholders and partners is essential to ensuring efficient and effective actions to address air quality.

Research on air quality and health generated 73 knowledge transfer activities, including client meetings, reports, publications and presentations, which represent 100% of Health Canada's target for 2013-14.

Sub-Program 2.3.3: *Water Quality*

Description

The Water Quality program works with key stakeholders and partners such as the provinces and territories, under the authority of the *Department of Health Act*, to establish guidelines for Canadian drinking water quality, as well as recreational water and household reclaimed water. These guidelines are used by provinces and territories as the basis for establishing their water quality requirements.

The program also works with national and international standard-setting organizations to develop health-based standards for materials that come into contact with drinking water, and works with partners to develop strategies and tools to enhance the safety of small community drinking water supplies.

In the delivery of this program, key activities include the development and dissemination of water quality guidelines/technical guidance documents, strategies and other tools.

The program objective is to help manage potential risks to the health of Canadians associated with water quality.

Budgetary Financial Resources (dollars)

2013-14 Planned Spending	2013-14 Actual Spending	2013-14 Difference (actual minus planned)
3,424,489	3,770,044	345,555

Note: The variance between planned and actual spending is mainly due to the reporting of actual costs that had been previously planned under Health Impacts of Chemicals.

Human Resources (FTEs)

2013-14 Planned	2013-14 Actual	2013-14 Difference (actual minus planned)
31	25	-6

Note: The variance in FTE utilization is mainly due to program hiring delays.

Performance Results

Expected Results	Performance Indicators	Targets	Actual Results
Federal, provincial and territorial partners use Health Canada water quality guidelines as the basis for their regulatory requirements to manage risks to the health of Canadians.	# of water quality guidelines/guidance documents approved by federal/provincial/territorial committees.	5 by March 31, 2014	5

Performance Analysis and Lessons Learned

The Department met its target of five final drinking water quality guidelines approved by provinces/territories: ammonia; nitrate; nitrite; 1, 2-dichloroethane; and selenium. These guidelines are used as the basis for drinking water quality requirements across Canada. In order to achieve this commitment of developing, on average, five guidelines/guidance documents per year on an ongoing basis, the Department worked simultaneously on 20-30 risk assessments, at any one time. This involved multiple partners/stakeholders to review and discuss scientific, technical and practical aspects of the active risk assessment documents at various stages of development.

Sub-Program 2.3.4: *Health Impacts of Chemicals*

Description

The *Canadian Environmental Protection Act,* provides the authority for the Health Impact of Chemicals program to assess the impact of chemicals and manage the potential health risks

posed by new and existing substances that are manufactured, imported, or used in Canada. This program activity links closely with Health Canada's Health Products, Food Safety and Nutrition, Consumer Product Safety and Pesticides program activities, as the *Food and Drugs Act*, the *Pest Control Products Act*, and the CCPSA provide the authority to manage the health risks associated with chemical substances in products in the purview of these program activities.

The CMP, implemented in partnership with Environment Canada, sets priorities and timelines for risk assessment and management for chemicals of concern, as well as the supporting research and bio-monitoring initiatives.

In addition to the above risk assessment and management activities, this program provides expert health-based advice and support to other federal departments in carrying out their mandates, as well as provides technical support for chemical emergencies that require a coordinated federal response.

The program objective is to identify and manage health risks to Canadians posed by chemicals of concern.

Budgetary Financial Resources (dollars)

2013-14 Planned Spending	2013-14 Actual Spending	2013-14 Difference (actual minus planned)
83,919,887	78,016,365	-5,903,522

Note: The variance between planned and actual spending is mainly due to a reprofile of funding for the retrofit of the Sir Frederick Banting Research Centre to 2014-15, and the transfer of the Travelling Public Program to PHAC.

Human Resources (FTEs)

2013-14 Planned	2013-14 Actual	2013-14 Difference (actual minus planned)
657	499	-158

Note: The variance in FTE utilization is largely attributed to program hiring delays and departures without backfills. In addition, 36 FTEs from the Travelling Public Program were transferred to PHAC.

Performance Results

Expected Results	Performance Indicators	Targets	Actual Results
Risks associated with chemical substances are assessed.	% of new substances for which industry has sent notification of their manufacture or import that are assessed within targeted timelines.	100 by March 31, 2014	100
	% of total 1,500 existing substances targeted by 2016 assessed.	33 by March 31, 2014	24

Expected Results	Performance Indicators	Targets	Actual Results
All levels of government have access to scientific information on how exposure to chemical substances impacts health.	% of targeted knowledge transfer activities accomplished.	95 by March 31, 2014	100

Performance Analysis and Lessons Learned

Health Canada continued to implement the CMP. The program received from industry 463 new substance notifications (substances manufactured or imported), and assessed all within targeted timelines. It also developed control measures for nine new substances assessed to be potentially harmful to human health. Success was the result of early identification of priorities and performance targets, ongoing tracking of progress and adjustment of resources as needed to meet targets.

Through the substance groupings initiative and rapid screening, Health Canada reached approximately 24% of the overall goal of assessing and managing the potential health and ecological risks associated with approximately 1,500 substances. While the 2013-14 target was not met due to the need for extensive preparatory discussions with stakeholders on information gathering, risk assessments, and internal and external discussions on approaches for class assessments and complex mixtures, Health Canada did publish the draft screening assessment reports for 362 substances and a final screening assessment report for 117 substances. In addition, Health Canada completed and published the draft screening assessment reports for 48 substances and the final screening assessment reports for 653 substances from the Challenge, Legacy, Petroleum, Rapid Screening I and High Hazard initiatives as well as concluded on 249 substances determined to have already been assessed or managed. To continue progress towards the assessment of 1,500 targeted substances by 2016, the program is actively managing the ongoing delivery of CMP products and continues to respond to stakeholder feedback.

Health Canada also continued to provide expert advice and oversight to minimize the risks to Canadians posed by environmental factors. The Department completed 100% (300) planned knowledge transfer activities such as client meetings, reports, publications and presentations, in support of research and monitoring and surveillance activities for the CMP. For example, Health Canada redefined its role as a federal authority under the *Canadian Environmental Assessment Act*[xlvii] by issuing new policy guidance on engagement and expert support. Under the Federal Contaminated Sites Action Plan, Health Canada provided expert support and guidance material to custodian departments on human health risk assessments in order to reduce the risks of contaminated sites on the health of Canadians.

Health Canada also released its Second Report on Human Biomonitoring of Environmental Chemicals in Canada in April 2013. This report presents national biomonitoring data on the Canadian population's exposure to chemicals, collected as part of Cycle 2 (2009-11) of the Canadian Health Measures Survey.

Program 2.4: *Consumer Product and Workplace Chemical Safety*

Description

The Consumer Product and Workplace Chemical Safety program supports efforts to protect Canadians from unsafe products and chemicals.

The Consumer Product Safety program supports industry's responsibility for the safety of their products and consumers' responsibility to make informed decisions about product purchase and use. Health Canada's efforts are focussed in three areas: active prevention; targeted oversight; and, rapid response.

The Workplace Chemical Safety program maintains a national hazard communication standard of cautionary labelling and material safety data sheets for hazardous chemicals supplied for use in Canadian workplaces. The program also provides for protection of confidential business information.

The program objectives are to protect Canadians by managing the potential health and safety risks posed by consumer products and cosmetics in the Canadian marketplace and from hazardous chemicals in the workplace.

Budgetary Financial Resources (dollars)

2013-14 Main Estimates	2013-14 Planned Spending	2013-14 Total Authorities Available for Use	2013-14 Actual Spending (authorities used)	2013-14 Difference (actual minus planned)
30,713,667	31,439,933	36,455,580	35,535,627	4,095,694

Note: The variance of $4.1 million between planned spending and actual spending is mainly due to the transfer of the functions and responsibilities of the former Hazardous Materials Information Review Commission Canada to Health Canada as of April 1, 2013, and paylist requirements (please refer to footnote 4 for explanation of paylist requirements).

Human Resources (Full-Time Equivalents [FTEs])

2013-14 Planned	2013-14 Actual	2013-14 Difference (actual minus planned)
249	282	33

Note: The variance in FTE utilization is mainly due to the transfer of the functions and responsibilities of the former Hazardous Materials Information Review Commission Canada to Health Canada as of April 1, 2013.

Performance Results

Expected Results	Performance Indicators	Targets	Actual Results
Risks associated with consumer products and cosmetics in the Canadian marketplace	% of non-compliant products identified through the Cyclical Enforcement Plan and	85 by March 31, 2014	97

Expected Results	Performance Indicators	Targets	Actual Results
are appropriately managed.	incident reporting, for which risk management action is taken in accordance with established operating procedures and timelines.		
Confidential Business Information is protected in accordance with the requirements of the *Hazardous Materials Information Review Act*.	# of breaches of confidentiality.	0 by March 31, 2014	0

Performance Analysis and Lessons Learned

Following the program evaluation in 2012-13 of Consumer Product Activities, Health Canada developed new procedures and service standards for select risk management actions. In 2013-14, Health Canada took action on non-compliant consumer products and cosmetics approximately 97% of the time within the service standard. Using the results of this performance evaluation, Health Canada continued to monitor the efficiency of its risk management operational procedures to ensure prompt action is taken to reduce the risks posed by dangerous consumer products and cosmetics in the Canadian marketplace.

The Workplace Chemical Safety Program provided protection of industry confidential business information in accordance with the requirements of the *Hazardous Materials Information Review Act*, while ensuring that accurate and complete health and safety information was available to workers. To deliver on a key initiative of the Canada-U.S. Regulatory Cooperation Council Action Plan, Health Canada continued to implement the Globally Harmonized System (GHS) of Classification and Labelling of Chemicals for workplace chemicals in support of reducing regulatory compliance burden, increasing protection of workers, and supporting cooperation with major trading partners.

Sub-Program 2.4.1: *Consumer Product Safety*

Description

The CCPSA and the *Food and Drugs Act* and its *Cosmetics Regulations*[xlviii] provide the authorities for this program to support industry's responsibility for the safety of their products and consumers' responsibility to make informed decisions about product purchase and use. Health Canada's efforts are focussed in three areas: active prevention; targeted oversight; and, rapid response.

Through active prevention, the program works with industry, standard setting bodies and international counterparts to develop standards and guidelines and share best practices as

appropriate. The program also promotes consumer awareness of the safe use of certain consumer products to support informed decision-making.

Through targeted oversight, the program undertakes regular cycles of compliance and enforcement in selected product categories, and analyses and responds to issues identified through mandatory reporting, market surveys, lab results and other means.

Under rapid response, when an unacceptable risk from consumer products is identified, the program can act quickly to protect the public and take appropriate enforcement actions – including issuing consumer advisories, working with industry to negotiate recalls or other corrective measures.

The program's objective is to manage the potential health and safety risks posed by consumer products and cosmetics in the Canadian marketplace.

Budgetary Financial Resources (dollars)

2013-14 Planned Spending	2013-14 Actual Spending	2013-14 Difference (actual minus planned)
31,439,933	30,184,564	-1,255,369

Note: The variance between planned and actual spending is mainly due to the transfer of resources to support efforts on the GHS of Classification and Labelling of Chemicals.

Human Resources (FTEs)

2013-14 Planned	2013-14 Actual	2013-14 Difference (actual minus planned)
249	243	-6

Note: The variance in FTE utilization is mainly due to the transfer of resources to support efforts on the GHS of Classification and Labelling of Chemicals.

Performance Results

Expected Results	Performance Indicators	Targets	Actual Results
Industry is informed / aware of regulatory requirements related to consumer products and cosmetics.	% of Canadian industries informed / aware of regulatory requirements.	95 by March 31, 2014	95
Early detection of potentially unsafe consumer products and cosmetics.	% of incident reports received and triaged within service standard.	90 by March 31, 2014	85

Performance Analysis and Lessons Learned

Health Canada continued the implementation of the CCPSA. In 2013-14, work continued on the development and implementation of new policies and procedures in accordance with the new Act. While Health Canada has worked extensively to inform industry of their obligations under the Act, a program evaluation of Consumer Product Activities revealed that there was still a portion of industry, in particular Small and Medium Enterprises (SMEs), who were unaware of some of their obligations. In response, the Department used webinars, factsheets, guides and awareness campaigns to raise industry's knowledge about their CCPSA obligations. According to information sessions evaluations, industry respondents somewhat/strongly agreed that, the sessions increased their awareness (90%) and understanding (100%) of their obligations under the Act. Health Canada will continue to undertake initiatives to increase industry's understanding of their obligations using the results of these evaluations.

Health Canada triaged incident reports to detect potentially unsafe consumer products and cosmetics at the earliest stage possible. Incident reports are then sent for appropriate risk assessment, risk management, compliance and enforcement, or placed under surveillance. In 2013-14, Health Canada received 1,793 incident reports (59% from industry, 41% from consumers) and triaged 85% of these reports within the service standard. Due to a disruption in the on-line reporting and case management tools, the service standard target was not met. To mitigate the impact, Health Canada immediately implemented manual triage of the incident reports in accordance with our service interruption protocol. All reports underwent an initial screening and all serious incidents were immediately actioned on a priority basis. Health Canada took action with Shared Services Canada to diagnose and correct the issue. Health Canada will use the lessons learned from the development of the triage service standards to finalize service standards for risk assessments in 2014-15.

In the spirit of international collaboration and alignment with the North American Cooperative Engagement Framework, Health Canada engaged with the U.S. and Mexico during the Second North American Summit held in Ottawa in September 2013. The Framework supports greater cooperation and sharing of information on consumer products that could present a hazard to human health and safety. Following the Summit, the three countries agreed to work collaboratively to address issues of common concern such as consumer outreach, customs communications with regulators and enforcement information sharing.

In 2013-14, the Deputy Minister approved an evaluation of the Consumer Products Activities[xlix] (horizontal initiative led by Health Canada).

Sub-Program 2.4.2: *Workplace Chemical Safety*

Description

The *Hazardous Products Act* and the *Hazardous Materials Information Review Act* provide the authorities for this program to protect the health and safety of Canadian workers.

Under the *Hazardous Products Act*, Health Canada regulates the sale and importation of hazardous chemicals used in Canadian workplaces by specifying the requirements for cautionary labelling and material safety data sheets.

Under the *Hazardous Materials Information Review Act*, Health Canada administers a timely mechanism to allow companies to protect confidential business information, ensuring industry competitiveness, while requiring that all critical hazard information is disclosed to workers.

This program sets the general standards for the Workplace Hazardous Materials Information System – a system based on interlocking federal, provincial, and territorial legislation that ensures the comprehensibility and accessibility of labels and material safety data sheets, the consistent application of classification and labelling criteria, and the alignment across Canada of compliance and enforcement activities.

The program objective is to ensure a coordinated national system that provides critical health and safety information on hazardous chemicals to Canadian workers.

Budgetary Financial Resources (dollars)

2013-14 Planned Spending	2013-14 Actual Spending	2013-14 Difference (actual minus planned)
0	5,351,063	5,351,063

Note: The variance between planned and actual spending is due to the transfer of the functions and responsibilities of the former Hazardous Materials Information Review Commission Canada to Health Canada as of April 1, 2013.

Human Resources (FTEs)

2013-14 Planned	2013-14 Actual	2013-14 Difference (actual minus planned)
0	39	39

Note: The variance in FTE utilization is due to the transfer of the functions and responsibilities of the former Hazardous Materials Information Review Commission Canada to Health Canada as of April 1, 2013.

Performance Results

Expected Results	Performance Indicators	Targets	Actual Results
Service delivery standards are maintained during a period of transition and program integration.	% of claims for exemption registered within 7-day service standard.	100 by March 31, 2014	75

Performance Analysis and Lessons Learned

On April 1, 2013, the functions and responsibilities of the Hazardous Materials Information Review Commission were transferred to the Workplace Hazardous Materials Directorate, a newly created directorate in Health Canada.

The Department continued to work on key priorities, including the implementation of the GHS of Classification and Labelling of Chemicals in support of reducing regulatory compliance burden, increasing protection of workers, and supporting cooperation with major trading partners as part of the Regulatory Cooperation Council commitment on workplace chemicals. A pre-consultation on the draft regulatory proposal for the *Hazardous Products Regulations* was held from June to September 2013. Legislative amendments to enable the implementation of the GHS for workplace chemicals in Canada were introduced in Parliament on March 28, 2014 as part of the *Budget Implementation Act*[i].

During the period of transition and program integration, 75% of complete claims for exemption under the *Hazardous Materials Information Review Act* were registered within the seven-day service standard. The Department identified significant business process improvements to the exemption process including re-evaluating processes and procedures with the goal of moving towards a more risk-based approach to claims for exemption.

Through this revised approach, changes have occurred to some claim-related roles and responsibilities, thus initially resulting in longer processing times and requiring some period of adjustment for staff to acquaint themselves with the revised approach. Under the revised approach, the program has also increased its diligence and ability to accurately track when complete claims met the seven-day service standard. Worth noting as well is the large influx of claims received within a very short period (18% of overall claims received within about a two-week span), which impacted on the ability to meet the service standard.

In future years, it is anticipated that the business process improvements implemented in 2013-14 will improve Health Canada's ability to meet the performance target of 100% for the registration of claims for exemption under HMIRA.

Program 2.5: *Substance Use and Abuse*

Description

Under the authority of several Acts, the Substance Use and Abuse program regulates tobacco products and controlled substances.

Through the *Tobacco Act* and its regulations the program regulates the manufacture, sale, labelling and promotion of tobacco products. The program leads the Federal Tobacco Control Strategy (FTCS), the goal of which is to further reduce the prevalence of smoking through regulatory, programming, educational and enforcement activities.

Through the *Controlled Drugs and Substances Act* (CDSA) and its regulations, the program regulates access to controlled substances and precursor chemicals to support their legitimate use and minimize the risk of diversion for illicit use. As a partner department under the National Anti-Drugs Strategy (NADS), the program supports prevention, health promotion, treatment initiatives, and enforcement with the goal of reducing substance use and abuse.

In addition, the program provides timely, evidence-based information to key stakeholders including, but not limited to, law enforcement agencies, health professionals, provincial and territorial governments and Canadians.

The program objective is to manage risks to the health of Canadians associated with the use of tobacco products, and the illicit use of controlled substances and precursor chemicals.

Budgetary Financial Resources (dollars)

2013-14 Main Estimates	2013-14 Planned Spending	2013-14 Total Authorities Available for Use	2013-14 Actual Spending (authorities used)	2013-14 Difference (actual minus planned)
84,926,070	85,652,336	88,593,095	88,591,578	2,939,242

Note: The variance of $2.9 million between planned spending and total authorities as well as actual spending is mainly due to funding to streamline government import regulations and border processes for commercial trade, resources required to ramp down the previous regime for medical marijuana and implement the new *Marihuana for Medical Purposes Regulations* (MMPR), and paylist requirements (please refer to footnote 4 for explanation of paylist requirements).

Human Resources (Full-Time Equivalents [FTEs])

2013-14 Planned	2013-14 Actual	2013-14 Difference (actual minus planned)
372	431	59

Note: The variance in FTE utilization is mainly due to an increase in resources required to ramp down the previous regime for medical marijuana and implement the new MMPR.

Performance Results

Expected Results	Performance Indicators	Targets	Actual Results
Reduction in tobacco prevalence.	% of current Canadian smokers (15+) reduced.	17 by March 31, 2015	16
Reduction in illicit drug use.	% of Canadians who abuse psychoactive drugs (15+) reduced.	10 by March 31, 2015	11
	% of youth (age 15-24) who abuse psychoactive drugs reduced. Note: The % of Canadians who abuse psychoactive drugs is defined as using at least	23 by March 31, 2015	22

Expected Results	Performance Indicators	Targets	Actual Results
	one of the following substances at least once in the past 12 months: cannabis, cocaine/crack, meth/crystal meth, ecstasy, hallucinogens, salvia, inhalants, heroin and pain relievers, stimulants or sedatives to get high.		

Performance Analysis and Lessons Learned

Health Canada has continued to make progress on priorities related to tobacco control and substance use and abuse.

With the national smoking rate at the lowest level ever recorded, the renewed tobacco program worked within the federal government's areas of core responsibility to continue the downward trend in smoking prevalence, including investments in new priorities for populations with higher rates of smoking.

In addition to the *Cracking Down* on *Tobacco Marketing Aimed at Youth Act*[li], Health Canada continued to implement new labelling requirements for cigarettes and little cigars which came into force in 2011. Although smoking rates have remained relatively stable in the last three years, youth smoking has declined to an all-time low of 7%.

Health Canada worked with the Department of Justice and other partners under NADS to advance the prevention, treatment and enforcement of illicit drug use. In February 2014, the Government of Canada announced $44.9 million in new funding over five years to address prescription drug abuse (PDA) and the expansion of NADS to include prescription drugs.

Health Canada also collaborated with the National Association of Chiefs of Police and Partnership for a Drug Free Canada to encourage Canadians to bring back their unused medications to pharmacies across the country. In 2013, Take Back Day saw between two and three tons of unused medications returned, thereby eliminating the possibility that they could be misused.

Under the enforcement action plan of NADS, Health Canada also helped prevent illicit drug use by conducting extensive follow-up work and targeted inspections of regulated parties; responding to high-risk situations stemming from emerging issues, loss and theft reports; and reporting suspicious transactions. Furthermore, the Department analyzed seized materials; helped with investigations and the safe dismantling of clandestine laboratories; and provided expert testimony in court.

Finally, under the prevention and treatment action plans of NADS, Health Canada continued to implement the Drug Strategy Community Initiatives Fund (DSCIF) and the Drug Treatment Funding Program (DTFP) to help reduce illicit drug use.

Sub-Program 2.5.1: *Tobacco*

Description

The *Tobacco Act* provides the authority for the Tobacco program to regulate the manufacture, sale, labelling, and promotion of tobacco products.

The program also leads the FTCS, in collaboration with federal partners as well as provincial and territorial governments, which supports regulatory, programming, educational and enforcement activities.

Key activities under the Strategy include: compliance monitoring and enforcement of the regulations under the *Tobacco Act* and associated regulations; monitoring tobacco consumption and smoking habits; and, working with national and international partners to ensure that Canada meets its obligations under the Framework Convention on Tobacco Control.

The program objective is to reduce the use of tobacco and the potential for tobacco-related death and disease in Canada.

Budgetary Financial Resources (dollars)

2013-14 Planned Spending	2013-14 Actual Spending	2013-14 Difference (actual minus planned)
24,598,917	20,440,669	-4,158,248

Note: The variance between planned and actual spending is mainly due to reductions in the cost of litigation due to success in Court, and lower than anticipated provincial and territorial funding requirements for the pan-Canadian Quitline. The balance of the Tobacco program activity funding was reallocated to help ramp down the previous regime for medical marijuana and implement the new MMPR.

Human Resources (FTEs)

2013-14 Planned	2013-14 Actual	2013-14 Difference (actual minus planned)
116	103	-13

Note: The variance in FTE utilization is mostly due to the reallocation of funding to help ramp down the previous regime for medical marijuana and implement the new MMPR.

Performance Results

Expected Results	Performance Indicators	Targets	Actual Results
Industry is compliant with the *Tobacco Act* and its regulations.	% of regulated parties that are deemed to be compliant with the *Tobacco Act* and its regulations through the inspection program.	95 by March 31, 2014	92

Performance Analysis and Lessons Learned

Few other countries have been as successful as Canada in lowering smoking rates and shifting public attitudes about tobacco. Smoking prevalence is now at its lowest-ever overall rate. In 2012, 16% of Canadians were current smokers, down from 22% in 2001. Further, the prevalence rate for teens aged 15-17 is 7%, the lowest it has ever been.

The 2012-17 FTCS refocused activities in tobacco control to continue the downward trend in smoking prevalence, including investments in new priorities for young adults and First Nations and Inuit – populations with higher smoking rates. Health Canada, which leads the FTCS, undertook a variety of regulatory, programming, educational and enforcement activities to further reduce smoking prevalence.

For example, Health Canada conducted compliance monitoring and enforcement activities pursuant to the *Tobacco Act*. Inspections found 92% of regulated parties compliant with the *Tobacco Act* and its regulations. There were no instances of non-compliance with the cigarette ignition propensity standard or with the prohibition on flavouring additives. Health Canada will continue to inform industry on their responsibilities under the *Tobacco Act*.

Health Canada, in collaboration with the Canadian Cancer Society, launched the "Break it Off Campaign[lii]" in Vancouver in January 2014 during National Non-Smoking Week. The Break it Off campaign is a young adult tobacco cessation, awareness and marketing campaign that will run until 2017.

New tobacco regulations under the *Tobacco Act* introduced in 2011, require graphic health warning messages that feature a national Quitline number and web portal on every package of cigarettes and little cigars. Health Canada provided funding to provinces and territories to support the implementation of the toll-free number and portal.

In 2013-14, Health Canada distributed over 148,000 tobacco publications and responded to over 580 public enquiries on tobacco issues.

Sub-Program 2.5.2: *Controlled Substances*

Description

Through the administration of the CDSA and its regulations, the program authorizes the possession, production, provision and disposition of controlled substances and precursor chemicals.

Key activities include: maintaining and updating the schedules for controlled substances and precursor chemicals; administering regulations for licensing and compliance monitoring activities; analyzing seized materials; providing training and assistance in investigating and dismantling of clandestine laboratories (Drug Analysis Services); monitoring the use of drugs through surveys; and working with national and international partners in the development of

sound and scientifically based recommendations for the analysis of illicit drugs available to Drug Analysis Laboratories worldwide.

As a partner in NADS, Health Canada supports initiatives related to illicit drugs including: education; prevention; health promotion; and treatment for Canadians, as well as compliance and enforcement initiatives.

The program objective is to authorize legitimate activities with controlled substances and precursor chemicals, while managing the risks of diversion, abuse and associated harms.

Budgetary Financial Resources (dollars)

2013-14 Planned Spending	2013-14 Actual Spending	2013-14 Difference (actual minus planned)
61,053,419	68,150,909	7,097,490

Note: The variance between planned and actual spending is mainly due to an increase in expenditures required to ramp down the previous regime for medical marijuana and implement the new MMPR.

Human Resources (FTEs)

2013-14 Planned	2013-14 Actual	2013-14 Difference (actual minus planned)
256	328	72

Note: The variance in FTE utilization is mainly due to an increase in resources required to ramp down the previous regime for medical marijuana and implement the new MMPR.

Performance Results

Expected Results	Performance Indicators	Targets	Actual Results
Holders of licences, authorizations and permits for controlled substances and precursor chemicals are compliant with the CDSA and its regulations.	% regulated parties that are deemed to be compliant with the CDSA and its regulations.	95 by March 31, 2015	99
Recipients of federal funding are enabled to deliver drug treatment and prevention programs.	# of funded projects delivering drug treatment and prevention programs.	55 by March 31, 2014	55

Performance Analysis and Lessons Learned

Health Canada conducted compliance monitoring and enforcement activities pursuant to the CDSA. The target was exceeded in that less than 1% of inspected parties were found to be non-compliant with the CDSA and its regulations.

The NADS is the federal government's comprehensive response to fighting illicit drug use in Canada. The strategy includes three action plans: preventing illicit drug use, treating those with illicit drug dependencies, and combating the production and distribution of illicit drugs. In support of NADS, the DTFP and the DSCIF continued to fund drug treatment and prevention projects. The two programs provided support to 55-targeted provincial, territorial and community projects. The 2013 Speech from the Throne announced that NADS would expand to include PDA. Call for proposals for new DSCIF and DTFP projects included PDA in the project scope or as a priority area.

In January 2014, the Minister of Health co-hosted a symposium on PDA with the Canadian Centre on Substance Abuse. The symposium brought together a number of government and First Nations leaders along with experts in the health and law enforcement fields to take collective action on PDA.

Health Canada finalized the new *Marihuana for Medical Purposes Regulations* (MMPR), which came into force in June 2013.

Health Canada also continued policy development related to controlled substance issues. For example, on October 17, 2013, the Minister of Health introduced Bill C-2, the *Respect for Communities Act*[liii], in the House of Commons. Bill C-2 is grounded in the dual purposes of the CDSA, which are the protection of public health and the maintenance of public safety. In addition, as part of its ongoing commitment to being a modern and effective regulator, Health Canada sought input from a range of key stakeholders on the CDSA and its regulations to identify gaps and/or suggested improvements to this important legislative framework.

In 2013-14, the Deputy Minister approved an evaluation of the Drug Treatment Funding Program[liv].

Program 2.6: *Radiation Protection*

Description

The *Department of Health Act*, the *Radiation Emitting Devices Act*, and the *Comprehensive Nuclear-Test-Ban Treaty Implementation Act*[lv] provide the authority for the Radiation Protection program to monitor, regulate, advise, and report on exposure to radiation that occurs both naturally and from man-made sources. In addition, the program is licensed under the Canadian Nuclear Commission's *Nuclear Safety and Control Act*[lvi] to deliver the National Dosimetry Service, which provides occupational radiation monitoring services.

The key components of the program are environmental monitoring, provision of technical support for a radiological/nuclear emergency that requires a coordinated federal response, occupational safety, and regulation of radiation emitting devices.

The program objective is to inform and advise other government departments, international partners, and Canadians in general about the health risks associated with radiation, and inform Canadians of strategies to manage associated risks.

Budgetary Financial Resources (dollars)

2013-14 Main Estimates	2013-14 Planned Spending	2013-14 Total Authorities Available for Use	2013-14 Actual Spending (authorities used)	2013-14 Difference (actual minus planned)
14,963,096	15,689,362	21,421,594	21,420,658	5,731,296

Note: The variance of $5.7 million between planned spending and total authorities as well as actual spending is mainly due to new funding to streamline government import regulations and border processes for commercial trade, the inclusion of certain spending for emergency management previously reported under the Specialized Health Services program and reallocations of funding from other programs within the Department, as well as paylist requirements (please refer to footnote 4 for explanation of paylist requirements).

Human Resources (Full-Time Equivalents [FTEs])

2013-14 Planned	2013-14 Actual	2013-14 Difference (actual minus planned)
171	186	15

Note: The variance in FTE utilization is mainly due to the inclusion of certain actual costs for emergency management previously reported under the Specialized Health Services program.

Performance Results

Expected Results	Performance Indicators	Targets	Actual Results
Canadians, Institutions and Government partners have the guidance they need to respond to potential and actual radiation risk.	% of planned guidance documents completed. Note: Guidance documents include emergency plans, safety codes, regulations, Memoranda of Understanding.	80 by March 31, 2014	100

Performance Analysis and Lessons Learned

Health Canada is the lead federal department responsible for coordinating the response to a nuclear or radiological emergency under the Federal Nuclear Emergency Plan (FNEP). As part of a series of exercises to test the revised FNEP, 5th edition, a command post exercise was held in

October 2013. Results from the exercise are used to inform the planning of the full-scale exercise in May 2014.

The Department continued to increase awareness on the risks, health impacts and mitigation strategies related to indoor radon exposure. In November 2013, Health Canada supported the New Brunswick Lung Association in launching National Radon Action Month, to encourage all Canadians to test the levels of radon gas in their homes, and to reduce radon levels if necessary.

In support of increasing Canadians' awareness and understanding of risks related to radiation emitting devices, Health Canada announced proposed changes to the *Radiation Emitting Devices Regulations*[lvii] that would strengthen the labelling requirements and the health warning messages for tanning equipment. The revised *Tanning Equipment Regulations*[lviii] were published in Canada Gazette II in February 2014. In addition, the Department published a new safety code for Mammography Radiation Protection and Quality Standards in Mammography - Safety Procedures for the Installation, Use and Control of Mammographic X-ray Equipment: Safety Code 36, which outlines the safe use of mammography equipment.

In support of the activities listed above, Health Canada exceeded the planned number of guidance documents completed. There were a number of guidance documents undertaken to inform the planning of the full-scale exercise in May 2014, to support the launch of National Radon Action Month and to increase Canadians' awareness and understanding of risks related to radiation emitting devices.

Sub-Program 2.6.1: *Environmental Radiation Monitoring and Protection*

Description

The Environmental and Radiation Monitoring and Protection program conducts research and monitoring activities under the authority of the *Department of Health Act* and the *Comprehensive Nuclear-Test-Ban Treaty Implementation Act*.

The program covers both naturally occurring forms of radioactivity and radiation, such as radon, and man-made sources of radiation, such as nuclear power.

In the delivery of this program, key activities include: implementing an education and awareness program on the health risks posed by radon in indoor air and how to reduce those risks; conducting research and risk assessment on the health effects of radiation; installing and operating monitoring stations to monitor for evidence of any nuclear explosion; and, reporting to the Comprehensive Nuclear-Test-Ban Treaty Organization and the International Atomic Energy Agency.

This program is also responsible for coordinating the Federal Nuclear Emergency Plan. In the case of a radio-nuclear emergency that requires a coordinated federal response, Health Canada coordinates the federal technical/scientific support to provinces/territories.

The program objectives are to monitor and inform Canadians of potential harm to their health and safety associated with environmental radiation.

Budgetary Financial Resources (dollars)

2013-14 Planned Spending	2013-14 Actual Spending	2013-14 Difference (actual minus planned)
9,941,458	14,794,204	4,852,746

Note: The variance between planned and actual spending is mainly due to increased costs for emergency management previously reported under the Specialized Health Services program, and paylist requirements (please refer to footnote 4 for explanation of paylist requirements).

Human Resources (FTEs)

2013-14 Planned	2013-14 Actual	2013-14 Difference (actual minus planned)
79	96	17

Note: The variance in FTE utilization is mainly due to the inclusion of certain actual costs for emergency management previously reported under the Specialized Health Services program.

Performance Results

Expected Results	Performance Indicators	Targets	Actual Results
Health Canada is prepared to respond to a nuclear or radiological emergency.	# of emergency preparedness exercises performed (in accordance to expectations of internal and external partners).	2 by March 31, 2014	5
Environmental radiation is monitored.	% of national radionuclear and Comprehensive Nuclear-Test-Ban Treaty monitoring stations and laboratories that are operational.	90 by March 31, 2014	99
Targeted partners collaborate to address health risks related to radiation/radon.	% of targeted partners participating in education and awareness and communication activities.	80 by March 31, 2014	100

Performance Analysis and Lessons Learned

As lead department for coordinating the federal response to a nuclear or radiological emergency, Health Canada conducted a number of exercises and drills to identify any problems, inadequacies, or gaps in preparedness and response plans so that these issues may be resolved prior to a real emergency. In 2013-14, a greater number of emergency preparedness exercises were undertaken to inform the planning for the full-scale exercise in May 2014.

Health Canada continued to meet international and national requirements related to environmental radiation monitoring. Environmental radiation monitoring activities support Canada's obligations under the Comprehensive Nuclear-Test-Ban-Treaty. Ninety-nine percent of national radionuclear and Comprehensive Nuclear-Test-Ban Treaty monitoring stations were operational, as well as all laboratories.

The National Radon Program engaged with provinces and territories, NGO's, health professionals, homebuilders and industry stakeholders across Canada to promote awareness and action-related to indoor radon exposure. Canadians and stakeholders were engaged through 86 education and awareness activities that included the distribution of radon materials at home shows, conferences, community and health centres. Participation rates of targeted partners in these activities were higher than anticipated.

In November 2013, Health Canada launched a new radon accredited on-line continuing medical education course for health care professionals.

Early and continued engagement of stakeholders and partners is essential to ensuring consistency in messaging to the public on radon.

Sub-Program 2.6.2: *Radiation Emitting Devices*

Description

Under the authority of the *Radiation Emitting Devices Act*, this program regulates radiation emitting devices, such as equipment for clinical/analytical purposes (X-rays, mammography, ultrasound), microwaves, lasers, and tanning equipment.

In the delivery of this program, key activities include: compliance assessment of radiation emitting devices at federally regulated facilities, research into the health effects of radiation (including noise, ultraviolet, and non-ionizing radiation from wireless devices such as cell phones and WiFi equipment); and, development of standards and guidelines for the safe use of radiation emitting devices.

The program provides expert advice and information to Canadians, as well as to other Health Canada programs, federal departments, and provincial authorities so that they may fulfil their legislative mandates.

The program objective is to manage the risks to the health of Canadians from radiation emitting devices.

Budgetary Financial Resources (dollars)

2013-14 Planned Spending	2013-14 Actual Spending	2013-14 Difference (actual minus planned)
5,165,004	5,818,799	653,795

Note: The variance between planned and actual spending is due to the inclusion of costs for emergency management previously reported under the Specialized Health Services program, and paylist requirements (please refer to footnote 4 for explanation of paylist requirements).

Human Resources (FTEs)

2013-14 Planned	2013-14 Actual	2013-14 Difference (actual minus planned)
44	33	-11

Note: The variance in FTE utilization is mainly due to program hiring delays.

Performance Results

Expected Results	Performance Indicators	Targets	Actual Results
Canadians have timely access to information on the health risks related to consumer and clinical radiation emitting devices.	% of public inquiries responded to within 5 business days.	90 by March 31, 2014	77
Institutions are enabled to take necessary action against radiation emitting devices that are non-compliant.	% of assessment and/or inspection reports completed upon request from institutions.	90 by March 31, 2014	100

Performance Analysis and Lessons Learned

Health Canada responded to 840 public inquiries associated with radiation emitting devices. Many of the inquiries related to the potential health effects of electric and magnetic fields, ultraviolet, infrared and visible light radiation and acoustics from consumer devices and manmade environmental sources.

At mid-year, the program developed generic responses for general and repeated inquiries from the public to better meet the five-day response standard. However, due to the complexity of many of the inquiries, the response rate still exceeded the five business day standard. Revision of the target from five days to 10 days will allow adequate time for response.

In support of increasing Canadians' awareness and understanding of risks related to radiation emitting devices, Health Canada posted on the GoC Healthy Canadians website fact sheets on Hand held lasers and laser pointers[lix] and The safety of compact fluorescent lamps[lx], and provided an information update on unlicensed laser hair removal products.

Health Canada also completed all requested assessments and/or inspection reports from institutions. Examples of some reports include *Radiation Emitting Devices Act* (REDA) assessments, laser and electro-optic assessments, interpretation/technical advice to industry under REDA, etc.

In 2013-14, the Deputy Minister approved the following evaluations: Medical Devices Program 1999-2000 to 2011-12 and, Consumer Products Activities (horizontal initiative led by Health Canada).

Sub-Program 2.6.3: *Dosimetry Services*

Description

The Dosimetry Services program monitors, collects information, and reports on the exposure to radiation of its clients, occupational radiation workers under the licence of the Canadian Nuclear Safety Commission's *Nuclear Safety and Control Act*, and/or provincial/territorial regulations.

Dosimetry is the act of measuring or estimating radiation doses and assigning those doses to individuals.

The National Dosimetry Services provides radiation monitoring services on a cost-recovery basis to Canadians exposed to ionising radiation in their places of work, and, the National Dose Registry provides a centralized radiation dose record system.

The program objective is to ensure that Canadians exposed to radiation in their places of work who are monitored by the Dosimetry Services program are informed of their radiation exposure levels.

Budgetary Financial Resources (dollars)

2013-14 Planned Spending	2013-14 Actual Spending	2013-14 Difference (actual minus planned)
582,900	807,655	224,755

Note: The variance between planned and actual spending is mainly due to the inclusion of costs for the National Dose Registry previously reported under Environmental Radiation Monitoring and Protection.

Human Resources (FTEs)

2013-14 Planned	2013-14 Actual	2013-14 Difference (actual minus planned)
48	57	9

Note: The variance in FTE utilization is mainly due to the inclusion of costs for the National Dose Registry previously reported under Environmental Radiation Monitoring and Protection.

Performance Results

Expected Results	Performance Indicators	Targets	Actual Results
Occupational radiation workers and their employers are informed of their exposure level.	% of dosimeters reported within 10 days of receiving client dosimeters.	90 by March 31, 2014	91
	% of dose history reports sent to clients within 10 days of receipt of request.	100 by March 31, 2014	100
	% of overexposure readings reported to Regulatory Authorities within 24 hours of dose information received into the National Dose Registry.	100 by March 31, 2014	100

Performance Analysis and Lessons Learned

Health Canada provided timely and reliable dosimetry services to 12,500 client groups. The Department processed and reported 91% of dosimeter readings to client groups and the National Dose Registry within 10 days of receipt and all dose history reports were sent to clients within 10 days of receipt of request. The 11 overexposure readings were reported to Regulatory Authorities within 24 hours of dose information received into the National Dose Registry.

Program 2.7: *Pesticides*

Description

The *Pest Control Products Act* provides Health Canada with the authority to regulate and register pesticides, under the Pesticides program.

In the delivery of this program, Health Canada conducts activities that span the lifecycle of a pesticide, including**:** product assessment for health and environmental risks and product value; risk management; post market surveillance; compliance and enforcement; changes in use, cancellation, or phase out of products that do not meet current standards; and, consultations and public awareness building.

Health Canada is also an active partner in international efforts (e.g., North American Free Trade Agreement; Organization for Economic Cooperation and Development (OECD), Regulatory Cooperation Council) to align regulatory approaches. These engagements provide access to the best science available to support regulatory decisions and promote consistency in the assessment of pesticides.

The program objective is to protect the health and safety of Canadians and the environment relating to the use of pesticides.

Budgetary Financial Resources (dollars)

2013-14 Main Estimates	2013-14 Planned Spending	2013-14 Total Authorities Available for Use	2013-14 Actual Spending (authorities used)	2013-14 Difference (actual minus planned)
40,442,256	41,168,522	47,823,266	46,299,835	5,131,313

Note: The variance of $5.1 million between planned spending and actual spending is mainly due to new funding to streamline government import regulations and border processes for commercial trade, and paylist requirements (please refer to footnote 4 for explanation of paylist requirements).

Human Resources (Full-Time Equivalents [FTEs])

2013-14 Planned	2013-14 Actual	2013-14 Difference (actual minus planned)
519	407	-112

Note: The variance in FTE utilization is mainly due to a reduction in staff as a result of savings achieved through simplifying and streamlining operations while maintaining services to Canadians. Reductions in FTEs were achieved through attrition and voluntary departures.

Performance Results

Expected Results	Performance Indicators	Targets	Actual Results
Industry meets the Canadian regulatory requirements for new pesticides.	% of submissions that meet regulatory requirements.	80 by March 31, 2014	Category A* = 97 Category B = 96 Category C = 65
Pesticides in the marketplace continue to meet modern scientific standards.	% of registered pesticides that are re-assessed according to the Re-evaluation Work Plan.	80 by March 31, 2014	80
International collaboration is leveraged to maximize access to global science for the risk assessment of pesticides.	% of new pesticides reviewed in collaboration with international partners.	80 by March 31, 2014	100

*Note: Category A includes new active ingredients or integrated system products, their related end-use products, and manufacturing-use products; major new use of registered pest control products; and specification of import Maximum Residue Limit (MRL) for an unregistered active ingredient. Category B includes new pest control products containing registered active ingredients; amendment to existing pest control products; conversion or renewal of conditional registration; emergency registration; and the addition of import MRLs for previously assessed active ingredients. Category C includes product registrations and amendments with no data requirements. These applications involve minor label or formulation reviews, such a product registration based on registered precedent products.

Performance Analysis and Lessons Learned

Health Canada continued to deliver on its responsibilities, under the *Pest Control Products Act*, through the evaluation and re-evaluation of pesticide products, compliance and enforcement, outreach and risk reduction strategies.

The Pesticide Re-evaluation program continued with the initiation and re-assessment of scheduled re-evaluations, according to the work plan, while managing an increased number of additional special review requests.

Health Canada continued its international collaboration with partners in standardizing and harmonizing global approaches. Through both the Canada-U.S. Regulatory Cooperation Council and OECD, Health Canada expanded the use of joint reviews, which facilitated same time access to new pesticide technology for Canadian growers. Furthermore, Health Canada has a very close working relationship with the U.S.-EPA and collaborates with them on all new Active Ingredients. Partnerships with other North American and international regulators, as well as industry partners, have resulted in the development of a scientific framework to better assess the potential risk of pesticides to pollinators, resulting in the development and communication of new best practices for managing treated seed. Health Canada, in coordination with the OECD Network of Government Officials for Pesticide Compliance and Enforcement, developed a public website that shares best practices and information on compliance and enforcement activities, and complements OECD activities on illegal international trade of pesticides.

The implementation of the Food and Consumer Safety Action Plan continued to meet all commitments. Funding under the Plan enabled the Pest Management Regulatory Agency to deliver compliance programs and projects, including active prevention and inspection activities for key sectors.

The evaluation of Consumer Products Activities (horizontal initiative led by Health Canada), under the Food and Consumer Safety Action Plan and approved by the Deputy Minister in 2013-14, found that significant targeted awareness building and outreach activities, related to pesticides, specifically in the areas of compliance and incident-reporting had been completed. Further evaluation findings are described in Sub-program 2.4.1.

Health Canada also continued to modernize its IT system to improve public reporting on pest control product submissions, products and activities. Public consultation on a revised cost recovery framework was initiated and responses will inform the development of a proposal in the next fiscal year.

Strategic Outcome 3: First Nations and Inuit communities and individuals receive health services and benefits that are responsive to their needs so as to improve their health status

Program 3.1: *First Nations and Inuit Primary Health Care*

Description

The *Department of Health Act* 1996, and the *Indian Health Policy* (1979)[lxi] provide the authority for the delivery of the First Nations and Inuit Primary Health Care program to First Nations and Inuit in Canada. Primary health care includes health promotion and disease prevention, public health protection (including surveillance), and primary care (where individuals are provided diagnostic, curative, rehabilitative, supportive, palliative/end-of-life care, and referral services).

The Department administers contribution agreements and direct departmental spending related to child development, mental wellness and healthy living, communicable disease control and management, environmental health, Clinical and Client Care (CCC), as well as home and community care.

The program objective is to improve the health and safety of First Nations and Inuit individuals, families, and communities.

Budgetary Financial Resources (dollars)

2013-14 Main Estimates	2013-14 Planned Spending	2013-14 Total Authorities Available for Use	2013-14 Actual Spending (authorities used)	2013-14 Difference (actual minus planned)
954,094,539	954,094,539	931,062,884	927,125,272	-26,969,267

Note: The variance of $27 million between planned spending and actual spending is mainly due to additional funding received through Supplementary Estimates to support First Nations and Inuit Health Programs and Services, which is offset by reductions associated with the realignment of resources for the implementation of the B.C. Tripartite initiative ($75 million), and a surplus of funding in the Indian Residential Schools Resolution Health Support program.

Human Resources (Full-Time Equivalents [FTEs])

2013-14 Planned	2013-14 Actual	2013-14 Difference (actual minus planned)
1,152	1,441	289

Note: The variance in FTE utilization is mainly due to a realignment of resources from plans in order to meet program needs. This is partially offset by reductions associated with the realignment of resources for the implementation of the B.C. Tripartite initiative. Health Canada receives annual growth of 3% on a portion of First Nation and Inuit Primary Health Care programs. These funds are appropriated as Operating fund. Consistent with program authorities approved by Treasury Board, Health Canada has annually realigned resources based on program needs from Operating to Salaries over the past several years; therefore, Actual FTE Utilization is higher than Planned. The department plans to make adjustments in future Main Estimates to reflect current business requirements now that DPRs are reporting at the Sub-Sub Program levels.

Performance Results

Expected Results	Performance Indicators	Targets	Actual Results
Health and safety of First Nations and Inuit are improved.	% of First Nations adults reporting being in excellent or very good health.	45 by March 31, 2017	44.1 18+years
	% of Inuit adults reporting being in excellent or very good health.	50.5 by March 31, 2017	42.1 18+years
	% of primary health care programs delivered to First Nations and Inuit that incorporate cultural approaches into programming.	80 by March 31, 2017	100

Performance Analysis and Lessons Learned

Health Canada continued to focus on health promotion and disease prevention programs, and enhanced access to services to help strengthen primary health care services for First Nations and Inuit communities. For example, the Department has exceeded its target for the incorporation of cultural approaches into health care programs for First Nations and Inuit. This achievement has been accomplished three years in advance of the original target date.

The Department supported First Nations and Inuit communities in developing their own health solutions, strengthening health related programming, and improving their access to health services through the integration of federal and provincial and territorial programs. These measures included access to Healthy Child Development (HCD) programs, the development of a national framework for addressing Sexually Transmitted and Blood-borne Infections (STBBI), investments in the Aboriginal Diabetes Initiative, and provision of essential nursing services in remote and isolated First Nations communities.

Sub-Program 3.1.1: *First Nations and Inuit Health Promotion and Disease Prevention*

Description

The First Nations and Inuit Health Promotion and Disease Prevention program delivers health promotion and disease prevention services to First Nations and Inuit in Canada.

The program administers contribution agreements and direct departmental spending for culturally appropriate community-based programs, services, initiatives, and strategies. In the delivery of this program, the following three key areas are targeted: healthy child development; mental wellness; and healthy living.

The program objective is to address the healthy development of children and families, to improve mental wellness, and to reduce the impacts of chronic disease on First Nations and Inuit individuals, families, and communities.

Budgetary Financial Resources (dollars)

2013-14 Planned Spending	2013-14 Actual Spending	2013-14 Difference (actual minus planned)
538,429,266	481,068,597	-57,360,669

Note: The variance between planned and actual spending is mainly due to reductions associated with the realignment of resources for the implementation of the B.C. Tripartite initiative, the reallocation of funding to other programs within this strategic outcome to address needs and priorities, and a surplus in the Indian Residential Schools Resolution Health Support Program due to the demand driven nature of the program.

Human Resources (FTEs)

2013-14 Planned	2013-14 Actual	2013-14 Difference (actual minus planned)
264	330	66

Note: The variance in FTE utilization is mainly due to a realignment of resources from plans in order to meet program needs. This is partially offset by reductions associated with the realignment of resources for the implementation of the B.C. Tripartite initiative.

Performance Results

Expected Results	Performance Indicators	Targets	Actual Results
The capacity of First Nations and Inuit communities to deliver community-based health promotion and disease prevention programs and services is improved.	# of workers who completed training during the reporting year for HCD programs (specifically Maternal Child Health [MCH]) (baseline 473).	473 by March 31, 2014	386*
	# of workers who completed training for healthy living programs (specifically Aboriginal Diabetes Initiatives - Community Diabetes Prevention Workers) (baseline 465).	465 by March 31, 2014	466
	% of addictions counsellors in treatment centres who are certified workers.	77 by March 31, 2014	79

* Approximately 50 MCH workers trained from B.C. were removed from the results due to the implementation of the B.C. Tripartite initiative. Had these numbers been included in the results, the target would have been exceeded. In addition, Ontario region trained 63 MCH workers in 2012-13.

Performance Analysis and Lessons Learned

Health Canada invested in community Health Promotion and Disease Prevention programs to reduce risk factors and support healthy living in First Nations and Inuit communities. This included creating supportive environments and increasing the practice of healthy behaviours through improved access to healthy foods; the promotion of healthy eating, physical activity, and healthy body weights; and, chronic disease prevention.

The Department continued to support training of workers through their participation HCD programs (such as Maternal Child Health). This training has resulted in increased access to prenatal and postnatal health services, such as screening and breastfeeding activities, in order to improve maternal and infant health outcomes. HCD programming offers access to an array of culturally appropriate support including early childhood development; home visits by community nurses and family visitors; and, clinical preventative oral health services for children and oral hygiene and nutritional counselling to parents, caregivers and pregnant women.

Aboriginal Diabetes Initiative (ADI) results to date have shown an increase in community and organizational capacity to deliver diabetes prevention programs and services, and greater access to services and support for clients and their care providers. As of March 2014, 466 community health workers have been trained under ADI.

A key element of the Mental Wellness program is addiction prevention and treatment programming delivered through a network of 55 treatment centres, as well as drug and alcohol prevention services in the majority of First Nations and Inuit communities across Canada. Since 2007, 36 treatment centres have expanded or re-profiled their services to meet community needs more effectively, such as services for women, youth, and/or people with co-occurring mental health issues or PDA issues. The percentage of accredited treatment centres also continued to increase from 76% in 2011-12 to 84% in 2012-13.

Sub-Sub-Program 3.1.1.1: *Healthy Child Development*

Description

The HCD program administers contribution agreements and direct departmental spending to support culturally appropriate community-based programs, services, initiatives, and strategies related to maternal, infant, child, and family health. The range of services includes prevention and health promotion, outreach and home visiting, and early childhood development programming.

Targeted areas in the delivery of this program include: prenatal health, nutrition, early literacy and learning, and physical and children’s oral health.

The program objective is to address the greater risks and lower health outcomes associated with First Nations and Inuit infants, children, and families.

Budgetary Financial Resources (dollars)

2013-14 Planned Spending	2013-14 Actual Spending	2013-14 Difference (actual minus planned)
123,101,727	107,517,805	-15,583,922

Note: The variance between planned and actual spending is mainly due to reductions associated with the realignment of resources for the implementation of the B.C. Tripartite initiative and a reallocation of funding within this strategic outcome to CCC to address needs and priorities.

Human Resources (FTEs)

2013-14 Planned	2013-14 Actual	2013-14 Difference (actual minus planned)
70	86	16

Note: The variance in FTE utilization is mainly due to a realignment of resources from plans in order to meet program needs. This is partially offset by reductions associated with the realignment of resources for the implementation of the B.C. Tripartite initiative.

Performance Results

Expected Results	Performance Indicators	Targets	Actual Results
First Nations and Inuit have access to HCD programs and services.	# of women accessing Prenatal and Postnatal Health, including Nutrition (specifically Canada Prenatal Nutrition Program) (baseline 9,000).	9,000 by March 31, 2014	10,200
	# of children accessing early literacy and learning (specifically Aboriginal Head Start On Reserve) (baseline 9,000).	9,000 by March 31, 2014	13,012
	% of children accessing Children's Oral Health (baseline 22,500).	22,500 by March 31, 2014	23,687

Performance Analysis and Lessons Learned

HCD programs, such as Maternal Child Health, Canada Prenatal Nutrition (First Nations and Inuit component), Aboriginal Head Start on Reserve, Fetal Alcohol Spectrum Disorder programs, and the Children's Oral Health Initiative, have increased access to services that support healthy outcomes. This increased access was demonstrated by the Department exceeding the established target of 9,000 women accessing Prenatal and Postnatal Health, including Nutrition (specifically Canada Prenatal Nutrition Program) by over 1,000. Recent data has demonstrated that pregnant clients who received healthy pregnancy and early infancy services,

four or more times, had no pregnancy complications and experienced healthier gestational weight gains, compared to women who did not participate as frequently in this initiative.

Opportunities for Aboriginal children to learn about their language and culture are important in supporting their knowledge of and connectedness to their community, which can build resiliency and promote better health. Health Canada surpassed its target by providing 13,200 children access to early literacy and learning through the Aboriginal Head Start on Reserve program. This is an increase of over 4,000 children. Evaluations have demonstrated that early childhood development under Aboriginal Head Start on Reserve has been successful in producing positive changes in children's readiness to learn, and First Nations language development.

These community-led, culturally-relevant programs and services support First Nations and Inuit children and their families in reaching their full potential. At the same time, ensuring equitable access to HCD programs and services for First Nations and Inuit communities continues to be of concern.

Sub-Sub-Program 3.1.1.2: *Mental Wellness*

Description

The Mental Wellness program administers contribution agreements and direct departmental spending that supports culturally-appropriate community-based programs, services, initiatives and strategies related to the mental wellness of First Nations and Inuit. The range of services includes prevention, early intervention, treatment, and aftercare.

Key services supporting program delivery include: substance abuse prevention and treatment (part of National Anti-Drug Strategy), mental health promotion, suicide prevention, and health supports for participants of the Indian Residential Schools Settlement Agreement.

The program objective is to address the greater risks and lower health outcomes associated with the mental wellness of First Nations and Inuit individuals, families, and communities.

Budgetary Financial Resources (dollars)

2013-14 Planned Spending	2013-14 Actual Spending	2013-14 Difference (actual minus planned)
341,757,466	314,915,568	-26,841,898

Note: The variance between planned and actual spending is mainly due to reductions associated with the realignment of resources for the implementation of the B.C. Tripartite initiative, which is partially offset by additional funding received through Supplementary Estimates to support the implementation of additional Mental Wellness Teams. The variance is also a result of a surplus in the Indian Residential Schools Resolution Health Support Program due to the demand driven nature of the program.

Human Resources (FTEs)

2013-14 Planned	2013-14 Actual	2013-14 Difference (actual minus planned)
90	110	20

Note: The variance in FTE utilization is mainly due to a realignment of resources from plans in order to meet program needs. This is partially offset by reductions associated with the realignment of resources for the implementation of the B.C. Tripartite initiative.

Performance Results

Expected Results	Performance Indicators	Targets	Actual Results
Abstinence from drug and alcohol use after addictions treatment.	# of treatment centre clients who terminated substance use of at least one substance after completing treatment.	30 by March 31, 2014	60
Reduced substance use following treatment.	% of treatment centre clients who reduced use of at least one substance after completing treatment.	50 by March 31, 2014	94
First Nations and Inuit have access to mental wellness programs and services.	# of projects providing suicide prevention programs (specifically National Aboriginal Youth Suicide Prevention Program) (baseline 150).	150* by March 31, 2014	136

* Mental Wellness Program adjusted the target to 125 to be consistent with the strategy's direction and an identified need to focus more on communities at risk and because the Program, to be more effective, is concentrating their efforts on some aggregated projects.

Performance Analysis and Lessons Learned

The First Nations and Inuit Mental Wellness program contributed to improving the quality and availability of comprehensive mental health and addictions services through its investments in 2013-14. Although gains in mental wellness continued, challenges remain due to the pervasive nature of mental health and addictions issues in First Nations and Inuit communities. A 2012-13 survey of clients who successfully completed treatment as part of Honouring Our Strengths (framework for the National Native Alcohol and Drug Abuse Program), showed that 94% of clients who had visited treatment centres had reduced their use of at least one substance since treatment, with 60% responding that they never used again.

The National Aboriginal Youth Suicide Prevention Strategy supported approximately 150 youth suicide prevention projects. These projects were diverse, firmly rooted in culture, based on community priorities, and focussed on reducing risk factors among First Nations and Inuit youth. Mental wellness teams supporting First Nation and Inuit communities increased from seven to eleven, improving access to these services.

A key component of the Mental Wellness program is the provision of professional counselling, cultural and emotional support services to former Indian Residential School students and their families. In 2013-14, Health Canada funded more than 120 First Nations and Inuit community-based organizations to make cultural and mental health support services available to eligible clients. The interim report of the Truth and Reconciliation Commission recognized the cultural component as a best practice.

Health Canada, in partnership with key stakeholders, supported the development of a First Nations Mental Wellness Continuum Framework that will strengthen programming, and support integration and alignment with community priorities along a continuum of care. Work continued with the Inuit Tapiriit Kanatami and regions on a plan for the development of an Inuit Mental Wellness Continuum Framework.

Sub-Sub-Program 3.1.1.3: *Healthy Living*

Description

The Healthy Living program administers contribution agreements and direct departmental spending that supports culturally appropriate community-based programs, services, initiatives, and strategies related to chronic disease and injuries among First Nations and Inuit.

This program aims to promote healthy behaviours and supportive environments in the areas of healthy eating, physical activity, food security, chronic disease prevention, management and screening, and injury prevention policy.

Key activities supporting program delivery include: chronic disease prevention and management, injury prevention, the Nutrition North Canada–Nutrition Education Initiative, and the First Nations and Inuit component of the FTCS (being implemented in 2012-13).

The program objective is to address the greater risks and lower health outcomes associated with chronic diseases and injuries among First Nations and Inuit individuals, families, and communities.

Budgetary Financial Resources (dollars)

2013-14 Planned Spending	2013-14 Actual Spending	2013-14 Difference (actual minus planned)
73,570,073	58,635,224	-14,934,849

Note: The variance between planned and actual spending is mainly due to a reallocation of funding within this strategic outcome to CCC to address needs and priorities, reductions associated with the realignment of resources for the implementation of the B.C. Tripartite initiative, and a reprofile of funding for the FTCS to future years.

Human Resources (FTEs)

2013-14 Planned	2013-14 Actual	2013-14 Difference (actual minus planned)
104	134	30

Note: The variance in FTE utilization is mainly due to a realignment of resources from plans in order to meet program needs. This is partially offset by reductions associated with the realignment of resources for the implementation of the B.C. Tripartite initiative.

Performance Results

Expected Results	Performance Indicators	Targets	Actual Results
First Nations and Inuit have access to health living programs and services.	# of communities providing healthy living programs (specifically Aboriginal Diabetes Initiatives).	673* by March 31, 2014	637*
	% of projects that deliver physical activities under the Aboriginal Diabetes Initiatives.	63 by March 31, 2014	83.4
	# of projects that deliver healthy eating activities under the Aboriginal Diabetes Initiatives.	66 by March 31, 2014	84.7

* The ADI is reaching all communities (either directly via a funding agreement or through activities provided to the community by a nearby organization/community receiving ADI funding).

Performance Analysis and Lessons Learned

Diabetes is a significant health concern among First Nations, as they experience rates of diabetes 3-4 times higher than the rate among non-Aboriginal Canadians. In 2013-14, Health Canada invested in the ADI, which works at reducing Type 2 diabetes through health promotion and disease prevention services in 637 First Nations and Inuit communities. ADI benefits these communities by increasing awareness and knowledge of risk factors and diabetes prevention approaches, and by providing access to diabetes prevention, screening, and management services.

The percentages of projects delivered under ADI (related to both physical activities and healthy eating activities) have increased beyond expected targets. Additionally, ADI results to date have shown an increase in community and organizational capacity to deliver diabetes prevention programs and services, and greater access to services and support for clients and their care providers. The 2008-10 First Nations Regional Longitudinal Health Survey found that more than half (53.6%) of all those with diabetes were currently attending a diabetes clinic or seeking treatment for diabetes, an increase of 4.2% from the 2002-03 survey findings.

ADI also supported activities to improve healthy food access and availability, including the development of strategic multi-sector plans, innovative partnerships and community-led

initiatives. Through Nutrition North Canada, Health Canada provided additional investments for community-based nutrition education in 78 isolated northern First Nations and Inuit communities. Notwithstanding gains made, factors such as poverty and food insecurity continue to impede the adoption of healthy lifestyles and improved health outcomes.

Sub-Program 3.1.2: *First Nations and Inuit Public Health Protection*

Description

The First Nations and Inuit Public Health Protection program delivers public health protection services to First Nations and Inuit in Canada. In the delivery of this program, the key areas of focus are communicable disease control and management, and environmental public health.

The First Nations and Inuit Public Health Protection program administers contribution agreements and direct departmental spending to support initiatives related to communicable disease control and environmental public health service delivery including public health surveillance, research, and risk analysis. Communicable disease control and environmental public health services are targeted to on-reserve First Nations, with some support provided in specific instances, (e.g., to address tuberculosis), in Inuit communities south of the 60th parallel. Environmental public health research, surveillance, and risk analysis are directed to on-reserve First Nations, and in some cases, (e.g., climate change and health adaptation, and biomonitoring), also to Inuit and First Nations living north of the 60th parallel.

Surveillance data underpins these public health activities, and all are conducted with the understanding that social determinants play a crucial role. To mitigate impacts from factors beyond the public health system, the program works with First Nations, Inuit, and other organizations.

The program objective is to address human health risks for First Nations and Inuit communities associated with communicable diseases, and exposure to hazards within the natural and built environments by increasing community capacity to respond to these risks.

Budgetary Financial Resources (dollars)

2013-14 Planned Spending	2013-14 Actual Spending	2013-14 Difference (actual minus planned)
162,005,013	136,591,202	-25,413,811

Note: The variance between planned and actual spending is mainly due to a reallocation of funding within this strategic outcome to address needs and priorities, as well as reductions associated with the realignment of resources for the implementation of the B.C. Tripartite initiative.

Human Resources (FTEs)

2013-14 Planned	2013-14 Actual	2013-14 Difference (actual minus planned)
318	371	53

Note: The variance in FTE utilization is mainly due to a realignment of resources from plans in order to meet program needs. This is partially offset by reductions associated with the realignment of resources for the implementation of the B.C. Tripartite initiative.

Performance Results

Expected Results	Performance Indicators	Targets	Actual Results
The community capacity to respond to health emergencies is improved.	% of First Nations communities with integrated Pandemic Preparedness/Response Plans and Emergency Preparedness/Readiness Plans.	75 by March 31, 2015	72.6
Environmental health risks relating to water quality are reduced.	% of on-reserve public water systems that met weekly national testing guidelines for bacteriological parameters (e.g., based on testing frequency recommended in the Guidelines for Canadian Drinking Water Quality).	50.6 by March 31, 2016	58
	% of First Nations communities that have access to a trained Community-based Drinking Water Quality Monitor or an Environmental Health Officer to monitor their drinking water quality.	100 by March 31, 2016	100

Performance Analysis and Lessons Learned

In 2013-14, Health Canada continued to assist First Nations communities in enhancing their capacity to monitor drinking water quality by working closely with targeted communities, and increase their knowledge on mould in First Nations communities. In November 2013, the *Safe Drinking Water for First Nations Act*[lxii] came into force. The Department is collaborating with Aboriginal Affairs and Northern Development Canada (AANDC) on the development of the associated regulations. Although there has been progress, compliance with monitoring frequency, as outlined in the Guidelines for Canadian Drinking Water Quality, continues to present logistical challenges typical of management of very small water systems that are often found in rural or remote locations.

Sub-Sub-Program 3.1.2.1: *Communicable Disease Control and Management*

Description

The Communicable Disease Control and Management program administers contribution agreements and direct departmental spending to support initiatives related to vaccine preventable diseases, blood borne diseases and sexually transmitted infections, respiratory infections, and communicable disease emergencies. In collaboration with other jurisdictions communicable disease control and management activities are targeted to on-reserve First Nations, with support provided to specific instances, (such as to address tuberculosis), in Inuit communities south of the 60th parallel. Communicable Disease Control and Management activities are founded on public health surveillance and evidence-based approaches and reflective of the fact that all provincial and territorial governments have public health legislation.

Key activities supporting program delivery include: prevention, treatment and control of cases and outbreaks of communicable diseases; and, public education and awareness to encourage healthy practices.

A number of these activities are closely linked with those undertaken in the Environmental Health program (3.1.2.2), as they relate to waterborne, foodborne and zoonotic infectious diseases.

The program objective is to reduce the incidence, spread, and human health effects of communicable diseases for First Nations and Inuit communities.

Budgetary Financial Resources (dollars)

2013-14 Planned Spending	2013-14 Actual Spending	2013-14 Difference (actual minus planned)
72,982,740	54,193,834	-18,788,906

Note: The variance between planned and actual spending is mainly due to a reallocation of funding within this strategic outcome to CCC, as well as reductions associated with the realignment of resources for the implementation of the B.C. Tripartite initiative.

Human Resources (FTEs)

2013-14 Planned	2013-14 Actual	2013-14 Difference (actual minus planned)
124	147	23

Note: The variance in FTE utilization is mainly due to a realignment of resources from plans in order to meet program needs. This is partially offset by reductions associated with the realignment of resources for the implementation of the B.C. Tripartite initiative.

Performance Results

Expected Results	Performance Indicators	Targets	Actual Results
Continue on-reserve access to tuberculosis control and management services and improved rates of treatment adherence.	% of patients diagnosed with active tuberculosis who are scheduled to complete treatment during the calendar year being reported on who do complete treatment.	90 by March 31, 2016	83.8
Public awareness and knowledge of vaccine preventable diseases and immunization is improved.	% of on-reserve caregivers who recognize the importance of childhood vaccination.	85 by March 31, 2016	Information will be available March 31, 2016
	% of health care providers servicing communities who are using First Nations and Inuit health Branch (Health Canada) immunization education and awareness materials.	70 by March 31, 2016	Information will be available March 31, 2016

Performance Analysis and Lessons Learned

Health Canada supported public health measures to prevent and control cases and outbreaks of communicable disease on-reserve; promoted public education and awareness to encourage healthy practices; strengthened community capacity; undertook monitoring, surveillance and reporting of communicable disease; and, provided a liaison and coordination function for all-hazard emergency management.

Based on the Canadian Tuberculosis Reporting System, 83.8% of reported active (new and re-treatment) tuberculosis cases among First Nations (Status and Non-Status) on-reserve diagnosed in 2011 were reported as cured or having completed treatment.

To address the high rates of blood-borne and sexually-transmitted infections in First Nations on-reserve, Health Canada initiated a national approach, with a particular focus on HIV/AIDS, in collaboration with partners and stakeholders. In 2013-14, Health Canada developed the goals, themes and a discussion paper for STBBI Framework; completed a four year Immunization Social Marketing Campaign; and, a final draft of the Monitoring and Performance Framework for tuberculosis programs, as part of the early implementation of Health Canada's Strategy Against Tuberculosis for First Nations On-Reserve.

The program gained a better understanding for the need of risk management in the planning process, while working on the STBBI framework. Alternative mechanisms, such as teleconferences and videoconferences instead of the approved face-to-face meetings, are being used in order to engage partners on the development of the Framework.

Sub-Sub-Program 3.1.2.2: *Environmental Public Health*

Description

The Environmental Public Health program administers contribution agreements and direct departmental spending for environmental public health service delivery. Environmental public health services are directed to First Nations communities south of the 60th parallel and address areas such as: drinking water; wastewater; solid waste disposal; food safety; health and housing; facilities inspections; environmental public health aspects of emergency preparedness response; and, communicable disease control. Environmental public health surveillance and risk analysis programming is directed to First Nations communities south of the 60th parallel, and in some cases, also to Inuit and First Nations north of the 60th parallel. It includes community-based and participatory research on trends and impacts of environmental factors such as chemical contaminants and climate change on the determinants of health (e.g., biophysical, social, cultural, and spiritual).

Key activities supporting program delivery include: public health; surveillance, monitoring and assessments; public education; training; and, community capacity building.

The program objective is to identify, address, and/or prevent human health risks to First Nations and Inuit communities associated with exposure to hazards within the natural and built environments.

Budgetary Financial Resources (dollars)

2013-14 Planned Spending	2013-14 Actual Spending	2013-14 Difference (actual minus planned)
89,022,273	82,397,368	-6,624,905

Note: The variance between planned and actual spending is mainly due to reductions associated with the realignment of resources for the implementation of the B.C. Tripartite initiative and a reallocation of funding within this strategic outcome to CCC to address needs and priorities.

Human Resources (FTEs)

2013-14 Planned	2013-14 Actual	2013-14 Difference (actual minus planned)
194	224	30

Note: The variance in FTE utilization is mainly due to a realignment of resources from plans in order to meet program needs. This is partially offset by reductions associated with the realignment of resources for the implementation of the B.C. Tripartite initiative.

Performance Results

Expected Results	Performance Indicators	Targets	Actual Results
Body of community-based research on environmental health hazards in First Nations and Inuit communities.	# of community-based/ participatory research reports on environmental health hazards that are available (baseline 18).	25 by March 31, 2016	20

Performance Analysis and Lessons Learned

As a result of the Health Canada's support for community-based participatory research, the Department continued to review infrastructure project proposals from a public health perspective, as well as fund community-based projects to monitor exposure to environmental hazards, and the impacts of climate change. Health Canada's First Nations Biomonitoring Initiative published the first ever report on representative baseline levels of First Nations exposure to environmental chemicals. The First Nations Food, Nutrition and Environment Study (FNFNES) is a national scope study collecting information on 100 randomly selected First Nations communities over a ten-year period (2008-18), to establish a baseline of contaminant levels in traditional foods of First Nations living on-reserve; to determine the nutrient values of traditional foods; and, to examine the structure of the modern First Nations diet and food security on reserve. The FNFNES completed sampling and data collection in Alberta.

Another highlight is the significant improvement in understanding the causes, prevention and clean-up of mould among First Nations on-reserve, as a result of the Health Promotion Campaign.

In 2013-14, Health Canada continued to assist First Nations communities in enhancing their capacity to monitor drinking water quality by working closely with targeted communities, and increase their knowledge on mould in First Nations communities. In November 2013, the *Safe Drinking Water for First Nations Act* came into force. The Department is collaborating with AANDC on the development of the associated regulations. Although there has been progress, compliance with monitoring frequency, as outlined in the Guidelines for Canadian Drinking Water Quality, remains a challenge.

Health Canada supported several longitudinal effects studies among northern Aboriginal populations through its participation in the Northern Contaminants Program, led by the AANDC. In regard to southern First Nations' exposure to environmental contaminants, the work of FNIHB is focussed on the monitoring and assessment of exposure levels, with reliance on published peer-reviewed scientific literature based on large cohort studies to continuously refine our understanding of the current state of scientific knowledge on associations between chemical exposures and a range of chronic diseases and developmental disorders.

In 2013-14, the Deputy Minister approved an evaluation of the Action Plan to Protect Human Health from Environmental Contaminants 2008-09 to 2012-13 (horizontal led by Health Canada).

Sub-Program 3.1.3: *First Nations and Inuit Primary Care*

Description

The First Nations and Inuit Primary Care program administers contribution agreements and direct departmental spending. These funds are used to support the staffing and operation of nursing stations on reserve, home and community care programs in First Nation and Inuit communities, and on-reserve hospitals in Manitoba, where services are not provided by provincial/territorial health systems. Care is delivered by a collaborative health care team, predominantly nurse-led, providing integrated and accessible health care services that include: assessment; diagnostic; curative; case-management; rehabilitative; supportive; respite; and, palliative/end-of-life care.

Key activities supporting program delivery include CCC in addition to Home and Community Care.

The program objective is to provide primary care services to First Nations and Inuit communities.

Budgetary Financial Resources (dollars)

2013-14 Planned Spending	2013-14 Actual Spending	2013-14 Difference (actual minus planned)
253,660,260	309,465,473	55,805,213

Note: The variance between planned and actual spending is mainly due to the additional funding, received through Supplementary Estimates and reallocations of funding from other programs within this strategic outcome, to assure continuity of access to CCC nursing services in remote and isolated First Nations communities. This is partially offset by reductions associated with the realignment of resources for the implementation of the B.C. Tripartite initiative.

Human Resources (FTEs)

2013-14 Planned	2013-14 Actual	2013-14 Difference (actual minus planned)
570	740	170

Note: The variance in FTE utilization is mainly due to a realignment of resources from plans in order to meet program needs. This is partially offset by reductions associated with the realignment of resources for the implementation of the B.C. Tripartite initiative.

Performance Results

Expected Results	Performance Indicators	Targets	Actual Results
Primary care services based on assessed need are provided to First Nations and Inuit communities.	Utilisation rate per 1,000 eligible on-reserve population (home and community care and CCC).	365.8 by March 31, 2015	364.18

Expected Results	Performance Indicators	Targets	Actual Results
Coordinated responses to primary care services.	% of First Nations communities with collaborative service delivery arrangements with external primary care service providers.	50 by March 31, 2015	65.2

Performance Analysis and Lessons Learned

Primary Care is a coordinated system of health services required to maintain health and treat illness. It is the first point of individual contact by First Nations and Inuit with the health system at the reserve and/or community level. Primary care was delivered by a collaborative health care team, predominately nurse led, providing a set of integrated and accessible health care services that include assessment, diagnostic, curative, rehabilitative, supportive and palliative/end-of-life care. Health Canada directed its health promotion and disease prevention actions towards individuals and families in the course of provision of care. The identification of cases requiring complex care, the coordination and/or integration of care, and timely referral to appropriate provincial or territorial secondary and tertiary levels of care outside the community were also essential elements of the primary care provided. Health Canada made available primary care services to First Nations and Inuit communities directly or through contribution agreements in locations where provincial or territorial health systems do not provide these services. This is necessary to ensure that First Nation and Inuit individuals and communities have access to the full range of health services as other provincial or territorial residents in similar geographic locations. Funds were used to support the staffing and operation of nursing stations on-reserve, home and community care programs in First Nation and Inuit communities and on-reserve hospitals in Manitoba.

Sub-Sub-Program 3.1.3.1: *Clinical and Client Care*

Description

The CCC program is delivered by a collaborative health care team, predominantly nurse-led, providing integrated and accessible health and oral health care services that include assessment, diagnostic, curative, and rehabilitative services for urgent and non-urgent care.

Key services supporting program delivery include: triage, emergency resuscitation and stabilization, emergency ambulatory care, and out-patient non-urgent services; coordinated and integrated care and referral to appropriate provincial secondary and tertiary levels of care outside the community; and, in some communities, physician visits and hospital in-patient, ambulatory, and emergency services.

The program objective is to provide CCC services to First Nations individuals, families, and communities.

Budgetary Financial Resources (dollars)

2013-14 Planned Spending	2013-14 Actual Spending	2013-14 Difference (actual minus planned)
132,450,035	195,883,436	63,433,401

Note: The variance between planned and actual spending is mainly due to additional funding, received through Supplementary Estimates and reallocations of funding from other programs within this strategic outcome, to assure continuity of access to CCC nursing services in remote and isolated First Nations communities. This is partially offset by reductions associated with the realignment of resources for the implementation of the B.C. Tripartite initiative.

Human Resources (FTEs)

2013-14 Planned	2013-14 Actual	2013-14 Difference (actual minus planned)
528	669	141

Note: The variance in FTE utilization is mainly due to a realignment of resources from plans in order to meet program needs. This is partially offset by reductions associated with the realignment of resources for the implementation of the B.C. Tripartite initiative.

Performance Results

Expected Results	Performance Indicators	Targets	Actual Results
First Nations and Inuit populations have access to CCC services.	% of eligible on-reserve population accessing CCC services.	29 by March 31, 2015	Information will be available by March 31, 2015
	% of urgent CCC services provided in nursing stations.	30 by March 31, 2015	27.2
Service delivery arrangements with external delivery partners are provided in First Nations and Inuit communities.	% of referrals to emergency/ hospital care.	28 by March 31, 2015	*

* Last years numbers were based on a one time study conducted by HSDM which looked at many issues including medical transportation. Data in this study focused on two regions, Manitoba and Ontario.

Presently NIHBs medical transportation system does not differentiate between referrals to emergency, hospitals, specialist appointment or external medical appointments.

To address this issue, over the past year FNIHB and NIHB have been working on a process that will define and differentiate the various referrals which will allow for improved data.

Performance Analysis and Lessons Learned

Health Canada provided access to essential nursing services and support around-the-clock in 77 remote and isolated First Nations communities, and another nine First Nations communities through funding to the B.C. First Nations Health Authority, where access to provincial or territorial health care services is limited.

Over the last five years (2008-13), Health Canada has investigated and designed new models of care and improved access, and integrated primary care services in remote and isolated First Nations communities. It has developed change management and performance measurement approaches to support the implementation of new health service delivery models, document the transformation, and ultimately enable the long-term renewal of primary health care in these communities.

Health Canada has renewed the national nursing recruitment strategy aimed at hiring more registered nurses, nurse practitioners, licensed practical nurses, pharmacy and lab technicians, and other health care providers; established a National Nursing Services Procurement Arrangement; and created Regional Nurse Resource Teams. The Department has also explored greater flexibility in nursing clinic hours; developed and implemented tele-health/virtual clinics for consultations; and, increased access to distance education through e-health initiatives.

In 2013-14, the Deputy Minister approved an evaluation of the First Nations Clinical and Client Care Program 2005-06 to 2011-12[lxiii].

Moving forward, the procurement of nursing services and a renewed strategy to support retention and recruitment remain the key focus.

Sub-Sub-Program 3.1.3.2: *Home and Community Care*

Description

The Home and Community Care program administers contribution agreements with First Nation and Inuit communities and territorial governments to enable First Nations and Inuit individuals with disabilities, chronic or acute illnesses, and the elderly to receive the care they need in their homes and communities. Care is delivered primarily by home care registered nurses and trained certified personal care workers.

In the delivery of this program, First Nations and Inuit Health Branch provides funding through contribution agreements and direct departmental spending for a continuum of basic essential services such as**:** client assessment and case management; home care nursing, personal care and home support, as well as in-home respite; and, linkages and referral, as needed, to other health and social services. Based on community needs and priorities, existing infrastructure, and availability of resources the Home and Community Care program may be expanded to include supportive services. These services may include**:** rehabilitation and other therapies; adult day programs; meal programs; in-home mental health; in-home palliative care; and, specialized health promotion, wellness, and fitness services.

The program objective is to provide home and community care services to First Nations and Inuit individuals, families, and communities.

Budgetary Financial Resources (dollars)

2013-14 Planned Spending	2013-14 Actual Spending	2013-14 Difference (actual minus planned)
121,210,225	113,582,037	-7,628,188

Note: The variance between planned and actual spending is mainly due to reductions associated with the realignment of resources for the implementation of the B.C. Tripartite initiative.

Human Resources (FTEs)

2013-14 Planned	2013-14 Actual	2013-14 Difference (actual minus planned)
42	71	29

Note: The variance in FTE utilization is mainly due to a realignment of resources from plans in order to meet program needs. This is partially offset by reductions associated with the realignment of resources for the implementation of the B.C. Tripartite initiative.

Performance Results

Expected Results	Performance Indicators	Targets	Actual Results
Home and community care services are provided in First Nations and Inuit communities.	Utilisation rate per 1,000 on-reserve population.	71.2 by March 31, 2015	69.5
	% of distribution of home and community care hours of care provided for home care nursing.	8.6 by March 31, 2014	17
Service delivery arrangements with internal and external delivery partners are provided in First Nations and Inuit communities.	% of communities with collaborative services delivery arrangements with external service delivery partners.	50 by March 31, 2015	64

Performance Analysis and Lessons Learned

The First Nations Home and Community Care program has been stable in the provision of services. As of 2013, the number of First Nation and Inuit clients served by the program increased from 31,485 to 35,081 with 2.5 million hours of care provided in 686 First Nation and Inuit communities.

Increasing rates of chronic diseases and an aging population point to an increasing demand for home and community care services in the future.

In 2013, a ten-year Strategic Business Plan was created to assist program staff, at all levels, to anticipate and respond to emerging health and demographic trends, complex and changing health needs, and other challenges related to the home care needs of First Nations and Inuit clients. The

Plan reflects the priorities of First Nations and Inuit and takes into consideration the trends and projections of home care in Canada as part of the health care continuum. Each goal is client-focused and supports health providers in the provision of exemplary care that considers the assessed needs of the client as he/she navigates through the experience of illness and loss.

In 2013-14, the Deputy Minister approved an evaluation of the First Nations and Inuit Home and Community Care Program 2008-09 to 2011-12[lxiv].

The First Nations Home and Community Care Program created a 10-year plan that will enable program officials, home care staff and communities to adequately respond to future challenges in a strategic and integrated fashion over the next ten years.

Program 3.2: *Supplementary Health Benefits for First Nations and Inuit*

Description

Under the Supplementary Health Benefits for First Nations and Inuit program, the Non-Insured Health Benefits (NIHB) program provides registered First Nations and recognized Inuit residents in Canada with a specified range of medically necessary health-related goods and services, which are not otherwise provided to eligible clients through other private or provincial/territorial programs. NIHB include: pharmaceuticals; medical supplies and equipment; dental care; vision care; short term crisis intervention and mental health counselling; and, medical transportation (MT) to access medically required health services not available on reserve or in the community of residence. The NIHB program also pays health premiums on behalf of eligible clients in B.C.

Benefits are delivered through registered, private sector health benefits providers (e.g., pharmacists and dentists), and funded through NIHB's electronic claims processing system or through regional offices. Some benefits are also delivered via contribution agreements with First Nations and Inuit organizations and the territorial governments in Nunavut and Northwest Territories.

The program objective is to provide non-insured health benefits to First Nations and Inuit people to improve their health status to be comparable to that of the Canadian population.

Budgetary Financial Resources (dollars)

2013-14 Main Estimates	2013-14 Planned Spending	2013-14 Total Authorities Available for Use	2013-14 Actual Spending (authorities used)	2013-14 Difference (actual minus planned)
1,017,260,925	1,017,260,925	1,113,116,336	1,071,034,484	53,773,559

Note: The variance of $53.8 million between planned spending and actual spending is mainly due to additional funding received through Supplementary Estimates to support First Nations and Inuit Health Programs and Services, a portion of which was not fully spent due to the demand driven nature of the program. This is offset by reductions associated with the realignment of resources for the implementation of the B.C. Tripartite initiative ($100 million).

Human Resources (Full-Time Equivalents [FTEs])

2013-14 Planned	2013-14 Actual	2013-14 Difference (actual minus planned)
488	492	4

Note: The variance in FTE utilization is mainly due to a small realignment of resources from plans in order to meet program needs. This is partially offset by reductions associated with the realignment of resources for the implementation of the B.C. Tripartite initiative.

Performance Results

Expected Results	Performance Indicators	Targets	Actual Results
First Nations and Inuit have access to non-insured health benefits.	% of eligible First Nations and Inuit population who accessed one of the following Non-Insured Health Benefit in a year: • Pharmacy/Medical Supplies & Equipment • Medical Transportation • Dental Care • Vision Care	72 by March 31, 2014	70.8
Efficient management of access to non-insured health benefits.	Administrative cost ratio (ratio of administration costs to benefit expenditures as a %).	< 5 by March 31, 2014	5.3*

* An incomplete year of First Nations Health Authority (FNHA) expenditures, due to a staggered transition of responsibility, resulted in lower total NIHB expenditures, and therefore a higher administrative cost as a proportion of that cost. In addition, there were salaries in NIHB that were tied to the transfer, as a result of the buy-back arrangement. Administrative costs are expected to return to more historic levels of under 5% in future years.

Performance Analysis and Lessons Learned

As a key activity under this program, Health Canada coordinated benefits in cases where clients have alternative health benefits plans. In 2013-14, the Department coordinated 1,848,006 pharmacy claims and 186,471 dental care claims.

In support of the implementation of the B.C. Tripartite Framework Agreement on First Nation Health Governance, Health Canada transitioned the funding associated with these benefits to the FNHA, while continuing to act as a service provider to FNHA, thereby facilitating a smooth transition.

Health Canada worked to improve turnaround times for dental benefit approvals, while completing the centralization of NIHB dental benefits administration in Ottawa.

In collaboration with the Inuit Tapiriit Kanatami, Health Canada produced a Handbook for Inuit - *A Guide for Inuit to Access Non-Insured Health Benefits*. As part of Health Canada's commitment to continual improvement in communications with clients, providers and their

representatives regarding NIHB coverage and administration, this joint publication will improve the reach of NIHB program communications.

Health Canada continued to implement the PDA strategy by delisting or restricting opioids and other drugs subject to misuse; increasing access to non-opioid medications (e.g., Cymbalta); providing access to opioid addiction treatment where appropriate; and, enhancing the Prescription Monitoring Program.

The evaluation conducted in 2009/10 found that NIHB is relevant and that there is an ongoing demonstrable need to facilitate access to health benefits and services among First Nations and Inuit populations. NIHB is providing access to eligible clients and NIHB's evidence-based benefits contribute to improvements in the health status of First Nations people and Inuit. There remains areas for improvement related to administration data in non-Health Information and Claims Processing Services System benefits area (medical transportation, vision care and mental health) in order to support Program management and policy decisions regarding the most effective use of resources.

Health Canada is working to address improving management of administrative data in these areas. We have committed to work towards a single IT platform for the vision care and (short term crisis intervention) mental health counselling benefits by including these benefit areas as part of the re-procurement of the national Health Insurance Claims Processing (HICPS) system, anticipated to be implemented by April 1, 2019. We are also working to implement, by 2017, a single, national MT system to replace the existing mix of MT systems, and improve the management of the MT benefit.

Program 3.3: *Health Infrastructure Support for First Nations and Inuit*

Description

The *Department of Health Act* 1996, and the *Indian Health Policy* (1979) provide the authority for the Health Infrastructure Support for First Nations and Inuit program to administer contribution agreements and direct departmental spending to support the delivery of health programs and services.

The program promotes First Nations and Inuit capacity to design, manage, deliver, and evaluate health programs and services. To better meet the unique health needs of First Nations and Inuit individuals, families, and communities this program also supports: innovation in health program and service delivery; health governance partnerships between Health Canada, the provinces, and First Nation and provincial health services; and, improved integration of First Nations and provincial health services.

The program objective is to help improve the health status of First Nations and Inuit people, to become comparable to that of the Canadian population over the long-term.

Budgetary Financial Resources (dollars)

2013-14 Main Estimates	2013-14 Planned Spending	2013-14 Total Authorities Available for Use	2013-14 Actual Spending (authorities used)	2013-14 Difference (actual minus planned)
231,648,633	231,648,633	525,566,179	525,066,806	293,418,173

Note: The variance of $293.4 million between planned spending and actual spending is mainly due to additional funding received through Supplementary Estimates to support First Nations and Inuit Health Programs and Services, and funding to support the implementation of the B.C. Tripartite initiative.

Human Resources (Full-Time Equivalents [FTEs])

2013-14 Planned	2013-14 Actual	2013-14 Difference (actual minus planned)
113	262	149

Note: The variance in FTE utilization is mainly due to a realignment of resources from plans in order to meet program needs. This is partially offset by reductions associated with the realignment of resources for the implementation of the B.C. Tripartite initiative. Health Canada receives annual growth of 3% on a portion of First Nations and Inuit Health Infrastructure programs. These funds are appropriated as Operating fund. Consistent with program authorities approved by Treasury Board, Health Canada has annually realigned resources based on program needs from Operating to Salaries over the past several years; therefore, Actual FTE Utilization is higher than Planned. The Department plans to make adjustments in future Main Estimates to reflect current business requirements now that DPRs are reporting at the Sub-Sub Program levels.

Performance Results

Expected Results	Performance Indicators	Targets	Actual Results
Innovative and integrated health governance relationships are increased.	% of provinces/territories with multi-jurisdictional agreements to jointly plan, deliver and/or fund integrated health services for aboriginal Canadians.	100 by March 31, 2015	Information will be available by March 31, 2015
The capacity of First Nations and Inuit to influence and/or control (design, deliver, and manage) health programs and services is improved.	Increase in the number of communities that have Flexible or Block funding agreements (e.g., communities that design, deliver and manage their health programs and services) (baseline 486).	496 by March 31, 2016	325

Note: the target was adjusted to reflect the removal of B.C. communities from the number of agreements due to the transfer of responsibilities to the FNHA as part of the B.C. Tripartite Framework Agreement.

Performance Analysis and Lessons Learned

Much of the ongoing work under this program involved engagement and coordination of health infrastructure initiatives with partners, particularly the Assembly of First Nations, the Inuit Tapiriit Kanatami, PHAC and AANDC. Through collaboration, partners developed approaches in areas of mutual interest for advancing First Nations and Inuit health, guided health survey

research and analysis, and sought to harmonize or improve the practices and systems that departments use to manage contribution agreements.

Health Canada and AANDC have committed to simplifying, standardizing and harmonizing policies, procedures and the management of transfer payments, and to validate promising funding arrangement models for Aboriginal recipients, which would provide a single funding arrangement on behalf of both departments. To streamline administrative processes, Health Canada and AANDC have developed joint recipient audits and recipient audit protocols; established a single federal standardized financial reporting package, including audited consolidated financial statements for common recipients; and, developed a common management control framework and default management approach. The framework includes a common response to the results of the recipient risk assessment in the areas of corporate management controls; default prevention and management; and, capacity development.

Health Canada provided ongoing support to First Nations and Inuit communities, provincial and territorial governments in the promotion of better integration of programs and services.

As part of the B.C. Tripartite Framework Agreement on First Nation Health Governance, on October 1 2013, Health Canada transferred its role in the design, management, and delivery of First Nations health programming in B.C. to the new FNHA.

Health Canada continued to work with regions to develop and implement a surveillance strategy that is relevant at both the regional and community levels.

Sub-Program 3.3.1: *First Nations and Inuit Health System Capacity*

Description

The First Nations and Inuit Health System Capacity program administers contribution agreements and direct departmental spending focussing on the overall management and implementation of health programs and services.

This program supports the promotion of First Nations and Inuit participation in**:** health careers including education bursaries and scholarships; the development of, and access to health research; information and knowledge to inform all aspects of health programs and services; and, the construction and maintenance of health facilities. This program also supports efforts to develop new health governance structures with increased First Nations participation.

Program engagement includes a diverse group of partners, stakeholders, and clients including**:** First Nations and Inuit communities, district and tribal councils; national Aboriginal organizations and NGOs; health organizations; provincial and regional health departments and authorities; post-secondary educational institutions and associations; and, health professionals and program administrators.

The program objective is to improve the delivery of health programs and services to First Nations and Inuit by enhancing First Nations and Inuit capacity to plan and manage their programs and infrastructure.

Budgetary Financial Resources (dollars)

2013-14 Planned Spending	2013-14 Actual Spending	2013-14 Difference (actual minus planned)
207,995,779	239,955,944	31,960,165

Note: The variance between planned and actual spending is mainly due to resources allocated to this strategic outcome from the operating budget carry forward and other departmental programs as well as by additional funding received through Supplementary Estimates to support the accreditation of First Nations community health centres, this is partially offset by reductions associated with the realignment of resources for the implementation of the B.C. Tripartite initiative.

Human Resources (FTEs)

2013-14 Planned	2013-14 Actual	2013-14 Difference (actual minus planned)
63	107	44

Note: The variance in FTE utilization is mainly due to a realignment of resources from plans in order to meet program needs. This is partially offset by reductions associated with the realignment of resources for the implementation of the B.C. Tripartite initiative.

Performance Results

Expected Results	Performance Indicators	Targets	Actual Results
Quality in the delivery of programs and services is improved.	# of communities accessing health care from accredited organizations (baseline 131).	138 by March 31, 2014	121*
Health facilities managed by First Nations and Inuit are safe.	% of health facilities subject to an Integrated Facility Audit that do not have critical property issues.	58 by March 31, 2014	25**

* 87 community health centres serving 207 communities are in the accreditation process, out of which 52 serving 121 communities have achieved accreditation.
** Of the 24 facilities audited, only seven did not have any critical issues. This represents 25% of facilities audited, which is below the target of 58%. Of the 34 critical issues identified, 24 have been addressed.

Performance Analysis and Lessons Learned

The health facility Long-Term Capital Plan (LTCP) links program operating requirements, including current and future needs and risks, with specific capital project proposals. Health Canada uses the LTCP to identify, assess, and prioritize capital projects for implementation. In 2013-14, LTCP funded 14 multi-year projects and 80 minor projects.

To facilitate ongoing health system improvements, Health Canada continued the process of developing service delivery standards for all programs. This is a large undertaking, as many program areas did not previously have service-delivery standards.

In 2013-14, regional LTCP planning cycles were not synchronized with the new Health Canada-wide planning cycles, resulting in increased pressure on the regions. To address this issue, adjustments will be made to capital program planning cycle for the upcoming year.

Sub-Sub-Program 3.3.1.1: *Health Planning and Quality Management*

Description

The Health Planning and Quality Management program administers contribution agreements and direct departmental spending to support capacity development for First Nations and Inuit communities.

Key services supporting program delivery include: the development and delivery of health programs and services through program planning and management; on-going health system improvement via accreditation; the evaluation of health programs; and, support for community development activities.

The program objective is to increase the capacity of First Nations and Inuit to design, manage, evaluate, and deliver health programs and services.

Budgetary Financial Resources (dollars)

2013-14 Planned Spending	2013-14 Actual Spending	2013-14 Difference (actual minus planned)
148,592,049	122,308,264	-26,283,785

Note: The variance between planned and actual spending is mainly due to the net effect of reductions associated with the realignment of resources for the implementation of the B.C. Tripartite initiative, and reallocations of funding between programs within this strategic outcome to address needs and priorities. This is partially offset by additional funding received through Supplementary Estimates to support the accreditation of First Nations community health centres.

Human Resources (FTEs)

2013-14 Planned	2013-14 Actual	2013-14 Difference (actual minus planned)
29	58	29

Note: The variance in FTE utilization is mainly due to funding received through Supplementary Estimates to support the accreditation of First Nations community health centres and a realignment of resources from plans in order to meet program needs. This is partially offset by reductions associated with the realignment of resources for the implementation of the B.C. Tripartite initiative.

Performance Results

Expected Results	Performance Indicators	Targets	Actual Results
The capacity to deliver health programs and services is increased.	% of accredited treatment centres.	82 by March 31, 2014	78*

* A total % of treatment centres in the process of accreditation is 82.

Performance Analysis and Lessons Learned

Accreditation is the nationally and internationally recognized process that ensures a standardized level of quality in health planning, management and delivery of health services. By evaluating the quality of care and services they provide, and comparing against national standards of excellence, organizations are able to evaluate their clinical and operational performance. This provides them with a clear picture of their strengths and areas to be improved.

In 2013-14, Health Canada increased the number of community health centres in the accreditation process from 75 to 87, and increased the number of communities that receive primary health care services from fully accredited health centres to 121. There are currently 46 addictions treatment centres in the accreditation process.

Health Canada implemented the Quality Improvement Framework to improve the way that programs and services are developed and delivered. In 2013-14, training sessions on quality improvement were offered to approximately 100 employees.

Health planning is a key program component that supports the development of Health Programs for First Nations and assists with capacity building within First Nation communities. Health Canada collaborated with the various First Nations and Inuit Health programs, along with AANDC on an ongoing basis.

Sub-Sub-Program 3.3.1.2: *Health Human Resources*

Description

The Health Human Resources program administers contribution agreements and direct departmental spending to promote and support competent health services at the community level by increasing the number of First Nations and Inuit individuals entering into and working in health careers and ensuring that community-based workers have skills and certification comparable to workers in the provincial/territorial health care system. This program engages many stakeholders, including: federal, provincial and territorial governments and health professional organizations; national Aboriginal organizations; NGOs and associations; and, educational institutions.

Key activities supporting program delivery include: health education bursaries and scholarships; health career promotion activities; internship and summer student work opportunities; knowledge

translation activities; training for community based health care workers and health managers; and, development and implementation of health human resources planning for Aboriginal, federal, provincial, territorial, health professional associations, educational institutions, and other stakeholders.

The program objective is to increase the number of qualified First Nations and Inuit individuals working in health care delivery.

Budgetary Financial Resources (dollars)

2013-14 Planned Spending	2013-14 Actual Spending	2013-14 Difference (actual minus planned)
17,578,574	14,087,816	-3,490,758

Note: The variance between planned and actual spending is mainly due to reductions associated with the realignment of resources for the implementation of the B.C. Tripartite initiative and savings achieved from simplifying and streamlining operations while maintaining services to Canadians.

Human Resources (FTEs)

2013-14 Planned	2013-14 Actual	2013-14 Difference (actual minus planned)
22	16	-6

Note: The variance in FTE utilization is mainly due to savings achieved from simplifying and streamlining operations while maintaining services to Canadians.

Performance Results

Expected Results	Performance Indicators	Targets	Actual Results
Greater participation of Aboriginal people in post-secondary education leading to health careers.	% of bursaries and scholarships provided to Aboriginal people per year (baseline 340).	425 by March 31, 2014	752

Performance Analysis and Lessons Learned

The Aboriginal Health Human Resources Initiative (AHHRI) was renewed for five years (2010-15), with the goal of increasing the number of Aboriginal peoples in health careers, and laying the foundation for systemic change in the supply and demand of Aboriginal health human resources.

The funding has enabled Health Canada, in collaboration with provinces, territories, Aboriginal groups, health professional associations and other key stakeholders, to play a strategic role in encouraging innovations with respect to health human resources that will serve to increase the recruitment and retention of Aboriginal peoples in the health care workforce.

Through Indspire, the AHHRI provides annual funding for student bursaries and scholarships. These bursaries and scholarships are available for wide range of health careers, including priority areas such as medicine, nursing, and dentistry. Since the beginning of the AHHRI, Aboriginal students have received over 3,000 bursaries and/or scholarships.

The AHHRI also increased its focus at the community level by supporting community-based worker training comparable to provincial and territorial standards, with the goal of increasing the quality of care for patients.

In 2013-14, the Deputy Minister approved an evaluation of the First Nations and Inuit Health Human Resources Program 2008-09 to 2011-12[lxv].

Sub-Sub-Program 3.3.1.3: *Health Facilities*

Description

The Health Facilities program administers contribution agreements and direct departmental spending that provide communities and/or health care providers with the facilities required to safely and efficiently deliver health programs and services. Direct departmental spending addresses the working conditions of Health Canada staff engaged in the direct delivery of health programs and services to First Nations and Inuit.

Key activities supporting program delivery include: investment in infrastructure that can include the construction, acquisition, leasing, operation, maintenance, expansion and/or renovation of health facilities and security services; preventative and corrective measures relating to infrastructure; and, improving the working conditions for Health Canada staff so as to maintain or restore compliance with building codes, environmental legislation, and occupational health and safety standards.

The program objective is to support the development and delivery of health programs and services through investments in infrastructure.

Budgetary Financial Resources (dollars)

2013-14 Planned Spending	2013-14 Actual Spending	2013-14 Difference (actual minus planned)
41,825,156	103,559,864	61,734,708

Note: The variance between planned and actual spending is mainly due to additional funding from other sources, such as carry forward in order to make essential and priority capital investments in First Nations and Inuit infrastructure, which is partially offset by reductions associated with the realignment of resources for the implementation of the B.C. Tripartite initiative.

Human Resources (FTEs)

2013-14 Planned	2013-14 Actual	2013-14 Difference (actual minus planned)
12	33	21

Note: The variance in FTE utilization is mainly due to a realignment of resources from plans in order to meet program needs. This is partially offset by reductions associated with the realignment of resources for the implementation of the B.C. Tripartite initiative.

Performance Results

Expected Results	Performance Indicators	Targets	Actual Results
Health facilities that support program delivery are safe.	% of “high priority” recommendations stemming from Integrated Facility Audits are addressed on scheduled.	50 by March 31, 2014	70
Health programs and services are supported through effective community capacity to manage their health plans.	# of recipients that have signed contribution agreements that start in 2011-12 or later that have developed plans for managing the operations and maintenance of the Health Infrastructure (baseline 2).	10 by March 31, 2014	40

Performance Analysis and Lessons Learned

In 2013-14, the national LTCP initiated 14 major projects, of which most were multi-year. Of the 14 projects, four were completed, four are ongoing, and for the last six, construction was started. In addition, more than 80 minor projects were delivered as planned. Throughout the year, an additional 14 major projects and 27 minor projects were delivered.

First Nations continued to work through the challenges of delivering these projects, such as inclement weather and the availability of service providers. Weather can affect delivery of materials, as well as shorten the construction season, while a shortage of service providers, especially in the western region, can result in the need to pay a premium to receive the service. This was further complicated for projects delivered in remote and/or isolated communities.

Sub-Program 3.3.2: *First Nations and Inuit Health System Transformation*

Description

The First Nations and Inuit Health System Transformation program integrates, coordinates, and develops innovative publicly funded health systems serving First Nations and Inuit individuals, families, and communities through the administration of contribution agreements and direct departmental spending.

This program includes the development of innovative approaches to primary health care, sustainable investment in appropriate technologies that enhance health service delivery, and support for the development of new governance structures and initiatives to increase First Nations and Inuit participation in, and control over, the design and delivery of health programs and services in their communities.

Through this program, Health Canada engages and works with a diverse group of partners, stakeholders, and clients including: First Nations and Inuit communities, tribal councils, Aboriginal organizations, provincial and regional health departments and authorities, post-secondary educational institutions and associations, health professionals and program administrators.

The program objective is that First Nations and Inuit health systems are more effective and efficient.

Budgetary Financial Resources (dollars)

2013-14 Planned Spending	2013-14 Actual Spending	2013-14 Difference (actual minus planned)
23,652,854	49,921,966	26,269,112

Note: The variance between planned and actual spending is mainly due to the net effect of additional funding received through Supplementary Estimates to support the eHealth Infostructure program (eHIP), and reallocations of funding between programs within this strategic outcome to address needs and priorities as well as reductions associated with the realignment of resources for the implementation of the B.C. Tripartite initiative.

Human Resources (FTEs)

2013-14 Planned	2013-14 Actual	2013-14 Difference (actual minus planned)
50	146	96

Note: The variance in FTE utilization is mainly due to additional resources received through Supplementary Estimates to support the eHIP and a realignment of resources from plans in order to meet program needs. This is partially offset by reductions associated with the realignment of resources for the implementation of the B.C. Tripartite initiative.

Performance Results

Expected Results	Performance Indicators	Targets	Actual Results
Key stakeholders in Aboriginal health are engaged in the integration of health services.	% of Provincial/ Territorial Advisory Committees in which key stakeholders in the integration of health services (First Nations and Inuit/Provincial/ Territorial) are represented.	100 by March 31, 2014	100

Performance Analysis and Lessons Learned

In 2013-14, Health Canada maintained current investments and progress on eHealth from the last five years to support and enable the delivery of modern primary and public health care services to geographically remote communities, raising the quality of health care for these communities. Approximately 95% of First Nations communities had high-speed or broadband connectivity. Connectivity is required to make TeleHealth services available in First Nation communities.

Announced in 2010, the Health Services Integration Fund (HSIF) supports inter-jurisdictional projects to improve the integration of federally funded health services with those of the provinces and territories, leading to improved access. As of March 2014, 75 projects were approved across all 13 provinces and territories. Funded projects vary in focus, with all partners working together to integrate health services in a range of areas such as chronic disease; integrated governance and tripartite planning; maternal/child/youth health; mental health and addictions; primary and continuing care; public health; and, system logistics.

Sub-Sub-Program 3.3.2.1: *Systems Integration*

Description

The Systems Integration program administers contribution agreements and direct departmental spending to better integrate health programs and services funded by the federal government with those funded by provincial/territorial governments.

This program supports the efforts of partners in health services, including: First Nations and Inuit, tribal councils, regional/district health authorities, regions, national Aboriginal organizations, and provincial/territorial organizations to integrate health systems, services, and programs so they are more coordinated and better suited to the needs of First Nations and Inuit. This program also promotes and encourages emerging tripartite agreements.

Two key activities supporting program delivery include: development of multi-party structures to jointly identify integration priorities and plans for further integrating health services in a given province/territory; and, implementation of multi-year, large-scale health service integration

projects consistent with agreed-upon priorities (i.e., a province-wide public health framework or integrated mental health services planning and delivery on a regional scale).

The program objective is a health system that is efficient and integrated resulting in increased access to care and improved health outcomes for First Nations and Inuit individuals, families, and communities.

Budgetary Financial Resources (dollars)

2013-14 Planned Spending	2013-14 Actual Spending	2013-14 Difference (actual minus planned)
15,018,292	17,934,212	2,915,920

Note: The variance between planned and actual spending is mainly due to the reallocations of funding from other programs within this strategic outcome to address needs and priorities, which is partially offset by reductions associated with the realignment of resources for the implementation of the B.C. Tripartite initiative.

Human Resources (FTEs)

2013-14 Planned	2013-14 Actual	2013-14 Difference (actual minus planned)
9	36	27

Note: The variance in FTE utilization is mainly due to a realignment of resources from plans in order to meet program needs. This is partially offset by reductions associated with the realignment of resources for the implementation of the B.C. Tripartite initiative.

Performance Results

Expected Results	Performance Indicators	Targets	Actual Results
Collaborative planning for, and integration of, Aboriginal health services is increased.	% of First Nations and Inuit communities involved in a HSIF project, which affirm that collaboration among the respective jurisdictions involved in planning, delivering and/or funding health services has increased.	100 by March 31, 2015	Information will be available by March 31, 2015

Performance Analysis and Lessons Learned

There are over 70 active HSIF projects with over 450 partners working together on improving access to care for First Nations and Inuit through better service integration and collaboration. Project reporting indicates that 55% of the partnerships are proceeding as planned and 11% exceeding planned expectations.

Sub-Sub-Program 3.3.2.2: *e-Health Infostructure*

Description

The eHIP administers contribution agreements and direct departmental spending to support and sustain the use and adoption of appropriate health technologies that enable front line care providers to better deliver health services in First Nations and Inuit communities through eHealth partnerships, technologies, tools, and services. Direct departmental spending also supports national projects that examine innovative information systems and communications technologies and that have potential national implications.

Key activities supporting program delivery include: public health surveillance; health services delivery (primary and community care included); health reporting, planning and decision-making; and, integration/compatibility with other health service delivery partners.

The program objective is to improve the efficiency of health care delivery to First Nations and Inuit individuals, families, and communities through the use of eHealth technologies for the purpose of defining, collecting, communicating, managing, disseminating, and using data.

Budgetary Financial Resources (dollars)

2013-14 Planned Spending	2013-14 Actual Spending	2013-14 Difference (actual minus planned)
8,634,562	31,987,754	23,353,192

Note: The variance between planned and actual spending is mainly due to the net effect of additional funding through Supplementary Estimates received to support the eHIP, reallocations of funding between programs within this strategic outcome to address needs and priorities, partially offset by reductions associated with the realignment of resources for the implementation of the B.C. Tripartite initiative.

Human Resources (FTEs)

2013-14 Planned	2013-14 Actual	2013-14 Difference (actual minus planned)
41	110	69

Note: The variance in FTE utilization is mainly due to additional funding received through Supplementary Estimates to support the eHIP and a realignment of resources from plans in order to meet program needs. This is partially offset by reductions associated with the realignment of resources for the implementation of the B.C. Tripartite initiative.

Performance Results

Expected Results	Performance Indicators	Targets	Actual Results
Access to e-Health Infostructure service is improved.	# of First Nations communities using Panorama or equivalent public health information system.	40 by March 31, 2015	Information will be available by March 31, 2015

Expected Results	Performance Indicators	Targets	Actual Results
Integration of the health systems serving First Nations and Inuit.	# of telehealth sites implemented (baseline 290).	300 by March 31, 2014	220

Performance Analysis and Lessons Learned

Many First Nations communities are in remote locations, therefore, the development of innovative eHealth partnerships, tools, services and technologies is integral to the overall improvement of First Nations health.

Approximately 95% of First Nations communities had some level of connectivity, which is a key element for modernizing community level health services delivery (especially telehealth). Health Canada helped sustain the existing 220 telehealth/videoconferencing sites in First Nation communities (not including 80 telehealth/videoconferencing sites in B.C.). These sites provided individuals and families better access to efficient and effective health care services in their communities. They made it possible for health care professionals to consult and collaborate with specialized health professionals. Distance education facilitated through these eHealth tools increased the knowledge and skills of health professionals in these communities.

Health Canada continued to collaborate with stakeholders on implementing public health surveillance systems in regions in step with provincial public health systems and plans. However, provincial delays of Panorama affected the First Nations integration/implementation schedule. As a result, the target number of communities using a public health information system was not reached.

Activities in eHealth supported trilateral planning to establish provincially integrated and interoperable electronic medical/health records within prioritized remote and isolated communities. Working with stakeholders, Health Canada built eHealth capacity in First Nations communities for several projects/initiatives, and strengthened governance structures and trilateral partnerships.

Despite the high level of connectivity in First Nations communities, challenges remain with ensuring that the data transfer speed is sufficient to run modern applications such as medical imaging programs.

Sub-Sub-Program 3.3.2.3: *Nursing Innovation*

Description

The Nursing Innovation program investigates new approaches to improve primary care services in remote and isolated First Nation communities.

This program supports the recruitment and retention of nurses for the delivery of primary care in remote and isolated First Nations communities. It also supports increased access to primary care education for nurses in remote and isolated practice as well as in home and community care.

Key services supporting program delivery include: implementing innovative pilot projects that test new health care delivery models involving collaborative teams; linking technology and nurses; and, investigating new hours of operation in target nursing stations.

The program objective is to sustain and/or improve primary health care services to First Nations individuals, families, and communities.

Budgetary Financial Resources (dollars)

2013-14 Planned Spending	2013-14 Actual Spending	2013-14 Difference (actual minus planned)
0	0	0

Note: Although the First Nations National Nursing Innovation Strategy Program (NNISP) ended on March 31, 2013, the Department's approved 2013-14 PAA included this sub-sub program.

Human Resources (FTEs)

2013-14 Planned	2013-14 Actual	2013-14 Difference (actual minus planned)
0	0	0

Note: Although the First Nations NNISP ended on March 31, 2013, the Department's approved 2013-14 PAA included this sub-sub program.

Performance Results

Expected Results	Performance Indicators	Targets	Actual Results
Access to primary care nursing education for remote and isolated practice is increased.	# of nurses completing primary care nursing education for remote and isolated practice is maintained.	N/A	N/A

Performance Analysis and Lessons Learned

The First Nations National Nursing Innovation Strategy Program (NNISP) ended on March 31, 2013.

From 2008-13, the federal government provided funding to pilot innovative practices and approaches under the NNISP. During this five-year period, the NNISP demonstrated progress towards improved access to primary care services with the implementation of new hours of operation involving the extension of regular business hours in select nursing stations to improve access to walk-in health care Capacity of the primary care workforce was increased by

incorporating technologies into health care delivery, such as telehealth, mobile devices, on-line tools (e.g., instructional websites), software applications, and pharmacy inventory/dispensing management systems. A National Education Strategy was developed that involved national and regional nursing education pilot projects as well as regional nursing education activities that provided increased access to continuing education and professional development for nurses. Collaboration among health care providers was improved with the introduction of collaborative teams which introduced new health care providers into existing nursing teams. It also involved the inclusion of new nursing staff such as nurse practitioners, licensed/registered practical nurses, and mental health nurse. The innovative practices and approaches to primary care made by many of the NNISP pilot projects, combined with the lessons learned from this initiative, are being incorporated in future models of primary care service delivery.

In 2013-14, the Deputy Minister approved an evaluation of the First Nations National Nursing Innovation Strategy Program 2008-09 to 2011-12[lxvi].

Health Canada continues to work to improve primary care services in remote and isolated First Nation communities through the implementation of the Nursing Recruitment and Retention Strategy and the development of enhanced models of primary health care in remote and isolated First Nations communities.

Sub-Program 3.3.3: *Tripartite Health Governance*

Description

FNIHB's longer-term policy approach aims to achieve closer integration of federal and provincial health programming provided to First Nations, as well as to improve access to health programming, reduce instances of service overlap and duplication, and increase efficiency where possible.

The B.C. Tripartite Initiative consists of an arrangement among the Government of Canada, the Government of B.C., and B.C. First Nations. Since 2006, the parties have negotiated and implemented a series of tripartite agreements to facilitate the implementation of health projects, as well as the development of a new First Nations health governance structure. In 2011, the federal and provincial Ministers of Health and B.C First Nations signed the legally-binding B.C. Tripartite Framework Agreement on First Nation Health Governance.

This B.C. Tripartite Framework Agreement commits to the creation of a new province-wide FNHA to assume the responsibility for design, management, and delivery/funding of First Nations health programming in B.C. The FNHA will be controlled by First Nations and will work with the province to coordinate health programming. It may design or redesign health programs according to its health plans. Health Canada will remain a funder and governance partner but will no longer have any role in program design/delivery.

Funding under this program is limited to the FNHA for the implementation of the B.C. Tripartite Framework Agreement.

The program objective is to enable the newly formed FNHA to develop and deliver quality health services that feature closer collaboration and integration with provincial health services.

This program uses funding from the following transfer payment: First Nations and Inuit Health Infrastructure Support.

Budgetary Financial Resources (dollars)

2013-14 Planned Spending	2013-14 Actual Spending	2013-14 Difference (actual minus planned)
0	235,188,896	235,188,896

Note: The variance between planned and actual spending is mainly due to existing and new resources ($44 million) related to the phased implementation of the B.C. Tripartite initiative which became effective July 2, 2013. Resources have been realigned from Programs 3.1 First Nations and Inuit Primary Health Care ($75M), 3.2 Supplementary Health Benefits for First Nations and Inuit ($100M), and also within sub-sub program levels of Program 3.3 Health Infrastructure Support for First Nations and Inuit ($18M) to sub-sub program 3.3.3 Tripartite Health Governance according to the terms of the B.C. Tripartite Framework agreement.

Human Resources (FTEs)

2013-14 Planned	2013-14 Actual	2013-14 Difference (actual minus planned)
0	9	9

Note: The variance in FTE utilization is mainly due to existing and new resources related to the phased implementation of the B.C. Tripartite initiative which became effective July 2, 2013.

Performance Results

Expected Results	Performance Indicators	Targets	Actual Results
Reciprocal accountability amongst tripartite governance partners, as stated in section 2.2 of the B.C. Tripartite Framework Agreement on First Nations Health Governance.	% of planned partnership and engagement activities implemented, as committed in section 8 of the B.C. Tripartite Framework Agreement.	100 by March 31, 2016	Information will be available by March 31, 2016*

* On July 2, 2013, headquarters programming and corporate supports were transferred to the FNHA. On October 1, 2013, all regional programming and the identified regional employees and positions were transferred to the FNHA.

Performance Analysis and Lessons Learned

On July 2, 2013, the first phase of the transfer to the FNHA took place. This transfer included headquarters programming and corporate supports. The final transfer occurred on October 1, 2013, when all regional programming, and the identified regional employees and positions were transferred to the FNHA. With the transfer complete, the FNHA successfully assumed

responsibility for the design and delivery of health programs previously provided by Health Canada's First Nations and Inuit Health Pacific Region.

Now B.C. First Nations, through the FNHA, have responsibility for their own health, and are in a position to incorporate their cultural knowledge, beliefs and values into the design and planning of their health programs and services. Working closely with the provincial government, this will result in better health outcomes for First Nations in B.C., and a more responsive and integrated model of health service delivery.

The relationship between First Nations in B.C. and the federal government is now redefined, as Health Canada no longer has day-to-day operational responsibilities in B.C. for First Nations health. Health Canada remains a funding and governance partner, providing support to the integration and accountability process.

Internal Services

Description

Internal Services are groups of related activities and resources that are administered to support the needs of programs and other corporate obligations of an organization. These groups are: Management and Oversight Services; Communications Services; Legal Services; Human Resources Management Services; Financial Management Services; Information Management Services; Information Technology Services; Real Property Services; Materiel Services; Acquisition Services; and Other Administrative Services. Internal Services include only those activities and resources that apply across the organization and not to those provided specifically to a program.

Budgetary Financial Resources (dollars)

2013-14 Main Estimates	2013-14 Planned Spending	2013-14 Total Authorities Available for Use	2013-14 Actual Spending (authorities used)	2013-14 Difference (actual minus planned)
260,970,174	261,571,214	405,591,219	364,976,909	103,405,695

Note: The variance of $103.4 million includes an increase of $144 million between planned spending and total authorities, which is offset by a decrease of $40.6 million between total authorities and actual spending.

The increase of $144 million is mainly due to the receipt of in-year funding through Supplementary Estimates and from the Department's operating budget carry forward that was allocated to fund strategic investments in IM/IT and Real Property. The total authorities were also supplemented by payments for paylist expenditures. Actual spending on Internal Services for 2013-14 was 9.2% of total departmental spending, which is relatively low when compared to other medium and large departments.

The variance of $40.6 million was primarily due to project delays.

Human Resources (FTEs)

2013-14 Planned	2013-14 Actual	2013-14 Difference (actual minus planned)
2,252	2,322	70

Note: The variance in FTE utilization is mainly due to the transfer of FTEs to Health Canada from PHAC is associated with the health portfolio Shared Services Partnership (SSP) model.

Performance Analysis and Lessons Learned

IS1 Governance and Management Support

Management and Oversight

Health Canada continued to advance its performance measurement capabilities at all levels. The Department strengthened executive level performance monitoring conducting reviews of operational performance data, on an exception basis, throughout the year; and assessed performance measurement strategies to ensure that they fully support program evaluations.

The Partnership Executive Committee (PEC) contributed to the continued success of the Shared Services Partnership (SSP) with PHAC, by supporting and approving the harmonization of policies, practices and services and the streamlining of financial approval processes. PEC created a Policy Harmonization Framework to guide the development of common sets of policies.

There is an opportunity to enhance flexibility, adapt to changing client needs and the evolving SSP. Enhanced engagement and collaboration including forward planning for committee meetings, leveraging intelligence from existing sources and clearly defining roles and responsibilities of contributors will be priorities in the coming year.

Communications Services

Health Canada and PHAC worked to ensure that Canadians have access to the information they need to take action on their health and safety. Numerous events, videos and social media initiatives were developed to support the Minister, as well as to engage with, and inform Canadians. To help Canadians better understand the work of Health Canada, the Department published its story "Health Canada – A Partner in Health for all Canadians".

Health Canada and PHAC developed social marketing campaigns and initiatives to help raise awareness and knowledge of key health and safety topics through advertising, partnerships, social media, and other outreach activities. In 2013-14, effective campaigns were developed to support people who are quitting smoking (Break It Off), to provide tools to Canadians to eat healthier (Eat Well), and to protect them against illnesses like Lyme disease and seasonal flu.

Under the SSP, Health Canada and PHAC also streamlined services and aligned communications activities and services to support and enhance ministerial, departmental/agency and program priorities.

IS2 Resource Management Services

Human Resources Management Services

To provide consistent, quality HR services across the SSP, a Health Canada/PHAC regional operational alignment was completed. Health Canada also implemented the Employee Performance Management Program, a government-wide priority; and worked on the Common Human Resources Business Process project to streamline and follow a standard HR process. However, a review to harmonize and align HR policies for the SSP was delayed, the result of competing priorities.

Financial Management Services

As part of its Procure to Pay (P2P) initiative, Health Canada re-engineered, using enabling technology and workflow, the end-to-end procurement and accounting transaction processes; eliminated "wet ink" and moved to a paperless environment where possible; introduced a new risk-based procurement service delivery model; and consolidated 14 district accounting sites into two national hubs.

The P2P initiative is yielding benefits in terms of efficiency, effectiveness, standardization of business processes, and compliance with central agency policies and internal controls on accounting and procurement, as well as an anticipated return on investment of 300% over 5 years. The shift to preventative, automated controls has improved the Department's internal control framework significantly, thereby enhancing compliance with the Treasury Board *Policy on Internal Control*.

An opening balanced audit was successfully conducted, which satisfies a past RPP commitment to ensure Health Canada is in the position to conduct a controls reliant audit of its financial statements, should it be called upon to do so.

Information Management / Information Technology Services

Health Canada advanced several Shared Services Canada and Treasury Board Secretariat (TBS) priorities, the email transformation initiative and Windows 7 implementation; and completed work on the IM/IT service transformation and alignment. Deployment delays of the TBS authorized tool for GCDOCs, caused Health Canada to shift its efforts from the implementation of an Enterprise Content Management System towards Information Management Readiness.

IS3 Asset Management Services

Real Property Services

The National Accommodation Strategy office modernization project achieved $4.3 million in savings, a year ahead of projected timelines. Regional accommodation projects supporting the B.C. Tripartite Framework Agreement contributed to accommodating the transfer of federal health programs to the FNHA. In addition, Health Canada developed an Integrated Real Property Management Framework, harmonizing nine policy instruments for Health Canada and PHAC, and enhancing real property governance.

The Department strengthened its corporate approach to real property and security management through continuous engagement with key stakeholders, such as Public Works and Government Services Canada and the Royal Canadian Mounted Police. Working groups helped to identify best practices, ensuring the successful transition and implementation of key initiatives.

Section III: Supplementary Information

Financial Statements Highlights

Health Canada
Condensed Statement of Operations and Departmental Net Financial Position (unaudited)
For the Year Ended March 31, 2014
(dollars)

	2013–14 Planned Results	2013–14 Actual	2012–13 Actual	Difference (2013–14 actual minus 2013–14 planned)	Difference (2013–14 actual minus 2012–13 actual)
Total expenses	3,519,961,000	3,945,992,000	3,782,097,000	426,031,000	163,895,000
Total revenues	115,849,000	258,814,000	147,607,000	142,965,000	111,207,000
Net cost of operations before government funding and transfers	3,404,112,000	3,687,178,000	3,634,490,000	283,066,000	52,688,000
Departmental net financial position	(582,646,000)	(259,479,000)	(413,245,000)	323,167,000	153,766,000

The Department's total expenses were $3.9 billion in 2013-14.

There was an increase of $426 million when comparing actual expenditures to planned results for 2013-14. This is primarily a result of funding received through Supplementary Estimates B to support First Nations and Inuit health programs and services, and to support the British Columbia (B.C.) Tripartite Framework Agreement.

There was an increase of approximately $163.9 million when comparing year-over-year actual expenditures. The significant changes were:

- An increase of $140.5 million in transfer payments due primarily to disbursements made to the FNHA under the B.C. Tripartite Framework Agreement.
- An increase of $33.6 million in salaries and employee benefits largely due to a prior year $42.5 million accrual reversal of workforce adjustment costs.
- An increase of $10.2 million in utilities, materials and supplies reflecting the ever-greening of a large volume of laptops and desktops to support the Windows 7 initiative.

These increases are offset by:

- A decrease of $15.2 million in professional and special services as a result of decreased noted in the NIHBP, where expenses previously paid for services in the Pacific Region are now administered by the FNHA through a transfer payment made to that organization, and a reduction in litigation costs for court cases which have now been settled in the Government's favour.

The Department's total revenues were $258.8 million in 2013-14 representing an increase of $111.2 million over the prior year actual revenues. This increase is primarily a result of:

- An increase of $73 million in services of a non-regulatory nature from the FNHA under the B.C. Tripartite Framework Agreement to recover expenses under the NIHBP.
- An increase of $30.8 million in rights and privileges revenue due to a timing in due dates for establishment licences.
- An increase of $17.4 million in services of a non-regulatory nature from Public Health Agency of Canada (PHAC) under the Shared Services Partnership delivery model.

These increases are offset by:

- A decrease of $7.8 million in services of a regulatory nature due to decreased volumes of drug submissions for evaluation.

Health Canada
Condensed Statement of Financial Position (unaudited)
As at March 31, 2014
(dollars)

	2013–14	**2012–13**	**Difference (2013–14 minus 2012–13)**
Total net liabilities	651,229,000	874,643,000	(223,414,000)
Total net financial assets	262,364,000	319,694,000	(57,330,000)
Departmental net debt	388,865,000	554,949,000	(166,084,000)
Total non-financial assets	129,386,000	141,704,000	(12,318,000)
Departmental net financial position	(259,479,000)	(413,245,000)	153,766,000

Total net liabilities were $651.2 million at the end of 2013-14, a decrease of $223.4 million from the previous year comprised mainly of:

- A decrease of $106.2 million as a result of payments to Canada Health Infoway Inc. drawing down the liability originating from the 2007 and 2009 Budgets.
- A decrease of $49.5 million in employee future benefits due to the liquidation of severance pay and termination benefits and cessation of accumulation of benefit obligations as a result of changes in some collective agreements.
- A decrease of $60.9 million in accounts payable and accrued liabilities due to changes in the nature of transfer payment agreements where payments are made in advance as a financing arrangement, more timely payment of invoices as a result of streamlined operations following the successful implementation of the innovative P2P module in the financial system, and a reduction in the accrual for workforce adjustment costs from the prior year.

The year-over-year decrease in total net financial assets of $57.3 million is primarily a result of the decrease in amounts due from the Consolidated Revenue Fund, reflecting changes in accounts payable and accrued liabilities.

Total non-financial assets decreased $12.3 million due primarily to a reduction in capital spending from the prior year as reflected in the main estimates.

Financial Statements

The financial statements including the Annex to the Statement of Management Responsibility Including Internal Control over Financial Reporting can be found on Health Canada's web site[lxvii].

Supplementary Information Tables

The supplementary information tables listed in the *2013–14 Departmental Performance Report* can be found on the Health Canada's website[lxviii].

- Departmental Sustainable Development Strategy;
- Details on Transfer Payment Programs;
- Horizontal Initiatives;
- Internal Audits and Evaluations;
- Response to Parliamentary Committees and External Audits;
- Sources of Respendable and Non-Respendable Revenue;
- Up-Front Multi-Year Funding; and,
- User Fees Reporting.

Tax Expenditures and Evaluations

The tax system can be used to achieve public policy objectives through the application of special measures such as low tax rates, exemptions, deductions, deferrals and credits. The Department of Finance Canada publishes cost estimates and projections for these measures annually in the *Tax Expenditures and Evaluations*[lxix] publication. The tax measures presented in the *Tax Expenditures and Evaluations* publication are the sole responsibility of the Minister of Finance.

Section IV: Organizational Contact Information

Marc Desjardins
Director General
Health Canada
DIRECTOR GENERAL'S OFFICE
200 Eglantine Driveway, Tunney's Pasture
Ottawa, Ontario K1A 0K9
Telephone : 613-948-6357
Fax : 613-946-0807
marc.desjardins@hc-sc.gc.ca

Appendix: Definitions

Appropriation: Any authority of Parliament to pay money out of the Consolidated Revenue Fund.

Budgetary expenditures: Include operating and capital expenditures; transfer payments to other levels of government, organizations or individuals; and payments to Crown corporations.

Departmental Performance Report: Reports on an appropriated organization's actual accomplishments against the plans, priorities and expected results set out in the corresponding Reports on Plans and Priorities. These reports are tabled in Parliament in the fall.

Full-time equivalent: Is a measure of the extent to which an employee represents a full person-year charge against a departmental budget. Full-time equivalents are calculated as a ratio of assigned hours of work to scheduled hours of work. Scheduled hours of work are set out in collective agreements.

Government of Canada outcomes: A set of 16 high-level objectives defined for the government as a whole, grouped in four spending areas: economic affairs, social affairs, international affairs and government affairs.

Management, Resources and Results Structure: A comprehensive framework that consists of an organization's inventory of programs, resources, results, performance indicators and governance information. Programs and results are depicted in their hierarchical relationship to each other and to the Strategic Outcome(s) to which they contribute. The Management, Resources and Results Structure is developed from the Program Alignment Architecture.

Non-budgetary expenditures: Include net outlays and receipts related to loans, investments and advances, which change the composition of the financial assets of the Government of Canada.

Performance: What an organization did with its resources to achieve its results, how well those results compare to what the organization intended to achieve, and how well lessons learned have been identified.

Performance indicator: A qualitative or quantitative means of measuring an output or outcome, with the intention of gauging the performance of an organization, program, policy or initiative respecting expected results.

Performance reporting: The process of communicating evidence-based performance information. Performance reporting supports decision-making, accountability and transparency.

Planned spending: For Reports on Plans and Priorities (RPPs) and Departmental Performance Reports (DPRs), planned spending refers to those amounts that receive Treasury Board approval by February 1. Therefore, planned spending may include amounts incremental to planned expenditures presented in the Main Estimates.

A department is expected to be aware of the authorities that it has sought and received. The determination of planned spending is a departmental responsibility, and departments must be able to defend the expenditure and accrual numbers presented in their RPPs and DPRs.

Plans: The articulation of strategic choices, which provides information on how an organization intends to achieve its priorities and associated results. Generally a plan will explain the logic behind the strategies chosen and tend to focus on actions that lead up to the expected result.

Priorities: Plans or projects that an organization has chosen to focus and report on during the planning period. Priorities represent the things that are most important, or what must be done first to support the achievement of the desired Strategic Outcome(s).

Program: A group of related resource inputs and activities that are managed to meet specific needs and to achieve intended results that are treated as a budgetary unit.

Results: An external consequence attributed in part, to an organization, policy, program or initiative. Results are not within the control of a single organization, policy, program or initiative; instead they are within the area of the organization's influence.

Program Alignment Architecture: A structured inventory of an organization's programs depicting the hierarchical relationship between programs and the Strategic Outcome(s) to which they contribute.

Report on Plans and Priorities: Provides information on the plans and expected performance of appropriated organizations over a three-year period. These reports are tabled in Parliament each spring.

Strategic Outcome: A long-term and enduring benefit to Canadians that is linked to the organization's mandate, vision and core functions.

Sunset program: A time-limited program that does not have an ongoing funding and policy authority. When the program is set to expire, a decision must be made whether to continue the program. In the case of a renewal, the decision specifies the scope, funding level and duration.

Target: A measurable performance or success level that an organization, program or initiative plans to achieve within a specified time period. Targets can be either quantitative or qualitative.

Whole-of-Government Framework: Maps the financial contributions of federal organizations receiving appropriations by aligning their Programs to a set of 16 government-wide, high-level outcome areas, grouped under four spending areas.

Endnotes

[i] Treasury Board of Canada Secretariat, http://www.tbs-sct.gc.ca/

[ii] Canada Health Act, http://laws-lois.justice.gc.ca/eng/acts/C-6/

[iii] Assisted Human Reproduction Act, http://laws-lois.justice.gc.ca/eng/acts/A-13.4/index.html

[iv] Canada Consumer Product Safety Act, http://laws-lois.justice.gc.ca/eng/acts/c-1.68/

[v] Canadian Environmental Protection Act, 1999, http://laws-lois.justice.gc.ca/eng/acts/C-15.31/

[vi] Controlled Drugs and Substances Act, http://laws-lois.justice.gc.ca/eng/acts/c-38.8/

[vii] Food and Drugs Act, http://laws.justice.gc.ca/eng/acts/F-27/

[viii] Tobacco Act, http://laws-lois.justice.gc.ca/eng/acts/T-11.5/

[ix] Hazardous Products Act, http://laws-lois.justice.gc.ca/eng/acts/H-3/index.html

[x] Hazardous Materials Information Review Act, http://laws-lois.justice.gc.ca/eng/acts/H-2.7/

[xi] Department of Health Act, http://laws-lois.justice.gc.ca/eng/acts/H-3.2/index.html

[xii] Radiation Emitting Devices Act, http://laws-lois.justice.gc.ca/eng/acts/R-1/

[xiii] Pesticide Residue Compensation Act, http://laws-lois.justice.gc.ca/eng/acts/P-10/index.html

[xiv] Pest Control Products Act, http://laws-lois.justice.gc.ca/eng/acts/P-9.01/

[xv] List of Acts and Regulations, http://www.hc-sc.gc.ca/ahc-asc/legislation/acts-reg-lois/acts-reg-lois-eng.php

[xvi] Food and Drug Regulations, http://laws-lois.justice.gc.ca/eng/regulations/C.R.C.,_c._870/

[xvii] Blood Regulations, http://laws-lois.justice.gc.ca/eng/regulations/SOR-2013-178/page-1.html

[xviii] Consumer Product Safety Regulations, http://www.hc-sc.gc.ca/cps-spc/legislation/acts-lois/index-eng.php

[xix] Marihuana for Medical Purposes Regulations, http://www.laws-lois.justice.gc.ca/eng/regulations/SOR-2013-119/

[xx] Gender Equity in Indian Registration Act, https://www.aadnc-aandc.gc.ca/eng/1308068336912/1308068535844

[xxi] Whole-of-government framework, http://www.tbs-sct.gc.ca/ppg-cpr/frame-cadre-eng.aspx

[xxii.] 2014-15 Main Estimates, http://www.tbs-sct.gc.ca/ems-sgd/esp-pbc/esp-pbc-eng.asp

[xxiii] Evaluation of Canadian Blood Services Grants and Contributions Programs 2008-09 to 2012-13, http://www.hc-sc.gc.ca/ahc-asc/performance/eval/cbsc-evaluation-pssb-eng.php

[xxiv] Canada Health Infoway, Annual Report 2013-14, https://www.infoway-inforoute.ca/index.php/resources/infoway-corporate/annual-reports/doc_download/2175-annual-report-2013-2014

[xxv] Health Care Policy Contribution Program, http://www.hc-sc.gc.ca/ahc-asc/performance/eval/hcpc-evaluation-pcpms-eng.php

[xxvi] Health Information Initiative 2007-08 to 2011-12, http://www.hc-sc.gc.ca/ahc-asc/performance/eval/2013-hii-iis-eng.php

[xxvii] Synthesis Evaluation of Transfer Payments to Pan-Canadian Organizations 2008-09 to 2012-13, http://www.hc-sc.gc.ca/ahc-asc/performance/eval/payments-paiements-eng.php

[xxviii] Health Canada's Transfer Payment to the Rick Hansen Foundation 2007-08 to 2012-13, http://www.hc-sc.gc.ca/ahc-asc/performance/eval/transfer-transfert-eng.php

[xxix] Official Languages Act, http://laws-lois.justice.gc.ca/eng/acts/O-3.01/

[xxx] Official Languages Health Contribution Program 2008-12, http://www.hc-sc.gc.ca/ahc-asc/performance/eval/olhc-evaluation-clos-eng.php

[xxxi] Protecting Canadians from Unsafe Drugs Act (Vanessa's Law), http://www.hc-sc.gc.ca/dhp-mps/legislation/unsafedrugs-droguesdangereuses-eng.php

[xxxii] Regulations Amending Certain Regulations Concerning Prescription Drugs, http://canadagazette.gc.ca/rp-pr/p2/2013/2013-06-19/html/sor-dors122-eng.php

[xxxiii] Veterinary Drugs Program 1999-2012, http://www.hc-sc.gc.ca/ahc-asc/performance/eval/vdp-evaluation-pmv-eng.php

[xxxiv] Human Drugs Program 1999-2000 to 2011-12, http://www.hc-sc.gc.ca/ahc-asc/performance/eval/hdp-evaluation-pmh-eng.php

[xxxv] Safety of Human Cells, Tissues and Organs for Transplantation Regulations, http://www.hc-sc.gc.ca/dhp-mps/brgtherap/reg-init/cell/cto_regs_rias-reir-eng.php

[xxxvi] Processing and Distribution of Semen for Assisted Conception Regulations, http://laws.justice.gc.ca/eng/regulations/SOR-96-254/

[xxxvii] Science.gc.ca, http://science.gc.ca/

[xxxviii] Canadian Blood Services Grant and Contribution Programs 2008-09 to 2012-13, http://www.hc-sc.gc.ca/ahc-asc/performance/eval/cbsc-evaluation-pssb-eng.php

[xxxix] Medical Devices Regulations, http://laws-lois.justice.gc.ca/eng/regulations/sor-98-282/

[xl] Medical Devices Program 1999-2000 to 2011-12, http://www.hc-sc.gc.ca/ahc-asc/performance/eval/medical_devices-materiels_medicaux-eng.php

[xli] Natural Health Products Regulations, http://laws-lois.justice.gc.ca/eng/regulations/sor-2003-196/

[xlii] Natural Health Products Directorate (NHPD) six-month calendar of activities: January to June 2014, http://www.hc-sc.gc.ca/dhp-mps/prodnatur/activit/calend/06-2014-eng.php

[xliii] Food Safety and Nutrition Quality Program 1999-2000 to 2011-12, http://www.hc-sc.gc.ca/ahc-asc/performance/eval/foodsafety-salubrite-eng.php

[xliv] Summative Evaluation of the Bovine Spongiform Encephalopathy (BSE) I and II Initiatives, http://www.hc-sc.gc.ca/ahc-asc/performance/eval/2013/bce-bovine-evaluation-esb-eng.php

[xlv] Canadian Environmental Protection Act, 1999, http://laws-lois.justice.gc.ca/eng/acts/C-15.31/

[xlvi] Action Plan to Protect Human Health from Environmental Contaminants 2008-09 to 2012-13, http://www.hc-sc.gc.ca/ahc-asc/performance/eval/contaminants-eng.php

[xlvii] Canadian Environmental Assessment Act, http://laws-lois.justice.gc.ca/eng/acts/c-15.21/index.html

[xlviii] Cosmetic Regulations, http://laws-lois.justice.gc.ca/eng/regulations/C.R.C.,_c._869/

[xlix] Consumer Products Activities, http://www.hc-sc.gc.ca/ahc-asc/performance/eval/2013/cpa-pdcfni-eng.php

[l] Budget Implementation Act, http://laws-lois.justice.gc.ca/eng/acts/B-9.858/

[li] Cracking Down on Tobacco Marketing Aimed at Youth Act, http://laws.justice.gc.ca/eng/AnnualStatutes/2009_27/page-1.html

[lii] The Break it off Campaign, http://breakitoff.ca/

[liii] Respect for Communities Act, http://www.parl.gc.ca/HousePublications/Publication.aspx?Language=E&Mode=1&DocId=6211134

[liv] Drug Treatment Funding Program, http://www.hc-sc.gc.ca/ahc-asc/performance/eval/drug-toxicomanie-eng.php

[lv] Comprehensive Nuclear Test-Ban Treaty Implementation Act, http://laws-lois.justice.gc.ca/eng/acts/C-36.5/

[lvi] Nuclear Safety and Control Act, http://laws-lois.justice.gc.ca/eng/acts/N-28.3/

[lvii] Radiation Emitting Devices Regulations, http://laws-lois.justice.gc.ca/eng/regulations/C.R.C.,_c._1370/

[lviii] Tanning Equipment Regulations, http://gazette.gc.ca/rp-pr/p2/2014/2014-02-26/html/sor-dors25-eng.php

[lix] Hand-held lasers and laser pointers, http://healthycanadians.gc.ca/consumer-consommation/home-maison/laser-eng.php

[lx] The safety of compact fluorescent lamps, http://healthycanadians.gc.ca/consumer-consommation/home-maison/cfl-afc-eng.php#health

[lxi] Indian Health Policy (1979), http://www.hc-sc.gc.ca/ahc-asc/branch-dirgen/fnihb-dgspni/poli_1979-eng.php

[lxii] Safe Drinking Water for First Nations Act, http://laws-lois.justice.gc.ca/eng/annualstatutes/2013_21/FullText.html

[lxiii] First Nations Clinical and Client Care Program 2005-06 to 2011-12, http://www.hc-sc.gc.ca/ahc-asc/performance/eval/fni-clinical-cliniques-pni-eng.php

[lxiv] First Nations and Inuit Home and Community Care Program 2008-09 to 2011-12, http://www.hc-sc.gc.ca/ahc-asc/performance/eval/2013-fni-commun-pni-eng.php

[lxv] First Nations and Inuit Health Human Resources Program 2008-09 to 2011-12, http://www.hc-sc.gc.ca/ahc-asc/performance/eval/2013-fni-hr-rh-pni-eng.php

[lxvi] First Nations National Nursing Innovation Strategy Program 2008-09 to 2011-12, http://www.hc-sc.gc.ca/ahc-asc/performance/eval/fni-innovation-pni-eng.php

[lxvii] Financial Statements, http://www.hc-sc.gc.ca/ahc-asc/performance/estim-previs/dpr-rmr/2013-2014/2013-2014-dfs-efm-eng.php

[lxviii] Supplementary Information Tables, http://www.hc-sc.gc.ca/ahc-asc/performance/estim-previs/plans-prior/2014-2015/supplement-eng.php

[lxix] Tax Expenditures and Evaluations publication, http://www.fin.gc.ca/purl/taxexp-eng.asp