Health Canada

1997-98
Estimates

Part III

Expenditure Plan

The Estimates Documents

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Part III

Expenditure Plan

Approved

Minister of Health Canada

HEALTH CANADA

OUR MISSION

- to help the people of Canada maintain and improve their health.

OUR VISION

- a renewed national health system that is based on a health determinants approach to population health, that manages risks to the health of Canadians, and that ensures universal access to appropriate and cost-effective health care.

OUR OPERATING PRINCIPLE

- a commitment to excellence in an environment characterized by teamwork, innovation, trust, and cooperation; and
- fairness, dignity and respect in our treatment of each other.

The Honourable David C. Dingwall, P.C., M.P.

Preface

This Part III document was prepared as part of a project to improve the expenditure management information that government provides to Parliament, and to update the processes used within the federal government to prepare the information. It is a report to Parliament to indicate how the resources voted by Parliament have or will be spent. As such, it is an accountability document that contains several levels of detail to respond to the various needs of its audience.

In January, 1995, the Expenditure Management System (EMS) was revised to introduce a strategic, multi-year perspective of planning and results reporting with an emphasis on reallocation to support a stable fiscal framework. In support of the new EMS, changes were made to expenditure management documentation presented to Parliament and the Treasury Board Secretariat. Key elements of the changes were a focus on results and performance, a longer term planning perspective, and clear communications.

Part III documents for 1997-98 are intended to align the information provided to Parliament with this expenditure management philosophy. They are based on a revised format intended to make a clear separation between planning and performance information and to focus on the higher level, longer-term plans and performance of departments. They are also intended to reflect lessons learned from revised Part III documents that were tested with Parliament in March, 1996, as part of the Improved Reporting to Parliament project. The intent is to maintain the level of disclosure to Parliament, but to do so in a clear fashion.

The document is designed to permit easy access to specific information that the reader may require. It is divided into four sections:-

- The Minister's Executive Summary;
- Departmental Plans;
- Departmental Performance; and
- Supplementary Information.

A Table of Contents lists the various chapters, a Topical Index lists where information on specific topics can be found and an Abbreviations section lists abbreviations used in the Plan. In addition, other specific page references are made throughout the document to guide the reader to more details on items of particular interest.

It should be noted that, in accordance with the Operating Budget principles, the human resource figures reported in the Expenditure Plan are measured in terms of employee full time equivalents (FTE). For example, one employee working half-time during the year is equivalent to half an FTE.

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I. The Minister's Executive Summary

Canadians cherish their health system; it represents what is good about Canada and what they want to see preserved for themselves and their children. For four decades, Health Canada has taken measures to provide Canadians with a modern and reliable health system they will continue to value in the 21st century. These measures and future actions will ensure we have a health system that embraces such social values as compassion, equity and shared responsibility.

In recent years, the federal government has repeated its promise to protect the health system. It has preserved and defended the principles of the *Canada Health Act* — universality, accessibility, comprehensiveness, portability and public administration. This legislation is, and will continue to be, the cornerstone of our health system. Through the Canada Health and Social Transfer, the federal government has also provided the provinces with a secure and stable cash floor to assure the future of Medicare.

Yet, despite ongoing efforts by all levels of government, health disparities persist in Canadian society especially among children, seniors, women and aboriginals. Factors such as income and education, while not integral to the health system, affect the health of individuals and their need for health services.

Federal-provincial-territorial jurisdictions recently released the first joint *Report on the Health of Canadians*. This profile of the health status of the Canadian population focuses on the factors that influence health and illustrates there is more to health than health care. The Report supports a comprehensive approach to health and well-being and calls for collective action by government, organizations, communities and individuals.

As we approach the new millennium, I envisage improved levels of health for all Canadians. To achieve this goal, we must address the factors that influence health. We must strike a balance between encouraging wellness through prevention/promotion activities and treating people after they are sick.

The federal government is committed to working with the provinces, territories and other partners to build a framework for action on healthy child development. This initiative will address such issues as parenting, balancing work and home, nutrition, food handling and product safety.

In concert with provincial and territorial governments, the federal government is also working with First Nations and Inuit communities to help them assume control of their health services at their own pace.

My responsibility for the health and safety of all Canadians falls under some 20 federal statutes. Health Canada continually plays a national role in ensuring the safety of food, drugs, cosmetics, chemicals and consumer products. My provincial and territorial counterparts and I have agreed to put in place a new blood authority to resolve problems with Canada's blood system. The federal government has also worked to renew and strengthen tobacco control legislation as well as a renewed Canadian Environmental Protection Act and a proposed Drinking Water Materials Safety Act.

Forces such as cost, increased consumer awareness and emerging diseases are generating significant pressures on the health system. Governments must take action to address these pressures.

We must restructure the health system to reflect today's realities. We must look at reallocating resources to prevention, promotion and protection measures. We must strive to reduce inefficiencies and make effective use of health information and research.

Canadians rely on the federal government to protect their health and safeguard their national health system. They deserve nothing less. As the Minister of Health, I am committed to upholding the mission of my department: to help the people of Canada maintain and improve their health.

The Honourable David C. Dingwall, P.C. M.P.
Minister of Health

II Departmental Plan

A. Summary of Departmental Plans and Priorities

The management of major health issues now and in the future demands a significant change in priorities and business approaches, particularly in a time of continuing and complex fiscal restraint. For example, new and emerging health pressures can only be met to the extent that Health Canada is able to strengthen the use of available research results and evidence in its own decisions and those of its partners within the health system.

To achieve efficiencies, the Department has integrated its business plans as shown in Figure 1 below. As shown, we are structuring cross-Department activities such as surveillance, policy, research, legislation, consultation, planning and review into a cohesive, cost-effective way to deliver the Government's federal health strategy and core departmental responsibilities.

On the outside circle are the four cross-branch business lines tied together by a stronger, more corporate Priority-setting and Management Core:

- Health System Support and Renewal;
- Management of Risks to Health - Products and Disease Control;
- Services to First Nations, Inuit and Yukon; and
- Population Health Strategy.

Figure 1: Business Plan Structure

The priorities for the **Priority-setting and Management Core** business line are:

i) refine federal health strategy and provide effective support for implementation of key elements - the implementation of the federal health strategy communications plan;

ii) strengthen coverage, quality and use of key information sources required for effective Departmental and health system decision making with emphasis on:

   a) Public Health Intelligence Networks - continue to address blind spots in the networks and strengthen capacity to support decision making across all departmental business lines;

   b) the development of a Health Research Agenda for Canada, the implementation of the Health Services Research Fund, refocused intra- and extramural Departmental research programs and the increased use of research, science and technology results across all business lines including the development and application of a research-priority framework that distinguishes between S&T in support of the risk-identification/issue-definition function, and the risk management/option-appraisal function; and

   c) the development of legislative and macro-policy frameworks that build on consultation and provide a framework for national action in critical areas such as the full integration of women's health issues and the more intensive participation of the Department in trade-related initiatives.

iii) continue to develop and implement more effective, evidence-based approaches to corporate review, planning, and decision making linking corporate priorities and effective resource management processes.

A list of the priorities and examples of activities and initiatives for each business line follows.

The **Health System Support and Renewal** business line promotes and advances the implementation of federal health strategy objectives. Its priorities and examples of associated initiatives are:

i) to interpret, enforce and renew the *Canada Health Act* - the renewal of the regulatory and legislative framework for Medicare while maintaining the principles of the Act;

ii) to advance the shift to a better-balanced, evidence-based health system - the development and implementation of more appropriate, cost-effective models of care; reduction in costs of inappropriate/ineffective health services and more appropriate human resources utilization; the adoption of a better balance among health promotion, prevention, and care; and the development and dissemination of information on indicators of system performance and population health status outcomes in the context of health systems reforms; and

iii) to control cost drivers - the examination of cost drivers in the public and private sectors, including pharmaceuticals, and the assessment of innovations and reforms.

The major purpose of the **Management of Risks to Health — Products and Disease Control** business line is to protect Canadians against current and emerging health risks through:

- national surveillance and monitoring by ensuring the safety of food, drugs, cosmetics, chemicals, pesticides, medical or radiation-emitting devices and other potentially hazardous consumer and industrial products; and

- environmental health activities.

Its priorities and examples of associated initiatives are:

i) to improve the governance of the Canadian blood system - key initiatives will include the development of a comprehensive strategic plan for restructuring the governance of Canada's blood system, building a national consensus and enhanced surveillance, investigation and regulation of blood, blood products and transplanted organs;

ii) enhance partnerships in the Canadian Food Safety System - creating a new Canadian Food Inspection Organization, implementing a Canadian Food Inspection System to streamline the food inspection process, reduce regulatory pressures on industry, facilitate harmonization, and provide a system that is flexible, responsive and timely;

iii) implement cost-effective, risk-based approaches to regulation, compliance and surveillance activities and continue to improve the capacity to anticipate, prevent and respond to health threats due to foods, drugs, medical devices, environmental health hazards and consumer products - activities will include regulatory renewal designed to build a more flexible regulatory environment that encourages innovation without compromising health and safety, the control of tobacco products and the implementation of a new Health and Environment Program to manage environmental health risks;

iv) continue to strengthen the capacity to anticipate, prevent and respond to priority and emerging health risks - address major blind spots in disease prevention and control and strengthen the Department's ability to respond to new and emerging health threats; and

v) improve program effectiveness and efficiency by implementing alternative delivery mechanisms and organizational structures, rationalizing activities and implementing cost-recovery initiatives - continue to implement the new Pest Management Regulatory Agency and establish Special Operating Agency status, implement provisional Special Operating Agency status for Occupational and Environmental Health services and full SOA status or alternative by April 1998, continue to implement cost-recovery initiatives to support the commitment to provide responsive, effective and affordable government and continue to work toward rationalizing laboratory programs and facilities.

The major objective of the **Services to First Nations, Inuit and Yukon** business line is to ensure the availability of, or access to, health services for First Nations, the Inuit population and residents of the Yukon. It is also responsible for assisting First Nations and Inuit in addressing health inequalities and disease threats so they may attain a level of health comparable to that of other Canadians living in similar locations. Its priorities and examples of associated initiatives are:

i) to manage the cost-effective delivery of health services within the fiscal limits of the First Nations and Inuit Health Envelope - develop options to implement new envelope targets, and continue to work with First Nations leadership on strategies to manage health programs within the envelope;

ii) to transfer existing health resources to First Nations and Inuit control, within a timeframe to be determined in consultation with them, and complete the transfer to the Yukon Territorial Government of the universal health programs — implement a Departmental process for health sector self-government negotiations with First Nations; and

iii) to support action on health status inequalities affecting First Nations and Inuit communities, according to priorities identified by them — initiatives will aim to strengthen regional interactions with First Nations and Inuit to identify their priority health needs and undertake and continue specific initiatives to address priority health inequalities among First Nations and Inuit communities.

The **Population Health Strategy** business line identifies, develops and responds to compelling evidence that health is influenced by various social, biological, and economic factors outside the health system, and that further gains to the health of Canadians must take these factors into consideration. It is an upstream approach designed to reduce the long term demand for health services. Its priorities and examples of associated initiatives are:

i) to complete the design and approval process and implement new approaches to a population health strategy — initiatives that will strengthen the evidence base and ensure that research results are correctly interpreted and applied;

ii) to reconfigure certain health promotion and disease prevention programs based on a life stages approach, i.e., children, adolescents, mid-adulthood, and later life; and

iii) to reinforce the federal government's capacity for managing existing and emerging horizontal health issues with other federal government departments supporting coordinated action on the factors affecting the health status of Canadians.

B. Departmental Overview

Roles, Responsibilities and Mission

Health Canada's mission is to help Canadians maintain and improve their health. This issue is dealt with in a broad context, taking into account a wide range of health determinants, e.g. genetic, behaviourial, social, biological, economic and environmental. The emphasis is on fostering healthy individuals, healthy families and a healthy society, with a focus on disease prevention and health promotion. To meet the challenges of maintaining a high quality and affordable health system, the Department relies on a broad range of activities including:

- administration and enforcement of the *Canada Health Act*;
- cooperation with provinces and territories in health system renewal and in addressing identified health-related issues;
- activities aimed at the protection of the health of Canadians;
- strengthening and expanding the health intelligence network to support evidence-based decisions across all the Department's business lines;
- the fostering of public health research;

- the transfer, the delivery, or assistance in the delivery, of health services to First Nations and Inuit;
- activities aimed at improving health care and health services in Canada;
- activities aimed at disease prevention and the promotion of good health; and
- activities targeted at issues affecting specific groups in society, e.g. women, children, seniors.

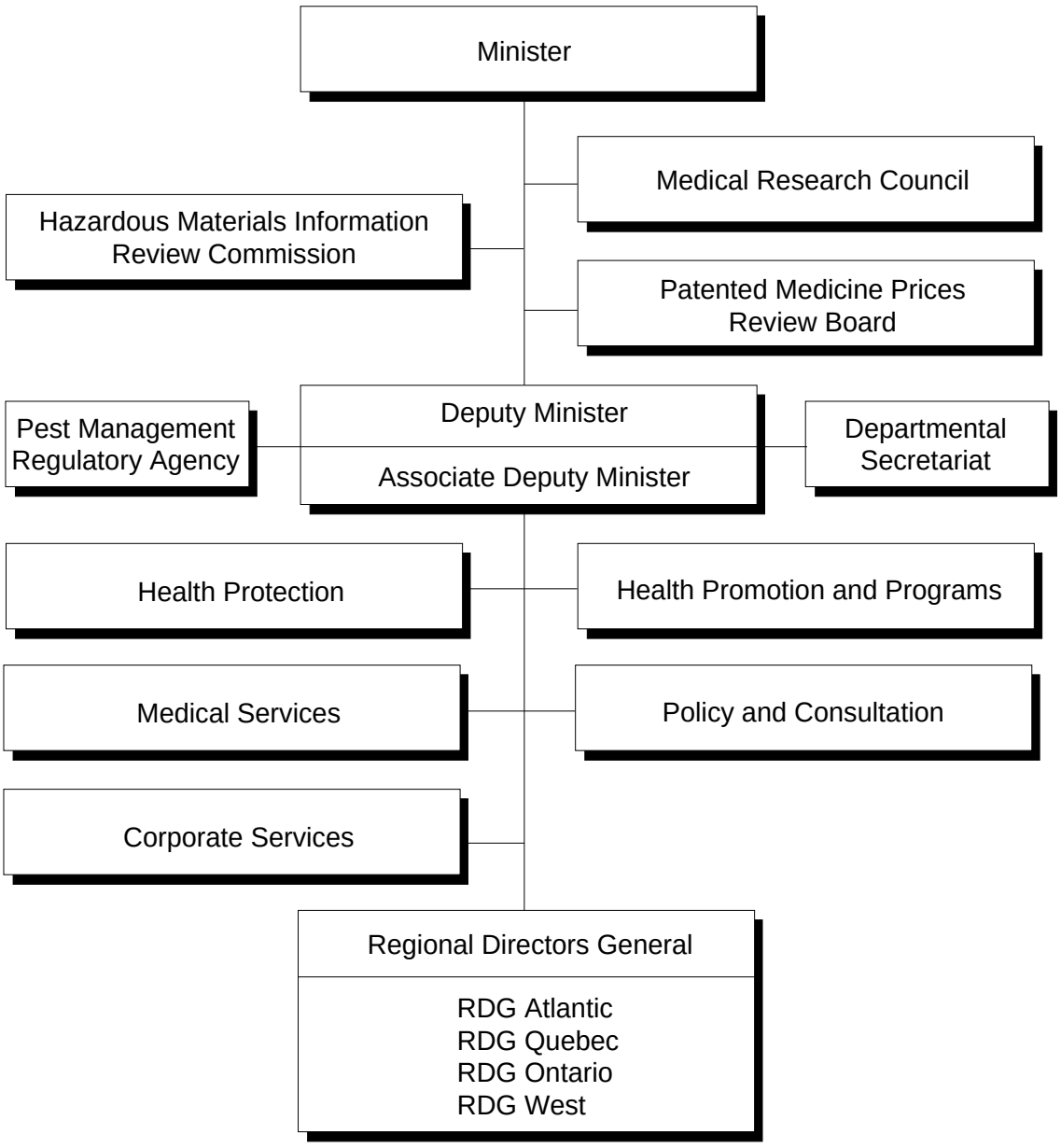
The major instruments through which the Department carries out its responsibilities are: grants and contributions to individuals, provincial and territorial governments, national associations and other related agencies, non-governmental organizations, universities and aboriginal groups; research and evaluation; surveillance, regulation and risk management activities; advice, consultation and information on health-related matters; and direct services to specific groups.

In fulfilling its national role with respect to population health, a significant proportion of the Department's activities entails collaboration with provincial and territorial authorities in efforts to maintain and improve the health of all Canadians. The need for joint activity in certain areas arises from the constitutional division of responsibilities.

Organization and Program Composition

Health Canada is composed of one Program, the Health Program. Its organizational structure is composed of five branches each headed by an Assistant Deputy Minister and the Pest Management Regulatory Agency, headed by an Executive Director. The Assistant Deputy Ministers and the Executive Director report to the Deputy Minister and the Associate Deputy Minister. The Department also has Regional Directors General across Canada providing a focal point for departmental programs and for federal-provincial-territorial relations. These Regional Directors General also report to the Deputy Minister and the Associate Deputy Minister. The Medical Research Council, the Patent Medicine Prices Review Board and the Hazardous Materials Information Review Commission report directly to the Minister. Figure 2 shows the current organization of the Department.

Figure 2: Program and Organization Structure



The **Health Protection Branch (HPB)** through four Activities, works to eliminate health hazards associated with the natural and man-made environments that lead to illness and untimely death. Its principal responsibilities involve assessment and control of the nutrition, quality and safety of food; the safety and effectiveness of drugs, cosmetics, medical devices, radiation-emitting devices and other consumer products; the identification and assessment of environmental hazards; the surveillance, prevention and control of diseases; and the provision of specialized laboratory services.

The **Pest Management Regulatory Agency (PMRA)** administers the federal pest management regulatory system. The PMRA is responsible for the regulation of pest control products and the development and implementation of related policies and strategies.

The **Health Promotion and Programs Branch (HPPB)**, through one Activity, operates its health and social programs. By focusing on the determinants of health, the Branch provides national leadership to develop, promote and support measures such as policy development, health research, and system enhancement in order to preserve and improve the health and well-being of Canadians.

The **Medical Services Branch (MSB)** through three Activities, delivers health services to several client groups. Major programs are directed towards First Nations and Inuit throughout Canada and other residents of the Yukon Territory. Services for the Northwest Territories, other than Non-Insured Health Benefits, have been transferred to the territorial government. MSB's clients also include federal public servants, civil aviation personnel and disaster victims.

The **Policy and Consultation Branch (PCB)** through two Activities, administers the *Canada Health Act* and provides technical support to the provinces and territories for insured health care services and certain extended health care services; supports the development and delivery of health programs by undertaking health policy research and analysis; carries out strategic planning within the Department; manages federal, provincial and territorial relations; manages the Women's Health Bureau; coordinates the administration of the Access to Information and Privacy legislation in the Department; develops Canada's position on international health issues; manages program evaluation; and manages and coordinates departmental communications activities.

The **Program Management Activity** contains the Departmental Executive organizations and the Corporate Services Branch. It also provides support services to the Department's legal advisors. **Corporate Services Branch (CSB)** provides services to the Department in the areas of planning and financial administration, information management, assets management, human resources and internal audit.

The **Departmental Executive** organizations provide the Minister, the Deputy Minister and the Associate Deputy Minister with strategic advice, executive coordination, support and intelligence gathering. The offices of the Regional Directors General, the Departmental Secretariat and the Secretariat for the National Forum on Health are amongst the organizations in the Departmental Executive.

Departmental Mandate

The Health Program primarily draws its mandate from the Department of Health Act, S.C. 1996, c. 8. Other Acts and regulations administered in whole or in part by Health Canada are given in Section IV, Supplementary Information (see page IV-143).

Departmental Objective

The objective of the Health Program is to protect, preserve and improve all aspects of Canadians' health.

Resource Plans and Financial Tables

Figure 3: Authorities for 1997-98 — Part II of the Estimates

Financial Requirements by Authority

Vote	(thousands of dollars)	**1997-98 Main Estimates**	1996-97 Main Estimates
	Health Department		
1	Operating expenditures	**912,450**	914,763
5	Capital expenditures	**11,417**	31,024
10	Grants and contributions	**562,041**	585,030
(S)	Minister of Health — Salary and motor car allowance	**49**	49
(S)	Contributions to employee benefit plans	**48,101**	45,983
Total Department		**1,534,058**	1,576,849

Figure 4: Proposed Schedule to the Appropriation Bill

Unless specifically discussed in the Preface, all vote wordings are as previously provided in earlier Appropriation Acts.

Section	Vote No.	Department or agency (dollars)	**1997-98 Main Estimates**
10		**Health Department**	
	1	Health – Operating Expenditures and, pursuant to paragraph 29.1(2)(a) of the *Financial Administration Act*, authority to spend revenues to offset expenditures incurred in the fiscal year arising from the provision of services or the sale of products related to health protection, regulatory activities and medical services.	**912,450,000**
	5	Health – Capital expenditures	**11,417,000**
	10	Health – The grants listed in the Estimates and contributions	**562,041,000**

Statutory Items in Main Estimates

Section	Department or agency (dollars)	**1997-98 Main Estimates**
10	**Heath Department**	
	Minister of Health — Salary and motor car allowance	**48,645**
	Contributions to employee benefit plans	**48,101,000**

Figure 5: Program by Activities

(thousands of dollars)	FTE	1997-98 Main Estimates					1996-97 Main Estimates*
		Budgetary					
		Operating	Capital	Transfer Payments	Revenues credited to the Vote	**Total**	
Food Safety, Quality and Nutrition	552	43,845	2,062	15	(2,306)	**43,616**	57,897
Drug Safety, Quality and Effectiveness	652	47,386	1,580		(35,935)	**13,031**	19,973
Environmental Quality and Hazards	526	37,984	1,848	105	(4,303)	**35,634**	43,880
National Health Surveillance	298	42,703	1,310			**44,013**	42,438
Pest Management Regulatory Agency	202	12,315			(185)	**12,130**	24,911
Programs and Services	430	62,075		130,095		**192,170**	218,976
Indian and Northern Health Services	1,396	644,119	560	394,984	(11,364)	**1,028,299**	1,046,535
Public Service Health	395	26,574			(4,472)	**22,102**	24,936
Health Advisory and Assessment Services	93	5,666			(1,799)	**3,867**	5,132
Policy and Consultation	191	15,138		16,828		**31,966**	18,998
Health Insurance	23	1,731				**1,731**	1,702
Program Management	910	82,766	4,057	20,014	(1,338)	**105,499**	71,471
Total Department	5,668	1,022,302	11,417	562,041	(61,702)	**1,534,058**	1,576,849
1996-97 FTE	6,362						

* Does not reflect Supplementary Estimates

Figure 6: Appropriated Planned Spending

(thousands of dollars)	1996-97 Main Estimates *	**1997-98 Main Estimates**	1998-99 Planned	1999-00 Planned
Food Safety, Quality and Nutrition	57,897	**43,616**	42,498	42,818
Drug Safety, Quality and Effectiveness	19,973	**13,031**	12,903	13,173
Environmental Quality and Hazards	43,880	**35,634**	33,605	33,828
National Health Surveillance	42,438	**44,013**	30,438	28,596
Pest Management Regulatory Agency	24,911	**12,130**	11,822	11,822
Programs and Services	218,976	**192,170**	149,424	149,468
Indian and Northern Health Services	1,046,535	**1,028,299**	1,036,974	1,068,690
Public Service Health	24,936	**22,102**	21,581	21,647
Health Advisory and Assessment Services	5,132	**3,867**	2,644	2,644
Policy and Consultation	18,998	**31,966**	31,192	31,211
Health Insurance	1,702	**1,731**	1,736	1,736
Program Management	71,471	**105,499**	97,780	97,905
Total Department	1,576,849	**1,534,058**	1,472,597	1,503,538

* Does not reflect Supplementary Estimates

Figure 7: Use of 1995-96 Authorities — Volume II of the Public Accounts

Vote	(dollars)	Main Estimates	Available for Use	**Actual Use**
	Department			
	Health Program			
1	Operating expenditures	986,179,000	995,576,415	**983,182,031**
5	Capital expenditures	59,279,000	51,088,900	**50,842,101**
10	Grants and contributions	523,327,000	566,375,500	**565,038,383**
(S)	Payments for insured health services and extended health care services	6,891,000,000	7,240,526,000	**7,240,526,000**
(S)	Contributions to employee benefit plans	39,943,000	41,946,610	**41,946,610**
(S)	Motor car allowance	48,645	48,645	**48,645**
(S)	Spending of proceeds from the disposal of surplus Crown assets	—	622,536	**578,088**
	Total Department — Budgetary	8,499,776,645	8,896,184,606	**8,882,161,858**

Figure 8: Departmental Appropriated Planned and Actual Spending

(thousands of dollars)	1993-94 Actuals	1994-95 Actuals	1995-96 Estimates*	**1995-96 Actuals**
Food Safety, Quality and Nutrition	63,072	57,760	64,318	**69,513**
Drug Safety, Quality and Effectiveness	69,520	73,530	59,256	**61,660**
Environmental Quality and Hazards	45,497	56,359	55,695	**49,381**
National Health Surveillance	59,505	38,854	43,423	**35,930**
Pest Management Regulatory Agency	—	—	—	**—-**
Programs and Services	179,485	215,980	247,046	**237,939**
Indian and Northern Health Services	824,636	917,233	994,790	**1,015,181**
Public Service Health	25,765	30,268	24,356	**22,593**
Health Advisory and Assessment Services	7,932	6,173	6,529	**5,001**
Policy and Consultation	18,078	20,421	19,050	**22,753**
Health Insurance	1,274	1,598	1,684	**1,479**
Program Management	96,035	130,663	92,630	**120,205**
Sub-total	1,390,799	1,548,839	1,608,777	**1,641,636**
Health Insurance	7,232,090	7,566,089	6,891,000	**7,240,526**
Total Department	8,622,889	9,114,928	8,499,777	**8,882,162**

* Does not reflect Supplementary Estimates

C. Details by Activity

Food Safety, Quality and Nutrition

Objective

To protect and improve the well-being of Canadians by defining, advising on and managing risks and benefits to health associated with the food supply.

Description

There were significant changes to the Department's food program in 1996-97, largely as a result of the decision of the Government to create a single food inspection agency.

The food program has for many years consisted of a food safety policy, research, and standard-setting core located in the National Capital Region and an inspection and compliance delivery arm located mainly in five regional offices across Canada. This compliance function has included, for the past ten years, responsibility for food safety audits.

The March, 1996, Budget announced the government's intention to create a single food inspection agency. At the same time, it gave the Minister of Health an enhanced food safety role. The budget announcement gave the Department new or increased responsibilities. The most important of these was the transfer of certain pre-market food safety responsibilities, e.g. microbiological surveillance programs on animals. These came with the incorporation into the Activity of the Guelph-based Health of Animals laboratory.

There were three main impacts of the Budget for the Department:

- it established once and for all that the Department had unequivocal responsibility for food safety policy, standard-setting, risk assessment, research, and audit;
- it transferred the Department's traditional compliance activities to a new agency. Since July 1, 1996, the compliance delivery arm has been located outside the Department; and
- the Budget left untouched the Department's important, legislated responsibilities for the safety evaluation of industry submissions for the use in Canada of a variety of food and food-related products, e.g. veterinary drugs (like BST), food additives (like saccharin), and novel foods (like genetically modified tomatoes).

In a totally unrelated action, one other group became part of the Activity at the end of May, 1996: the Animal Resources Division, which had been part of the former Management and Program Services Directorate.

Food Research, Evaluation and Standards: This sub-activity undertakes a wide range of regulatory and non-regulatory initiatives to ensure that the Canadian food supply is safe, nutritious and of high quality.

Programs are oriented to minimize chemical and microbiological contamination, enhance nutritional quality aspects of food and to provide meaningful health-related label information. Data generated by industry and by surveillance and research efforts internally and elsewhere are continually assessed to assure the safety, nutritional adequacy and quality of food. Certain classes

of compounds, such as food additives and veterinary drugs, are subject to statutory pre-market clearance; infant formulas and foods represented for use in very low energy diets are subject to pre-market notification. Resources required for these tasks are dictated by the submission workload.

Much of the work involves the development of methods for the identification, determination and control of food-borne risks and the provision of advice to government, the public and the media. The current activities in this area include the development of regulations concerning the introduction of novel foods into the food supply, and consultations concerning the sixty-one initiatives arising from the 1993 Regulatory Review.

The Food Program represents the Department as the Canadian contact point for the Codex Alimentarius Commission through which it ensures that the provisions of the Agreement on the Application of Sanitary and Phytosanitary Measures and the Agreement on Technical Barriers to Trade are appropriately applied when situations occur that involve health and safety issues.

In the area of imports, international cooperation is strengthened by participation in the Codex Committee on Import and Export Inspection and Certification Systems, a committee of the Joint Food and Agriculture Organization of the United Nations/World Health Organization Food Standards program, as well as by bilateral communications with the United States Food and Drug Administration. The Department also participates in the Asia Pacific Economic Committee on ground nuts and shell fish.

Food Inspection and Compliance: As mentioned above, there were major changes to this sub-activity in 1996-97. In the main, the Department's food inspection and compliance activities ceased on 1 July, 1996. Exceptions are the food safety audit program and certain interprovincial and inter-agency work, for example, the Canadian Food Inspection Initiative.

Under the Food Safety Audit Program, which began in November, 1994, the sub-activity conducts systematic, independent examinations of the food safety components of the food inspection programs of Agriculture and Agri-Food Canada and Fisheries and Oceans Canada. The program is designed to provide assurance to the Minister of Health that the food safety provisions of the Food and Drugs Act are effectively applied. The audits support the primacy and accountability of the Minister in all matters related to the health and safety of the Canadian food supply and are consistent with direction provided by the Interdepartmental Committee on Food Regulation.

The Canadian Food Inspection System (CFIS) is a federal, provincial, and territorial initiative to harmonize food inspection standards and integrate delivery of inspections. The Food Program is working to promote the implementation of federal food safety standards and policies within CFIS.

In addition, the Food Program cooperates closely with all federal food inspection departments to advise on uniform inspection protocols and to minimize duplication and overlaps. The goal is to have a single federal standard of inspection procedure and delivery. For example, a federal interdepartmental task force has developed a common inspection approach for low-acid canned foods. It is serving as a model for other commodity areas. Other draft documents covering the dairy, meat and seafood industries have been prepared and are being reviewed interdepartmentally.

Resource Summaries

This Activity accounts for approximately 2.8% of 1997-98 total Program expenditures and 9.7% of the total full-time equivalents.

Figure 9: Activity Resource Summary

	1996-97 Estimates		**1997-98 Estimates**		1998-99 Planned		1999-00 Planned	
	$000	FTE	**$000**	**FTE**	$000	FTE	$000	FTE
Food Research, Evaluation and Standards	24,144	289	**26,995**	**335**	26,730	335	25,889	335
Food Inspection and Compliance	35,835	473	**18,927**	**217**	17,947	217	19,108	217
Sub-total	59,979	762	**45,922**	**552**	44,677	552	44,997	552
Less: Revenue credited to the Vote	(2,082)		**(2,306)**		(2,179)		(2,179)	
Total	57,897	762	**43,616**	**552**	42,498	552	42,818	552

* Full time equivalent (FTE) is a measure of human resource consumption based on average levels of employment. FTEs are not subject to Treasury Board control but are disclosed in Part III of the Estimates in support of personnel expenditure requirements specified in the Estimates.

Of the total expenditures for 1997-98, 74.6% is for personnel costs, 20.9% is for operations and maintenance and 4.5% is for capital costs.

Explanation of Change: The 1997-98 Main Estimates are $14.281 million lower than the 1996-97 Main Estimates. This is mainly due to:

	($000)
• net transfer to Agriculture and Agri-food Canada for food inspection;	(9,320)
• decrease due to Program Review adjustments; and	(3,275)
• decrease for the Action Plan on Health and the Environment.	(2,413)

Key Initiatives

Health Canada's food program is facing significant change brought on by a number of factors:

- the reorganization of the federal food safety responsibilities, in particular the creation of a new food inspection agency;
- continuing budgetary reductions; and
- new consumer and food trends.

As a consequence, the Food Program's executive team decided that the program should be carefully examined and that an important first step was the creation of a strategic framework. The Strategic Framework for the Food Program, currently under development, will be refined and distributed to stakeholders in 1997-98. It will underpin operational planning of the Program.

The Framework clearly articulates that the core business of the Food Program is to protect and improve the health of the Canadian public by managing the risks and promoting the benefits associated with the food supply. This is accomplished through public health policy related to the safety and nutrition of foods and its consumption. Several core activities are carried out in this connection: policy development, standard setting, risk and benefit assessment, research, surveillance, premarket review, and assessment of the food safety activities of the Canadian Food Inspection Agency.

Policy Development and Standard-Setting: Our new approach to policy development will be to consider the broadest possible range of options in response to an issue, and select the most appropriate strategies, including: information gathering and synthesis; consultation; consensus building, education (professional, public); standard-setting, regulation; codes of practice; guidelines; funding; and research. Thus, all other activities, standard-setting, research, risk/benefit assessment, surveillance, pre-market review, and consultation/communication, derive from our role in policy.

All of these activities will be undertaken in a collaborative fashion. For policy and standard setting, we will work closely with the provinces, as well as the food industry, academia and the public, involving them as full participants in developing policy and standards. We will work at achieving international harmonization, reviewing, accepting and contributing to international policies and standards. We will recognize that many of the inputs required by our program are available elsewhere and we will access that information, not duplicate it. In addition, we will recognize that funding to implement our policies and strategies is often available outside of the Department and we will endeavour to access those funds and leverage them.

Risk and Benefit Assessment: Risk and benefit assessment provide important tools to support the policy and standard setting functions of the Food Program. In this context, policy development and standard setting may be considered as the means to manage the risk/benefit and communicate regarding the risk/benefit. This demonstrates how integral risk and benefit assessment is to policy and standard setting activities. For example, without risk and benefit assessment, resources may be allocated to activities whose impact on health may be negligible.

Research: The Department's Food Program will be structured to ensure that the best professional judgement and knowledge are integrated into all of the program's functions. We recognize that it is not possible to maintain in-house research to meet all of the requirements for the Food Program. However, we will have a core capability and a commitment to research as an integral component of its activities. Increasingly, Departmental researchers will broaden their roles to become "knowledge brokers", accessing wider information sources.

Surveillance: Surveillance activities conducted on food from production through to consumption provide more comprehensive health perspectives of Canadians. The Food Program will use an integrated approach to data collection and synthesis that incorporates data from various forms of surveillance such as market basket surveys, food consumption survey data, the Canadian Nutrient File, product/food additive post-market surveillance, food inspection data, disease data, and consumer surveys.

Pre-Market Review: A key responsibility of the Food Program will continue to be the premarket review of industry submissions. Submissions in traditional areas, e.g. veterinary drugs, novel foods, infant formula, will continue and there will be significantly increased activity in novel foods and functional foods. We will, to the extent possible, eliminate all non-safety related premarket review activities and will focus on health-related evaluations only. Increasing use will be made of evaluations carried out by foreign governments on the same products.

Audit/Assessment Program: The assessment (formerly called "food safety audit") program was created to provide the Minister of Health with assurance that food inspection programs and related activities achieve reasonable compliance with Canadian health and safety standards. While aspects of the assessment program will be delivered by the Department, alternate methods of delivering some aspects, such as through the Office of the Auditor-General, will be examined and, if appropriate, implemented.

Consultation /Communication: Consultation and communication will be an integral consideration in every Food Program activity. Risk/benefit communication will be recognized as a key tool in ensuring the application of the results of risk assessments, and will be accomplished largely by partnerships and with the assistance of the expertise available in HPPB.

In order to advance the Food Program's message, there will be widespread use of the Regional Directors General's offices and strategic partnerships will be formed with agencies outside the Department. As well, we will tap into the formal and informal networks of individuals and companies who share views on particular issues.

Drug Safety, Quality and Effectiveness

Objective

To protect and improve the health of Canadians by:

- assessing, effectively and efficiently, the benefits associated with the manufacture, sale and use of drugs and by taking the appropriate action;
- promoting the scientific approach of risk/benefit assessment;and
- developing and disseminating information that encourages the rational use of drugs.

Description

The Drug Safety, Quality and Effectiveness Activity is referred to as the Drugs Program. It is delivered by the Drugs Directorate, in Ottawa, and staff of the regional offices of the Health Protection Branch across Canada.

The Drug Program addresses the safety, effectiveness, and quality of the full range of drug products available to Canadians. If the product is intended “for medicinal purposes”, it is covered. The Program also sets out the parameters for the safe and effective medicinal use of narcotics and controlled drugs and regulates the safety of cosmetics. The Program is responsible for the evaluation of drugs prior to marketing as well as their continued safety and effectiveness after approval, and for ensuring that an appropriate legislative and control framework exists for prohibited psychoactive drugs. Analyses of suspected illicit drugs are conducted on behalf of the Solicitor General of Canada.

Not only does the Program occupy itself with the safety of the product *per se* but also with the claims being made and with the effectiveness of the product in meeting those claims. The Program is designed to be in step with and to enhance the development process of the products it regulates. It tracks the life cycle of drug products and addresses each stage in an intelligent fashion. It includes provisions for special access to the product at various stages if that is in the best interests of Canadians.

The Program also ensures safety nets. Acknowledging the imperfection of things human requires putting in place adequate monitoring and recall processes. When Canadians are placed at risk, the system must react quickly and move expeditiously to minimize the impact of that risk. Therefore, mechanisms for monitoring adverse drug reactions, ensuring post-approval surveillance, and managing recalls and removals are in place.

Full use is made of expertise outside of the Program. Expert advisory committees are used to obtain advice, in an efficient, organized manner. Like other industrialized nations, it is our intention to ensure that new active substances are not approved in Canada without the input of practicing health professionals.

The Drugs Program is committed to applying scientific evidence whenever possible as a basis for risk benefit and policy decision making. Scientific information generated by stakeholders, in-house research, and contract work will address gaps critical to managing the risks presented by new substances and by new methods of drug delivery or targeting. In addition, by maintaining a strong capacity to create and evaluate scientific evidence, the Program will remain a major player in the move

to harmonize the technical requirements for drug review through participation in international scientific committees.

One of the principal tools of the Program in achieving its objectives is communication. Timely and open communication is fostered, within and outside the Program, with the full range of stakeholders and clients. A basic principle adopted by the Program is that all information should be made available unless so doing would be detrimental to the health and safety of Canadians.

The Drugs Program supports the regulatory philosophy of shared responsibility and consequently sees as one of its key roles, the forming and support of partnerships with others who have an interest in assuring that the drugs available to Canadians are safe, effective, and of high quality and that drugs contribute to an efficient health care system.

Resource Summaries

This Activity accounts for approximately 0.8% of 1997-98 total Program expenditures and 11.5% of the total full-time equivalents.

Figure 10: Activity Resource Summary

	1996-97 Estimates		**1997-98 Estimates**		1998-99 Planned		1999-00 Planned	
	$000	FTE	**$000**	**FTE**	$000	FTE	$000	FTE
Drug Safety and Effectiveness	29,384	453	**34,434**	**427**	28,853	425	28,942	425
Control of Dangerous Drugs	7,917	139	**5,998**	**121**	6,336	119	6,427	119
Quality of Marketed Drugs	10,201	190	**8,534**	**104**	8,895	102	8,985	102
Sub-total	47,502	782	**48,966**	**652**	44,084	646	44,354	646
Less: Revenue credited to the Vote	(27,529)		**(35,935)**		(31,181)		(31,181)	
Total	19,973	782	**13,031**	**652**	12,903	646	13,173	646

* Full time equivalent (FTE) is a measure of human resource consumption based on average levels of employment. FTEs are not subject to Treasury Board control but are disclosed in Part III of the Estimates in support of personnel expenditure requirements specified in the Estimates.

Of the total expenditures for 1997-98, 76.5% is for personnel costs, 20.2% is for operations and maintenance and 3.2% is for capital costs.

Explanation of Change: The 1997-98 Main Estimates are $6.942 million lower than the 1996-97 Main Estimates. This is mainly due to:

	($000)
• decrease due to Program Review adjustments;	(5,890)
• sunsetting of Canada's Drug Strategy; and	(2,342)
• reprofiling of Population Health Strategy funds.	1,475

Key Initiatives

The following are priorities for the Drugs Program, and will be implemented within a quality management framework.

Framework for Strategic Management: the Strategic Framework for the Drugs Program will be refined and disseminated to stakeholders in 1997-98 and will continue to drive operational planning of the Program.

Transition to Quality Management/Service Standards: the Quality Initiative, to instill a philosophy which promotes quality and continuous improvement, will continue and will include the application of quality management tools appropriate for the Drugs Program. Business processes will be clearly defined and documented. Service standards compatible with international standards for each business process will be developed and implemented, in collaboration with stakeholders. Service standards will include timeliness, quality, and client satisfaction. Performance indicators will be evaluated annually.

Policy and Program Development: the Drugs Program will strengthen its systems for obtaining expert advice through the use of expert advisory committees. Drug categorization and product licensing will be implemented to complement establishment licensing. Other initiatives include:

- a revised regulatory program for cosmetics;
- a post-approval surveillance system using a team-based approach across the Drugs Program;
- an evidence-based consumer-oriented approach to regulation of complementary medicines;
- in conjunction with the Food Program, a review of the Canadian regulatory approach to “nutriceuticals”;
- the development and implementation of a regulatory framework for tissues and organs, and for hospital blood banks;
- a revised Clinical Trial Review policy; and
- the implementation of a Special Access Program to replace the Emergency Drug Release Program.

The amalgamation of the Drugs and Medical Devices Programs has recently been approved. While there are many similarities between the two Programs, the rationalization of different practices, policies and regulatory frameworks will be a key issue for the new Program over the next several years.

Stable Funding: the Drugs Program operates in a mixed funding environment — appropriations and revenue generated through cost recovery. In order to meet performance targets in the most cost-effective manner, the following activities will be undertaken:

- complete the introduction of fees according to the cost recovery plan and evaluate and revise the approach as appropriate;

- implement a strategic plan for cost reduction based on improved efficiency and the pursuit of partnerships;

- enhance budget management practices within the Program; and

- continue to rationalize resources among Program activities.

Enforcement: initiatives are under way to implement Program strategies in the areas of inspection, investigation and analysis. These initiatives will result in better focused, more consistent and higher efficiency post market surveillance activities. Other activities include:

- implementing pending decisions on the rationalization and devolution or alternate delivery of the Drug Analysis Service; and

- examining the place of Good Laboratory Practices, Good Clinical Practices, and Clinical Trial Audits in the Canadian regulatory framework.

Enhanced Communications: the Drugs Program is committed to quality management and the evaluation and reporting of accomplishments against performance standards. The Program will implement the Drugs Program Communications Strategy, including mechanisms to better convey policies and activities to staff and stakeholders, program information to decision makers and general information to the public. One mechanism will be the increased use of the Drugs Program world wide web site.

Liaison/Harmonization: mutual recognition agreements are being pursued with the U.S., Japan and the European Union. Following a suitable confidence building period, these agreements will result in acceptance of other agencies' conclusions regarding Good Manufacturing Practices compliance by foreign manufacturers, thereby reducing the need for the Program to do foreign inspections. Liaison activities with national industry and health professional groups have been coordinated and strengthened over the past year. The Program now meets with thirteen industry or health professional groups on a regular basis, between two and six times per year. As well, senior management participate in several international initiatives, including Tripartite (Canada, U.S. and Mexico), Trilateral (Canada, U.S. and UK), and International Conference on Harmonization (ICH) meetings. Future activities include:

- refining the consultation framework outlined above;

- adopting an active strategy to influence and adopt international standards; and

- clarifying federal-provincial roles and programs since increasingly the Program is pursuing partnership or third party approaches to regulation.

Management Practices: effective management practices are fundamental to the quality management and continuous improvement of the Drugs Program. Current and future activities include:

- continuing to rationalize the organizational structure and responsibilities;

- implementing business plans for each Program unit;

- implementing a human resource plan addressing development and morale;

- implementing a personal learning system with links to training and individual potential;
- implementing reward and recognition programs; and
- delivering a world-class continuing education operation and program.

Environmental Quality and Hazards

Objective

To protect the health of Canadians by identifying, assessing and managing the risks to health and safety and benefits associated with the natural and technological environments, with marketed radiation-emitting and medical devices and with chemical and other consumer products.

Description

Environmental, Occupational and Medical Device Hazards: This sub-activity is responsible for:

- assessing and managing the direct and indirect health risks of microbiological agents; tobacco products; environmental pollutants (chemical and radiological); clinical diagnostic equipment, consumer, commercial and industrial chemicals and products;

- assessing and managing health and safety risks associated with the use of medical devices, radiation sources and products;

- administering and enforcing the *Radiation Emitting Devices Act* and *Regulations*;

- inspecting and ensuring compliance with Occupational Health and Safety Requirements for radiation-emitting devices within facilities that are under the responsibility of the Federal Government;

- assessing and managing the health risks of technological and sociological environments, in conjunction with other organizational units of the Department; and

- delivering Health Canada's lead federal role for coordinating Canada's nuclear emergency preparedness and response under the Federal Nuclear Emergency Plan.

Medical Device Quality: This sub-activity is responsible for:

- maintaining a data base on all devices notified for sale in Canada;

- conducting a pre-market review of Part V medical devices, research into medical device hazards, post-market surveillance of existing devices, development of new regulations, standards and test methods, harmonization of regulations with other countries (particularly the USA, Mexico, Japan and the European Union); and

- providing information to health professionals and the general public on specific device hazards and the safe use of medical devices.

The Medical Devices Bureau and the regional offices of the Health Protection Branch collaborate by:

- monitoring manufacturers' recalls;

- conducting compliance testing to established standards, enforce compliance with general provisions of the regulations; and

- taking special regulatory actions such as seizures, import bans, stoppage of sale and prosecutions.

Product Safety: This sub-activity involves the administration and enforcement of the *Hazardous Products Act*, and has the sole responsibility for the safety of consumer products that do not fall under other legislation, and to develop mandatory labelling and material safety data sheet requirements to inform workers of the hazards associated with products used in the workplace.

Regional, laboratory and headquarters staff address problems in the marketplace by:

- developing bans where no feasible safety standard would adequately protect the public;

- monitoring compliance with safety regulations for consumer products under the *Hazardous Products Act,* and taking appropriate actions where there is non-compliance;

- sampling, testing, and taking corrective actions when needed;

- working with industry and standards organizations to develop voluntary safety programs and standards; and

- carrying out information programs directed at the public to promote safe use and maintenance of certain products and at industry to promote safe design. Efforts are made with other countries to harmonize standards and develop joint strategies to deal with hazardous products.

Resource Summaries

This Activity accounts for approximately 2.3% of 1997-98 total Program expenditures and 9.3% of the total full-time equivalents.

Figure 11: Activity Resource Summary

	1996-97 Estimates		**1997-98 Estimates**		1998-99 Planned		1999-00 Planned	
	$000	FTE	**$000**	**FTE**	$000	FTE	$000	FTE
Environmental, Occupational and Medical Device Hazards	33,297	358	**28,175**	**378**	25,562	375	25,637	375
Medical Device Quality	2,582	37	**3,900**	**39**	4,192	39	4,266	39
Product Safety	12,322	137	**7,862**	**109**	8,154	109	8,228	109
Sub-total	48,201	532	**39,937**	**526**	37,908	523	38,131	523
Less: Revenue credited to the Vote	(4,321)		**(4,303)**		(4,303)		(4,303)	
Total	43,880	532	**35,634**	**526**	33,605	523	33,828	523

* Full time equivalent (FTE) is a measure of human resource consumption based on average levels of employment. FTEs are not subject to Treasury Board control but are disclosed in Part III of the Estimates in support of personnel expenditure requirements specified in the Estimates.

Of the total expenditures for 1997-98, 67.7% is for personnel costs, 27.4% is for operations and maintenance, 0.3% is for grants and contributions and 4.6% is for capital costs.

Explanation of Change: The 1997-98 Main Estimates are $8.246 million lower than the 1996-97 Main Estimates. This is mainly due to:

	($000)
• reprofiling of Population Health Strategy funds:	12,707
• decrease for the Action Plan on Health and the Environment;	(9,917)
• decrease for sunsetting of the Tobacco Demand Reduction Strategy;	(7,794)
• internal transfers;	(6,433)
• net increase due to Program Review investment.	3,096

Key Initiatives

On May 18, 1995, approval was obtained from Treasury Board to move forward on cost recovery related to pre-market approval of selected (Part V) medical devices. After long and careful negotiations with industry, cost recovery was implemented in January, 1996. The revenue target of $150,000 for 1995-96 was slightly exceeded. The revenue target for 1996-97 is approximately $1.35 million. With the planned introduction of new regulations in 1997-98, the Activity is planning to review its cost recovery schedule in line with them. The Activity plans to concurrently improve industry compliance. Part of this strategy is to improve communications with industry and device purchasers. To this end, the Medical Devices Bureau has published three Medical Device Newsletters to make stakeholders better aware of who we are and what we do. These communications have been met with

great enthusiasm and will be continued into 1997-98. Additionally, the Medical Device data base will be accessible via internet before the end of 1996-97.

The Activity continues to participate on the international stage to encourage harmonious regulatory and conformity assessment practices with the Department's international partners. The Activity has formulated a comparison of the Canadian, U.S. and E.U. risk classifications (and associated regulatory requirements), for all devices currently offered for sale in Canada. This data base is presently being used to assess the feasibility of the development of an international nomenclature for medical devices. Additionally, a project involving joint review of medical devices is being worked out with the United States FDA. Formal negotiations for the development of a mutual recognition agreement with the European Union are under way. A two-year confidence building exercise where involved parties mutually review their regulatory practices has already started. Industry is very supportive of the Activity's harmonization efforts. Both parties recognize that harmonized regulatory requirements will reduce industry's compliance costs and the Program's enforcement costs.

The Supreme Court decision of September, 1995, restated that the federal government has jurisdiction over tobacco control due to the health problem that this product represents. Furthermore the provinces look to the federal government for leadership in this area. The enforcement component of the Tobacco Demand Reduction Strategy (TDRS) continued during 1996-97 in collaboration with the provinces.

An evaluation of the enforcement program is planned to be completed, as is an audit of the contribution agreements with the provinces. The results of the Youth Smoking Survey were released in January, 1996, and a detailed analysis completed in October, 1996. In view of the Supreme Court decision, which also overturned many sections of the Tobacco Products Control Act, studies were undertaken in support of new legislation. New legislative measures are currently being developed. In 1997-98 the development of the new legislation will continue, including its passage through Parliament. There will also be a requirement to develop the regulations for the new legislation and to formulate and possibly implement an enforcement program. Research initiatives will continue in the area of tobacco control, so as to ensure that the government has available the most up-to-date knowledge in dealing with the issue of tobacco control and to support regulatory development.

A renewed program on Health and the Environment was initiated to succeed the APHE/ Green Plan program which sunsetted in March, 1997. The program on Health and the Environment involves partnerships with other federal and provincial government departments and agencies, as well as international organizations including the International Program on Chemical Safety. With the Minister of Health and the Minister of Environment jointly responsible for the *Canadian Environmental Protection Act*, Environment Canada is a critical partner in Health and the Environment. Consequently, the Department and Environment Canada have established a "Board of Directors" to oversee joint priority setting and program planning to ensure that complementary programs are properly coordinated.

Key activities in the new Health and the Environment program include environmental health risk assessment and risk management activities under the *Canadian Environmental Protection Act*. These regulatory responsibilities are expected to be expanded with the promulgation of the *Canadian Environmental Assessment Act* and the proposed *Drinking Water Materials Safety Act*. Bio-regional environmental health programs in the Great Lakes, St. Lawrence, and Northern and Arctic regions

will continue. Other priority initiatives include the management of risks from air pollution and environmental radiation.

Because the economic impacts of major environmental health risk management decisions can be substantial, economic analysis of both the costs and benefits of alternative risk management options will be conducted. These analyses will ensure that pollution management strategies are cost-effective and serve to promote competitiveness and sustainability.

The Department, through the Environmental Quality and Hazards Activity (which has the lead role and coordinating function), continued to implement the St. Lawrence Health Effects Program and the Great Lakes Health Effects Program. The Great Lakes Health Effects Program will continue until 2001. There will be a full state of knowledge report available in 1997 and further characterization of at-risk groups. The St. Lawrence 2000 Program health component will complete the first assessment of health concerns in the St. Lawrence River region in 1998. Public consultation and population surveys will be finalized in the British Columbia and Nova Scotia bio-regional activities.

The Activity is proceeding with its work related to introducing a *Drinking Water Materials Safety Act* and continuing ongoing efforts to ensure that drinking water and recreational water are safe for Canadians. The Act would reduce chemical and microbiological risks to public health. In addition, the objectives of the Water Quality Program are to identify the hazards, estimate the risks to human health, participate in the management of risks to human health and communicate the risks to human health associated with exposure to waterborne contaminants.

Assessment and imposition of measures to control the health risks of biotechnology substances covered by CEPA will begin around the end of 1996. Assessments will be required for transitionals (substances in the marketplace prior to June 30, 1994) and post transitionals (substances entering the marketplace between July 1, 1994 and July 1, 1997). It is estimated that approximately 200 assessments per year will be necessary.

A Bill to implement the government's response to the Parliamentary Committee regarding the WHMIS exclusions, and to make improvements to the *Hazardous Products Act* is planned in 1997-98. The subsequent *Regulations* will be developed in consultation with stakeholders and are expected to be completed in 1997-98. It has been estimated that this initiative could produce $4 billion in savings to workmen's compensation, health care and other social costs over a ten-year period.

WHMIS continued a collaborative project with the Canadian Centre for Occupational Health and Safety to review and prepare summaries of toxicological information of WHMIS-controlled products. This initiative will reduce enforcement costs associated with WHMIS and provide cost effective information to industry. To date, 59 toxicological profile summaries (TPS) have been produced. This has increased the efficiency of the advice documents. In 1996-97, the cost of TPS was shared with the Pesticide Management Regulatory Agency.

In 1997-98, the Product Safety Laboratory will apply to the Standards Council of Canada for accreditation of its laboratory to ISO/IEC Guide 25. The implementation of a quality system will increase the efficiency and confidence in the work of the laboratory.

Amendments to the *X-Ray Diagnostic Devices and Analytical X-ray Equipment Regulations* will be made to ensure that regulatory requirements reflect present day technology and international standards, thereby minimizing trade barriers. This will benefit both manufacturers and consumers through decreased costs, especially within the health care system, since many of the regulated products are used in hospitals.

National Health Surveillance

Objective

To provide national leadership and coordination in the identification, investigation, monitoring and control and prevention of human disease through national surveillance and disease control programs.

Description

HPB's Laboratory Centre for Disease Control (LCDC) carries out disease surveillance, risk assessment and control of diseases of national and international importance and concern through well-established Canadian public health networks. Ongoing surveillance programs provide a national capacity to detect and analyze changing health and disease patterns and to support effective interventions at the local, regional or national level. Identification, surveillance and risk assessment of communicable and non-communicable diseases, injuries, risk factors, and determinants of health are collected through national surveillance programs, targeted surveillance activities, hospitals and community-based sentinel surveillance systems.

LCDC is Canada's only national public health and disease control agency. It is the hub of specifically created surveillance networks of public health laboratories, public health professionals, universities and acute care facilities. These networks include more than 7,000 professionals across Canada - the first line of public health defence. LCDC does not have a regional structure but rather orchestrates and builds on provincial and territorial surveillance infrastructure in order to create a national picture of health risks, patterns and trends across Canada.

LCDC delivers public health risk management through nine bureaux, with 32 program areas addressing major public health issues (e.g. cancer, cardio-respiratory, perinatal health) and communicable diseases (e.g. bloodborne pathogens, nosocomial infections, HIV/AIDS). The program bureaux, Cancer, HIV/AIDS & STDs, Reproductive & Child Health, Infectious Diseases, Cardio-Respiratory Diseases and Diabetes, Surveillance & Field Epidemiology, and the Office of Special Health Initiatives, conduct national surveillance, identification of risk factors and health determinants, and disease prevention and control. Laboratory services are provided by two bureaux, Microbiology and HIV/AIDs, where advanced diagnostic technology, viral isolation, molecular diagnosis and cellular immunological tests are conducted to improve detection and diagnosis of diseases.

LCDC shares with the provinces the cost of eight external microbiology National Reference Centres located across the country. Together, these centres form a nation-wide public health laboratory network providing universal access to reference level diagnostic laboratory services for a wide variety of life threatening bacterial, viral and zoonotic diseases. The result is the efficient delivery of state-of-the-art diagnostic and investigative laboratory diagnostic services related to infectious disease, outbreak investigations, and technology transfer to various client authorities. In addition, each laboratory or centre provides voluntary proficiency testing and quality control of provincial and hospital microbiological laboratories throughout Canada and the provision of training in analysis and biotechnology related to the laboratory diagnosis of infectious disease.

In a rapidly changing world, LCDC must respond to fundamental changes in public health practice. Modern public health has become much more complex and, as a result, a national public health intelligence network has been established to respond quickly to constantly changing public health demands and priorities. Globalization has eliminated provincial and national borders in any disease control effort.

Resource Summaries

This Activity accounts for approximately 2.9% of 1997-98 total Program expenditures and 5.3% of the total full-time equivalents.

Figure 12: Activity Resource Summary

	1996-97 Estimates		**1997-98 Estimates**		1998-99 Planned		1999-00 Planned	
	$000	FTE	**$000**	**FTE**	$000	FTE	$000	FTE
National Health Surveillance and Disease Control Programs	42,438	287	**44,013**	**298**	30,438	251	28,596	238
Total	42,438	287	**44,013**	**298**	30,438	251	28,596	238

* Full time equivalent (FTE) is a measure of human resource consumption based on average levels of employment. FTEs are not subject to Treasury Board control but are disclosed in Part III of the Estimates in support of personnel expenditure requirements specified in the Estimates.

Of the total expenditures for 1997-98, 44.9% is for personnel costs, 52.1% is for operations and maintenance and 3.0% is for capital costs.

Explanation of Change: The 1997-98 Main Estimates are $1.575 million higher than the 1996-97 Main Estimates. This is mainly due to:

	($000)
• decrease for the Action Plan on Health and the Environment;	(5,307)
• internal transfers;	5,356
• increased funds for the Winnipeg Microbiology Laboratory; and	2,863
• decrease due to Program Review adjustments.	(1,575)

Key Initiatives

To build on past national surveillance efforts and disease prevention and control priorities, future initiatives will be emphasized in the following areas:

Strengthened Public Health Intelligence: LCDC will strengthen the public health intelligence base in support of all of the Department's business lines. National disease surveillance systems will continue to be established and consolidated through provincial, territorial and international networks. New information will be generated, analyzed and synthesized on a broad range of intelligence required for knowledge based decisions. This includes incidence, trends and burden of disease, health determinants, health outcomes, risk determinants, and evaluation of disease prevention and control efforts.

National surveillance systems will be expanded and strengthened in priority areas such as cancer control, reproductive and child health, infectious diseases, STDs, HIV/AIDS, cardio-respiratory diseases and diabetes. Examples of new project activities include, and are not limited to:

- monitoring the human health impacts of the environment on infants and children;
- developing a national surveillance system to evaluate environmental risks to cancers;
- monitoring the changing HIV/AIDS epidemic in Canada by measuring the trends and scope of the HIV infection;
- addressing neural tube defects by collaborating with Newfoundland on a pilot study of folic acid fortification;
- developing a national strategy for the prevention and control of tuberculosis in Canada;
- establishing a new surveillance system for child abuse to determine the prevalence and determinants of child maltreatment;
- monitoring selected antimicrobial resistant organisms, through hospital based surveillance;
- enhancing and integrating laboratory based electronic surveillance systems for enteric/food borne diseases; and
- supplying surveillance expertise to collect, analyze and disseminate surveillance information relevant to First Nations people based on issues identified by them.

To ensure collaboration and coordination of a truly national approach, LCDC will continue to utilize federal-provincial-territorial and expert advisory committees. Through expert consultation and consensus, national guidelines, position statements and standards for monitoring, managing and controlling priority public health concerns will be developed.

Diagnostic and Reference Laboratory Services: LCDC is improving its capacity for diagnostic and outbreak investigation service throughout Canada. The Bureau of Microbiology is scheduled to relocate to a new joint Health Canada-Agriculture and Agri-food Canada laboratory in Winnipeg in the fall of 1997. Once open, this state of the art building with two high risk level 3 and the only level 4 biocontainment laboratory in the country, will have a capacity to focus on the world's deadliest of pathogens.

Universal provision of technologically advanced diagnostic laboratory services is being provided through provincial reference laboratories, and the HIV/AIDS laboratory. Together these centres form a nation-wide public health laboratory network providing universal access to reference level diagnostic laboratory services for a wide variety of life threatening bacterial, viral and zoonotic diseases. Diagnostic and investigative laboratory diagnostic services related to infectious disease, outbreak investigations and technology transfer will continue to be provided to various client authorities. In addition, each laboratory or centre will provide voluntary proficiency testing and quality control of provincial and hospital microbiological laboratories throughout Canada and the provision of training in analysis and biotechnology related to the laboratory diagnosis of infectious disease.

Canada's Blood System Surveillance: Public concern regarding the safety of the blood system, as a result of the findings of the Krever Inquiry, has spurred the government to take on a more active leadership role in protecting Canadians from emerging health risks associated with blood and blood products. LCDC plans to increase fundamental surveillance and investigation activities of infectious agents transmissible by blood; enhance reference laboratory and diagnostic testing of these new threats; and formulate with pubic health partners, strategies to manage risk and determine appropriate public health responses.

Timely National Public Health Information: LCDC will enhance its capacity to provide a national picture of the incidence and mortality resulting from chronic and infectious diseases in Canada by utilizing the internet. An LCDC web site will be a key resource for the public health community in Canada and abroad and will enable timely, targeted surveillance information to reach key partners and clients. Surveillance data, research findings, evaluation results, national publications such as the Canada Communicable Disease Report, and outcomes of LCDC conferences and workshops will be disseminated widely through the web site. Electronic linkages will be utilized to strengthen communication with key partners through restricted access web sites for sharing information and data on surveillance and policy development.

International Collaboration and Liaison: International liaison and surveillance will strengthen Canada's ability to address disease control issues on a global scale. LCDC will continue to support six WHO Collaborating Centres (tuberculosis, AIDS/HIV, gonococcus, arboviruses, biosafety and influenza) and has been invited by WHO to make an application as a Collaborating Centre in perinatal epidemiology. The Collaborating Centres provide technical training, develop international consensus on priority disease control issues, transfer information and technologies, and provide expert consultation on laboratory and quality assurance programs. LCDC will continue to actively collaborate with the U.S. Centre for Disease Control and Prevention, PAHO, the Caribbean Epidemiology Centre, CIDA and UNICEF.

Pest Management Regulatory Agency

Objective

To protect human health and the environment by minimizing the risks associated with pest control products, while enabling access to pest management tools, including sustainable pest management strategies.

Description

The Activity is responsible for management of the following three sub-activities:

Applications Review: For this sub-activity, under the authority of the Pest Control Products Act, PMRA is principally concerned with evaluating data submitted by applicants to determine whether their products pose an acceptable risk to people and the environment and whether they have value. Products which pose an unacceptable risk or do not have value are not registered. PMRA also establishes maximum residue limits (MRLs), under the authority of the Food and Drugs Act, for products intended for use on food crops. The review process is undertaken with a view to support the integration of pest management with the broader goals of environmental sustainability by engaging in a variety of activities. These activities include the encouragement, through linkages with the research and promotion programs of sectoral departments, of the development of viable, ecologically sound pest management strategies.

Compliance: This sub-activity is responsible for ensuring compliance with the Pest Control Products Act and for collaborating with the provinces in ensuring compliance with all pest control product legislation. With regard to compliance with maximum residue limits for pest control products under the Food and Drugs Act, advice is provided to the Health Protection Branch which is responsible for coordinating federal and provincial food safety programs.

Policy and Communications: This sub-activity is responsible for developing and implementing policies, guidelines, codes of practice and legislative amendments that relate to the regulatory process, as well as developing and implementing effective information, communications and consultation mechanisms. It is also responsible for collaborating and coordinating pest management regulatory activities with other levels of government, other countries and international organizations.

Resource Summaries

This Activity accounts for approximately 0.8% of 1997-98 total Program expenditures and 3.6% of the total full-time equivalents.

Figure 13: Activity Resource Summary

	1996-97 Estimates		**1997-98 Estimates**		1998-99 Planned		1999-00 Planned	
	$000	FTE	**$000**	**FTE**	$000	FTE	$000	FTE
Applications Review	13,213	167	**6,483**	**98**	6,175	93	6,175	93
Compliance	9,047	135	**4,440**	**80**	4,440	80	4,440	80
Policy and Communications	2,836	41	**1,392**	**24**	1,392	24	1,392	24
Sub-total	25,096	343	**12,315**	**202**	12,007	197	12,007	197
Less: Revenue credited to the Vote	(185)		**(185)**		(185)		(185)	
Total	24,911	343	**12,130**	**202**	11,822	197	11,822	197

* Full time equivalent (FTE) is a measure of human resource consumption based on average levels of employment. FTEs are not subject to Treasury Board control but are disclosed in Part III of the Estimates in support of personnel expenditure requirements specified in the Estimates.

Of the total expenditures for 1997-98, 92.9% is for personnel costs and 7.1% is for operations and maintenance.

Explanation of Change: The 1997-98 Main Estimates are $12.781 million lower than the 1996-97 Main Estimates. This is mainly due to:

	($000)
• termination of Green Plan funding.	(13,018)

External and Internal Environment

The creation of the Agency on April 1, 1995 is the government's response to recommendations made by the 1990 Pesticide Registration Review (PRR). The PRR was conducted by a diverse group of stakeholders, including representative of manufacturers, farmers, foresters, and public interest groups. Key issues and concerns which gave rise to the PRR include the following:

- farmers' concerns about timely access to cost-effective pest control products, particularly for minor uses and new products;
- manufacturers' concerns about the time taken to approve products; and
- the concerns of public interest groups about the safety of pest control products to people and the environment, their desire for reduced use of chemical pesticides, the introduction of safe alternatives, and the opportunity for the public to influence policy and registration decisions.

In response to fiscal pressures, cost containment, and the continuing focus on alternative delivery systems for government services, the Agency will continue to seek increased shared responsibility with its partners, adopt a more business like approach and improve service delivery.

The Agency is introducing a cost recovery regime in 1997-98. Of great concern is the impact of flow-through fees on the competitive position of the Canadian agricultural sector. Farmers are

particularly concerned with the impact of fees on low-use agricultural pesticides and the potential impact on their competitiveness in international markets. The authority to spend the anticipated additional revenues of $12.3 million will be sought in Supplementary Estimates.

Key Initiatives

The Agency will:

- pursue international cooperation to accelerate the registration, reevaluation and special review processes through harmonization of test methods and risk assessment procedures and work sharing with other regulatory bodies;

- explore potential areas for cost reduction and cost avoidance in the Agency's operation through consultations and discussions with the pesticide industry;

- develop and implement streamlined registration procedures for minor uses and alternatives to traditional chemical products, and ensure that any cost recovery regime does not deter these registrations;

- provide greater opportunities for the public to contribute to improving the pest management regulatory system through:

  – consultation on major policies, procedures, standards, and regulations;

  – consultation on major registration decisions through comments on the Proposed Regulatory Decision Documents (PRDDs) which will include the risk and value assessments upon which registration decisions are to be based; and

  – post-registration access to test data;

- develop a risk reduction policy and strategies in consultation with federal government departments, the provinces and territories, the EPA, and international organizations;

- introduce performance service standards;

- develop and maintain a national pesticide use data base to meet requirements for comprehensive, accurate and up-to-date information on pesticide usage provincially and nationally; and

- implement mandatory reporting of adverse effects.

In order to support the integration of pest management with the broader goals of environmental sustainability, PMRA's Alternatives Division is to find efficient and effective approaches to integrating sustainability into Agency functions and user sector activities.

Applications Review

- develop, in consultation with stakeholders, a submission management policy which will encourage industry to file complete submissions and lead to the development of electronic submissions;

- develop and publish, in consultation with stakeholders, performance standards. These standards will be based on an 18-month target review of new active ingredients that the government has committed to implement contingent upon adequate resourcing;

- develop and implement a reevaluation policy for older pesticides, through a multilateral approach with countries of the European Union and the EPA with a target to reduce the backlog of re-evaluations over the next six years;

- reduce the backlog work on hand by the end of 1997-98;

- elevate the submission screening activity from pilot status to operational level. This activity has helped reduce the number of incomplete submissions from clogging the system; and

- switch over from the submission types classification to categories, thus reducing the number from 13 submission types to 5 categories, thereby simplifying the process.

Compliance

- develop and publish, in consultation with provincial and territorial governments, a guideline for compliance;

- develop and implement a process for administrative monetary penalties, including an appeal process; and

- complete the transfer of the laboratory resources from Agriculture and Agri-food Canada while maintaining accreditation to ISO quality standards.

Policy and Communications

- publish Proposed Regulatory Decision Documents relating to applications;

- review and improve as required, mechanisms for communicating, consulting and collaborating with provinces, stakeholders registrants, applicants, and the general public;

- participate in the OECD program for the development of test guidelines and assessment guidance documents; and

- participate with the International Program of Chemical Safety (WHO), the OECD and the EPA in harmonizing risk assessment procedures.

Relationship between PMRA and Departments

While PMRA is responsible for pest control product regulation within the broad policy framework of sustainable pest management, other federal departments retain responsibility for areas that affect and are affected by PMRA operations. These include pest management research, environmental research and monitoring, technology transfer, sectoral advocacy, toxics management and food safety.

Because of their interest in matters relating to PMRA operations, the Ministers of Agriculture and Agri-Food, Environment, Natural Resources, Fisheries and Oceans, and Industry can advise, through their officials, on pest control product regulation but do not have any formal responsibility for

registration decisions. They also may propose policies to the PMRA and advise on the direction of policy development to ensure that PMRA policy is consistent with their policies relating to their areas of responsibility. Likewise, PMRA advises on the programs and policies of these other departments and on broad policies related to health, environment, agriculture and forestry. Memoranda of Understanding are being developed with most of these departments to facilitate this exchange and promote strong working relationships.

Programs and Services

Objective

To generate policies, programs, knowledge and strategies that are based on the determinants of health model (population based), holistic in scope and application, and used to operationalize the Department's mission.

Description

Provides programs and national leadership in health promotion, disease prevention and fitness; promotes research and the development of expertise in the physical and mental health, social and fitness fields; provides national leadership and professional and consultative services to aid in the development, operation and change of health and social programs; undertakes activities in the areas of AIDS, drug abuse, tobacco reduction, family violence, women, seniors and children, particularly those that are at risk.

Resource Summaries

This Activity accounts for approximately 12.5% of 1997-98 total Program expenditures and 7.6% of the total full-time equivalents.

Figure 14: Activity Resource Summary

	1996-97 Estimates		**1997-98 Estimates**		1998-99 Planned		1999-00 Planned	
	$000	FTE	**$000**	**FTE**	$000	FTE	$000	FTE
Operating Costs	53,302	564	**62,075**	**430**	54,368	358	54,412	359
Capital	264							
Grants	16,018		**12,350**		7,775		7,775	
Contributions	149,392		**117,745**		87,281		87,281	
Total	218,976	564	**192,170**	**430**	149,424	358	149,468	359

* Full time equivalent (FTE) is a measure of human resource consumption based on average levels of employment. FTEs are not subject to Treasury Board control but are disclosed in Part III of the Estimates in support of personnel expenditure requirements specified in the Estimates.

Of the total expenditures for 1997-98, 14.0% is for personnel costs, 18.3% is for operations and maintenance and 67.7% is for grants and contributions.

Explanation of Change: The 1997-98 Main Estimates are $26.806 million lower than the 1996-97 Main Estimates. This is mainly due to:

	($000)
• decrease due to sunsetting of various strategies;	(84,600)

- increase due to Population Health Strategy; and 63,200

- decrease due to net Program Review adjustments. (4,700)

Currently, the Programs and Services Activity is delivered through three sub-activities, Population Health, Systems for Health and Research and Program Policy.

I. Population Health

Based on the determinants of health model, work in the **Population Health** sub-activity develops and implements programs that promote health and encourage the avoidance of health risks. The focus is on health issues (family violence prevention, tobacco, alcohol and other drug use, and AIDS) and the special needs of certain population groups (families, children and youth, women, seniors). Major program activities include knowledge and information dissemination, program development, research, promotion of best practices, provision of policy and expert content advice, intersectoral consultation, coordination and negotiation, and funding of community-based projects that advance health and well-being.

Work is carried out in partnership with other levels of government, non-government organizations, professional organizations, community groups and organizations, academia, business, and across all sectors, forging linkages between the health and social sectors, and promoting:

- **reduction of substance abuse** by providing national leadership and by coordination of federal activities on drug issues and acting as the focal point within the Department for harm reduction and prevention initiatives around alcohol and other drugs issues.

- **time-limited funding to non-profit voluntary organizations for innovative health promotion projects** that advance the renewal of Canada's health system through the national component of the Health Promotion Contributions Program.

- **prevention, control and treatment of AIDS** by undertaking activities in HIV/AIDS policy and coordination, HIV/AIDS prevention and community action, and HIV/AIDS care, treatment and support.

- **non-legislative approaches to address the health consequences of family violence.** The Department is a centre of expertise within the federal government for family violence issues, and also administers the National Clearinghouse on Family Violence by distributing video and print material to front-line workers, policy makers, professionals and individuals.

- **tobacco reduction** by developing and promoting non-legislative approaches to increasing the number of Canadians who become and remain tobacco free. One approach is to champion innovative stategies to reducing the harm caused by tobacco use and/or exposure to environmental tobacco smoke. Priority is given to populations at greatest risk for tobacco use, including youth.

- **health of children and youth**. The Department provides leadership within the federal government for children and youth by monitoring and seeking to improve the broad determinants of their health and well-being. To achieve this, programs are delivered on child development, children's mental health and parent support, and three community-based funding programs. The Community Action Program for Children provides funding for communities to provide a range of support and services to at-risk children and their families.

Through the Canada Prenatal Nutrition Program, assistance is provided to communities to develop or improve programs for at-risk pregnant women to enhance birth outcomes. The Aboriginal Head Start Program addresses the needs of Aboriginal children living in urban centres and large northern communities. In addition, this sub-activity is the focal point for children's rights in both an international and a domestic context.

- **the health and well-being of aging and seniors**. The Department provides leadership within the federal government on aging and seniors issues to support the Minister in his role as Minister responsible for seniors. It functions as a centre of expertise and a catalyst for change, and develops, delivers and coordinates activities and programs including the New Horizons: Partners in Aging Program and the Seniors Independence Research Program. It also supports policy development, develops and conducts extramural research activities, conducts research and surveillance to identify trends, assesses risk determinants, and evaluates program and policy initiatives.

Plans for 1997-98

- 1997-98 will be a year of transition as the Department, with fewer resources, moves toward the implementation of the Population Health Strategy. Because the health of Canadians can be improved by investing in a more active and preventive manner, the Department has made the Population Health Strategy one of its four main business lines. The Strategy is based on the determinants of health approach, which recognizes that health depends on much more than a good health care system. Other health factors include gender, income, education, social support networks, the environment and employment and working conditions. The Strategy will focus on three life stages, early life, mid-life and later life. The emphasis will be on early life, given evidence that investing in early childhood development is crucial to positive health outcomes.

- The Department will continue to play a leadership role on substance abuse issues and on issues relating to tobacco use, especially with respect to youth. The Department will also continue to play a leadership role in the area of family violence, coordinating federal efforts to prevent and address the problem, maintaining a clearinghouse function to disseminate information on best practices, and conducting research related to the health consequences of family violence against women and their children, and seniors. The National AIDS Strategy will continue to be implemented in fiscal year 1997-98 with ongoing emphasis on research, prevention and community action programs, as well as care and treatment activities and international collaboration and policy coordination.

- Implementation of the Community Action Program For Children and the Canada Prenatal Nutrition Program will carry on across the country in cooperation with the provinces and territories, as will the Aboriginal Head Start Initiative.

- It is anticipated that the Alcohol and Drug Treatment and Rehabilitation Program will be transferred to Health Canada from Human Resources Development Canada in 1997-98. Through the program, the Department will collaborate with the provinces and territories on the articulation of national guidelines and best practices, and the synthesis and dissemination of information on alcohol and other drug issues. Through agreements with the provinces, the Department supports alcohol and drug treatment and rehabilitation programs.

II. Systems For Health

The overall goal of the **Systems for Health** sub-activity is to help Canadians maintain and improve their health and well-being by improving the capacity, efficiency and effectiveness of health and social systems and organizations to respond to health-related needs.

Initiatives of the sub-activity support the Department's objectives in regard to the renewal of the health system, the management of health risks through disease prevention, and population health issues and priorities. In pursuing these initiatives, work is carried out in the health and social sectors, in partnership with other levels of government, non-government organizations, business and academia. This work is undertaken in the context of a changing environment characterized by increased public awareness, concern and expectation regarding the quality, accessibility, and affordability of health services, and financial pressures affecting the capacity of non-government organizations and other partners.

Given this changing environment, new stategies and approaches have been developed. Partnerships have been strengthened with provincial and territorial governments and non-government organizations. Activities have also been undertaken to build national consensus on strategies necessary to address existing and emerging issues, and to support the capacity of organizations and networks to implement appropriate activities. In addition, information technology systems are being increasingly employed to disseminate knowledge to partner organizations, decision makers and the public.

One goal of the sub-activity is to support and contribute to the renewal of Canada's health care system by enhancing the capacity of the health care system to provide appropriate, effective and high quality health care (including mental health care); by advancing the shift toward a better balance between institutional and community-based care (including self care), and between health care, prevention and health promotion; and by contributing to the management of costs through more appropriate utilization of health services and health human resources. Activities include collaborating in the development of national evaluation frameworks; identifying and promoting best practices in the organization and in the delivery of services; and developing tools and resources to promote effective service utilization and enhance self-care practices.

A second goal is to support the development, implementation and dissemination of policy oriented to disease prevention, and involves undertaking the roles of facilitator, catalyst and broker in helping others make progress in prevention. Key strategic areas include:

- supporting the development of policies, programs and models for the prevention of non-communicable diseases; enhancing implementation capacity at the provincial and local levels, and in the health professional sector; and promoting, monitoring and evaluating preventive programs and relevant research.

- supporting the development and implementation of approaches to prevention based on evidence.

A third goal is to address selected determinants of health that contribute to health inequalities and affect groups at risk throughout the life cycle. Key strategies include:

- fostering healthy public policy that addresses the broader determinants of health and related health challenges (e.g., preparation of the joint Federal-Provincial-Territorial *Report on the Health of Canadians*);

- promoting healthy, active lifestyles to reduce risk factors and enhance well-being;

- promoting mental health through the development of a national strategic framework and the identification and dissemination of effective practices in mental health;

- facilitating change to social and physical environments and settings that affect the determinants of health and the health status of Canadians; and

- supporting the capacity of systems and networks to respond to population health issues and needs in an integrated and comprehensive manner (e.g., development of the *Framework for Sexual and Reproductive Health*).

The expected results of these activities include the widespread use of strategic frameworks and program models that strengthen the capacity of networks and stakeholders to address existing and emerging health issues. In response to these issues, it is expected that better, innovative, more cost-effective programs and initiatives will be developed and implemented through improved intersectoral collaboration. The National Strategy on Healthy Child Development, for instance, links federal-provincial-territorial governments with partners in various sectors to build a common framework for action on healthy child development, including child poverty in Canada.

Plans for 1997-98

- pursue the mobilization of intersectoral partnerships to achieve a system response (in health and other sectors) to the challenges identified in the Federal-Provincial-Territorial *Report on the Health of Canadians*;

- consolidate knowledge and experience regarding interrelationships among health determinants and in terms of their impact on health system policies;

- continue to provide leadership and support, in collaboration with provinces, territories and non-government organizations, in regard to national strategies and initiatives that address population health priorities, including nutrition and healthy eating, active living and fitness, sexual and reproductive health and mental health promotion;

- continue to address social and physical environments and settings that affect the determinants of health, including development of a framework for health and the environment, and activities that support the development of healthy workplaces and comprehensive school health programs;

- continue to support the development of preventive policies, programs and models in the area of non-communicable diseases, with particular emphasis on dissemination of existing knowledge and approaches to intervention, to the public health and health care systems across the country;

- continue to jointly support, with provinces, the work of the Canadian Task Force on the Periodic Health Examination, and work closely with professional organizations, non-government organizations and provinces to support strategies for implementing the evidence-based preventive practice guidelines;

- continue to support efforts towards health system renewal, in collaboration with provinces, territories and health professional associations by contributing to the development of

innovative delivery models for primary health care, core national standards for home care and an evaluation framework for integrated regionalized health services;

- continue to contribute to the development and promotion of knowledge regarding best practices for quality in health care (particularly in the continuing care and community-based mental health service sectors), and to the developement and promotion of program tools and programs, aimed at enhancing practices on the part of physicians and nurses to promote self care among their patients; and

- continue, in collaboration with provinces and territories, to develop and promote national strategies for enhancing the integrated planning and management of the full range of health human resources, in the context of emerging service delivery frameworks.

III. Research and Program Policy

This sub-activity guides and supports knowledge development and decision making based on evidence to help the people of Canada maintain and improve their health. It integrates the Department's extramural research capacity with program policy, planning, inter-governmental relations, social marketing and health promotion functions.

Areas under this sub-activity act as a department-wide resource providing expertise through peer review of extramural research, expertise in contracts and contributions, social marketing, partnership development, and health promotion for strategic initiatives. They specialize in the analysis and dissemination of information. Most importantly, they provide strategic analysis that influences both policy and program decision making within the Health Promotion and Programs Branch.

To achieve its objectives, partnerships have been developed with provincial and territorial governments, the research community, other federal departments, universities, voluntary organizations, professional associations and industry. Stronger linkages between research, policy and practice continues to be a priority, with special emphasis on coordination of women's health issues.

Plans for 1997-98

- the Extramural Research Division will continue to administer the National Health Research and Development Program (NHRDP) which provides for the generation of scientific evidence through the development and funding of research, and will continue to help shape the national health research infrastructure.

- continue to map the current health promotion situation in Canada for strategic planning and action; foster interaction among health promotion research, policy and practice communities; and explore the implementation of health impact assessments in developing federal policy and program initiatives.

- continue to support the federal-provincial-territorial advisory committees, including gathering information about key provincial and territorial initiatives to assess their impact on current advisory committee discussions and providing the secretariat to these committees.

- continue to provide the Department and clients with strategic marketing advice and expertise by providing social marketing services, creating and implementing communication initiatives and effectively disseminating health information. The sub-activity will also continue to

develop and enhance partnerships by bringing governments, the private sector and non-government organizations together to coordinate cost-efficient, multi-dimensional health promotion activities.

- maintain existing and pursue new research partnerships between NHRDP and other federal departments, other governments and non-government sectors.

- continue to create and strengthen linkages to support evidence-based decision making; synthesize information to support long-range planning and policy development within the Activity; lead the development of the Population Health Strategy; provide research and evaluation advice; and coordinate the development and analysis of the national health survey data for the Activity.

- planning for the implementation of the Population Health Strategy will continue during 1997-98. Ensuring the effective and timely evaluation of the Strategy, as it is fully implemented, will be a priority.

- continuous review of longer term research and policy priorities, including the development of measures to evaluate changes in population health status and identification of emerging population health issues, will continue to be a central activity.

Indian and Northern Health Services

Objective

To assist Status Indians, Inuit and residents of the Yukon to attain a level of health comparable to that of other Canadians living in similar locations.

Description

The Activity's efforts to improve the health status of First Nations and Inuit is performed within the framework of MSB's mission, which is to ensure that "First Nations and Inuit people will have autonomy and control of their health programs and resources within a time frame to be determined in consultations with them".

The direct delivery of health services by Medical Services Branch represents only part of the health benefits and services offered to Native people and the residents of the Yukon.

The Canadian health system is one of specialized and interrelated elements, which may be the responsibility of federal, provincial or municipal governments, Indian bands, or the private sector. The most significant roles of the Indian and Northern Health Services Activity in this interdependent system are in public health activities on reserves, health promotion, and the detection and mitigation of hazards to health in the environment.

In support of the policy of self-government and devolution, First Nations interested in assuming control over their own health services have negotiated transfer agreements with Medical Services Branch. It is expected that, over time, most First Nations will assume control of their own health services either through health transfer or through their self-government arrangements.

This Activity ensures the availability of, or access to, health services for the Status Indian and Inuit population of Canada by maintaining a program with the following sub-activities:

Non-Insured Health Benefits: Through this sub-activity, health-related goods and services are provided to Canada's Status Indian population, to its Inuit population and to the Innu of Labrador when they are not provided by other agencies. The benefits fall into the following categories: pharmacy, dental care, vision care, medical transportation, medical insurance premiums, and other health care services.

Community Health Services: Through this sub-activity, various health promotion and disease prevention programs such as health education, immunization, nutrition counseling, dental health, communicable disease control, and immunization are made available to First Nations on-reserve, to the Inuit and to residents of the Yukon. Training is provided for nurses and dental therapists. Through the Indian and Inuit Health Careers program, the Activity supports and encourages aboriginal participation in educational opportunities leading to professional careers in the health field.

This sub-activity is also responsible for the provision of the First Nations and Inuit components of Departmental special initiatives and strategies such as AIDS, Family Violence, the Canada Drug Strategy, the Tobacco Demand Reduction Strategy, the Canada Prenatal Nutrition program and the Building Healthy Communities program.

Child Development Initiative (CDI): Within the CDI, the Activity has the responsibility for the delivery of the Community Action component. The total CDI financial commitment is $176.4 million for the first

five years of which $160 million is for the program elements within the Community Action component which addresses the following three areas: community mental health, child development and solvent abuse. $16.4 million is allocated from the Promotion component for three additional program elements which include injury prevention, healthy babies and parenting skills. All components are for the benefit of Status Indians on-reserve and Inuit populations.

National Native Alcohol and Drug Abuse Program (NNADAP): This sub-activity is responsible for the provision of support to First Nations and Inuit people and their communities to establish and operate programs aimed at arresting and off-setting high levels of alcohol and drug abuse among the population living on-reserve and in Inuit communities. It also provides community-based prevention programs, as well as alcohol and drug residential treatment programs, limited training for alcohol and drug field workers, research and development activities specific to First Nations and Inuit communities and health promotion activities.

Environmental Health and Surveillance: This sub-activity provides a comprehensive environmental health program to First Nations communities. It provides health advice to its various client groups based on its inspections and investigations, including responses to emergency situations. Environmental contaminants continue to be an issue of great concern. A comprehensive environmental health program is carried out, through on-reserve inspections of water and sewage systems, food premises, recreational facilities, public buildings, waste disposal, occupational health and safety and environmental contaminants. Other activities include research on the health effects of environmental contaminants, consultations, education and promotion of environmental health to native communities. This sub-activity assists in compliance of the use of fuel storage tanks, disposal of biomedical waste, and the transportation of dangerous goods on reserves.

Hospital Services: The Activity continues to operate five general hospitals providing services ranging from primary to limited secondary levels of care. These hospitals link with provincial health-care systems and smaller Medical Services Branch facilities such as nursing stations. They promote local First Nations involvement on hospital advisory boards.

Health Services under First Nations and Inuit Control: This sub-activity's role is to develop the policies and processes and provide support for the transfer of federal health services and resources to First Nations and Inuit communities south of the 60th parallel, to the Yukon Territorial Government, and to Yukon First Nations. This work is done through Integrated Community-Based Health Services Arrangements, Transfer Agreements, Single Funding Agreements with other Federal Departments, or Self-Government Agreements. The sub-activity also provides assistance, support, resources and payments to First Nations communities as negotiated in transfer agreements.

Resource Summaries

This Activity accounts for approximately 67.0% of 1997-98 total Program expenditures and 24.6% of the total full-time equivalents.

Figure 15: Activity Resource Summary

	1996-97 Estimates		**1997-98 Estimates**		1998-99 Planned		1999-00 Planned	
	$000	FTE	**$000**	**FTE**	$000	FTE	$000	FTE
Non-insured Health Benefits	533,991	210	**545,537**	**166**	546,525	166	563,038	166
Community Health Services	260,637	977	**247,174**	**779**	257,538	777	272,741	777
Brighter Futures	76,854	14	**48,758**	**19**	48,759	19	48,759	19
NNADAP	52,880	26	**46,992**	**28**	46,994	28	46,994	28
Environmental Health & Surveillance	10,855	95	**17,939**	**109**	17,945	109	17,945	109
Hospital Services	53,296	355	**29,344**	**247**	26,656	247	26,656	247
Community Health Services under First Nations Control	74,322	47	**103,919**	**48**	103,921	48	103,921	48
Sub-total	1,062,835	1,724	**1,039,663**	**1,396**	1,048,338	1,394	1,080,054	1,394
Less: Revenue credited to the Vote (Hospitals)	(16,300)		**(11,364)**		(11,364)		(11,364)	
Total	1,046,535	1,724	**1,028,299**	**1,396**	1,036,974	1,394	1,068,690	1,394
Revenue to CRF	6,710							

* Full time equivalent (FTE) is a measure of human resource consumption based on average levels of employment. FTEs are not subject to Treasury Board control but are disclosed in Part III of the Estimates in support of personnel expenditure requirements specified in the Estimates.

Of the total expenditures for 1997-98, 8.7% is for personnel costs, 53.3% is for operations and maintenance and 38.0% is for grants and contributions.

Explanation of Change: The 1997-98 Main Estimates are $18.236 million lower than the 1996-97 Main Estimates. This is mainly due to:

	($000)
• decrease due to regional integration of corporate services;	(35,400)
• increase in the First Nation's health envelope;	30,500
• net decrease in requirements for the Whitehorse General Hospital; and	(11,300)
• decrease for sunsetting of the Tobacco Demand Reduction Strategy.	(2,400)

Figure 16: First Nations and Inuit Health Envelope
1997-98 Distribution of Resources ($000s)

Activity	Medical Services Branch	Departmental Executive	Corporate Services Branch	Total	Full Time Equivalents
Indian & Northern Health Services	1,010,461			1,010,461	1,293
Program Management		5,473	29,901	35,374	167
Total	1,010,461	5,473	29,901	1,045,835	1,460
Full time equivalents	1,293	123	44	1,460	

Key Initiatives

Non-Insured Health Benefits: The costs of providing health benefits such as prescription drugs, transportation to health services and dental services to First Nations and Inuit people across Canada continues to increase in response to the following factors: 3% annual population increase in eligible First Nations and Inuit clients; continuing increases in the cost of health benefits to all Canadians; and increased use of benefits by clients as they become more aware of the program. The rate of cost growth has declined from 20.9% in 1990-91 to an estimated 3% in 1996-97. The key challenges for managing the Non-Insured Health Benefits sub-activity in 1997-98 will be:

- managing the provision of services to First Nations and Inuit clients within budgetary limits based on the implementation of cost management strategies;
- re-tendering the contract for automated claims processing under the parameters of the Aboriginal procurement policy; and
- enhancing First Nations and Inuit participation in the management of the program.

Community Health Services: The health problems of First Nations and Inuit are similar in nature to those of other Canadians. However the root causes, emphases and consequences can be quite different from the general population. This is the result of significantly less favourable socio-economic conditions and frequently negative environmental circumstances. In common with the Canadian population in general, lifestyle diseases have become more prominent in First Nations and Inuit communities; programs aimed at health promotion are more important than ever. Various factors including poor housing, over-crowding, poor hygiene and adverse environmental conditions on reserves have led to higher rates of communicable disease than among the Canadian population as a whole. These factors have also been seen to cause an increased incidence of alcohol and drug abuse, and deaths (especially in the young) from respiratory disease. Deaths from non-intentional accidents, violence and suicide are at rates strikingly higher than that for other Canadians. The federal government is working in close partnership with First Nations and Inuit communities to develop community-based health programs that are tailored to their specific culture, responsive to their needs and which support the transfer of the control of health programs and resources to Native control.

The key activities for the planning period for this sub-activity will be:

- continue to facilitate First Nations and Inuit control of HIV/AIDS activities by serving as a national liaison forum for providing leadership and expert advice; advocating the creation and transfer of a HIV/AIDS program infrastructure at national, regional and community levels;

- plans are under way during 1996-97 to decentralize the administration and management of the nurses education programs. Regional offices, in consultation with First Nations, will assume responsibility for establishing nurse training programs within their jurisdictions as well as managing the financial resources for this training;

- the Department announced in May, 1995, the selection of six permanent solvent abuse treatment centres for First Nations and Inuit people across Canada. With the establishment of these new centres, a comprehensive range of solvent abuse services will be available to First Nations and Inuit people. These services include, but are not limited to, prevention and intervention services (pre-treatment, treatment, and post-treatment). Solvent abuse activities are partially funded through the Child Development Initiative, and the Building Healthy Communities Initiative;

- First Nations and Inuit health surveillance activities will continue to be enhanced through the introduction of the Health Information System into First Nation and Inuit communities and the finalization and release of the report of the regional health surveys;

- the mental health/crisis management component of the Building Healthy Communities Initiative will continue to support crisis intervention and management, after-care and rehabilitation and training to deal with crises within communities;

- the Activity continues to support the provision of the Dental Therapy Training Program. It is expected that this will increase access to oral health care services by First Nations and Inuit communities. This program is delivered through the National School of Dental Therapy in Prince Albert, Saskatchewan under the auspices of the Saskatchewan Indian Federated College in affiliation with the Faculty of Dentistry of the University of Saskatchewan; and

- the Department and IANC have initiated a joint working group to develop a Federal-First Nations continuing care strategy. The intent is to provide options concerning the overall effectiveness and coordination of First Nations' continuing care programs within both departments.

Child Development Initiative: This sub-activity will continue to be community-driven and focus on community-based and community-managed mental health and child development programs. It will also work on the establishment of training programs dealing with mental health and child development, and in the sharing of this information amongst Aboriginal communities.

National Native Alcohol and Drug Abuse Program (NNADAP): The NNADAP program includes a network of 49 treatment centres with approximately 700 in-patient treatment beds. As well, there are more than 500 alcohol and other drug abuse community based prevention programs under way, involving approximately 700 workers.

A comprehensive review of the NNADAP program is presently being conducted and should be completed by the end of the fiscal year 1996-97. The recommendations flowing from this review will impact on the activities of NNADAP for 1997 and beyond.

Environmental Health and Surveillance: Green Plan funding is now being included within the base budget of the Environmental Health and Surveillance Program so that key activities such those dealing with drinking water and the effects of environmental contaminants on native peoples can be pursued.

Hospital Services: The Department is moving out of the hospital business through the transfer of existing MSB hospitals to local health boards, First Nation organizations or provincial governments.

Health Services under First Nations' Control: This sub-activity aims to position the Department for:

- self-government negotiations within the context of the federal government's inherent right policy;
- renewing a consultation process with the six national aboriginal organizations for the development of a national aboriginal health policy framework;
- reviewing the existing administrative arrangements for the transfer of community-based health transfers; planning for the reinvestment of resources; and
- defining the residual role of Medical Services Branch and the Department once second, third and fourth level services have been transferred to First Nations.

Self-government negotiations will impact on both MSB and the Department. It will therefore be critical that all affected within the Department be involved in the process of developing the Department's negotiation mandate. It is expected that a draft of the mandate and negotiation guidelines will be ready for submission to the Federal Steering Committee on Self-Government during the planning period.

Public Service Health

Objective

To protect and preserve the health of federal public servants as it relates to the work-place by providing a program of occupational and environmental health services under authority delegated by the Treasury Board.

Description

Occupational Health: The role of this sub-activity is to advise and assist federal public service managers to fulfil their responsibilities to protect and promote the occupational health and safety of federal employees.

This program provides occupational health, environmental health and safety services to federal public servants through direct services including occupational health nursing, medicine, environmental health, industrial hygiene, counselling management and management of health programs. Engineering, scientific and technical support services are provided to front-line staff.

Major service areas include health assessment and surveillance, workplace assessment, health promotion, health education, response to emergency situations, assisting Departments to fulfil their responsibilities under the Treasury Board Occupational Safety and Health Standards, providing expert advice to Treasury Board on health and safety issues and the updating of legislation, providing health counselling and health advice to employees, and special studies. The program also provides consultative service to government management regarding employee health and safety issues.

The program also includes the Employee Assistance Service (EAS). Each federal department is responsible for implementing an effective Employee Assistance Program (EAP), with the EAS providing professional advice to Departments to assist them with appropriate EAP services for their staff.

In addition, EAS co-ordinates the EAP services for a number of Departments thereby lowering operating costs through economies of scale and improving the collection and quality of related statistics. This program operates on an incremental cost recovery basis, through Memoranda of Understanding with participating departments.

This sub-activity also coordinates the health care required for foreign VIPs during their stay in Canada.

Environmental Health Services: This sub-activity is concerned with maintaining safe and healthy working environments by identifying work-place hazards and recommending solutions. Issues such as indoor air quality, ergonomics and monitoring high-risk work-places such as laboratories are taking on increasing prominence in this work.

Resource Summaries

This Activity accounts for approximately 1.4% of 1997-98 total Program expenditures and 7.0% of the total full-time equivalents.

Figure 17: Activity Resource Summary

	1996-97 Estimates		**1997-98 Estimates**		1998-99 Planned		1999-00 Planned	
	$000	FTE	**$000**	**FTE**	$000	FTE	$000	FTE
Occupational Health	15,661	255	**19,262**	**277**	14,244	232	14,287	232
Environmental Health Services	9,275	102	**7,312**	**118**	7,337	119	7,360	119
Sub-total	24,936	357	**26,574**	**395**	21,581	351	21,647	351
Less: Revenue credited to the Vote	0		**(4,472)**		0		0	
Total	24,936	357	**22,102**	**395**	21,581	351	21,647	351

- Full time equivalent (FTE) is a measure of human resource consumption based on average levels of employment. FTEs are not subject to Treasury Board control but are disclosed in Part III of the Estimates in support of personnel expenditure requirements specified in the Estimates.

Of the total expenditures for 1997-98, 84.2% is for personnel costs and 15.8% is for operations and maintenance.

Explanation of Change: The 1997-98 Main Estimates are $2.834 million lower than the 1996-97 Main Estimates. This is mainly due to:

	($000)
• internal transfers; and	(1,700)
• Program Review reductions.	(1,200)

Key Initiatives

The Activity will continue its move towards becoming an alternative service delivery organization. Treasury Board and Departmental legal staff have already determined that expanding the customer base to include federal agencies and corporations and other levels of government in Canada is acceptable. A Provisional Special Operating Agency Treasury Board submission was approved during 1996-97. Through this submission, the Activity received the authority to re-spend revenue generated from the provision of services to customers outside of the federal government.

In support of the change in direction and in recognition of the need for the organization to be better positioned to provide direct service to the customer, the Activity is implementing an ambitious restructuring program which will continue into the planning period. This restructuring exercise reduces the number of regions from six to three, reduces the middle management structure and amalgamates activities into multidisciplinary teams rather than individual professional disciplines. The resulting organization will foster local decision making and support a matrix operation which will improve responsiveness to customer demands and facilitate integrated program results.

Consistent with this change in direction there exists the need to improve data capture and reporting systems. Two initiatives will be implemented during the planning period:

- a time reporting and billing system will allow management to report time utilized in the delivery of services to individual customers and to bill customers for services; and

- a health program information system will allow the collation and analysis of health information data and trend analyses. A pilot project is presently under way for federal customers in British Columbia.

Marketing of services will be key to the redirection anticipated within the Activity. Several potential customers have already approached the Occupational and Environmental Health Services Directorate to obtain its services. In order to provide services to these or other non-traditional customers, it will be necessary to build partnerships with other service providers. The development, maintenance and auditing of organizations that are providing services on behalf of the Directorate will be fundamental to the success of the organization in the future.

The Activity is developing a risk assessment and management tool to assist in occupational safety and health services delivered to client departments through contracts. Changes in program direction will be based on a careful analysis and needs assessment, risk management and justification through cost-benefit analysis.

The Activity has reached agreement with HPB to relocate a portion of the Occupational Health Unit laboratory (OHU) operation to an HPB facility in Ottawa. The OHU operation will be rationalized while continuing the performance of key analyses.

During 1995-96, a cost management initiative was developed with the aid of consultants from Queen’s University. It was seen as imperative that wherever possible cost drivers be identified, quantified and controlled. This process will continue to be essential during the planning period.

Health Advisory and Assessment Services

Objective

To assist Canadians in determining their medical eligibility for certain benefits and types of licenses by providing professional advice and assistance in the areas of civil aviation medicine.

To provide health interventions to protect the Canadian public through activities in emergency services, quarantine services and regulatory services.

Description

Civil Aviation Medicine: This sub-activity plays a key role in ensuring that pilots and air traffic controllers are medically fit to perform their duties in a safe manner. This sub-activity contributes to aviation safety in Canada by assessing the fitness of all aviation personnel prior to licensing and before renewals by Transport Canada. It also promotes health and aviation safety through lectures and seminars to the aviation community. The sub-activity ensures ready access to timely medical examinations by providing aeromedical training for Civil Aviation Medical Examiners. The program, through international collaboration and research, develops aviation medical policies and guidelines for Canada.

Emergency Services: Emergency Services cooperates with all levels of government to support health care and social service systems when peacetime disasters occur. Emergency Services also ensures that a mechanism is in place to help the Canadian government respond to the health and social services needs of foreign countries hit by disasters.

Quarantine and Regulatory Services: The objective of the quarantine program is to meet the requirements of the Canadian Quarantine Act and the World Health Organization International Health Regulations. Activities include inspection of vessels arriving at designated ports from international waters and the issuing of deratting exemption certificates. The Quarantine program also supplies the operational arm in times of crises to prevent the egress, or to control the spread, of quarantinable diseases in Canada.

The regulatory program is aimed at protecting the health of the travelling public by ensuring that adequate standards of food handling and sanitation are maintained. Inspections of common carriers and their ancillary services and federal facilities hosting official visitors to Canada are carried out.

Resource Summaries

This Activity accounts for approximately 0.3% of 1997-98 total Program expenditures and 1.6% of the total full-time equivalents.

Figure 18: Activity Resource Summary

	1996-97 Estimates		**1997-98 Estimates**		1998-99 Planned		1999-00 Planned	
	$000	FTE	**$000**	**FTE**	$000	FTE	$000	FTE
Civil Aviation Medicine and Medical Advisory Services	2,419	43	**2,813**	**59**	177	29	177	29
Emergency Services	2,667	29	**2,596**	**29**	2,460	29	2,460	29
Quarantine and Regulatory Services	296	5	**257**	**5**	257	5	257	5
Sub-total	5,382	77	**5,666**	**93**	2,894	63	2,894	63
Less: Revenue credited to the Vote	(250)		**(1,799)**		(250)		(250)	
Total	5,132	77	**3,867**	**93**	2,644	63	2,644	63

* Full time equivalent (FTE) is a measure of human resource consumption based on average levels of employment. FTEs are not subject to Treasury Board control but are disclosed in Part III of the Estimates in support of personnel expenditure requirements specified in the Estimates.

Of the total expenditures for 1997-98, 81.5% is for personnel costs and 18.5% is for operations and maintenance.

Explanation of Change: The 1997-98 Main Estimates are $1.265 million lower than the 1996-97 Main Estimates. This is mainly due to:

	($000)
• Program Review reductions.	(1,600)

Key Initiatives

Civil Aviation Medicine: A full operational review of the Civil Aviation Medicine program, in partnership with Transport Canada and in consultation with industry representation, was initiated in 1996-97. The objective of the review is to critically analyze the mandate and to make recommendations for increasing the efficiency and effectiveness of the program for future years. The final report is expected to be tabled in January, 1997. The implementation of the approved recommendations will occur during the planning period.

During the planning period, Civil Aviation Medicine and Transport Canada will explore mutually acceptable service delivery options in light of a $2M reduction in the appropriation. Cost recovery from the users of this service is a possibility that will be under discussion.

It is difficult to forecast accurately the expected volume of medical assessments. An on-going review will continue into the planning period to assess various medical standards and to address the needs of a changing aviation industry.

The seminars for the Civil Aviation Medical examiners will continue and be increased to three per year in the planning period.

Emergency Services: A review of the role and mandate of the Emergency Services Division was conducted during the 1995-96 fiscal year. The program is developing an action plan to implement the recommendation in 1996-97 and following years. The changes will be significant and require planned implementation over a period of time. The implementation will include:

- review and restructuring of the national emergency medical and pharmaceutical drug supplies;

- review of the training program with emphasis on assisting provinces to manage basic training and upon the Emergency Services program to focus its attention on advanced or value added training;

- analysis of the information needs of the provinces and federal departments and consideration of an automated information system; and

- restructuring of the program to meet the new directions, and increased partnerships with provinces, academia and others for all aspects of the work.

Quarantine and Regulatory Services: Annual revenues of $250K are forecast for the quarantine program.

Initiatives for the planning period include:

- to enable the common carrier industry to initiate shared inspections using federal industry guidelines and standards, OEHSD will undertake the following activities: professional upgrading for Environmental Health Officers; development, in close co-operation with industry, of comprehensive training which includes hazard analysis and other quality control systems; transfer of expertise to industry to make across-the-industry improvements in food safety; and provision of a comprehensive audit function;

- seek authorities to initiate cost recovery and the spending of revenues received for regulatory services, such as inspections and client staff training. Consultation and negotiation towards full cost recovery has already occurred; and

- complete the revision of the Department of Health Act Potable Water Regulations, in close cooperation with regulatory program clients.

VIP Services: It is difficult to forecast the number of VIP visits to Canada. However, based on previous years, OEHS is expected to coordinate the health care requirements for an average of 50 VIP visits per year, not including major events. Known major events include a Royal Visit planned for July, 1997, as well as the Asia-Pacific Economic Leaders Meeting in Vancouver in November, 1997. A summit on “Réunion des chefs d’états de la Francophonie” is also planned in Moncton, New Brunswick, in 1999.

Policy and Consultation

Objective

To provide advice and support to the Minister, the Departmental Executive and to program branches in the areas of policy development, intergovernmental affairs, strategic planning and review, communications and consultation, and international affairs.

Description

Provides policy analysis, advice and information to senior management and program branches through strategic planning, policy development and public information activities. Within the Activity are a number of program areas, including Communications and Consultation, Strategic Planning and Review, Intergovernmental Affairs, Health Policy and Information, International Affairs and the Women's Health Bureau. The Secretariat for Health System Renewal and the National Forum on Health Liaison are also included in the Activity.

Resource Summaries

This Activity accounts for approximately 2.1% of 1997-98 total Program expenditures and 3.4% of the total full-time equivalents.

Figure 19: Activity Resource Summary

	1996-97 Estimates		**1997-98 Estimates**		1998-99 Planned		1999-00 Planned	
	$000	FTE	**$000**	**FTE**	$000	FTE	$000	FTE
Health Policy and Information	7,147	34	**16,483**	**35**	17,681	30	17,700	30
Women's Health Bureau	1,198	8	**4,350**	**15**	3,911	15	3,911	15
Intergovernmental Affairs	1,282	12	**854**	**35**	993	35	993	35
International Affairs	2,068	15	**1,190**	**14**	968	14	968	14
Communications and Consultation	4,168	66	**4,667**	**65**	3,809	60	3,809	60
Strategic Planning and Review	1,374	18	**1,599**	**15**	1,300	13	1,300	13
Management Services	1,761	12	**2,823**	**12**	2,530	12	2,530	12
Total	18,998	165	**31,966**	**191**	31,192	179	31,211	179

* Full time equivalent (FTE) is a measure of human resource consumption based on average levels of employment. FTEs are not subject to Treasury Board control but are disclosed in Part III of the Estimates in support of personnel expenditure requirements specified in the Estimates.

Of the total expenditures for 1997-98, 37.6% is for personnel costs, 9.8% is for operations and maintenance and 52.6% is for grants and contributions.

Explanation of Change: The 1997-98 Main Estimates are $12.698 million higher than the 1996-97 Main Estimates. This is mainly due to:

	($000)
• increase due to a grant to the Canadian Health Services Research Foundation;	11,000
• internal transfers;	3,580
• decrease due to Program Review adjustments;	(1,800)
• decrease for sunsetting of the Tobacco Demand Reduction Strategy; and	(1,651)
• increase for the Centres of Excellence for Women's Health.	1,400

Currently the Policy and Consultation Activity is delivered through seven sub-activities within the Policy and Consultation Branch, as follows:

Health Policy and Information Directorate: Develops advice on comprehensive strategies and policies based on a health determinants approach focussing on health outcomes and measurement of health status and potential gains from various forms of intervention. It provides policy development, analysis and advice to the Minister and senior officials concerning a wide range of health policy issues that affect Canada's health system and the health and well-being of Canadians. The sub-activity also coordinates corporate activities related to the collection and dissemination of information, including the administration for the Department of the *Access to Information Act* and *Privacy Act*.

Women's Health Bureau: Ensures that women's health concerns receive appropriate attention and emphasis within the Department, and promotes an understanding of gender as a critical variable in health by analyzing and assessing the impact of policies, programs and practices in the health system broadly-defined on women and women's health. The Bureau has a strong policy orientation, and its staff work with other parts of the department to ensure that the Department's programs and policies properly address women's health. The Bureau also works to enhance the responsiveness of the Canadian health system to the health needs and concerns of women.

Intergovernmental Affairs Directorate: Develops and provides strategic advice, coordination and logistical support on the full range of federal-provincial-territorial issues and develops and provides policy advice to support the administration of the *Canada Health Act*. The Federal-Provincial Relations Division will focus on expanding its support to branches in the strategic management of federal-provincial relations issues. The Division will also continue to support key departmental priorities, such as blood system management, pharmaceuticals, tobacco control, etc.

International Affairs Directorate: Initiates, coordinates and monitors departmental policies, strategies and activities in the international field by providing advice on the Department's strategic approach to international affairs, ensuring the Department's international activities are internally coherent and consistent with government-wide policies, recommending departmental representation at international meetings at which governments are represented and assisting line branches in pursuing international activities which support their domestic objectives.

Communications and Consultation Directorate: Provides strategic communications advice to the Department and the Minister's office. Carries out media and public environmental research and analysis, undertakes consultations with stakeholder groups, develops communications plans and action plans for program and policy issues, coordinates ministerial speeches, evaluates communications activities and prepares communications plans for Memoranda to Cabinet. Provides communications support services at headquarters and in the regions.

Strategic Planning and Review Directorate: Brings together policy, line and resourcing expertise from branches, regions and external sources into integrated recommendations, scenarios, and plans that enable timely and effective decision-making by the Departmental Executive Committee within the Expenditure Management System including departmental priorities, the assessment of results, the adjustment of capacity and the realignment of programs and activities. The Directorate is also responsible for developing the performance measurements and indicators by which departmental programs and activities can be reviewed as required by the Expenditure Management System, and for conducting and reporting evaluations of departmental programs under the Treasury Board and Departmental evaluation policies.

Management Services Directorate: Develops and provides management services in support of priority setting and planning, coordinates operations across the Branch, provides leadership in the management of cross-branch projects, problem solving and management of change, coordinates Branch input to the various departmental corporate requirements and leads Branch management in the adoption of a culture that will integrate sound management principles and a client-based approach to the policy development process.

The **Secretariat for Health System Renewal** and the **National Forum on Health Liaison** are also included in the Branch. These groups are responsible for providing strategic advice and support to the Minister on the renewal of Canada's health system.

Key Initiatives

In the upcoming years, the Policy and Consultation Activity will continue to focus on regulatory policy and stakeholder consultations in the Management of Risks to Health business line. Work will also continue on Aboriginal Self-government Policy and extensive consultations with First Nations under the Services to First Nations, Inuit and Yukon business line. Under the Population Health Strategy business line, work will continue on developing interdepartmental frameworks for action on specific areas such as Child Development or consultation with a broad range of NGOs and provinces on initiatives such as Heart Health.

Specific priority initiatives include the following:

Canadian Health Services Research Foundation: the Government will provide $65 million over five years to establish and help endow the Health Services Research Fund, to be held by the Canadian Health Services Research Foundation. $10 million will be awarded by the MRC from within its existing allocation, and $5 million will be reallocated from within existing Departmental resources. The immediate objective is to bring together partners — from provincial governments, health institutions and the private sector — who are interested in building a shared fund, thereby making better use of the human and financial resources in the health care system. The research will identify what works in our health care system, what does not work, and what procedures and interventions require further evaluation. By jointly setting priorities and pooling efforts, the results of the research would be more readily and widely adopted to the benefit of all Canadians.

The government's contribution will serve two purposes, to help get research under way during the course of the five years, and to help endow the Fund so it can continue on an on-going basis after the five-year period, if it proves its merit. The Fund will be held by the Canadian Health Services Research Foundation. Representatives of the Department, the MRC, and the other partners will make up the governing body of the Foundation with the Department and the MRC occupying a single seat each, to reinforce the Foundation's arm's length partnership characteristics.

International Policy Issues: develop plans and internal co-ordination mechanisms to provide leadership on national and international health technology applications, trade policy and other trade initiatives; plan and co-ordinate activities that place the Department in a leadership role in developing priorities for the World Health Organization (WHO) and the Pan American Health Organization (PAHO).

Women's Health: assess the impact of health reform on women's health and develop strategy for integration into the Department's Business Plan; develop resources and methodology for conducting gender analysis of Departmental health policies and programs; complete the Department's Women's Health Strategy; complete multi-year funding agreements and implementation of Year I workplans for the Centres of Excellence for Women's Health; ensure long-term contribution of Centres' work to health policy and health system issues and complete a *Report Card on the Health of Canadian Women*.

Ethics: consider the merits of the new National Advisory Council on Bioethics to promote public debate; monitor developments and advise decision makers; develop a sexual and reproductive health policy framework; review current privacy protection mechanisms with the provinces and territories with respect to the extent of genetic testing; develop a regulatory framework regarding the extent of genetic testing; and develop a regulatory framework to address the ethical, legal and social issues raised by research in the health sciences and their application in a health care delivery context.

Care at the end of life: complete consultations with palliative care specialists; assess and synthesize existing research on effective service delivery models, on pain and symptom management, education needs of care providers, and related family issues; address care issues by the Special Senate Committee on Euthanasia and Assisted Suicide, through the development of a coordinated departmental plan of action to (1) support surveillance and research on needs and care at the end of life, (2) facilitate the development of services for the terminally ill within a continuum of care (including home care), and (3) improve support for caregivers and families of terminally ill persons.

Pharmaceuticals: continue preparatory work in anticipation of the Parliamentary review of Bill C-91 (including a contract study on the health system impact), and develop government response in conjunction with Industry Canada; work with provinces and territories in addressing federal-provincial-territorial priority issues: drug prices, utilization, marketing, consumer education, wastage and research and development activities; and ensure a coordinated and strategic Departmental approach to pharmaceutical issues.

Health Insurance

Objective

To ensure that all residents of Canada have reasonable access to insured health care services on a pre-paid basis and to support extended health care services.

Description

The Activity administers the *Canada Health Act*, which establishes criteria and conditions for federal contributions to the provinces and territories in support of insured health services and certain extended health care services; monitors and assesses the compatibility of provincial and territorial health care insurance plans with the *Canada Health Act*; and develops expertise in and provides assistance to health insurance plans and programs. It also provides policy advice on the role of the *Canada Health Act* in the overall direction of the Canadian health care system.

Resource Summaries

This Activity accounts for approximately 0.1% of 1997-98 total Program expenditures and 0.4% of the total full-time equivalents.

Figure 20: Activity Resource Summary

	1996-97 Estimates		**1997-98 Estimates**		1998-99 Planned		1999-00 Planned	
	$000	FTE	**$000**	**FTE**	$000	FTE	$000	FTE
Operating Costs	1,702	23	**1,731**	**23**	1,736	23	1,736	23
Total	1,702	23	**1,731**	**23**	1,736	23	1,736	23

* Full time equivalent (FTE) is a measure of human resource consumption based on average levels of employment. FTEs are not subject to Treasury Board control but are disclosed in Part III of the Estimates in support of personnel expenditure requirements specified in the Estimates.

Of the total expenditures for 1997-98, 82.4% is for personnel costs and 17.6% is for operations and maintenance.

Key Initiatives

- renew the regulatory and legislative framework for Medicare, while maintaining the principles of the *Canada Health Act*. Implied in this initiative is the provision of interpretations within the existing legislation to ensure adaptation of the Act to new realities of modern health care, e.g., alternative providers, and venues for service delivery other than hospitals, such as community clinics. Ultimately this initiative might, as a result of the emergence of a broad-based national consensus, involve broadening the coverage of public health insurance, and hence the application of national principles, to include drugs, home care, and preventive measures. This initiative could also lead to the establishment of new interpretation and dispute settlement mechanisms;

- work on the federal-provincial-territorial vision exercise to ensure the future of Canada's publicly financed health care system, based on an unwavering commitment to the five principles of the *Canada Health Act*. Consistent with the Throne Speech, the federal approach is to work with provinces and territories to develop agreed-upon values and principles to underlie the social union and to explore new approaches to decision-making in social policy;

- bring about compliance with the government's private clinics/facility fees policy, in order to ensure that Canadians have access to medically necessary insured services without point-of-service charges, regardless of the venue where they are received; and

- promote public support for single-tiered public health insurance through effective communication.

Program Management

Objective

To provide advice and direction in the development of policies and programs that will ensure the provision of an appropriate level of health services throughout the nation, and to provide management services to the Departmental Executive and management services and functional direction to Program branches.

Description

The Program Management Activity has four sub-activities.

The first sub-activity, **the Departmental Executive,** consists of the offices of the Minister, Deputy Minister, Associate Deputy Minister, the Regional Directors General, the Secretariat for the National Forum on Health and the Departmental Secretariat.

Regional Directors General: The Regional Directors General provide strategic advice on health issues, serve as a corporate link to provinces, territories and other groups in the health sectors and are the regional leads for cross-branch programs and corporate initiatives.

Departmental Secretariat: The Departmental Secretariat provides a strategic/advisory role and specialized support services to the Minister, Deputy Minister, Associate Deputy Minister and the Departmental Executive Committee to facilitate departmental business and corporate decision making as well as providing a focal point for major corporate initiatives. It also provides ongoing Headquarters support to the Regional Directors General. The components of the Departmental Secretariat include the Executive Services Office, the Departmental Services Division and the Parliamentary Relations Office.

Executive Services Office: The Executive Services Office (ESO) is responsible for providing support to the corporate functions of the Department including Headquarters support to the Regional Directors General, particularly the decision-making processes, and a broad range of activities. ESO provides the strategic planning and coordination of the weekly Departmental Executive Committee meeting agenda as well as all secretariat support to the Committee. The Office coordinates all support to the Minister for his full participation at Cabinet committee meetings. Ministerial appointments to Departmental agencies and Ministerial recommendations of nominations to Governor-in-Council boards and agencies are coordinated in consultation with the Minister's Office and Departmental officials. The Executive Services Office plans and coordinates the annual Departmental Management Council and undertakes special projects at the request of the Deputy and Associate Deputy Ministers.

Departmental Services Division: This Division is responsible for the management and quality control of all correspondence addressed to the Minister. This correspondence includes write-in-campaigns, invitations, grants and contributions. The Division registers Cabinet Documents, maintains a computerized ministerial correspondence tracking system and reporting system, is the custodian of ministerial records and provides information for executive decision making by senior departmental officials. It promotes and manages executive information renewal in the Department to maximize the benefits of information technology in the management of executive correspondence.

Parliamentary Relations Office: The Parliamentary Relations Office (PRO) provides services to the Minister, the Deputy Minister and the Associate Deputy Minister in fulfilling their parliamentary responsibilities, including briefing the Minister's and Acting Minister's staff for daily Question Period.

PRO provides advice and recommendations, and manages departmental responses to issues identified through careful analysis of current events relating to the Department. It monitors and analyzes all activities of Parliament presenting senior management and the Minister's office with detailed reports and assessments. With regard to Government Bills involving the Department, PRO is responsible for all requirements throughout the legislative process, serving both the Minister's office and the Department in a coordinating and advisory capacity including providing assistance in strategic planning and preparation.

The second sub-activity, **Program Services**, consists of the following four components:

Departmental Planning and Financial Administration: Designs, develops and implements corporate planning processes to contribute to the Department's effectiveness and efficiency in program delivery, to improve the availability of information and to facilitate decision-making. The Directorate is also responsible for ensuring that policies and systems of financial administration are established and maintained; for exercising financial and budgetary controls; for coordinating departmental operational resources; and for advising senior departmental managers on financial management.

Information Management: Develops and maintains department-wide information systems and networks, including those information systems required for the delivery of programs of all branches, except those of the Health Protection Branch. The Directorate also ensures the compatibility of systems, hardware and software; leads and coordinates long-range and operational informatics systems planning; sets standards and guidelines for hardware and software; establishes protocols for computer communications; and has responsibility for document management and departmental library services.

Assets Management: Develops and implements effective departmental policies and systems for procurement and utilization of materiel, real property, accommodation and security of the workplace, employees and information. The Directorate also provides advisory services and assistance to the Departmental Executive Committee and Branch managers on all matters related to physical assets and departmental security. The Directorate has taken on the lead role in the management of the Federal Laboratories Project in Winnipeg and Sustainable Development and also provides direct support to such initiatives as the Laboratory Rationalization Study.

Human Resources: The Human Resources Directorate provides human resources support and advice to Branches in the areas of staffing, classification, staff relations, compensation, official languages, and the application of human resources legislation and policies. The Directorate also administers programs for employees, such as the Employee Assistance Program, the Management Trainee Program, the Departmental Assignments Program, and the Career and Learning Centres. Through its programs and services, the Human Resources Directorate endeavours to ensure that departmental managers promote fairness, recognize competence and encourage opportunities for growth and development.

The third sub-activity, **Internal Audit**, carries out independent reviews of operations, activities, systems and functions to make sure they are conducted in an economic, efficient and effective manner. The sub-activity also conducts special investigations of suspected losses of public money or other allegations of financial improprieties, and is the focal point for liaison with the Auditor General's office.

The fourth sub-activity, the **National Forum on Health**, was established in October, 1994, with a mandate to look at health and the health care system in Canada, to engage in dialogue with Canadians and to provide advice to government which can be used to form health policy.

Resource Summaries

This Activity accounts for approximately 6.9% of 1997-98 total Program expenditures and 16.1% of the total full-time equivalents.

Figure 21: Activity Resource Summary

	1996-97 Estimates		**1997-98 Estimates**		1998-99 Planned		1999-00 Planned	
	$000	FTE	**$000**	**FTE**	$000	FTE	$000	FTE
Departmental Executive	6,172	98	**16,095**	**305**	18,027	303	18,051	303
Program Services	60,666	617	**89,485**	**596**	79,697	550	79,798	550
Internal Audit	831	11	**738**	**9**	738	9	738	9
National Forum	4,268	20	**519**	**—**	—	—	—	—
Sub-total	71,937	746	**106,837**	**910**	98,462	862	98,587	862
Less: Revenue credited to the Vote	(466)		**(1,338)**		(682)		(682)	
Total	71,471	746	**105,499**	**910**	97,780	862	97,905	862

* Full time equivalent (FTE) is a measure of human resource consumption based on average levels of employment. FTEs are not subject to Treasury Board control but are disclosed in Part III of the Estimates in support of personnel expenditure requirements specified in the Estimates.

Of the total expenditures for 1997-98, 41.1% is for personnel costs, 36.4% is for operations and maintenance, 18.7% is for grants and contributions and 3.8% is for capital costs.

Explanation of Change: The 1997-98 Main Estimates are $34.028 million higher than the 1996-97 Main Estimates. This is mainly due to:

	($000)
• increase due to the centralization of regional corporate support services;	32,630
• increase due to a transfer from PWGSC for grants in lieu of taxes;	5,488
• increase related to the ongoing operating costs of the Winnipeg Microbiology Laboratory;	5,203
• decrease due to Program Review adjustments;	(4,525)

- decrease related to the National Forum on Health; and (3,749)

- decrease for sunsetting of the Tobacco Demand Reduction Strategy; (1,728)

Key Initiatives

Departmental Planning and Financial Administration: Departmental Planning and Financial Administration (DPFA) will take the lead role in the reassignment of resources from an Activity based structure to a business line structure. This will necessitate developing cross-walks which illustrate the accountability of the various components being moved from an Activity and split amongst all four business lines.

A Treasury Board Submission will be developed during 1997 to request changes to our Operational Planning Framework (now called the Planning, Accounting and Reporting Structure) to effect the transition from Activity based accounting and reporting to business line planning and reporting for fiscal year 1998-99.

By the end of 1996-97, DPFA should be in a position to select a new automated procurement payment FIS compliant system or make changes to the present system in order to comply with the FIS strategy to deal with the year 2000 issue.

Information Management Services: The Information Management Services Directorate will continue the work begun in 1996-97 to introduce the use of service agreements to guide working relations with its internal clients. This will ensure that client requirements, service standards and respective accountabilities are clearly defined, and will provide a sound basis for resourcing decisions and performance management activities.

The Department will implement the new Health Canada Information Management /Information Technology (IM/IT) committee structure recently approved by senior management. This new structure will help to ensure effective and collaborative decision-making on IM/IT issues of corporate interest, and provide strong links to similar committees in the branches and regions.

The Department will continue to aggressively introduce corporate policies aimed at ensuring the effective use of departmental IM/IT resources, using the IM/IT committee structure as an important vehicle for consulting upon, gaining endorsement of, and communicating these policies.

The Department will undertake the following major and closely linked corporate infrastructure projects.

- Capital Upgrade Project;

- Netware 4.1 Migration and Remote Access;

- Integrated Help Desk, Software and Network Management Services;

- Asynchronous Network Migration; and

- Lotus Notes Version 4 Rollout.

The Health Canada Electronic Work Environment is a major initiative that will see the introduction of electronic work flows in government and commercial transactions, as well as improved management of/access to departmental information regardless of the form it takes. It will involve participation in government-wide initiatives such as secure electronic commerce/public key infrastructure and Information Highway initiatives, as well as internal partnerships with program branches on a variety of related pilot projects.

The Management of Executive Information Project represents one of Treasury Board's shared systems projects. This will result in a department-wide system for the management of executive information, including executive correspondence, briefing notes and press releases.

Assets Management: Plans for 1997-98 include the establishment, implementation and maintenance of service standards for facilities management services (FMS), and investigation of alternative service delivery methods for FMS. The Directorate will support Departmental and Governmental initiatives such as the Food Inspection Agency, Space Envelopes, and the Pest Management Regulatory Agency. In compliance with Bill C-83 which amended the *Auditor General Act*, the Directorate will coordinate departmental efforts to develop a sustainable development strategy (SDS) which will outline the Department's objectives and plans of action to integrate sustainable development into the planning and decision making processes. The Directorate will implement the SDS and monitor compliance.

In addition, the Directorate will develop and implement an environmental management system (EMS) that conforms to ISO 14000 standards. The EMS will report on the progress that the Department has made towards the achievement of the objectives set out in the SDS as well as ensure that the Department's internal daily operations are conducted in an environmentally friendly manner, in accordance with federal environmental regulations.

During 1998-99, Directorate activities will include support to the Laboratory Rationalization Study currently under way within the Department, and investigation of alternative service delivery methods for Material Management in preparation for the Department's move to accrual accounting. In addition, the Directorate will maintain the Department's health, safety and security programs.

During 1999-2000, the Directorate will update and revise the SDS as required to comply with Bill C-83. The Directorate will also continue to report on the Department's progress through EMS and monitor compliance.

Human Resources: The Human Resources Management Strategy is the Department's framework to deal with branch and departmental human resources issues. While this document will evolve to incorporate emerging changes and issues, it currently describes the main challenges facing the Department, presents strategic human resources actions to address these issues and offers factual demographic information on its population. It also provides forecasts of the impacts of changes in each branch.

The challenges facing Health Canada include: 1) transfer, sunset programs, relocation, rationalization, budgetary cutbacks and program review; 2) changing our Corporate culture; 3) business improvements; 4) the aging workforce (Scientific and Professional category); 5) Leadership development and support; 6) career management; 7) supporting continuous learning; 8) obtaining a representative and adaptable workforce/organization; 9) ensuring the well being of employees; 10) technology; and 11) communications.

The Human Resources Management Strategy recommends programs, measures, practices and initiatives that could be implemented to have a workforce that will effectively respond to the issues and challenges. The Human Resources Directorate will continue to develop the strategy in consultation with managers, analyze the demographics of the Department and provide information regarding its population, attrition rate, retirement projections, age distribution, alternative work arrangements, employment equity and anglophone/francophone distribution.

In addition, the Department commenced a vigorous HC2000 strategic planning exercise outlining the departmental issues, the HR implications and the actions and decisions over the coming months in order to effectively manage its resources over the next three year period. The Department approved its Employment Equity Plan for 1995-97. The second year of the plan will include launching the diversity management framework, an innovative experiential learning program designed to sensitize but also implement concrete tools including a Code of Conduct which will foster and further diversity management in the Department.

National Forum on Health: The Forum expects to complete its work by the end of December, 1996, and make its report to Government in early 1997. The dissemination of material from the work will follow until March, 1997. Any continuing work will most likely be pursued within the Department.

III Departmental Performance

A. Summary of Departmental Performance

The achievements described below give an indication of the Department's performance during the 1995-96 fiscal year. Further performance details can be found starting on page 73.

- discussions about the current *Canada Health Act* enforcement measures, in combination with other factors at play, led to federal-provincial-territorial efforts to address, at a conceptual level, larger questions on the roles and responsibilities of the respective levels of government in providing leadership to and administering Canada's health care system. The federal-provincial-territorial response was the launch of a vision exercise in which the Department plays a significant leadership role.

- the Department worked intensively with provincial and territorial Ministries of Health to clarify respective federal-provincial-territorial roles and responsibilities and eliminate overlap and duplication in the health system. Deputy Ministers of Health are actively engaged in a vision exercise.

- in September, 1995, federal-provincial-territorial Ministers of Health endorsed the release and launch of public consultations on a discussion paper entitled *"A Model for the Reorganization of Primary Care and the Introduction of Population-based Funding"*.

- recognizing that drug costs represent the fastest rising component of health care costs, federal-provincial-territorial Deputy Ministers of Health endorsed in March, 1995, a number of national pharmaceutical initiatives put forward by the Department in response to concerns about rising drug costs, inequities in access to pharmaceuticals, and inappropriate utilization. Work is being performed on a number of initiatives by federal, provincial and territorial governments and other national agencies.

- the Department continues to implement a broad range of strategies to improve its ability to meet the Regulatory Renewal objective. These include promoting acceptance of Canadian standards at the international level, moving from reactive, comprehensive regulation to a more strategic, risk-based focus, removing roadblocks and improving the efficiency of the regulatory process in collaboration with other federal departments.

- as an initial response to the Supreme court ruling that invalidated the main sections of the *Tobacco Products Control Act,* a discussion paper, *Tobacco Control: A Blueprint to Protect the Health of Canadians,* was released in December, 1995. This paper sets out the legislative directions the Government proposes to take on advertising, promotion, sponsorship, access to minors, point-of-sale activities, packaging and labelling, and product regulation with the provinces and territories.

In addition, the Department conducted several studies and assessments including the following:

- the attitudes, beliefs and behaviour of youth aged 10 to 19 that will improve programming of influence tobacco uptake and cessation;

- the potential value of controlling packaging to restrict its promotional value and to improve awareness of the hazards of smoking; and

- the basis for renewing and extending the control of tobacco marketing in Canada with a view to further reducing tobacco consumption.

- improved crisis response capacity by developing and implementing a crisis response framework for quick and effective response to major disease outbreaks,e.g. plague, Ebola, hanta virus.

- developed new genetic diagnostic tools to facilitate earlier detection of emerging infectious diseases.

- developed prevention and disease control guidelines that have been distributed nationally to key public health partners in priority areas such as drinking water, infection control, and sexually transmitted diseases (STDs).

- the Department delivered community health programs and Non-Insured Health Benefits (NIHB) to First Nations within the limits established by the First Nations and Inuit Health envelope. Measures to reduce NIHB growth have included the automation of claims payments, establishment of community funding for mental health and solvent-abuse treatment, and improved program and financial management practices.

- the Department continued to move forward on its commitment to transfer responsibility for the delivery of health-care services to First Nations and Inuit. Since 1989, a total of 67 Transfer Agreements have been signed, representing a total of 142 (out of 567).

- documents were drafted on the Transfer of Resources for Second and Third Level Services, and the Refocused Role of the Medical Services Branch. The purpose of these documents was a) to facilitate the transfer of regional and zone-level services, and b) to reconsider the ongoing role of the Minister in support of community health services.

- a document entitled “Pathways to First Nations control” was released to MSB regional offices for distribution to First Nations and Inuit communities. The long-term evaluation of transfer was completed in collaboration with First Nations' representatives. This evaluation considered the impacts and effects of transfer.

- in December, 1995, the Fort qu’Appelle Indian Hospital was transferred to First Nations control. In addition, through an administrative arrangement effective April 1, 1996, the Weeneebayko Health Authority is administering the Moose Factory General Hospital. Finally, negotiations to close the Blood Indian Hospital have recently been concluded successfully.

- developed an injury prevention kit for seniors to enhance accessibility to multi-media information disseminations systems such as Health Promotion OnLine.

- expanded projects under the Canada Prenatal Nutrition Program to address needs of low-income pregnant women and give high-risk children the best possible start in life.

- implemented the four-year Aboriginal Head Start Program, which directly involves parents and communities in the design and implementation of pre-school early intervention projects.

- launched the New Horizons: Partners in Aging Program.

- completed the Report of Canada's Response to HIV/AIDS, Nutrition for Health: An Action Plan for Canada.

- began re-structuring the Heath Promotion and Programs Branch to move more strategically toward the population health concept and to prepare for the sunsetting of special initiatives.

B. Departmental Overview

Development of Performance Measures

The following Departmental performance indicators have been published in the *Annual Report to Parliament by the President of the Treasury Board.*

To provide Canadians with:	To be demonstrated by:
Health System Support and Renewal Access to health services consistent with the principles of the *Canada Health Act*, universality, portability, accessibility, public administration and comprehensiveness.	- the interpretation, enforcement and renewal of the *Canada Health Act*; - a balanced, evidence-based health system; and - the control of cost drivers.
Management of Risks to Health - Products and Disease Control Management of health risks.	- improved governance of the Canadian Blood system; - an enhanced food safety system; - anticipation, prevention and response to health threats due to food, drugs, medical devices, environmental hazards and consumer products; - implementation of cost-recovery and service improvement initiatives; and - cost-effective, risk-based approaches to regulation, compliance and surveillance activities.
Services to First Nations, Inuit and Yukon Effective health services to First Nations and Inuit, within the limits of the Indian Health envelope.	- improved health status of First Nations and Inuit communities; - the transfer of existing health resources to First Nations and Inuit control, within a time frame to be determined through consultation; - health inequalities and disease threats addressed according to First Nations' priorities; and - effective implementation of a clear mandate for the Non-Insured Health Benefits program.

To provide Canadians with:	To be demonstrated by:
Population Health Strategy A more integrated, balanced approach to the health concerns of Canadians.	- action in partnership with the provinces and others to promote health and prevent disease, with an emphasis on healthy child development.
Priority Setting and Management Core Better information for health-related decisions.	- improved data on the impact of environmental contamination on human health; - public health intelligence networks that include data regarding determinants of health; - strengthened capacity for intelligence on aboriginal health; - establishment of a Health Services Research Fund; - the development of a health research agenda for Canada; - pilot projects for health applications of the information highway; and - funding for Centres of Excellence for Women's Health.

C. Details by Activity

Food Safety, Quality and Nutrition

Objective

To protect and improve the well-being of Canadians by defining, advising on and managing risks and benefits to health associated with the food supply.

Figure 22: Financial Performance

	1993-94 Actuals		1994-95 Actuals		1995-96 Estimates		**1995-96 Actuals**	
	$000	FTE	$000	FTE	$000	FTE	**$000**	**FTE**
Food Research, Evaluation and Standards	25,825	347	28,413	357	27,872	364	**22,996**	**311**
Food Inspection and Compliance	37,247	474	29,347	399	35,635	467	**25,280**	**393**
Program Review adjustments to be allocated					811			
Pest Management Regulatory Agency							**21,468**	
Sub-total	63,072	821	57,760	756	64,318	831	**69,744**	**704**
Less: Revenue credited to the Vote							**(231)**	
Total	63,072	821	57,760	756	64,318	831	**69,513**	**704**

* Full time equivalent (FTE) is a measure of human resource consumption based on average levels of employment. FTEs are not subject to Treasury Board control but are disclosed in Part III of the Estimates in support of personnel expenditure requirements specified in the Estimates.

Explanation of Change: The 1995-96 actual expenditures are $5.195 million higher than the 1995-96 Main Estimates. This is mainly due to internal tranfers.

Performance Information

The Department has primary responsibility for food safety and nutrition. To achieve this objective, it acts in concert with other departments, notably Agriculture and Agri-Food Canada and Fisheries and Oceans Canada. In addition, an Interdepartmental Committee on Food Regulation composed of federal departments who have food-related responsibilities and chaired by Health Canada, coordinates federal food regulation and inspection. It reports periodically to Cabinet through the Minister of Health and acts as an expert advisory body to the Minister on food issues. The Committee also coordinates policy for the harmonization process arising out of Article 708 of the Canada-U.S. Free Trade Agreement, and provides expertise to address issues resulting from the North American Free Trade Agreement. Within the Canadian Food Inspection System (CFIS) initiative, the Department has the lead at the federal level for the development of food safety standards and policies.

The Activity is composed of two sub-activities: Food Research, Evaluation and Standards; and Food Inspection and Compliance.

Food Research, Evaluation and Standards: In 1995-96, nearly 200 mandatory pre-market evaluations of food additives were completed. In addition, 2,782 voluntary submissions of food packaging materials and incidental additives were carried out, representing the completion of 98.8% of food packaging material submissions carried over from the previous year and 86% of new submissions. Projects other than pre-market evaluations, including but not limited to public inquiries, briefings and media contacts, totalled more than 3,000 in all areas involving chemicals in food.

Mandatory pre-market evaluations of new veterinary drugs in 1995-96 totalled 407, a decrease of 17% from 1994-95. An additional 93 reviews (an decrease of 29% over 1994-95) relative to cleared new veterinary drugs were also conducted. Mandatory pre-market reviews of 298 Drug Identification Number applications for new veterinary drugs (a doubling of applications in comparison to 1994-95), were completed in 1995-96. Mandatory review of applications for Experimental Studies Certificates to allow investigators to conduct clinical studies with unapproved veterinary drugs increased slightly to 178 in 1995-96 (176 in 1994-95), while Emergency Drug Release requests from veterinary practitioners also increased slightly to 872 in 1995-96 (869 in 1994-95).

In 1995-96, a total of 20 submissions were reviewed and evaluated. Nine were related to novel food notification and eleven concerned food irradiation, genetically modified enzymes, cleaners, food additives, or ingredients and pesticides.

In 1995-96 analytical methods were developed for pyrethroid neutral metabolites, the herbicide difenzoquat, and for soya allergens in foods. New methods were also developed for nitrosodibutyl- and dibenzylamines in hams, volatile contaminants in bottled water, a fumonisin in beer, and paralytic shellfish toxins. Technology for the determination of peanut protein in foods was licensed commercially. A methodology for the determination of lead was transferred to a laboratory in Turkey to enable them to become compliant with Canadian requirements. In the food colour certification program, 264 colour samples were certified and four manufacturers were audited with successful results.

As part of a national exposure study, PCBs were measured in human plasma from the Maritimes and Quebec. Human milk was surveyed and found to contain PCB metabolites which are potent inducers of liver enzymes. Corn-based foods were found to contain fumonisin B1 and AP1, and a survey of coffee indicated the presence of ochratoxin A.

A sampling device for the determination of presence of bacteria on food contact surfaces was developed and patented. This non-destructive surface sampler has been licensed to a commercial firm.

An Interdepartmental Working Group on Food Safety Research comprising representatives from Health Canada, Agriculture and Agri-Food Canada, and Fisheries and Oceans Canada was struck to identify priorities in areas of food safety, to foster collaboration, and to minimize overlaps and duplication in food safety research.

A collaboration was established with the Food and Nutrition Board of the U.S. National Academy of Sciences to harmonize the American and Canadian Recommended Nutrient Intakes. A harmonized set of recommendations will simplify their implementation with respect to nutrition education materials aimed at improving public health, and will lessen trade impediments which currently result from two sets of standards. Departmental liaison members have been appointed to the oversight committee and the sub-committee to establish safe upper levels of nutrient intake. Other Canadian scientists have been appointed to the various expert panels, which are now starting to formulate the recommendations.

In 1995-96, 85 health hazard evaluations, 27 requests for advisory opinions, and over 200 Ministerial briefings, media contacts and consumer inquiries concerning the safety of foods due to microbial or extraneous material contamination were completed. Class I recalls, where a potential life-threatening hazard was involved, were recommended six times, and class II recalls, where a potential health hazard was involved, were recommended eight times.

Efforts are being made to continue the development of a model for assessing the risks of pathogens in meat, poultry and dairy products. A one-day workshop was held on the "Voluntary labelling of ground meats and raw poultry with safe handling instructions". This workshop included participants from the meat industry and representatives from different levels of the government. In addition, a one-week workshop on "Rapid Biotechnological Methods for Detecting bacteria in Foods" was held.

The electronic version of the Departmental Office Consolidation of the *Food and Drugs Act and Regulations* and an overnight fax service for regulatory amendments published in the Canada Gazette remain in operation. These activities are provided to the private sector on a fee for service basis.

In 1995-96, under the CFIS initiative, the Department participated in the development of the National Dairy Code and continued to participate in the development of codes in other industry sectors. As well, through CFIS, the Department presented a national risk analysis framework.

Food Inspection and Compliance: As mentioned on page 13, in July of 1996, the Department transferred most of its responsibilities for food inspection under Phase I of the transition to the new Food Inspection Agency. With its previous mandate, the Department engaged in the following activities in the Food Inspection and Compliance sub-activity:

- surveillance of domestic and imported foods through plant inspections and laboratory analyses to determine conformity with standards of safety and nutritional quality.

  In 1995-96, the following compliance actions were undertaken:

Food Inspections	1,403
Consumer Complaints	3,052
Food Samples Analyzed	12,305
Service to Industry and Science Canada	2,207

In 1995-96, the regional staff conducted 1,328 inspections of non-registered establishments. New regulations have been proposed to incorporate GMP requirements into the Food and Drug Regulations.

- responding with effective crisis management, including public alerts and notification, when product or process failures do occur in the food system;

- auditing the health and safety aspects of food inspection conducted by other federal departments;

- developing and promoting the use by the food industry of Good Manufacturing Practices (GMP) assessment guidelines, and assessing major food industries for compliance with good manufacturing practices;

Good Manufacturing Practice Regulations are being proposed as a Food GMP Division of the *Food and Drug Regulations*. In conjunction with these proposed regulations are inspection standards which are being developed for those specific commodities that are considered to be potentially hazardous, such as low-acid canned foods. These inspection standards describe in detail the acceptable practices that are required to manufacture in conformance with this division of the Regulations. The standards are designed in such a manner that they will accommodate alternate manufacturing controls and new technologies. Their intent is to assure a common inspection approach in interpretation and compliance action by all regulatory agencies. As of July 1, 1996, with the implementation of Phase I of the creation of the new Food inspection Agency, the initiative on inspection standards became the responsibility of Agriculture and Agri-food Canada.

Interpretative guidelines for the GMP regulations are being developed to further elaborate the generally applicable principles and practices that are acceptable in order to facilitate compliance by manufacturers and importers with the proposed Regulations.

- carrying out cooperative programs with federal, provincial and municipal agencies engaged in food surveillance and corrective action; and improving coordination of the federal-provincial food regulatory system and data exchange through the coordinating committees (involving federal, provincial and municipal officials); and

- maintaining effective liaison with Canada's trading partners to exchange information on marketed products.

At the national level, the Department participates in the Import Sub-committee of the Interdepartmental Committee on Food Inspection, resulting in improved coordination and cooperation between departments involved in the inspection of food imports. The sub-committee has produced an interdepartmental guide for importers of food products which provides an overview of the regulatory requirements for imported food and the federal departments involved in food inspection.

The Department works closely with Foreign Affairs and International Trade Canada, providing scientific expertise in support of international trade disputes over food products. With Revenue Canada, the Department is working to establish electronic links and gain electronic access to import information. Such access would result in improved monitoring of food imports.

Drug Safety, Quality and Effectiveness

Objective

To protect and improve the health of Canadians by:

- assessing, effectively and efficiently, the benefits associated with the manufacture, sale and use of drugs and by taking the appropriate action;
- promoting the scientific approach of risk/benefit assessment;and
- developing and disseminating information that encourages the rational use of drugs.

Figure 23: Financial Performance

	1993-94 Actuals		1994-95 Actuals		1995-96 Estimates		**1995-96 Actuals**	
	$000	FTE	$000	FTE	$000	FTE	**$000**	**FTE**
Drug Safety and Effectiveness	37,191	360	37,357	415	30,655	353	**35,601**	**431**
Control of Dangerous Drugs	21,965	93	22,613	96	17,737	147	**24,962**	**83**
Quality of Marketed Drugs	10,365	209	13,560	205	9,895	189	**11,723**	**204**
Program Review adjustments to be allocated					969			
Sub-total	69,521	662	73,530	716	59,256	689	**72,286**	**718**
Less: Revenue credited to the Vote							**(10,626)**	
Total	69,521	662	73,530	716	59,256	689	**61,660**	**718**

* Full time equivalent (FTE) is a measure of human resource consumption based on average levels of employment. FTEs are not subject to Treasury Board control but are disclosed in Part III of the Estimates in support of personnel expenditure requirements specified in the Estimates.

Explanation of Change: The 1995-96 actual expenditures are $2.404 million higher than the 1995-96 Main Estimates. This is mainly due to:

	($000)
• additional resources for prosecution services, recovery initiatives and the National Biotechnology Strategy; and	12,489
• internal transfers.	(9,987)

Performance Information

Drugs Directorate Renewal, the comprehensive change process started in 1993, was formally completed in August, 1995, to be superseded by implementation of the Strategic Framework for the Drugs Program Quality Initiative.

The Strategic Framework is the logical continuation of Renewal, and will result in a revitalized and streamlined drug regulatory program which will take Canada into the 21st Century. It is composed of several major elements, including a revised regulatory framework based on risk management principles and a drug licensing framework. The licensing framework encompasses the concepts of categorization of the pre-market assessment of drugs based on risk, licence classes for products based on post-market assessment of risk/benefit and the periodic reassessment of the risks associated with products prior to re-licensing. Combined with licensing of manufacturers, this will provide a risk-based mechanism for the regulation of drugs in Canada.

The 1994-95 Program Review resulted in the Drugs Program defining a three-year plan for the introduction of revenue generation through fees for Program services. The first stage, annual fees for authority to sell drugs, was implemented in January, 1995, and was followed in September, 1995, with submission evaluation fees, in January, 1996, with drug master file fees, and in May, 1996, with fees for export certificates. With the introduction of establishment license fees, anticipated in January, 1997, the Drugs Program will be over 60% funded through revenue.

The introduction of cost recovery has not been without problems. However, there have also been benefits. The introduction of submission evaluation fees required the Program to deliver on efforts already under way to improve performance of the drug review process. Performance targets had been defined, a stringent policy governing the management of submissions implemented, and emphasis placed on the reduction of backlogs of old submissions. A computer-based submission tracking system had been introduced in 1994, and enhanced with the introduction, in 1996, of the capability for industry to query the status of their own submissions. Industry insistence that fees for submission review were only acceptable if review times were improved to match those of leading countries led to a study of other countries' review systems, which provided the evidence that Canadian drug review performance, while still somewhat slower in some areas, had improved to the point that it was competitive with the best in the world. Further improvements are still being made.

Initiatives are under way to set Program strategy in the areas of inspection, investigation and analysis. These initiatives will result in better focussed, more consistent and higher efficiency post market surveillance activities. The anticipated introduction of an establishment licensing framework will also help in this regard.

Liaison activities with national industry and health professional groups have been coordinated and strengthened over the past year. The Program now meets with thirteen industry or health professional groups on a regular basis, between two and six times per year. As well, senior management participate in several international initiatives, including Tripartite, Trilateral, and International Conference on Harmonization meetings. An infrastructure is in place to ensure that management is well briefed prior to these meetings, with appropriate staff experts attending as necessary. This activity is critical to maintaining an effective relationship with client and stakeholder groups, as well as with other regulatory agencies. The open and responsive nature of these meetings have been cited as a key reason for the improved relationship with client and stakeholder groups.

Systems for obtaining expert advice have been strengthened and regularized through the design and implementation of two new Expert Advisory Committees, the EAC on New Active Substances and the EAC on Non-prescription Drug Regulation. This increases the total number of such committees to five (existing committees include the EAC on Blood Regulation, the EAC on HIV Therapies, and the Canadian Adverse Drug Reaction Advisory Committee). The committees are designed to provide advice on matters of science and policy within their respective areas. Members of these committees also serve on appeal committees when appropriate and required. Each committee is supported by an internal working group, to identify and develop the issues being put

forward for advice. These committees enable the Drugs Program to systematically consult with outside experts, thereby obtaining valuable input into the decision-making process.

The Drugs Program has continued to put significant effort into developing and implementing a Continuous Learning and Development (CL&D) Program, which is instrumental in managing the provision of training and development opportunities for Program staff. As an example, the Program recently launched a management development initiative, designed to provide internal opportunities to staff interested in pursuing careers in management. This initiative complements the Health Protection Branch Management Development Program, by providing beginner or intermediate level assignments. A full CL&D curriculum has been developed for courses not otherwise available, or only available at much higher cost. The courses are available to all staff meeting selection criteria, based on job need.

Organizational changes have been made to increase efficiency within the Program. The most recent change has been the amalgamation of the former Bureaux of Non-prescription and Prescription Drugs, into the Bureau of Pharmaceutical Assessment (BPA). It is expected that this merger will increase consistency in reviews, as well as allowing for operational efficiencies by combining units with similar functions. The formation of BPA is the latest step in the Program's examination of the optimum organizational structure, which has already resulted in reorganization and refocusing of activities in a number of other Bureaux.

As part of the transition from the Drugs Directorate Renewal, the Program has taken the first steps toward the Drugs Program Quality Initiative. The objective is to instill a philosophy which promotes quality and continuous improvement. To date, progress has been limited to an orientation session for all Program managers, the appointment of a Quality Coordinator and the formation of a sub-committee of the Drugs Program Management Committee, responsible for quality.

The Drugs Program is a leader in developing electronic templates for filing comprehensive summaries of submission data, and a key player in international efforts to enable filing of drug submissions electronically. The Drugs Program has also been a key player in the pursuit of Mutual Recognition Agreements (MRAs) on the acceptance of inspection results with the European Union, the U.S. and Japan. Once fully developed, these MRAs will allow conclusions regarding compliance of manufacturers with Good Manufacturing Practices to be provided to, and accepted by, all signatories to the Agreement, thereby eliminating the need for foreign inspections or assessment of foreign inspection reports as is now the case. In yet another area, Canada has been involved with the development of international agreements on the control of active pharmaceutical ingredients, having been selected to chair the Asia-Pacific Economic Conference delegation to an upcoming World conference.

Finally, one area where significant progress has been made, is in the conversion from a “Drugs Directorate” culture to a “Drugs Program” culture. This change, while superficially a name change, reflects a change in mind set which recognizes that the Drugs Program consists of a variety of functions and activities undertaken in Ottawa and across Canada, and that all units play a critical role in meeting the objectives of the Program. Communication is critical to making this change work, and the development of a Drugs Program bulletin board system available to all Program staff is an important early measure. The result is a greater understanding by all staff of their role in the Program as a whole, and elimination of the ususal “headquarters-regions” class structure.

The Program still has some way to go in improving efficiency and performance to the degree possible, but evidence that things are on the right track can be seen in the improved relationships and changed environment with most client groups with which the Program deals.

Environmental Quality and Hazards

Objective

To protect the health of Canadians by identifying, assessing and managing the risks to health and safety and benefits associated with the natural and technological environments, with marketed radiation-emitting and medical devices and with chemical and other consumer products.

Figure 24: Financial Performance

	1993-94 Actuals		1994-95 Actuals		1995-96 Estimates		**1995-96 Actuals**	
	$000	FTE	$000	FTE	$000	FTE	**$000**	**FTE**
Environmental, Occupational and Medical Device Hazards	41,998	383	46,424	377	41,701	384	**43,064**	**396**
Medical Device Quality	3,499	43	2,854	32	3,127	49	**999**	**33**
Product Safety			9,736	124	16,666	151	**8,064**	**126**
Program Review adjustments to be allocated					(2,828)			
Sub-total	45,497	426	59,014	533	58,666	584	**52,127**	**555**
Less: Revenue credited to the Vote			(2,655)		(2,971)		**(2,746)**	
Total	45,497	426	56,359	533	55,695	584	**49,381**	**555**

* Full time equivalent (FTE) is a measure of human resource consumption based on average levels of employment. FTEs are not subject to Treasury Board control but are disclosed in Part III of the Estimates in support of personnel expenditure requirements specified in the Estimates

Explanation of Change: The 1995-96 actual expenditures are $6.314 million lower than the 1995-96 Main Estimates. This is mainly due to:

	($000)
• internal transfers; and	(8,396)
• additional resources for cost recovery initiatives and the National Biotechnology Strategy.	1,491

Performance Information

Under the Health and Environment Program, the Department continues its efforts to examine the effects of air pollution on the health of Canadians (Air Health Effects Program). This hazard assessment research is focusing on three areas of expertise, animal toxicology, human (clinical and epidemiologic) studies and exposure assessment. The primary pollutants of concern are ground-level ozone, airborne particles and hazardous air pollutants. Toxicological evidence has been produced which suggests that the aging lung may be more susceptible to air pollution insults than previously assumed. Canadian epidemiologic studies have suggested that permanent lung function loss in children may be associated with exposure to air pollutants. Studies have shown increased

hospitalization, emergency department visits for cardio-respiratory illness, and other health care costs have been strongly associated with air pollution. Investigations conducted through this program have identified that current air quality guidelines and emission control measures may not be protective of Canadians. Many national initiatives and strategies to reduce air pollution require detailed assessments of the health risk and benefit to be derived to protect public health effectively and efficiently. The results of this program will promote improving air, establish appropriate air quality guidelines and support the multi-billion dollar industry of pollution mitigation strategies at the national and international level.

The Department demonstrates its active approach to addressing concerns related to the effects of environmental contaminants on human health through its actions under the Canadian Environmental Protection Act (CEPA). Risk assessments for existing and new substances and biotechnology products provide guidance in the development of domestic risk management measures. They also have contributed, and will continue to contribute, to international efforts aimed at assessing the risks to human health posed by environmental contaminants. Health risk assessments for several of the 25 substances selected for the Second Priority Substances List (PSL-2) under CEPA have been initiated. All PSL-2 assessments are scheduled for completion by 2001.

Of the backlog of 5,000 notifications made by industry shortly after the New Chemicals Notification Regulations (under CEPA) came into force, 1,600 have been assessed for impacts on health. Assessments of these notifications will continue through 1997-98. In addition, assessments will continue for new chemical notifications submitted by industry on an on-going basis of approximately 600 per year.

Product safety is a major health issue in Canada. Consumer product-related accidents are estimated to result in 220,000 injuries, 2,000 deaths and have social costs of $2.8 billion per year. Injuries are the number one cause of death for children between 1 and 15 years of age. Since the *Hazardous Products Act* was promulgated in 1969, the rate of product-related fatalities among children has decreased from more than 90 deaths per 100,000 of population to less than 20 per 100,000. Enforcement of regulations under the *Hazardous Products Act* and safety information campaigns have been important contributing factors to this decrease. The 1997 amendment to the *Ice Hockey Helmets Regulations* is designed to enhance head injury prevention among ice hockey players, especially among the younger players.

Harmonization of product safety standards, in particular the *Toys Regulations* under the *Hazardous Products Act*, is on-going with the U.S. through discussions under the provisions of a Memorandum of Understanding between the Department and the U.S. Consumer Product Safety Commission. The Product Safety Bureau assumed the lead role in coordinating the Canadian position and representing Canada in international discussions on harmonization of requirements related to hazardous chemicals labelling and notification systems. Harmonization efforts are aimed at increasing the effectiveness of regulatory schemes and reducing compliance and enforcement costs of regulations.

Reacting to the unexpected identification of health hazards in mini blinds in the United States, the Product Safety Program managed the crisis of the hazardous lead levels in imported PVC blinds in Canada. During the Summer of 1996, Product Safety staff conducted an extensive investigation of the public risk from these products. This required discussions with affected industries, coordination with other departments and governments and management of the various aspect of this highly publicized issue.

Under the Health and Environment initiative, the Department continued to assess the effects of noise, electromagnetic fields and solar radiation on the health of Canadians. Public education is essential to reduce the incidence of skin cancer and its expensive, adverse effects on the health care system. Research was conducted on the influence of magnetic fields on cancer development, on the potential effects of aircraft flyover noise on the immune system and on UV-induced damage in human skin cells. Results of this risk identification research will enable the Department to formulate appropriate risk management decisions for these emerging public health concerns.

The National Dosimetry Services (NDS) in 1995-96 provided radiation monitoring services to approximately 105,000 workers at 12,000 organizations across the country by issuing and evaluating some 525,000 personal dosimeters (devices worn by workers to determine exposure to ionizing radiation). The NDS is now financially self-sufficient, depending entirely on the revenue generated by the charges made to its clients. Exposure records from the NDS are forwarded to the National Dose Registry (NDR). Including input from nuclear power generating stations and uranium and hardrock mines and commercial dosimetry processors, the NDR now maintains radiation exposure records for over 500,000 Canadian workers.

Several large-scale epidemiology studies are currently under way using the information contained in the NDR. One study involving dose records for just over 200,000 individuals has been completed and the results will be published this year. These data have been linked to the Cancer Mortality Database maintained by Statistics Canada and analyzed for trend and risk estimates. A second study, that of cancer incidence, is entering the analysis phase. Similarly, a third one, involving international collaboration with the International Agency for Research on Cancer, is to begin its analysis phase in 1997. Improvements in both the NDS and NDR operation contribute to a more cost effective approach to delivering these programs. In addition, these changes further enhance the level of protection from possible radiation over-exposure for Canadian workers.

The Development Plan for an Improved Medical Devices Regulatory Program has been put into effect. Risk-based classification systems for medical devices and for in-vitro diagnostic devices have been developed. New regulatory requirements based upon risk classification, have been written to better address safety and efficacy issues and will be published in *Canada Gazette*, *Part I*, during 1997. The regulations, which allow Canada to monitor the entry of new medical devices onto the Canadian market, are written to ensure that resources are allocated according to the risk/hazard posed by the device. This removes unnecessary regulatory burdens from the manufacturers of low risk devices and affords an appropriate level of scrutiny for high risk devices to adequately protect the Canadian public. Industry and all other stakeholders have been involved in a consultative process in the development of these regulations to ensure that they deliver both a satisfactory level of service to industry and adequate protection for the consumer/user. Third party review of quality systems/good manufacturing practices is part of the new regulatory package.

National Health Surveillance

Objective

To provide national leadership and coordination in the identification, investigation, monitoring and control and prevention of human disease through national surveillance and disease control programs.

Figure 25: Financial Performance

	1993-94 Actuals		1994-95 Actuals		1995-96 Estimates		**1995-96 Actuals**	
	$000	FTE	$000	FTE	$000	FTE	**$000**	**FTE**
National Health Surveillance and Disease Control Programs	59,505	275	38,854	294	31,786	259	**35,930**	**324**
Add: Program Review investment					11,637			
Total	59,505	275	38,854	294	43,423	259	**35,930**	**324**

* Full time equivalent (FTE) is a measure of human resource consumption based on average levels of employment. FTEs are not subject to Treasury Board control but are disclosed in Part III of the Estimates in support of personnel expenditure requirements specified in the Estimates.

Explanation of Change: The 1995-96 actual expenditures are $7.493 million lower than the 1995-96 Main Estimates. This is mainly due to internal transfers.

Performance Information

The focus of activities was on the reinvestment and strengthening of national surveillance and disease prevention and control, as described in LCDC's Re-Investment Action Plan, and the planning of the relocation of the Bureau of Microbiology to Winnipeg. The surveillance areas being strengthened are based both on federal and provincial-territorial priorities, and reflect the highest ranked causes of illness, disability, death and health care costs in Canada. The targeted public health areas include cancer, blood-borne pathogens, perinatal health surveillance, cardio-respiratory disease, sexually transmitted diseases, infectious respiratory diseases and tuberculosis, nosocomial infections and occupational health, emerging pathogens, foodborne and enteric diseases, vaccine preventable diseases in infants and children, laboratory diagnostic and surveillance, and international surveillance.

Surveillance networks reduce system fragmentation and build on the investments already made by the provinces and territories. The Department's decision to strengthen work in national surveillance and disease control represents a major commitment to the provinces and territories. There is strong support for this from the provinces, and consensus that public health intelligence will pay significant dividends, through early detection of emerging health threats, and cost effective targeting of interventions.

Perinatal Health Surveillance: The Canadian Perinatal Surveillance System (CPSS) contributes to the health of mothers and babies by providing important, timely and relevant information on trends and disparities in perinatal health in Canada. A high-profile multidisciplinary steering committee is guiding the development of the system and has helped achieved the following accomplishments:

- expert analyses of existing national health databases for maternal and child health;

- implementation of several record linkage studies to increase knowledge on determinants of fetal and infant mortality and maternal health;

- establishment of a working list of national perinatal health indicators;

- strengthened links with international agencies for global surveillance of perinatal outcomes; and

- publication of the first CPSS Progress Report.

Healthy Child Development: Through a series of consensus conferences, the Department is developing and establishing national immunization goals for major vaccine preventable diseases in infants and children (eg. Rubella, mumps, diphtheria, tetanus, polio, Haemophilus influenza B, hepatitis and measles) . The goal of measles elimination was adopted as the first national health goal at the Conference of Deputy Ministers of Health in December, 1995, and the Department will seek approval for the remaining goals at the Conference of Deputy Ministers of Health in December, 1996.

In support of the national goal of measles elimination, LCDC has established a National Centre for Measles and has become an international partner in the PAHO Measles Laboratory Network. The National Centre facilitates communication and provides specialized services to all regions of Canada. A two-dose measles schedule was implemented in 11 provinces/territories and catch-up campaigns were implemented in at least seven provinces.

In the areas of injury surveillance and cancer control, LCDC has initiated the following:

- Canadian Hospitals Injury Reporting and Prevention Program (CHIRPP): an emergency room-based injury surveillance system is operating in 10 pediatric and 6 general hospitals across Canada collecting information on the circumstances and environments in which injuries occur.

- child maltreatment surveillance: a new program has been created in collaboration with federal, provincial and territorial governments, health professionals, child welfare agents, non-governmental associations and academics.

- Canadian Childhood Cancer Surveillance and Control: this year's major accomplishments include the production of a Canadian childhood cancer monograph entitled "*This Battle Which I Must Fight; Cancer in Canada's Children and Teenagers*", targeted at the general Canadian public. A Manitoba childhood cancer economic burden evaluation and a national survey of parents of children with cancer have been initiated to assess the financial impact of the disease and better understand access and utilization of non-medical care.

- Asthma Incidence Surveillance System for pre-school children: the system has been established in the western provinces where childhood asthma mortality rates are the highest, and is being extended to eventually include all Canadian provinces.

Cancer Prevention and Control: LCDC continues to be active in a number of high priority cancer areas including: skin, prostate, brain, cervical, colorectal, breast, lung and childhood cancer.

The Canadian cancer projection system has produced national age-sex cancer incidence and mortality projections for colorectal, prostate, breast, melanoma and all cancers combined. The system will be used by the provincial cancer registries and LCDC to achieve consistent long-term cancer projections in Canadian provinces.

The health burden of cancer was quantified in a report on the direct and indirect costs associated with cancer in Canada. The report provides essential information for decision makers on the economic consequences of failing to prevent cancer.

Canadian Cancer Statistics 1996, an annual monograph, was produced jointly with the National Cancer Institute of Canada, Statistics Canada and provincial/territorial cancer registries. In addition, maps and tables for the first Canadian Cancer Incidence Atlas have been completed.

Development of a palliative care surveillance system is being coordinated with key stakeholders, whereby routinely collected information on palliative care patients will be used to describe access to palliative care services, symptomology, and interventions.

Cardio-Respiratory Diseases (CRD) and Diabetes: Existing Canadian cardio-respiratory diseases and diabetes databases are being consolidated to create a national database. The Activity has established CRD surveillance networks with other stakeholders and is collaborating with key organizations to develop pilot projects. The Activity has also been regularly providing surveillance information to stakeholders in the areas of coronary heart disease, stroke, asthma and diabetes. A multi-sectoral National Asthma Control Task Force has been established to develop and implement a national asthma control strategy for the effective prevention and control of asthma in Canada.

National Surveillance: Through the field epidemiology and training program, ten public health trainees provide service to agencies and institutions; support is being provided for surveillance of infectious diseases and other health risks; and follow-up is provided for targeted studies such as determinants of childhood immunization, cancer clusters, and risk assessments for novel agents. Co-operation was initiated with sixteen other countries to ensure that training objectives and evaluation standards remain relevant to global public health. Through the emergency response capacity, field epidemiologists participated in eighteen major investigations or surveillance studies last year.

The Sentinel Health Unit Surveillance System (SHUSS), a network of nine public health units, is developing and evaluating surveillance and research methodologies to address targeted public health issues. Information is being collected for analysis at both the regional and national levels on incidence/prevalence, demographic and risk factors for a range of health issues, particularly on children's health issues.

Infectious Diseases: LCDC is collaborating with the Canadian Infectious Disease Society to revise the Infection Control Guidelines series.

A pilot sentinel physician surveillance activity was initiated with the Canadian College of Family Physicians. A national meeting on influenza surveillance was held to review the project's outcomes and make recommendations on the expansion of the pilot for national surveillance.

Tuberculosis (TB): A National Expert Committee on Tuberculosis (ECOT) and a federal- provincial-territorial TB control committee have been established. ECOT is addressing five key areas related to TB prevention and control: TB in aboriginal people, case management, HIV and TB co-infection, immigration, and laboratory. At a future conference, a national strategy for the prevention and control

of TB with recommended standards and priorities will be developed through a consensus process with key stakeholders.

The federal-provincial-territorial TB control committee is continuing national co-ordination of provincial TB programs. A common position on national management procedures to manage immigrant and travel-related cases has been developed and the TB surveillance reporting form and database have been redesigned.

Foodborne and Enteric Diseases: A National Consensus Conference on Foodborne/Enteric Disease Surveillance was held in November, 1995, and a summary of the proceedings published in the June, 1996, issue of Canada Communicable Disease Report. Sixty-five specific recommendations to enhance the national foodborne, waterborne and enteric disease surveillance system resulted from the consensus conference, including the creation of a national technical steering committee.

This National Technical Steering Committee on Foodborne/Waterborne/Enteric Disease Surveillance is composed of relevant federal, provincial and regional agencies and the water industry. They first met in June, 1996, to set common priorities and to identify specific surveillance strategies and action plans. As an outcome of the consensus conference, a pilot project to enhance the timeliness of laboratory surveillance of selected human-borne diseases was initiated with five provinces.

Blood-borne Pathogens: An expert steering group on blood-borne pathogens has been established and a forum was held at the end of May, 1996, to provide the most up-to-date information to all concerned stakeholders on blood-borne diseases. Strengthening of surveillance and detection activities, the initiation of targeted risk assessment studies and information exchanges on blood-borne pathogens continue to be the focus of the main activities. Funding has been provided to provinces, health care facilities and NGOs to define risk factors for hepatitis C, the long-term consequences of hepatitis C and for a national general education program on hepatitis C.

Sexually Transmitted Diseases (STDs): To help control the spread of STDs, routine monitoring where infections are occurring, studies of the risk factors involved in the transmission of the virus, and studies of the rates of change in different populations are being conducted. Enhanced surveillance of STDs continues in targeted populations including aboriginal, street youth and the incarcerated. Data analysis is being shared with those health professionals who provide STD care and treatment and those concerned with the economic impacts of the epidemic. In addition, national consensus on STD goals and national guidelines for chlamydia screening are also under way.

International Surveillance: LCDC is working in collaboration with the G-7 Global Public Health Information Network nations to improve worldwide cooperation in public health by bridging the developments in G-7 countries' public health networks and international health organizations. Two areas have been selected for initial cooperation, public health early warnings and communicable diseases, and vital statistics. The G-7 project will work towards linking regional public health information networks as they evolve. The first two emerging regional networks are the Pan American Public Health Information Network led by LCDC and the European Union Public Health Information Network lead by the European Commission.

A feasibility study to test the early warning system and communicable disease system has been successfully completed. In the area of tropical medicine and travel, the Department provides advice to the Canadian public and continues to prepare statements and recommendations for travellers. This information is made available by the Committee to Advise on Tropical Medicine and Travel and is accessable through a FaxLink system.

Information Dissemination: The creation of a central information dissemination capacity became operational in April, 1996, and activities are under way to disseminate timely and targeted surveillance and disease control information to public health partners and clients across Canada and internationally. Internal and external advisory structures have been established to provide a strong client focus to LCDC's dissemination activities. The electronic dissemination area has been strengthened to expand the FaxLink services to target client groups and to establish a web site in lieu of the old BBS system. The web site, launched in October, 1996, will give LCDC a dynamic presence on the world wide web as part of the Department's Canadian Health Network. The site will be a key resource for the public health community in Canada and abroad. Restricted access sections within the site will be utilized for surveillance and policy development work with key partners (e.g. the Committee of Chief Medical Officers of Health).

Pest Management Regulatory Agency

Objective

To protect human health and the environment by minimizing the risks associated with pest control products, while enabling access to pest management tools, including sustainable pest management strategies.

Figure 26: Financial Performance

	Actual 1993-94		Actual 1994-95		Estimates 1995-96		**Actual 1995-96**	
	$000	FTE*	$000	FTE	$000	FTE	**$**000	**FTE**
Applications Review	—	—	—	—	—	—	**12,451**	**162**
Compliance	—	—	—	—	—	—	**6,440**	**84**
Policy and Communications	—	—	—	—	—	—	**2,577**	**34**
Sub-total	—	—	—	—	23,025	324	**21,468**	**280**
Less: Revenue credited to the Vote	—	—	—	—	(185)	—	**(231)**	**—**
Sub-total	—	—	—	—	22,840	324	**21,237**	**280**

* Full time equivalent (FTE) is a measure of human resource consumption based on average levels of employment. FTEs are not subject to Treasury Board control but are disclosed in Part III of the Estimates in support of personnel expenditure requirements specified in the Estimates.

In 1994-95, PMRA was not a consolidated organization. PMRA was established on April 1, 1995, through the consolidation of the responsibilities and resources for pest management regulation of four departments: Agriculture and Agri-food Canada, Environment Canada, Natural Resources Canada and Health Canada.

Explanation of change: The 1995-96 actual expenditures are $1.6 million lower than the 1995-96 Main Estimates. This is primarily due to:

	($000)
• delay in the co-location, staffing and purchase of capital equipment; and	(1,000)
• postponement of the development of a tracking system.	(600)

Performance Information

Since its creation on April 1, 1995 the Agency has:

- implemented a new organizational structure in which senior officers are expected to effectively promote an environment that encourages innovation, risk-taking, open communication, team building and continuous learning;

- introduced amendments to the *Pest Control Act* and *Regulations* which provide for a modern, effective legal foundation for the system;

- established an Alternatives Division to find efficient and effective approaches to integrating environmental sustainability into the Agency's functions;

- conducted consultations for the implementation of a cost recovery regime linked to standards of service following extensive analyses and consultation with the stakeholders; and

- consolidated pesticide regulatory activities from four departments to one agency.

I. Applications Review

During 1995-96, the Applications Review sub-activity:

- initiated the development of a submission tracking system which is a single tracking system that can electronically partition a data submission and track it through the evaluation and review process;

- reduced the number of submissions on hand in order to be in a position to achieve the new performance standards. Despite a constant number of new submissions annually, the work on hand for complex submissions and the total number of submissions are at an all-time low. In addition there have been 50% more minor use products approved in 1996 than in the previous year.

Figure 27: Submission Counts

Date	Type 1* On Hand	New Received Jan-July	All Types on Hand	New Received Jan-July
July 1, 1993	844	86	3272	1435
July 1, 1994	844	57	3027	999
July 1, 1995	914	60	3057	829
July 1, 1996	796	55	2660	981

* Type 1 was defined as a complex submission requiring interdepartmental reviews.

- achieved significant progress toward harmonization with the EPA;

- implemented a *Joint Review Policy for Reduced Risk Chemicals* with the EPA with a performance standard of 365 days;

- completed a project on integrated management strategies for late blight on potatoes, in partnership with the Canadian Horticultural Council and the Research Branch of Agriculture and Agri-food Canada and in conjunction with provinces, growers, pesticide manufacturers and the EPA;

- instituted a project on integrated management strategies for sea lice on salmon raised in aquaculture operations, in partnership with the Salmon Health Consortium and in conjunction with growers, provinces and pesticide manufacturers;

- initiated planning of a project on integrated management strategies for Colorado potato beetles with the cooperation of the Canadian Federation of Agriculture, the Research Branch of Agriculture and Agri-food Canada and in conjunction with the EPA; and

- harmonized environmental data requirements for registration of chemical pesticides with the EPA.

II. Compliance

During 1995-96, the Compliance sub-activity:

- implemented the delivery of a regional pesticide program;

- the *Administrative Monetary Penalty Act (AMP)* was passed by the Senate in December 1995, and steps are under way for its implementation starting in 1997. The Act will allow PMRA officials to issue fines for non-compliance with the *Pest Control Products Act*. The main goal of the AMP Act is to obtain compliance rather than to punish. The system is therefore amenable to negotiated solutions to a non-compliance. Because the AMP Act is more efficient and cost-effective than the prosecution process, it will allow PMRA to increase its enforcement activities;

- PMRA laboratories provided scientific, technical and analytical support to the Agency's registration and compliance activities;

- performed over 1,500 analyses for guarantee, micro contaminants, and residues in support of the investigation (short turnaround time in response to complaint and/or legal samples) and compliance testing programs; and

- in May, 1995, the Ottawa laboratory successfully passed a Standards Council of Canada quality system audit and maintained its ISO accreditation status.

III. Policy and Communications

During 1995-96, the Policy and Communications sub-activity:

- conceived, organized and implemented a world wide web site for the PMRA resulting in a 24 hours, 365 days per year window for PMRA clients to access the Agency's documents, and an arena for external consultation on major policy papers;

- completed the conversion of the registered product labels into label text format giving the Agency a complete collection of retrievable label text for all the 7,000+ registered products thereby adding efficiency to the review process and realizing considerable time savings; completed an electronic label review whereby incoming draft labels can be reviewed electronically thereby reducing the label review time;

- produced a new use report called Updates, which captures timely, clear and factual information on the regulatory activities that are relevant to stakeholders;

- developed and published the following policies and guidelines in the format of Regulatory Directives:

- *Importation for Manufacturing and Export Program*, which sets out regulatory procedures and information requirements for registering pest control products imported solely for the purpose of manufacturing and export. This policy enhances the international competitiveness of the Canadian formulators;

- *Pesticide Export Guidelines* which provides information on the requirements for exporting pesticides under the current provisions of the *Pest Control Products Act and Regulations* and the *Canadian Environment Protection Act*, and reflects Canada's commitment to the International Code of Conduct on the Distribution and Use of Pesticides under the United Nations;

- *Guidelines for Efficacy Assessment of Fungicides, Bactericides, and Nematicides* which provides specific guidance for assessing efficacy of chemicals for control plant diseases caused by various pathogens;

- *Environmental Label Claims and Advertising of Pest Control Products* which outlines the regulatory position regarding environmental labelling and advertising claims on pest control products, thus avoiding misleading information; and

- *Aerial Application of Pesticides* which outlines a new policy that is intended to assist farmers and aerial applicators by clearly defining proper aerial uses and application instructions, as well as situations that are not suitable for aerial application.

- produced a set of draft guidelines for the implementation of good laboratory practice which is intended to ensure the quality and validity of test data and improve the ability of the Organization of Economic Cooperation and Development's member countries to accept each others' data. The document has been published for public consultation;

- prepared draft guidelines on pesticide resistance management labelling to provide a framework for labelling pesticide resistance management strategies;

- produced a new draft of the *Guidelines for the Regulation of Pheronomes and other Semiochemicals* that are virtually harmonized with the requirements of the EPA;

- instituted a new publication series entitled *Sustainable Pest Management Series*;

- initiated work under the North American Free Trade Agreement Technical Working Group on Pesticides for the development of harmonization in the area of drugs and pesticides used in aquaculture;

- worked with the EPA on spray drift data development and modelling. As a result of this collaboration, the PMRA and the EPA will have access to a model that has the capability to generate drift and deposit information for pest control products in both agriculture and forestry, for both ground and aerial application;

- developed a field residue mapping system for Canada to complement the USA map so as to maximize the use of pesticide residue data;

- initiated work under NAFTA on mapping of ecozones for field dissipation studies in North America; and
- participated in IPCS, OECD, and EPA programs for the purpose of harmonizing test and evaluation procedures and developing work sharing programs.

Programs and Services

Objective

To generate policies, programs, knowledge and strategies that are based on the determinants of health model (population-based), holistic in scope and application, and help to operationalize the Department's mission.

Figure 28: Financial Performance

	1993-94 Actuals		1994-95 Actuals		1995-96 Estimates		**1995-96 Actuals**	
	$000	FTE	$000	FTE	$000	FTE	**$000**	**FTE**
Operating Costs	62,863	411	70,382	544	91,514	548	**76,872**	**580**
Capital	1,163		1,411		274		**1,303**	
Grants	13,543		13,024		19,193		**14,760**	
Contributions	101,916		131,163		150,337		**145,004**	
Program Review adjustments to be allocated					(14,272)			
Total	179,485	411	215,980	544	247,046	548	**237,939**	**580**

* Full time equivalent (FTE) is a measure of human resource consumption based on average levels of employment. FTEs are not subject to Treasury Board control but are disclosed in Part III of the Estimates in support of personnel expenditure requirements specified in the Estimates.

Explanation of Change: The 1995-96 actual expenditures are $9.107 million lower than the 1995-96 Main Estimates. This is mainly due to:

	($000)
• lower than estimated expenditures for the Health Promotion Grants Program, the Health Promotion Contributions Program and the Seniors Initiative;	(18,600)
• higher than estimated expenditures for the National Health Research and Development Program, the Community Action Program for Children and the Child Development Initiative; and	8,400
• miscellaneous increased expenditures.	1,100

Performance Information

I. Population Health

During 1995-96, the Population Health sub-activity:

- completed the evaluation of the Child Development Initiative, highlighting initial program outcome achievements related to implementation and delivery;

- created national goals to ensure healthy child and youth development, and compiled them into *Turning Points: Canadians from coast to coast set a new course for healthy child and youth development*. Other significant achievements included:

  - the development of the *Joint Statement on the Prevention of Fetal Alcohol Syndrome and Fetal Alcohol Effects* in consultation with 19 national stakeholders;

  - the completion of a series of videos, *Adventures in Parenting*, aimed at increasing parental knowledge and understanding of their child's health, safety, development and behaviour; and

  - the development of a prototype of a National Child Health Record to promote awareness of the importance of healthy child development.

- funded 468 Community Action Program for Children (CAPC) projects. As CAPC funded projects reach the end of their first phase of funding, a national framework for renewal was developed in consultation with provincial joint management committees;

- funded 226 projects under the Canada Prenatal Nutrition Program on the recommendation of the provincial joint management committees. In consultation with various expert groups a multi-level evaluation framework was designed to generate impact and outcome measures at the community, provincial and national levels;

- developed a framework of mental health services for children and youth in Canada, and examined the best practices in integrated service and program delivery for children's mental health. This work was carried out by the Federal-Provincial-Territorial Working Group on the Mental Health of Children and Youth;

- completed the Partners for Children Fund, a response to enhance innovative international programs following the 1990 World Summit on Children. The projects demonstrated high youth participation and consistent promotion of the U.N. Convention on the Rights of the Child;

- supported Phase II of the multi-year Canadian Study on Health and Aging on the incidence and risk factors of dementias under the Seniors Independence Research Program;

- supported the National Advisory Council on Aging in its work, including the presentation of briefs to the government on the issue of retirement income and pensions, and the preparation of a variety of documents on health care;

- enhanced HIV/AIDS and drug use initiatives, e.g., established a National Task Force on HIV/AIDS and Injection Drug Use; funded the Vancouver Cohort Study of Injection Drug Users; directed prevention research concerning the broader determinants of HIV-related behaviours (including drug use) by marginalized men and women;

- worked with all provinces and territories on national approaches, such as *Guidelines for Partner Notification* on HIV infection; worked with various private sector partners to produce and disseminate *The Business Case for AIDS*; continued collaboration with Correctional Services Canada on addressing HIV/AIDS in federal prisons;

- supported a dramatic increase in the number of Canadian youth receiving effective tobacco prevention programming, as a result of the distribution of the school-based prevention program *Improving the Odds* to over 12,000 schools across Canada; increased knowledge of the specific needs of priority populations, such as women with disabilities, Aboriginal women, francophones and ethnic populations for access to appropriate tobacco control programming; developed resource material and training on media literacy skills regarding tobacco; assessed workplace non-smoking policies and programs; increased the number of organizations and individuals working in tobacco control activities;

- coordinated a project, in partnership with provincial and territorial governments, community groups and youth, to assist and facilitate diverse sites in Canada to undertake community development for at-risk youth. Valuable information was collected and will be distributed to a broad range of partners; best practices vis-à-vis community development processes and experiences related to at-risk youth will assist other communities to undertake similar processes;

- acting on recommendations from *Working Together: A National Workshop for Action on Women and Substance Use* (held in February of 1994) projects were initiated to explore and respond to the unique needs of rural women and immigrant women. *Rural Women and Substance Use: Issues and Implications for Programming* was developed to provide guidance for rural women and service providers on community development. As well, *Immigrant Women and Substance use - Current Issues, Programs and Recommendations* reflects a comprehensive literature review and report of consultations with key informants and program deliverers concerning substance use issues and programs specifically for immigrant women; and

- conducted Canada's Alcohol and Other Drugs survey from September to November, 1994, updating and expanding upon data collected in 1989. This endeavour was a major commitment of Phase II of Canada's Drug Strategy and was made possible through the collaborative efforts of each province and territory and key federal departments. It provides basic facts on alcohol and other drug use patterns, problems and consequences, and public attitudes regarding policies and programs.

Figure 29: Population Health Grants and Contributions Program

(thousands of dollars)	Forecast 1996-97	Actual 1995-96*	Actual 1994-95	Actual 1993-94
Target Area				
Health Promotion Grants and Contributions Program	3,330	3,513	4,072	4,355
AIDS	11,700	11,647	11,441	12,325
AIDS Care, Treatment & Support	8,038	8,772	—	—
Canada's Drug Strategy	1,520	5,112	7,372	7,624
Healthy Environment Program	—	—	1,161	950
Child Development Initiative (Brighter Futures)	1,079	6,915	749	590
Tobacco Demand Reduction Strategy	7,945	13,206	4,156	—
Community Action Program for Children & Prenatal Nutrition	57,960	44,665	35,255	14,579
Seniors	18,000	10,862	15,003	—
Aboriginal Head Start	16,275	5,413	—	—
Family Violence	—	1,311	7,011	—
Total	125,847	111,416	86,220	40,423

* 1995-96 figures reflect the new Population Health Directorate structure after the reorganization of the Health Promotion and Programs Branch.

II. Systems for Health

During 1995-96, the Systems for Health sub-activity:

- strengthened the capacity of networks to respond to key health issues through leadership and support to the development of strategic frameworks (e.g., Nutrition for Health: An Agenda for Action), national guidelines and program models (e.g., Comprehensive School Health);

- facilitated consensus among key stakeholders in the health system through the release of the federal-provincial-territorial report *Strategies for Population Health: Investing in the Health of Canadians* and development of the *Report on the Health of Canadians*, on the need to address the broader determinants of health through intersectoral action;

- facilitated and supported the initiation of national policy and program initiatives in conjunction with partner organizations. Accomplishments included: agreement by federal-provincial-territorial Ministers responsible for fitness that physical inactivity represents a significant health risk and that a framework for action should be developed to address this issue; facilitation of initiatives to address healthy environments and related issues such as the *Active Transportation Strategy* and the *Canada Sun Guide (UVA/UVB)*; initial support to the development of a federal-provincial-territorial Atlantic Canada Youth-at-Risk initiative involving healthy physical activity; federal-provincial-territorial consultations on the *Framework For Sexual and Reproductive Health*;

- advanced the availability of evidence-based knowledge on population health to decision makers and program leaders through the development and dissemination of resources including *Exploring the Links Between Substance Use and Mental Health*; and *The Health of Youth: A Cross-National Survey*;

- advanced the development and use of indicators of health, e.g., development of core nutrition-related indicators; and prepared *Shared Indicators of Health and Learning: Actions for Governments, School Districts, and Health Units*;

- assisted in the implementation of national and regional consultations with a range of stakeholders on innovative models for reorganizing primary care;

- produced and evaluated an inventory of current health services research activities in order to assist policy makers with their decisions concerning health care renewal and service delivery. This was done in collaboration with provinces and territories and with the support of various research centres;

- worked with le Collège des médecins du Québec, and le Collège des médecins de famille du Canada, section Québec, to help them develop a sophisticated interactive province-wide outreach program to implement the recommendations of the Task Force on the Periodic Health Examination. The Task Force's *Guide canadian de médecine clinique préventive* received the Prix Préscrire in Paris, France, as the best publication in medicine and therapeutics for 1995. By year's end, sales (of the French and English versions) were over 4,600;

- applied the accomplishments, strategic capacities, and strong networks established under the Breast Cancer Initiative to work-related and other cancers. As part of the professional education component of the Initiative, facilitated a successful workshop, Communication in

Breast Cancer — A Forum to Develop Strategies to Enhance Physician-Patient Interaction (held in February, 1996). Participants representing practicing physicians, continuing medical education specialists, communications researchers and breast cancer survivors, agreed to take the issue back to their local setting and advocate for an increased focus on communication skills; and

- compiled the Canadian Heart Health Database, the largest of its kind in the world, from ten provincial heart health surveys. Four provincial heart health programs have started to disseminate their information, opening new possibilities for prevention and health services research. Activities to enhance the capacity of the primary care sector to implement preventive practices have been limited by resource availability. The challenge in the years ahead is to enlarge partnerships and to promote greater attention and allocation of resources to prevention.

III. Research and Program Policy

During 1995-96, the Research and Program Policy sub-activity:

- provided input to the federal-provincial-territorial Advisory Committee on Health Services to determine future research priorities and develop a national health research agenda through consultations with stakeholders in Ottawa and the regions;

- reaffirmed the importance and focus of NHRDP's mandate to fund scientifically meritorious research to support the Department's mission and national health priorities as a result of a year-long consultation process known as the Future Directions Initiative. To this end, NHRDP refined key areas of program development, strategic research themes, and new approaches to the management and administration of the research projects and personnel awards. Key consultation activities included:

  - a departmental consultation that outlined Departmental research priorities;

  - a meeting with federal-provincial-territorial representatives that identified shared health policy and research priorities;

  - five regional workshops that identified priorities and strategies for research; and

  - a workshop that further refined the priorities and strategies based on the advice received at the federal-provincial-territorial meeting and the workshops;

- announced the results of a special competition under the Tobacco Demand Reduction Strategy to stimulate research on the evaluation of tobacco reduction programs and their impact on the Canadian population, in particular youth, women, lower socio-economic groups, the psychiatrically disabled, native peoples and minority populations;

- provided funding in the amount of $37.2M under the NHRDP for extramural research in fiscal year 1995-96. This included support for population-based applied health research in a number of targeted areas, including the AIDS Initiative, Phase II; Canada's Drug Strategy, Phase II; the Seniors Independence Research Program; the Child Development Initiative; the Canadian Breast Cancer Research Initiative; the Tobacco Demand Reduction Strategy; and the Health Promotion Research Centres;

- entered into a research partnership with the Social Sciences and Humanities Research Council of Canada, Citizenship and Immigration Canada and eight other federal departments and agencies to study the impact of immigration in urban environments. This partnership, the Metropolis project, will fund research conducted through Centres of Excellence established in Montreal, Toronto, Edmonton, and Vancouver over six years;

- entered into a partnership with Statistics Canada to fund research to analyze the data collected under the National Population Health Survey;

- funded targeted research on breast cancer through a partnership with the Medical Research Council, the National Cancer Institute of Canada and the Canadian Cancer Society. The Canadian Breast Cancer Research Initiative has broadened the traditional focus of research to include psycho-social and behavioral research areas;

- funded targeted research on heart health and cardiovascular disease through a partnership with the Heart and Stroke Foundation and the Medical Research Council. This research is a component of the Canadian Heart Health Initiative;

- participated in other research partnerships including St. Lawrence Vision 2000 (with the Fonds de la recherche en santé du Québec) and worked towards developing new partnerships with other federal departments, other governments, and organizations outside government;

- convened a round table dialogue of key researchers and policy makers in the population health and health promotion fields on taking collaborative action on the determinants of health;

- developed strategic partnerships with the private sector, other levels of government and non-profit organizations to leverage program resources and increase the impact of our activities and programs; and

- developed and implemented various social marketing campaigns in conjunction with departmental programs to promote departmental messages and affect the health of Canadians.

Figure 30: National Health Research and Development Program

(thousands of dollars)	Forecast 1996-97	Actual 1995-96	Actual 1994-95	Actual 1993-94
Projects				
Organization and Delivery of Health Care	4,508	6,453	6,947	4,977
Risk Assessment	1,973	2,878	3,169	3,162
Health Promotion and Illness Prevention	2,619	3,199	2,924	3,134
Health of Native People	720	1,184	644	791
AIDS	4,795	4,945	5,963	5,929
Canada's Drug Strategy	1,135	1,513	680	448
Breast Cancer Initiative	500	500	500	1,000
Brighter Futures	481	642	644	174
Tobacco	1,500	1,104	274	67
Seniors	5,195	6,050	3,731	1,725
Sub-total	23,426	28,468	25,476	21,407
Awards				
Training	2,375	2,700	1,604	1,378
Career	3,479	3,726	2,871	2,434
Sub-total	29,280	34,894	29,951	25,219
Conferences	32	280	559	368
Total (Contributions)	29,312	35,174	30,510	25,587
Grant to the National Cancer Institute of Canada	2,000	2,000	2,000	—
Total	31,312	37,174	32,510	25,587

Note: Awards and conferences includes funding from the special initiatives (e.g. AIDS, Seniors, etc.)

Indian and Northern Health Services

Objective

To assist Status Indians, Inuit and residents of the Yukon to attain a level of health comparable to that of other Canadians living in similar locations.

Figure 31: Financial Performance

	1993-94 Actuals		1994-95 Actuals		1995-96 Estimates		**1995-96 Actuals**	
	$000	FTE	$000	FTE	$000	FTE	**$000**	**FTE**
Non-insured Health Benefits	466,613	200	494,734	210	560,981	210	**519,218**	**166**
Community Health Services	187,000	1,020	251,174	1,081	228,214	917	**279,366**	**1,037**
Brighter Futures	17,715	23	25,989	16	40,825	25	**27,683**	**19**
NNADAP	58,089	65	53,771	36	53,100	60	**51,444**	**30**
Environmental Health & Surveillance	7,075	63	9,936	68	11,124	61	**12,338**	**118**
Hospital Services	44,809	488	34,110	402	47,417	381	**53,593**	**399**
Community Health Services under First Nations Control	43,335	67	63,392	48	69,429	70	**86,494**	**60**
Sub-total	824,636	1,926	933,106	1,861	1,011,090	1,724	**1,030,136**	**1,829**
Less: Revenue credited to the Vote (Hospitals)	—		(15,873)		(16,300)		**(14,955)**	
Sub-total	824,636	1,926	917,233	1,861	994,790	1,724	**1,015,181**	**1,829**
Revenue to CRF	32,710		6,675		10,250		**6,146**	

Explanation of Change: The 1995-96 actual expenditures are $20.390 million higher than the 1995-96 Main Estimates. This is mainly due to:

	($000)
• Supplementary Estimates for Non-Insured Health Benefits; and	14,963
• a payment to the Government of Saskatchewan for the transfer of the Fort Qu'Appelle Hospital.	5,427

Performance Information

The Activity's effectiveness is demonstrated by improvements in the health of the native population relative to other Canadians. It can also be measured by the number of communities that have transferred or are in the process of transferring health services. This is achieved by:

- providing or arranging for the provision of health services to Status Indians, Inuit and residents of the Yukon at a level comparable to that of other Canadians in similar circumstances;

- ensuring that services are delivered by suitably qualified health-care workers; and

- ensuring that the program and the way its services are delivered supports the needs and aspirations of First Nations and Inuit communities by working closely with them in planning, developing and delivering Community Health Services.

The Activity's performance can be demonstrated by the following operational and program outputs:

Non-Insured Health Benefits: This sub-activity contributes to the health of First Nations and Inuit individuals by providing supplementary health benefits. Benefit categories are divided as follows:

- pharmacy benefits include prescription drugs, over-the-counter drugs and medical supplies and equipment. In 1995-96 approximately 71% of all clients accessed benefits in this category;

- dental services respond to the oral health needs of First Nations and Inuit individuals. Claims processing data indicates that 40% of all eligible clients accessed this benefit category in 1995-96; this figure does not include those who received services from the Department's dental hygienists or dentists contracted to provide services to remote communities;

- the transportation benefit enables First Nations and Inuit people, especially those living in isolated communities, to access required medical services. This includes transportation by community operated vehicles, through self-employed community drivers, and air travel. It also includes the cost of accommodation while in transit;

- the vision care benefits provides eye glasses and eye glass repairs as well as eye examinations to eligible clients; and

- provincial medical insurance premiums are paid on behalf of eligible clients in Alberta and British Columbia.

Other health care services including crisis intervention, mental health counselling and other health professional services are provided on an exceptional basis, when not available through any other program.

The evolution and trends of this sub-activity can be seen from the following figures:

Figure 32: Non-Insured Health Benefits, Annual Expenditures by Benefit, 1988-89 to 1995-96 (in thousands of dollars)

	1988-89	1989-90	1990-91	1991-92	1992-93	1993-94	1994-95	1995-96
Vision Care	$11,674	$13,110	$14,416	$17,744	$16,386	$14,101	$16,040	$17,242
Premiums	13,566	16,211	19,186	22,797	24,387	26,350	28,610	30,094
Health Care	19,289	19,778	29,070	36,675	41,196	36,735	32,151	27,307
Dental	46,101	54,532	74,146	84,427	97,976	110,346	116,277	123,302
Transportation	61,881	71,016	84,937	104,531	113,844	128,007	138,826	150,019
Drugs	61,421	74,731	84,851	104,415	120,856	133,481	146,134	157,297
Total	$213,932	$249,378	$306,606	$370,589	$414,645	$449,020	$478,038	$505,261
Percentage increase	11.6%	16.6%	22.9%	20.9%	11.9%	8.3%	6.5%	5.6%

Figure 33: Non-Insured Health Benefits, Annual Expenditures by Benefit, 1988-89 to 1995-96 (in thousands of dollars)

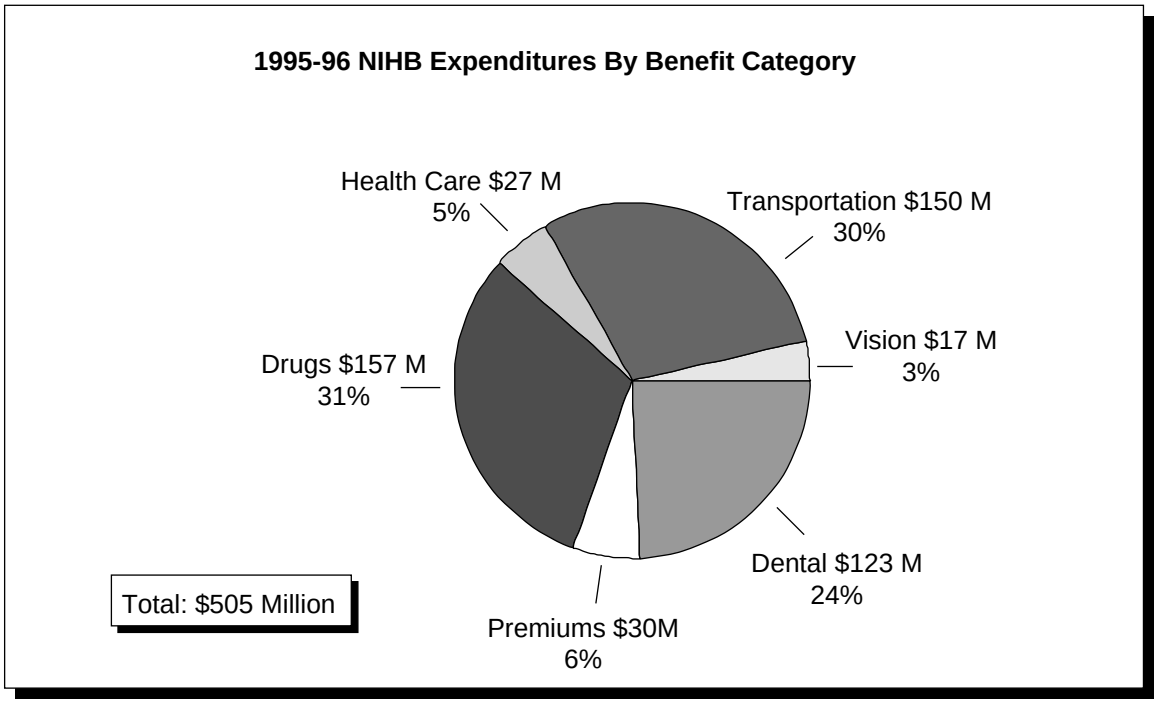
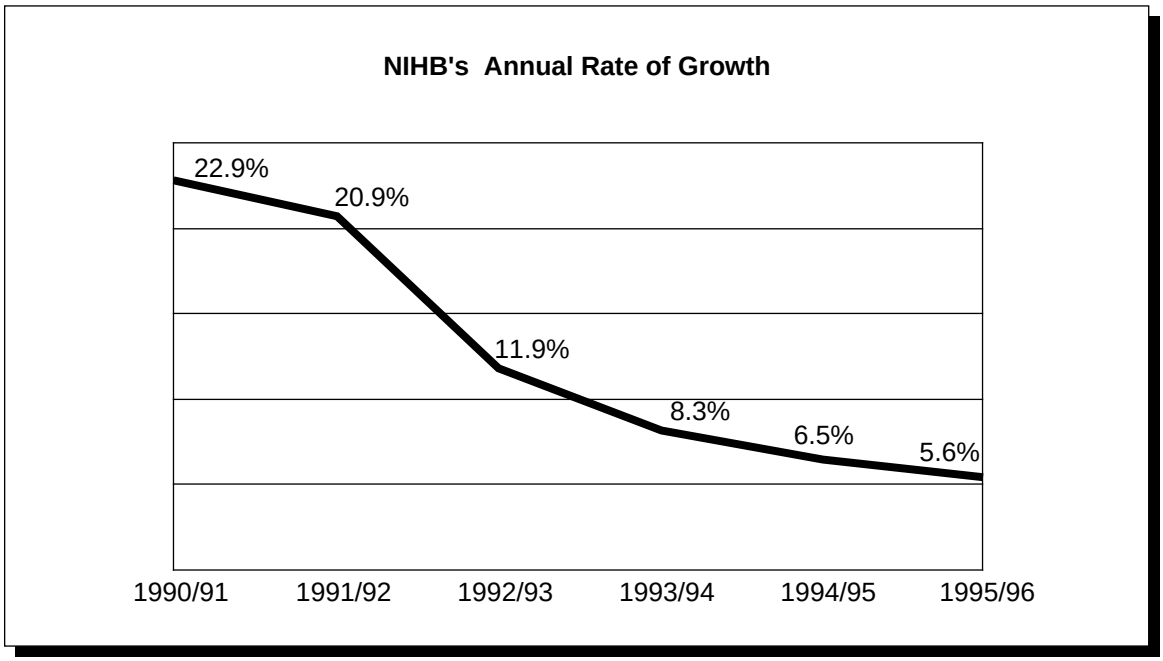


Figure 34: Percentage Change in NIHB Annual Expenditures



- In 1995-96, NIHB benefit expenditures were $505 million, an increase of 5.6% over the previous year. Expenditures for the major categories were $157.3 million for drugs, $150.0 million for medical transportation and $123.3 million for dental care. The actual expenditures for the sub-activity were $522 million and included $17 million for management and administration.

Figure 34 demonstrates the steady decline in the rate of annual growth in Non-Insured Health Benefits' total expenditures over the past six years. Growth has been reduced largely as a result of the following factors:

- the automation of claims payment processing for dental and pharmacy benefits (55% of NIHB expenditures);
- the establishment of more appropriate community-based funding for programs formerly paid out of NIHB, (e.g., Building Healthy Communities, funding for mental health programming and solvent abuse treatment);
- improved enforcement of the national program directives as a means of ensuring greater consistency across Canada; and
- improved program management practices.

However, the sub-activity faces continuing cost growth pressure as a result of:

- annual client population growth of 3% (nearly three times the rate for the total Canadian population);

- continuing increases in the costs of prescription drugs: this pressure is reflective of similar trends for health benefits in the general population;

- increased benefit utilization resulting from greater awareness of the availability of the benefits; and

- emerging or evolving benefit needs resulting from provincial health care reforms, such as the transfer of some hospital-based programs over to communities, where such services are often not covered by provincial insurance programs.

Community Health Services: Under the National AIDS Strategy and in partnership with First Nations and Inuit, MSB has provided programming and related health services addressing HIV/AIDS education, care, treatment, support and research. These include an Aboriginal Palliative Care Manual, an Inuit Community Health Workers Training workshop, an Education Curriculum for First Nations' Schools and an Aboriginal Women and AIDS Study.

The **Tobacco Demand Reduction Strategy** completed the following national projects: a review of Non-Traditional Use of Tobacco literature, a National Education Workshop, a Community Health Workers Training Workshop, and the development of a Smoking Cessation Model for Women of Childbearing Years. A First Nations and Inuit Youth and Smoking Survey was completed to measure the beliefs, attitudes and practices of youth in regard to the non-traditional use of tobacco. The development and data collection components of the Regional Health Survey initiative were completed, under the direction of a National First Nations and Inuit Steering Committee.

In May, 1995, the Minister announced the establishment of five permanent national youth residential treatment centres offering standard six-month programs and a sixth centre to offer long-term treatment. Funding for interim youth solvent abuse treatment programs is being provided to five treatment centres until such time as the new treatment programs are operational. It is anticipated that all six permanent centres will be operational during the 1996-97 fiscal year, with all funding to interim centres ceasing by June 15, 1997.

Nurses employed in facilities where the expanded nursing role is required are provided with additional clinical skills training through the Northern Clinical Program at McMaster University and the Outpost Nursing Program at Dalhouise University. During 1995-96, fifty nurses completed the Northern Clinical Program and twelve nurses graduated from the Outpost Nursing Program. Nurses who required additional education in community health practice received training through the Northern Community Nursing Program at McMaster University. Sixty students can be accommodated in this course each year.

Since the beginning of the Indian and Inuit Health Careers Program in 1984-85, approximately 495 students have enrolled in health programs and a total of 319 bursaries have been awarded. A total of 176 awards have been made to exceptional achievers through the Scholarship Component, introduced in 1988.

The Nutrition Program supported the following activities: the Third International Conference on Diabetes and Indigenous Peoples; the Canada Prenatal Nutrition Framework; the Canada Prenatal Nutrition Workers Training Workshop; and the development of various supporting tools, such as a resource training manual and evaluation questionnaire.

A working group of internal and external experts released a report and recommendations related to prescription drug misuse. The report recommended a comprehensive framework dealing

with education, prevention, monitoring, intervention, training and treatment. Community-based education, training and treatment activities were introduced along with a computerized Drug Utilization Review and monitoring system that is managed through the NIHB program.

The year 1996-97 was the third year of the National Tuberculosis Control Strategy to reduce the incidence of tuberculosis among First Nations people living on reserve. A mid-term evaluation of this strategy was conducted to review all aspects of the TB control and elimination program and to determine the extent to which the program is meeting its objectives.

In 1995, in partnership with the Saskatchewan Indian Federated College, Medical Services Branch established an Advisory Board for the National School of Dental Therapy. This Board was established to identify issues and advise the SIFC and MSB on policies and principles for the operation of the NSDT.

Hospital Services: On December 1, 1995, the Fort Qu'Appelle Indian Hospital was transferred to the Touchwood File Hills Qu'appelle Tribal Hospital; it is now being operated by a hospital board. The Blood Indian Hospital is scheduled to close on March 31, 1997. On April 1, 1996, the Weeneebayko Health Ahtuskaywin assumed responsibility for the administration of the Moose Factory Hospital, as an interim step to full transfer at a later date. Plans are also under way to amalgamate the operation of the Sioux Lookout Zone Hospital with the provincial hospital under one board. The long term objective is to close the existing hospitals and for the federal government to contribute to the construction of a new hospital, to be operated according to provincial regulations.

Transfer of Indian Health Services to Community Control: The Transfer Program, which deals with the transfer of health services and resources to Native control, was developed in consultation with Native partners and was approved by Cabinet in 1989. This initiative supports both the Department's and First Nations' efforts to achieve improvement in the health status of First Nations and Inuit.

In support of the transfer of health resources to First Nations and Inuit control, initiatives aimed at assisting communities to plan and assume control of health programs and resources continue. To date, 68 transfer agreements have been signed, representing 143 communities and 56 integrated agreements representing 67 communities. As well, 98 pre-transfer planning projects are under way involving 155 communities.

Northern Health Services Transfer: The transfer of the Whitehorse General Hospital is complete. Construction of the new Whitehorse General is on schedule and it will open in the late fall of 1996. Negotiations to conclude Phase II (the transfer of community health services and facilities) of the Yukon Health Transfer initiative continue. Discussions are under way with Yukon First Nations to assume control of First Nation Health programs under their legislated self-government authority.

Child Development Initiative (CDI): The CDI's Community Action Component continues to assist First Nations and Inuit communities in the development of community-based and community-managed mental health and child development programs, in creating culturally relevant resource material and videos and in the distribution of these materials to aboriginal communities. The Healthy Babies Framework was validated through the community review process and has been extensively distributed to First Nations/Inuit communities and other interested parties. An epidemiological study on Fetal Alcohol Syndrome has been completed to assist First Nations with program planning. A community-based injury surveillance information system was developed, piloted and evaluated.

National Native Alcohol and Drug Abuse Program (NNADAP): The NNADAP program includes a network of 49 treatment centres which represent approximately 700 in-patient treatment beds. As

well, there are more than 500 alcohol and other drug abuse community based prevention programs with approximately 700 workers now active in community based prevention activities.

NNADAP is collecting data through the Treatment Activity Reporting System (TARS) and the data will be the subject of intensive review during 1996.

Environmental Health and Surveillance: The Program worked with First Nations and Inuit people to ensure that a comprehensive environmental health program continued to be carried out on-reserve. It also continued its work to ensure that the special initiatives were conducted under the Action Plan on Health and the Environment, which are aimed at groups at greater risk from exposure to environmental contaminants.

A joint HC/DIAND survey showed that 20% of First Nations' water systems had problems which have the potential to negatively affect the health and safety of the community if the problems are not addressed and 9% of sewer systems are experiencing problems that could negatively affect the health and safety of the community. The Department is working in partnership with DIAND and First Nations in order to address these problems as quickly as possible.

Over 30 First Nations communities have followed the training program for the administration of the Presence/Absence Test which is used to monitor the bacteriological quality of drinking water. this was done in partnership with the Split Lake Cree First Nation, who now have community laboratories in place. In addition, approximately 100 other First Nation communities have set up community-based drinking water monitoring programs which utilize a similar test.

A training program for First Nations water treatment plant operators was piloted in northwestern Ontario. Because of its success, DIAND has agreed to fund the operation of this training program in Ontario and Manitoba regions, with First Nation organizations managing the process.

The EAGLE Project has conducted a variety of activities including the validation of data obtained from a survey of eating patterns, the completion of fish consumption guidelines and the development of a risk exposure estimate model. A health survey methodology has been established and a community-based pilot health survey has been carried out in the Georgina Island First Nation.

The Northern and Arctic Initiative has involved First Nations from Labrador, Northern Ontario, Manitoba, Saskatchewan, Alberta, British Columbia and the Yukon in providing information, education, problem-identification and project support to address concerns about the environmental contaminants in their areas and the risk to health and well-being which this exposure may entail.

The Pregnancy and Child Development Project in Grassy Narrows and Whitedog has established a protocol to conduct in-depth neuropsychological research involving the review of school records, teachers' evaluations, neuropsychological test battery results and the collection of hair samples. In partnership with the communities, the data collection processes have taken place involving four psychologists and various community members.

Health Status: Although the health status of First Nations and Inuit people has improved over the past decade, there remain significant disparities between the health of First Nations and Inuit and that of Canada's general population.

MSB collects health status data for registered Indians in all its regions; while there are presently concerns about the coverage and accuracy of the data at the national level, work is in progress to address the matter. Some regions obtain data for both on and off-reserve Indians (Manitoba, Saskatchewan, Alberta, Pacific, and Yukon) and are able to link to provincial and territorial

mortality databases. Other regions (Atlantic, Quebec, Ontario) provide figures for on-reserve Indians only. Data are not available for most communities in Quebec that have had health services transferred to them or for Labrador. Since the transfer of health services to the Government of the Northwest Territories, no data has been available from the territory.

The data which follows has proven useful for MSB and First Nations communities. It should, however, be read within the limits outlined above.

Population: There were 593,050 Registered Indians in Canada at the end of 1995. The population pyramid (figure 36) shows that this population contains a very high proportion of children. Birth rates among registered Indian people remain double the Canadian average.

Figure 35: First Nations and Inuit Population, 1995

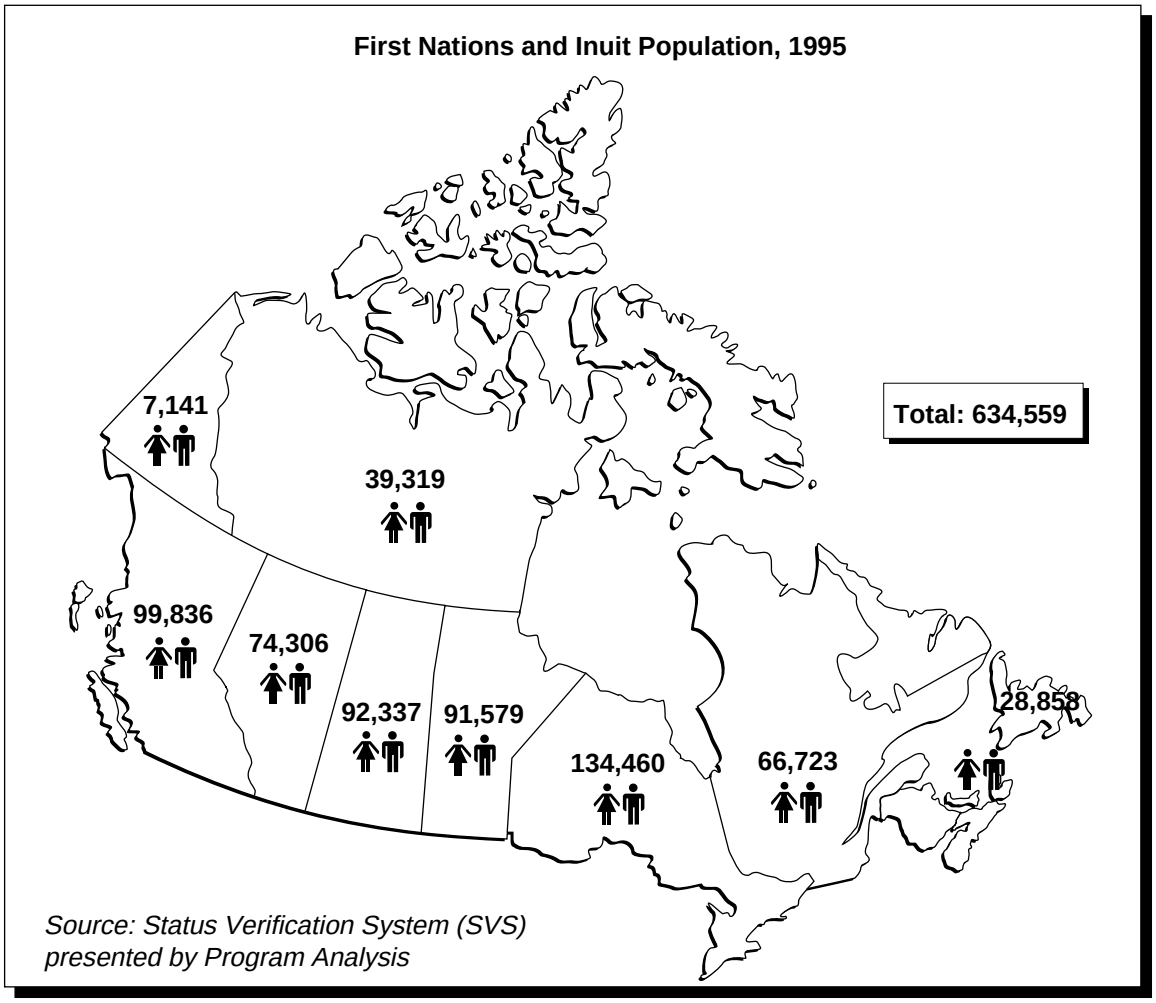
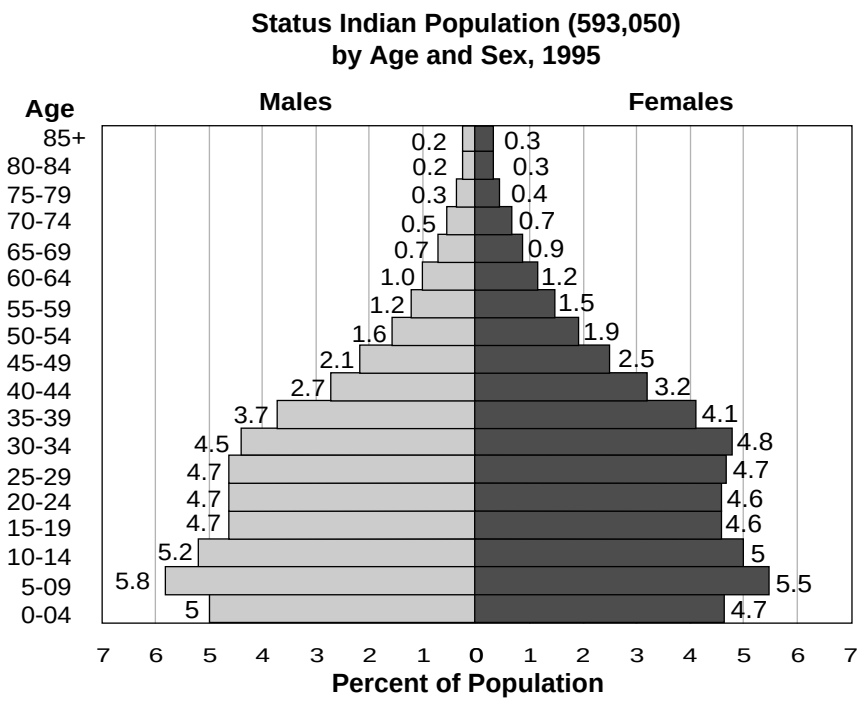


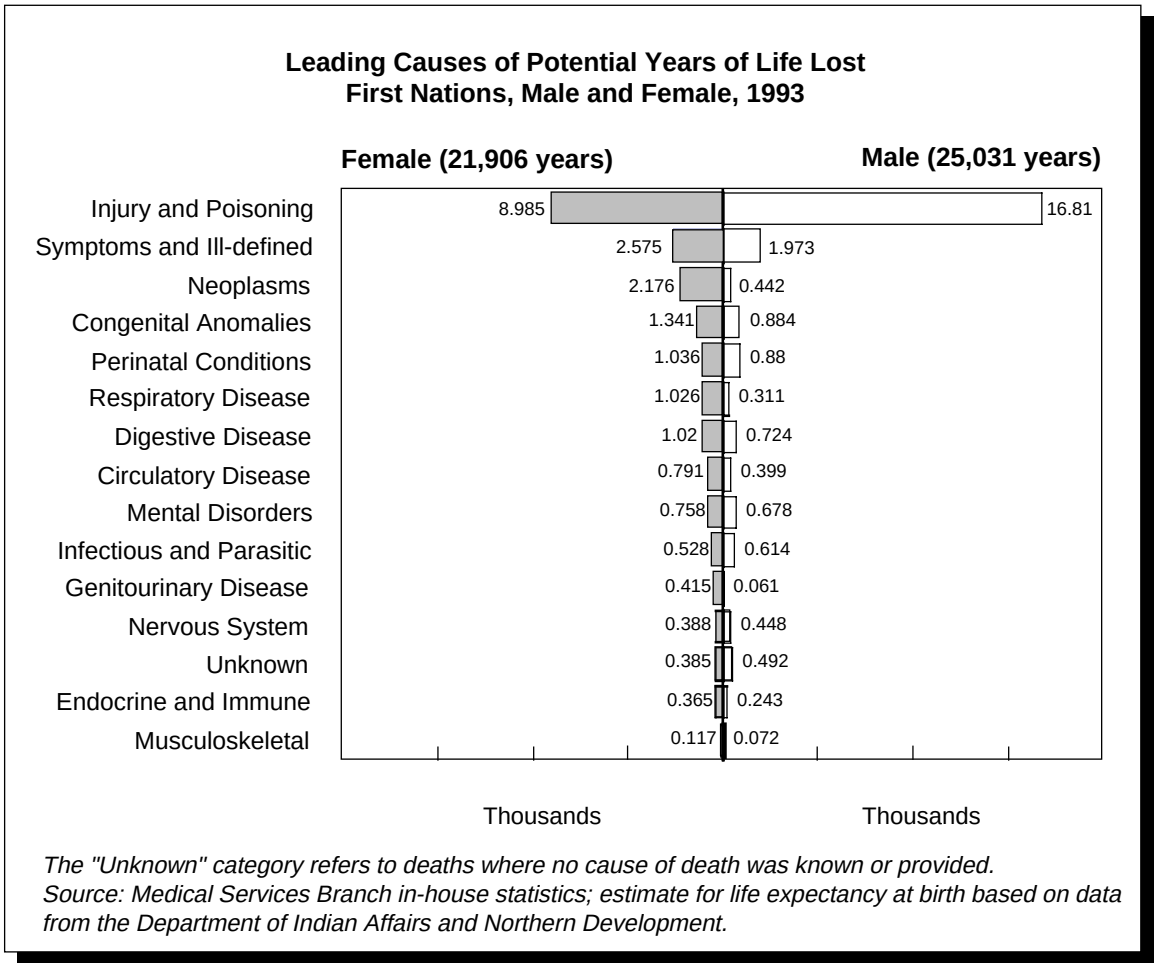
Figure 36: Status Indian Population (593,050) by Age and Sex, 1995



Source: Department of Indian Affairs.
Refers to total registered Indian population, on and off-reserve.

Life expectancy: Life expectancy at birth for Registered Indians is improving and is expected to continue to increase. Between 1975 and 1995 the life expectancy at birth of Registered Indians increased by approximately 10 years; by 2015 it is expected to increase by an additional 3.8 years. The main reasons for this increase are a decline in infant mortality rates and a decline in rates of death from most types of injury.

Figure 37: Leading Causes of Potential Years of Life Lost, First Nations, Male and female, 1993



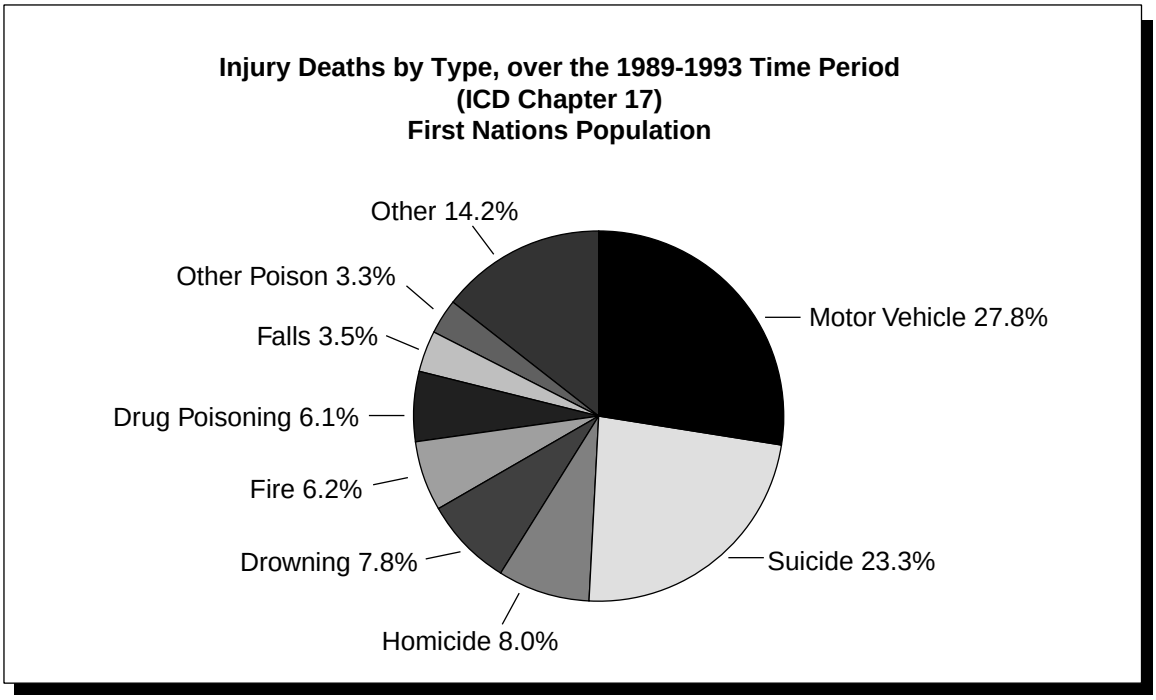
The "Unknown" category refers to deaths where no cause of death was known or provided.
Source: Medical Services Branch in-house statistics; estimate for life expectancy at birth based on data from the Department of Indian Affairs and Northern Development.

Mortality: The rate of mortality among Registered Indians has been decreasing but remains higher than for other Canadians. The principal causes of death are injury and poisoning, diseases of the circulatory system, cancers and respiratory diseases.

Intentional and Unintentional Injuries: Injuries remain the leading cause of death for Registered Indian and Inuit people, although mortality rates from this cause have decreased. Deaths from injury may be unintentional, as in the case of motor vehicle accidents or drownings, or intentional as in the case of suicide or homicide. Injury remains the most significant cause of death from the point of view of potential years of life lost.

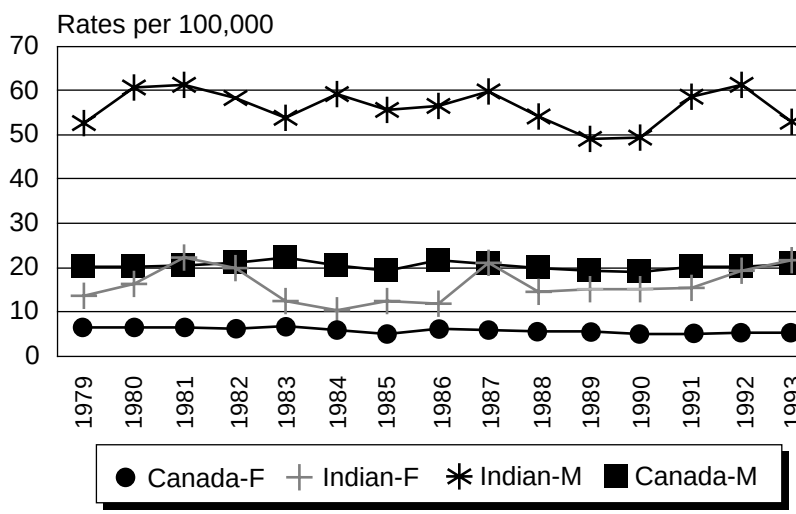
Various efforts are under way to reduce the incidence and severity of such injuries. Communities are attempting to deal with the problem through community-based projects and activities. At the national level, the Activity's efforts include the development and production of a number of resource materials for injury prevention. Additionally, under the guidance of First Nations and Inuit people, an injury surveillance system is being developed. A portion of the Child Development Initiative funding will be directed towards this effort.

Figure 38: Deaths due to Injuries



Suicide: Rates of completed suicides for Registered Indians are approximately three times higher than that of the general male Canadian population and two times higher for the female population. Trends are difficult to interpret considering the limitations of the data available; however, it appears that this elevated incidence has persisted over the past two decades with little appreciable change. National data can conceal substantial variations between individual communities, particularly since there is some tendency for suicides and attempted suicides to occur in clusters.

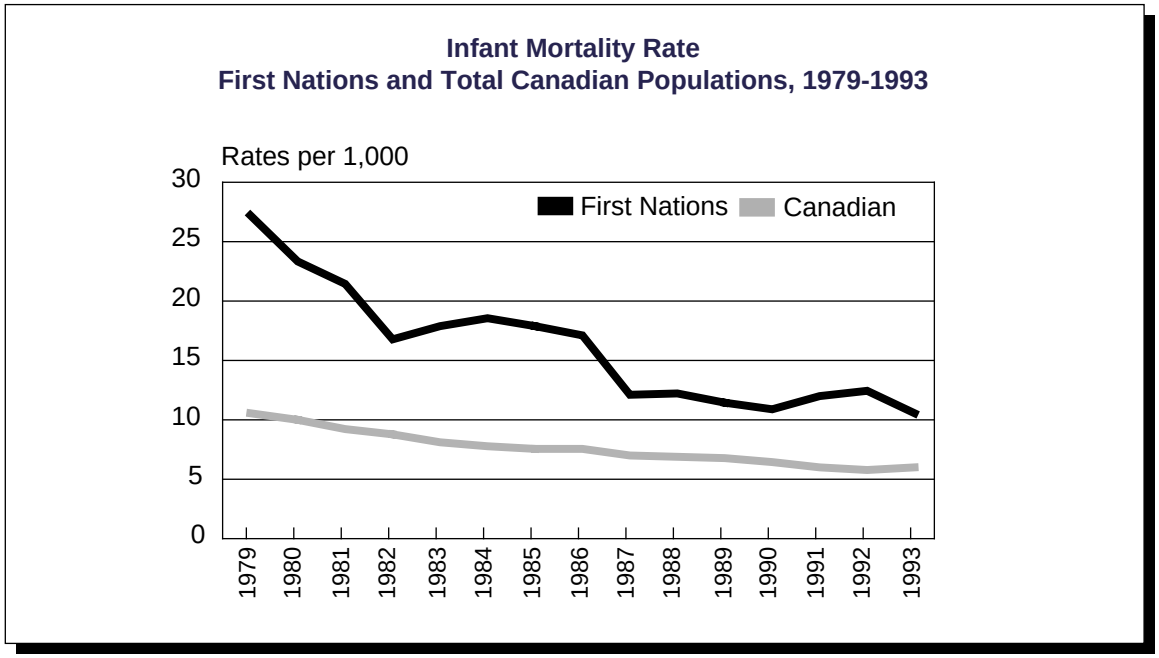
Figure 39: First Nations and Canadian Suicide Rates



First Nations data exclude B.C. 1985-1986 and NWT, and are subject to variations in coverage.
Note: Rates have not been age-standardized.
Source: Health Programs Analysis, Health Canada, February 1996. Data for Canadian population based on information provided by Statistics Canada.

Infant mortality: The infant mortality rate among Registered Indian people declined markedly during the 1980s, although it remains higher than the rate for all Canadians. The main contributor to this disparity is post-neonatal mortality (deaths between 28 days and one year of life). Deaths at this age are often more closely linked to social and environmental conditions than to the quality and availability of health care services.

Figure 40: Infant Mortality Rate



Public Service Health

Objective

To protect and preserve the health of federal public servants, as it relates to the work-place, by providing a program of occupational and environmental health services under authority delegated by the Treasury Board.

Figure 41: Financial Performance

	1993-94 Actuals		1994-95 Actuals		1995-96 Estimates		**1995-96 Actuals**	
	$000	FTE	$000	FTE	$000	FTE	**$000**	**FTE**
Occupational Health	15,852	228	20,766	227	14,450	234	**16,228**	**228**
Environmental Health Services	9,913	126	9,502	129	9,400	126	**6,365**	**90**
Program Review adjustments to be allocated					506			
Total	25,765	354	30,268	356	24,356	360	**22,593**	**318**

* Full time equivalent (FTE) is a measure of human resource consumption based on average levels of employment. FTEs are not subject to Treasury Board control but are disclosed in Part III of the Estimates in support of personnel expenditure requirements specified in the Estimates.

Explanation of Change: The 1995-96 actual expenditures are $1.763 million lower than the 1995-96 Main Estimates. This is mainly due to lower than anticipated salary and major capital expenditures.

Performance Information

Occupational Health Services: The Public Service Health Activity and this specific sub-activity are administered through the Occupational and Environmental Health Services Directorate (OEHSD). The Directorate is moving towards an alternative service delivery model such as a Special Operating Agency. During 1995-96, the Directorate began implementation of a revised organization structure. The number of Regions was reduced from five to three (West, Central and East) and the organization is also reducing the number of management levels. With this flatter structure, increased emphasis will be placed on maximizing the number of front-line staff. As part of this restructuring the historical professional-discipline based structure (Doctors reporting to Doctors, nurses reporting to nurses) will be changed to an interdisciplinary team structure. This breaking of “stovepipes” will allow the organization to provide a more comprehensive and more effective response to the needs of its customers.

The Directorate is becoming more customer-focused in its delivery of services. Efforts during 1995-96 included the creation of Customer Advisory Groups at both the National and Regional levels and the development of service standards and performance indicators in partnership with customers. These service standards and performance indicators will be in force by January, 1997. Service

standards and performance indicators are viewed as critical quality assurance tools aimed at improving both service and accountability. They are expected to enhance the program's ability to meet customer and service provider expectations.

During 1995-96, a marketing function was implemented in the Directorate. This function will be responsible for helping staff develop new service offerings, coordinating the response to requests for proposals, training staff in marketing functions and improving responsiveness to changing customer needs.

For many departments, the costs associated with lost time from injuries, occupational illness and the effects of stress remain hidden. In order to help departments in that regard, OEHSD has developed a protocol in response to the National Joint Council document "Report of the National Joint Council Special Committee on Benefits for Work-Related Illness or Injury in the Public Service" (December, 1995). As well, the Directorate will develop targeted programming in the most critical health and safety areas and assist departments in identifying high loss areas. By exposing these costs, departmental managers and supervisors will be encouraged to make responsible investments in occupational health and safety practices.

In accordance with the Occupational Health and Safety policy of the Treasury Board, 5,300 public service work places were inspected and assessed for hazards in 1995-96. The data indicates that the demand for Employee Assistance Services continues to increase. Although the total number of federal employees is declining, the number of employees served is on the increase. During 1995-96, 7.2% of the client population (51,354) sought assistance. Of these, 30% reported problems related to the work place. The counselling services being provided are for health and personal concerns which include medical and psychological problems, addictions, traumatic stress and work stress situations.

In the area of occupational health medical assessments, the services can be broken down into three groups; pre-employment (evaluations done prior to placement in jobs) of which 2,800 were carried out; periodics (physical examinations conducted as part of a health maintenance program to detect adverse health effects at an early stage and/or to routinely determine if employees continue to be medically fit to carry out their duties) of which 6,695 were done; and "special" medical assessments including physical examinations for eligibility to purchase prior service, superannuation benefits, return to work after illness, and referrals from Departments to evaluate fitness to work. Assessment of fitness to work is generally the most demanding and time consuming of all medical categories. There were 16,502 fitness to work medical assessments carried out in 1995-96.

Occupational health nurses provided a wide variety of health services to approximately 114,000 clients during the fiscal year 1995-96, and gave approximately 1,500 information sessions to public servants on occupational health related topics.

VIP Services: Under the Geneva Convention for Diplomatic Missions, the host country must provide essential and emergency health care for visiting dignitaries. OEHSD coordinates the health care required for VIPs during their official visits to Canada in accordance with security levels established by the RCMP. Some VIP activities are:

- planning and coordinating medical contingency plans for VIP visits within Canada;
- determining the level, extent and availability of medical care;
- verifying preparedness of local medical and hospital facilities
- providing food inspection services; and
- liaising with government agencies concerning the administration of this policy.

Health Advisory and Assessment Services

Objective

To assist Canadians in determining their medical eligibility for certain benefits and types of licenses by providing professional advice and assistance in the areas of civil aviation medicine.

To provide health interventions to protect the Canadian public through activities in emergency services, quarantine services and regulatory services.

Figure 42: Financial Performance

	1993-94 Actuals		1994-95 Actuals		1995-96 Estimates		**1995-96 Actuals**	
	$000	FTE	$000	FTE	$000	FTE	**$000**	**FTE**
Civil Aviation Medicine and Medical Advisory Services	3,741	50	3,873	50	3,314	46	**2,716**	**33**
Emergency Services	2,724	30	2,009	28	2,796	28	**2,011**	**24**
Quarantine and Regulatory Services	259	3	291	3	292	4	**359**	**5**
Immigration Medical Services	1,208	16						
Program Review adjustments to be allocated					127			
Sub-total	7,932	99	6,173	81	6,529	78	**5,086**	**62**
Less: Revenue credited to the Vote							**(85)**	
Total	7,932	99	6,173	81	6,529	78	**5,001**	**62**

* Full time equivalent (FTE) is a measure of human resource consumption based on average levels of employment. FTEs are not subject to Treasury Board control but are disclosed in Part III of the Estimates in support of personnel expenditure requirements specified in the Estimates.

Explanation of Change: The 1995-96 actual expenditures are $1.528 million lower than the 1995-96 Main Estimates. This is mainly due to lower than anticipated salary expenditures.

Performance Information

Civil Aviation Medicine (CAM): The mandate of Civil Aviation Medicine includes:

- clinical assessment of medical fitness of licensed aviation personnel;
- assessment of health hazards to aircrew;
- development of medical standards for aviation personnel;
- development of educational programs for aircrew and medical examiners; and
- medical aspects of air traffic controllers occupational health program.

Many factors impact upon the medical standards for fitness to fly; CAM must ensure that standards and decisions are based on contemporary medical knowledge and will withstand legal challenges. Pilots continue to challenge medical decisions through the Civil Aviation Tribunal, Canadian Human Rights Commission and the Courts. As a result more resources are being utilised for the preparation and attendance at the Civil Aviation Tribunal Hearings.

During the 1995-96 fiscal year, Civil Aviation Medicine accomplished the following:

- the recommendations made in the structural review, completed in fiscal year 1994-95, have been implemented. This has resulted in a reduction of the regional offices from six to three with resultant cost savings, but no reduction in quality or service levels. The program was able through these cost management processes to achieve an expenditure reduction of over 15% compared to the expenditures in 1994-95.

The program has identified opportunities for cost recovery in medical assessment processes. The Transport Canada methodology was used and completed in November, 1995. Negotiations are ongoing with Transport Canada to institute appropriate fees in support of these medical acts. Since Program Review I decisions require that Civil Aviation Medicine achieves revenue targets of $1M in 1996-97 and an additional $1M in 1997-98, the agreement of Transport Canada to support these fees will be critical to the future of the program.

During the year, 60,801 aviation medical assessments were processed, a slight increase from the previous year. The forecasted volume for 1996-97 is 63,000, reflecting a four percent increase. The additional workload has not required additional staff.

A plan was developed to rationalize the Civil Aviation Medicine Laboratory, in line with the Program Review I targets specific to Medical Services Branch. This was done in cooperation with the Health Canada Laboratory Rationalisation process. The plan was implemented in 1995-96, with final closure of the facility in July, 1996. The staff have been deployed within the HPB laboratory system and the physical facility transferred to the Department of National Defence.

The program has continued to maintain the aviation medical seminars for Civil Aviation Medical Examiners in order to ensure their knowledge remains current.

Emergency Services: This sub-activity supports the health care and social services systems in peacetime disasters.

During 1995-96 initiatives have included: contribution to the signing of the Canada/United States Joint Radiation Emergency Response Plan; the preparation of a final draft of a revised Federal Nuclear Emergency Plan and initial preparations for Exercise CANATEX 3 to test the revised plan; contribution to the development of a National Emergency Support Framework, a new Government Emergency Book, a new Federal Policy for Emergencies, and the development of an Emergency Operations Centre exercise for Emergency Social Services.

The program also conduced 22 courses at the Canadian Emergency Preparedness College in Arnprior covering Emergency Health Services Planning, Emergency Social Services Planning, Special Care Facilities Emergency Planning and Hospital Emergency Planning. It also provided assistance to provinces and territories in the conduct of courses/workshops on emergency health and social services topics including emergency food services (14 workshops, 589 participants) and psycho-social outreach (15 workshops, 332 participants). At the request of the provinces, it provided advice during disasters.

Quarantine and Regulatory Services: Work within the Quarantine and Regulatory Services sub-activity includes:

- inspection of international vessels for the presence of disease-carrying rats and the provision of certificates required by international health regulations;

- emergency intervention at Canadian ports of entry for the investigation of suspected disease agents or diseases on vessels or aircraft; and

- application of the powers of a quarantine officer, according to the Quarantine Act, such as the removal of a ship or airplane from a Canadian port or airport.

The majority of derat certificates issued annually by OEHSD are to foreign vessels. To be consistent with most other maritime nations, fees are charged to issue certificates to international shipping. Authority for the implementation of these charges was received in the fall of 1995. Revenues of $127K were achieved in 1995-96.

Activities within the Regulatory Program were:

- inspection of food, potable water, recreation facilities and sanitation services on aircraft, trains, ferries, cruise ships and other conveyances under federal jurisdiction, as well as their ancillary services;

- inspection of food, potable water and sanitation services at federal facilities open to the public; and

- investigation of suspected food or water-borne diseases on conveyances or in public federal facilities.

Policy and Consultation

Objective

To provide advice and support to the Minister, the Departmental Executive and to program branches in the areas of policy development, intergovernmental affairs, strategic planning and review, communications and consultation, and international affairs.

Figure 43: Financial Performance

	1993-94 Actuals		1994-95 Actuals		1995-96 Estimates		**1995-96 Actuals**	
	$000	FTE	$000	FTE	$000	FTE	**$000**	**FTE**
Health Policy and Information	10,128	94	4,242	40	7,247	34	**8,564**	**48**
Women's Health Bureau			660	10	1,198	8	**1,073**	**10**
Intergovernmental Affairs			857	16	1,282	12	**1,633**	**15**
International Affairs			3,647	15	2,176	14	**2,487**	**12**
Communications and Consultation	5,442	77	4,724	73	4,284	66	**5,545**	**71**
Strategic Planning and Review	2,508	14	1,541	25	1,498	17	**1,489**	**16**
Management Services			4,750	13	1,365	12	**1,962**	**21**
Total	18,078	185	20,421	192	19,050	163	**22,753**	**193**

* Full time equivalent (FTE) is a measure of human resource consumption based on average levels of employment. FTEs are not subject to Treasury Board control but are disclosed in Part III of the Estimates in support of personnel expenditure requirements specified in the Estimates.

Explanation of Change: The 1995-96 actual expenditures are $3.703 million higher than the 1995-96 Main Estimates. This is mainly due to:

	($000)
• various Departmental reallocation of funds to cover additional operating requirements; and	1,980
• increased requirement for salary items that are not funded from Departmental budgets.	912

Performance Information

The Activity has the functional lead for supporting the federal health strategy. It is responsible for cohesive intergovernmental processes and national policies that cut across all business lines of the Department. This corporate activity also carries responsibility for co-ordinating legislative review and inputs to new/revised legislation throughout the Department.

In 1995-96, considerable progress was made on the development of legislative proposals and policy frameworks in areas of critical importance to the federal health agenda. These issues are increasingly complex and multidisciplinary, both in terms of content and extent of consultations. During 1995-96, significant progress was made in the following areas:

Ethics: all branches were canvassed and an inventory of department-wide ethics issues was produced in preparation for Branch Executive Committee/Departmental Executive Committee discussions of priorities and options.

New Reproductive Technologies: an advisory panel was named and announced January 24, 1996; the work of the embryo research panel is completed; a public discussion document was prepared but not released; drafting of legislation has been initiated; the federal-provincial-territorial working group continues; and work on registries continues.

International trade: intelligence capacity has been strengthened; a departmental focal point has been established for health exports; an analysis of key areas of trading patterns of major health products has been prepared; Phase I of the G-7 Global Health Care Initiative was coordinated; and successful collaborative interdepartmental work on health related aspects of NAFTA was completed.

Women's Health: steps were taken to ensure consideration of women's health concerns and differential impacts in all areas of departmental business including completion of a proposed Women's Health Bureau organization, development of the Preliminary Report Card on Health of Canadian Women, and substantial inclusion of the Canadian perspective on women's health incorporated in the Platform for Action adopted at the 4th United Nations World Conference on Women in Beijing, September, 1995. Five Centres of Excellence for Women's Health were selected and a related health network structure will be put in place in 1996-97. Plans are also under way for the bi-national Canada-USA Conference on Women's Health and the preparation of joint projects to improve health system responsiveness to women.

Children: there was an extremely successful interdepartmental examination of children's issues, incorporating an innovative states of wellness paradigm capable of accommodating multiple federal objectives. The Department and the federal government are poised to move on children's issues. This includes a high priority placed on early intervention and children in the new Population Health Strategy.

Bill C-91: the preparation for Parliamentary review of Bill C-91 amendments to the *Patent Act* in conjunction with the interdepartmental working committee. (These amendments brought Canadian patent protection for pharmaceuticals into line with protection for other fields of technology in Canada, and with patent protection available in other industrialized countries.)

Control of Tobacco Products:

- completed a major study of the attitudes, beliefs and behaviour of youth aged 10 to 19 that will improve programming to influence tobacco uptake and cessation;

- completed assessment of the potential value of controlling packaging to restrict its promotional value and to improve awareness of the hazards of smoking;

- updated estimates of mortality attributable to smoking in Canada to reinforce policy and programming directed toward reduction;

- completed a study of the changes in nicotine levels in cigarettes sold in Canada, and continued surveillance of the constituents of tobacco products and smoke that may affect the health of Canadians;

- initiated a comprehensive review of the basis for renewing and extending the control of tobacco marketing in Canada with a view to further reducing tobacco consumption; and

- coordinated preparation of a tobacco control policy and renewal of the legislation.

International Affairs:

- provided grants to three major international tobacco projects as part of the international component of the Tobacco Demand Reduction Strategy. These projects are aimed at assisting other countries to develop anti-tobacco programs and at developing science-based information on the effects of tobacco on human health;

- managed a program of 278 international visits including ministerial delegations from China, Nigeria, Finland, and Albania. The Directorate also managed Canada's participation in the 48th World Health Assembly. The Assembly was attended by the Minister; and

- the Department played a strong role in the Directing Council of the Pan American Sanitary Conference. In both bodies, Canada took a leading position on budget reduction, women's health issues and disease surveillance. In 1996-97, the Department will host two major international conferences, a conference on Women's Health with the U.S. Department of Health and Human Services and a conference on health policy and health reform issues.

Federal Provincial Relations: provided support and advice to the federal-provincial-territorial Conferences of Ministers and Deputy Ministers of Health. Ministers met three times and Deputy Ministers met four times informally. The outcomes of the meetings were positive and advanced work with regard to health system renewal.

Canada Health Act: continued to administer the *Canada Health Act* (CHA), advise the Minister on issues related to the Act and effected health care transfer payments to the provinces and territories. The government adopted a policy of administering the CHA in a consistent, coherent and comprehensive manner. First, it addressed the issue of extra-billing by doctors in British Columbia, starting deductions under the CHA in May, 1994, and continuing them until the issue was resolved and extra-billing stopped in September, 1995. On January 6, 1995, the federal government announced a policy for dealing with facility fees charged by private clinics for medically necessary insured services. Penalties related to the government's private clinics policy began in November, 1995. Ministerial correspondence related to the CHA and the health system more than doubled from 1993 to 1994 and 1995 and the Activity handled replies to this correspondence. *Canada Health Act* Annual Reports were produced in accordance with legislated requirements. Interpretations of the Act and various policy positions were also developed.

Communications and Consultation: provided departmental support on the production of communications materials, planning announcements, responded to enquiries from the media and the public and coordinated all ministerial speeches. The work included key departmental announcements on the *Canada Health Act* and facility fees, Medicare strategy, Aboriginal Head Start programs, Solvent Abuse Treatment Centres, a Management Regime for New Reproductive Technologies, and the response to the Krever Inquiry interim report on Canada's blood system. Support was provided for several Tobacco Demand Reduction Strategy reports, studies and community action projects, the

Ebola virus threat from Zaire, and for two federal-provincial-territorial meetings of Ministers of Health.

Health System Renewal and Forum Liaison Secretariat: continued to co-ordinate departmental work on the renewal of Canada's health system. Strategic advice and support was provided to the Minister, and recommendations to departmental management on health renewal priorities (within the federal-provincial-territorial and overall health system contexts).

An important aspect of the Secretariat's work is helping to facilitate concerted action to meet the Department's renewal priorities.

Strategic Planning and Review:

- initiated a cross-Department planners' network to enhance the identification and integration of horizontal issues in programs and policies. This resulted in the completion of the Outlook, the first Health Canada Business Plan and other documents which provide clear evidence of the improved accounting of horizontal issues in the Department;

- provided the focal point for portfolio activities to support the development of the Federal Science and Technology Strategy which was released in March, 1996. This included the preparation and publication of *"The Science and Technology Action Plan of the Health Portfolio — S&T at Work for the Health of Canadians"*;

- coordinated the Departmental position for an integrated Health Information Highway, and provided the Department's input to the government's response to the Information Highway Advisory Council's Recommendations; and

- conducted program evaluations of Departmental programs under the Treasury Board policy on Review, Internal Audit and Evaluation. The Directorate also provided advice to business line managers on the development and reporting of performance indicators under the department's Business Plan.

Health Insurance

Objective

To ensure that all residents of Canada have reasonable access to insured health care services on a pre-paid basis and to support extended health care services.

Figure 44: Financial Performance

	1993-94 Actuals		1994-95 Actuals		1995-96 Estimates		**1995-96 Actuals**	
	$000	FTE	$000	FTE	$000	FTE	**$000**	**FTE**
Operating Costs	1,232	23	1,568	26	1,684	23	**1,467**	**23**
Capital	42		30				**12**	
Contributions	7,232,090		7,566,089		6,891,000		**7,240,526**	
Total	7,233,364	23	7,567,687	26	6,892,684	23	**7,242,005**	**23**

* Full time equivalent (FTE) is a measure of human resource consumption based on average levels of employment. FTEs are not subject to Treasury Board control but are disclosed in Part III of the Estimates in support of personnel expenditure requirements specified in the Estimates.

Explanation of Change: The net change within this Activity is mainly due to increases in statutory payments due to revisions to the underlying data used to calculate provincial health care entitlements.

Performance Information

From 1993-94 through 1995-96, the Activity supported the development and delivery of health programs by undertaking health policy research and analysis, developing and proposing health policies and programs and coordinating activities and providing advice on health policy issues. Specific results include:

- A number of issues relating to *Canada Health Act* compliance were investigated over the period, some were resolved through discussions with the provinces and territories while others are the subject of ongoing federal-provincial-territorial consultations;

- Extra-billing by physicians in British Columbia ended in September, 1995, 17 months after it began and after federal penalties totalling just over $2 million had been taken from that province's transfer payments; and

- In January, 1995, a deadline of October 15, 1995, was imposed for provincial government compliance with the private clinics/facility fee policy. Beginning November, 1995, penalties were imposed on four provinces. Throughout the period leading up to and following the imposition of these penalties, the federal government was engaged in high level consultations with its provincial counterparts. These consultations continue with a view to resolving outstanding non-compliance incidents in a number of provinces.

Figure 45: 1995-96 Federal Health Care Cash Payments (at March 31st, 1996)

(thousands of dollars)	Insured Health Payments	Extended Health Care Payments	Total Cash Payments
Province/Territory			
Newfoundland	135,301	29,544	164,845
Prince Edward Island	32,015	6,989	39,004
Nova Scotia	219,914	48,019	267,933
New Brunswick	176,229	38,936	215,165
Quebec	916,467	377,230	1,293,697
Ontario	2,299,888	569,418	2,869,306
Manitoba	266,876	58,323	325,199
Saskatchewan	235,920	51,960	287,880
Alberta	581,700	140,939	722,639
British Columbia	836,300	192,997	1,029,297
Yukon	12,733	3,387	16,120
Northwest Territories	7,917	1,524	9,441
Total	5,721,260	1,519,266	7,240,526

These amounts are calculated by the Department of Finance based on the Federal-Provincial Fiscal Arrangements and Post-Secondary Education and Health Contribution Act. The federal contributions to the provinces are made up of tax and cash components. The tax transfer was effected in 1977 through a simultaneous lowering of federal income tax rates and raising of provincial income tax rates, thereby increasing provincial revenues while leaving taxpayers unaffected. Figure 46, following, presents the amount of health care entitlement to provinces for the years indicated.

Figure 46: Provincial Health Care Entitlements 1995-96

(thousands of dollars)	Cash	1995-96 Actual Tax	Total*
Province/Territory			
Newfoundland	163,647	139,617	303,264
Prince Edward Island	38,661	32,983	71,644
Nova Scotia	266,334	227,228	493,562
New Brunswick	215,773	184,089	399,862
Quebec	1,261,395	2,598,350	3,859,745
Ontario	2,830,176	3,006,292	5,836,468
Manitoba	322,947	275,528	598,475
Saskatchewan	288,406	246,058	534,464
Alberta	717,486	727,247	1,444,733
British Columbia	1,020,481	958,874	1,979,355
Northwest Territories	16,327	18,311	34,638
Yukon	8,710	7,135	15,845
Total	7,150,343	8,421,712	15,572,055

* These figures represent the most recent estimates of the final Established Programs Financing (EPF) entitlements for 1995-96, divided into tax transfer and cash components. Final entitlement figures for a particular year are not available until 30 months after year end, when official figures for the relevant inputs GNP, population, and the volume of the tax transfer are known. The cash component of the entitlements shown in this table differs from the cash payments shown in Figure 45 because of recoveries or additional payments, made during the year, which relate to recalculations of prior year entitlements, which in turn are based on changes in the inputs referred to above.

Note: As of April 1, 1996, Health Insurance statutory transfer payments to the Provinces and Territories are being shown in the Department of Finance Estimates as part of the Canadian Health and Social Transfer payments.

Program Management

Objective

To provide advice and direction in the development of policies and programs that will ensure the provision of an appropriate level of health services throughout the nation, and to provide management services to the Departmental Executive and management services and functional direction to Program branches.

Figure 47: Financial Performance

	1993-94 Actuals		1994-95 Actuals		1995-96 Estimates		**1995-96 Actuals**	
	$000	FTE	$000	FTE	$000	FTE	**$000**	**FTE**
Departmental Executive	11,765	136	8,577	110	7,505	98	**7,458**	**102**
Program Services	83,542	676	119,517	705	81,062	641	**109,305**	**723**
Internal Audit	728	9	997	11	863	11	**974**	**12**
National Forum			1,572	9	3,200	20	**3,031**	**19**
Sub-total	96,035	821	130,663	835	92,630	770	**120,768**	**856**
Less: Revenue credited to the Vote							**(563)**	
Total	96,035	821	130,663	835	92,630	770	**120,205**	**856**

* Full time equivalent (FTE) is a measure of human resource consumption based on average levels of employment. FTEs are not subject to Treasury Board control but are disclosed in Part III of the Estimates in support of personnel expenditure requirements specified in the Estimates.

Explanation of Change: The 1995-96 actual expenditures are $27.575 million higher than the 1995-96 Main Estimates. This is mainly due to:

	($000)
• internal transfers from Health Protection Branch;	20,762
• transfer from Health Protection Branch to cover a shortfall in Facilities Management;	2,770
• increased requirement for salary items that are not funded from Departmental budgets;	2,422
• departmental reallocation of funds to cover centralized corporate support in Informatics, Human Resources and other areas; and	2,002
• transfer of the AIDS Secretariat to the Health Promotion and Programs Branch.	(1,438)

Performance Information

Departmental Planning and Financial Administration Directorate

In 1995-96, DPFA was successful in implementing the Lotus Notes-based Operating Budget Reporting System across the country and providing training to the system users. It also continued to play a key role in developing and implementing departmental policies, procedures and systems related to cost recovery. In partnership with Medical Services Branch, the Health Protection Branch and the Pest Management Regulatory Agency, the Directorate helped managers to steer their proposals through to approval. The Directorate also ensured the success of both the Department's Program Review and Business Plan. DPFA developed financial options, identified the financial impacts of alternatives and the financial flexibilities required by the Department to meet its planning objectives over the next three years. This role will continue because of shrinking budgets and the likelihood of further program reductions.

Assets Management Directorate

Construction of New Federal Laboratories: The construction of the new federal laboratories in Winnipeg, Manitoba, is approximately 93% complete. The project is proceeding according to schedule. The project is a joint venture of the Departments of Agriculture and Agri-food Canada and Health Canada. The state of the art complex contains the only level 4 biosafety containment laboratories in Canada as well as animal holding areas, training and research facilities, and offers Canadians enhanced security against emerging diseases of people and animals. The facility is unique as it is the first of its kind to house both public health and animal health programs.

Space Optimization Project (Formerly known as Headquarters Consolidation): The Space Optimization Program is progressing on schedule. The construction of fit-up for the tower and podium of the Brooke Claxton building in Tunney's Pasture, Ottawa, has been completed and the building is now fully occupied by departmental personnel. A mid-term review of the project has been completed. The project is now entering into its next phase which is the rehabilitation and fit-up of the Jeanne Mance building in Tunney's Pasture, Ottawa. The development of the design and planning of the space and the fit-up requirements for all floors of the Jeanne Mance building is nearing completion. The overall project is scheduled for completion in April, 1998.

Information Management Services Directorate

Enterprise Network Project: With the completion of this major initiative in 1995-96, the Department has put in place the basic technology infrastructure required to support planned enterprise-wide communications and business re-engineering initiatives. E-mail networks are now connected into a cohesive framework capable of supporting communications and information sharing regardless of location. As part of this initiative, the Department began the roll-out of Lotus Notes, a work group computing tool that will facilitate work flow, easy access to departmental applications and further information sharing throughout the Department.

Governance: With the establishment of its Information Management Resource Division (IMRD) in 1995-96, the Information Management Services Directorate (IMSD) is now taking an integrated approach to the provision of corporate information technology (IT) and information management (IM) services, attending to the critical requirement for enhanced information security and establishing the necessary planning and governance infrastructure.

A department-wide IM/IT annual planning process, designed to guide planning and decision-making associated with IM and IT investments, and to link these activities with business planning processes, was introduced in 1995-96. A departmental IM/IT business case development methodology has also been designed to support IM/IT planning and decision-making. A departmental IT standards framework has recently been developed. It will ensure that the introduction of standards is based on clear business needs and is the result of a collaborative process.

Internet Services: Integrated Internet services have been established for Departmental users. To ensure the effective use of this powerful tool, an Internet "home page" (see page 140) has been created on the world wide web, which serves as the first point of entry to those wishing to access Health Canada as well as a link to other Internet sites delivering health information. Ultimately, Health Canada information made available via the Internet will be organized according to a departmental information classification structure which reflects Departmental business lines.

Library Services: A major departmental library services review was completed in 1996-97. Its goal was to provide the foundation for streamlining the Department's library services, modernizing delivery to clients and resolving some issues of duplication and redundancy.

Human Resources Directorate

Diversity: In 1995-96, the Department began implementation of its two-year Employment Equity Action Plan. A Diversity Management Framework and a one-day training session, "Leading Diverse Work Teams", were developed and piloted to senior managers. In addition, a "Diversity on the Frontline" workshop on bias-free recruitment was delivered to all HR specialists across the country.

Career Centre: The Career Centre officially opened its doors on February 15, 1996. Services and programs include: individual career counselling, workshops on career management, a resource room, assignments and development programs. The Career Centre works in partnership with regional Learning and Employee Development Centres.

Official Languages: In 1995, Health Canada negotiated a Letter of Understanding (LOU) with the Treasury Board Secretariat in the area of Official Languages. This LOU outlines the Official Language's strategic goals and objectives for the Department for the next three years, linked with an accountability framework.

Employee's Kit on Work Force Adjustment: An Employee's Kit has been prepared on Work Force Adjustment. It will be distributed as needed to employees who are or may become surplus to requirements, to provide them with information concerning work force adjustment and to serve as a guide to the services available in the department. It also contains tips on drafting a résumé and on preparing for a job interview.

Orientation Program: An innovative Departmental Orientation Program was developed and implemented, including guides for employees and supervisors and a video entitled "Making a Difference".

Departmental Learning Needs Analysis: An extensive departmental learning needs analysis was undertaken, aimed at identifying future organizational and individual learning objectives so as to ensure that Departmental staff have the requisite skills of the future. This analysis also included an evaluation of the existing learning programs and a review of the Learning Centres.

Internal Audit Directorate

Government-wide Audit Priorities: Internal Audit responded quickly and professionally to requests for special audits on specific topics of government-wide concern. Examples are Workforce Adjustment, irregular advance payments, and year-end spending.

Deputy Ministers' Priorities: The Deputy Minister and the Associate Deputy Minister periodically have a need for independent, objective reviews of the management control frameworks of selected programs or organizational units within the Department. Examples are Children's programming and Environmental Stewardship.

Selected Issues and Potential Efficiency Gains: Internal Audit has continued to do audits to test the reliability of selected systems or processes, using a risk-based selection process. Areas include Departmental security, the integrity of the Departmental Financial System, contract management, pay and benefits and acquisition cards.

Special Investigations: Internal Audit has kept pace with an increased volume of allegations of impropriety or wrongdoing relating to the spending of Departmental funds. Each case has been treated very seriously. Special investigations have consumed an increasing proportion of internal audit resources during the planning period.

Joint Audits: Health Canada has collaborated successfully on joint audits with the Auditor General (Non-Insured Health Benefits) and with internal audit units of selected other government departments and agencies (e.g., construction of the federal laboratories in Winnipeg).

National Forum on Health

From its launch in the fall of 1994 to March, 1996, the Forum completed the first part of its mandate. In order to make recommendations for the future of Canada's health and health care system the Forum identified and defined the key issues which had to be addressed; sought practical and innovative ways to improve the health of Canadians; looked at ways to ensure that decisions are based on solid evidence and shared values; and developed strategies to ensure the best value for money in our health system.

The Forum held meetings and workshops with experts in the fields of health information, child health, youth health and population health. Members attended more than 100 public activities and made presentations at numerous major conferences. Canadian values were studied through a survey and in focus groups, and specific issues were examined through over 40 commissioned papers.

As well, the Forum sought to involve and inform Canadians through consultation with the public, the health community and non-governmental organizations with an interest in health. From November, 1995, to March, 1996, the Forum held 71 discussion groups in 34 communities across Canada including Aboriginal communities and it reached out to people with special health needs. In April, 1996, stakeholders from the health community and non-governmental organizations were consulted during a national conference.

From March, 1996, to December, 1996, the Forum analyzed the information it collected, synthesized the material into four working group reports and prepared a document containing their analysis and key strategic directions and options for further consultation.

In November, 1996, the Forum continued its dialogue with Canadians by holding two national conferences (one in Vancouver, British Columbia, and one in Montréal, Quebec) with participants from the Stakeholder Group and the public discussion group. The objective of these conferences was to seek participants' views on proposed options and directions, as well as to receive advice on implementation.

Participants of the Phase I consultation who were unable to attend the conferences, those who completed the self-directed workbook of the first phase and an additional 500 Canadians randomly chosen, were given the opportunity to take part in this process through telephone interviews.

The findings from this set of consultations were analyzed and considered in arriving at the Forum's recommended actions to governments. The final report of the Forum will be presented to Canadians and the Government in early 1997.

IV Supplementary Information

A. Profile of Program Resources

1. Financial Requirements

Figure 48: 1997-98 Resources by Organization and Activity

(thousands of dollars)	Health Protection Branch	Pest Management Regulatory Agency	Health Promotion & Programs Branch	Medical Services Branch	Policy & Consultation Branch	Departmental Executive & Corporate Services Branch	**Activity Total**	**Full Time Equivalents**
Food Safety, Quality and Nutrition	43,616						**43,616**	**552**
Drug Safety, Quality and Effectiveness	13,031						**13,031**	**652**
Environmental Quality and Hazards	35,634						**35,634**	**526**
National Health Surveillance	44,013						**44,013**	**298**
Pest Management Regulatory Agency		12,130					**12,130**	**202**
Programs and Services			192,170				**192,170**	**430**
Indian and Northern Health Services				1,028,299			**1,028,299**	**1,396**
Public Service Health				22,102			**22,102**	**395**
Health Advisory and Assessment Services				3,867			**3,867**	**93**
Policy and Consultation					31,966		**31,966**	**191**
Health Insurance					1,731		**1,731**	**23**
Program Management						105,499	**105,499**	**910**
Total	136,294	12,130	192,170	1,054,268	33,697	105,499	**1,534,058**	
FTE	2,028	202	430	1,884	214	910		**5,668**

Figure 49: Details of Financial Requirements

(thousands of dollars)	1994-95 Actuals	1995-96 Actuals	1996-97 Estimates	**1997-98 Estimates**	1998-99 Planned	1999-00 Planned
Personnel	372,005	374,450	363,136	**331,096**	312,740	313,215
Goods and Services	650,722	680,510	646,594	**691,206**	663,508	693,974
Minor Capital	2,102	1,577	2,198	**0**	0	0
Total operating	1,024,829	1,056,537	1,011,928	**1,022,302**	976,248	1,007,189
Controlled Capital	82,603	49,265	31,024	**11,417**	12,960	12,960
Transfer Payments	8,026,024	7,805,565	585,030	**562,041**	533,533	533,533
Less: Revenue credited to the Vote	(18,528)	(29,206)	(51,133)	**(61,702)**	(50,144)	(50,144)
Total Department	9,114,928	8,882,162	1,576,849	**1,534,058**	1,472,597	1,503,538

2. Personnel Requirements

The Health Program's personnel costs of $331 million account for 21.6% of the Program's total Main Estimates. Information on human resources (FTE) is provided in Figures 50 and 51.

Figure 50: Details of Personnel Requirements by Activity

Full Time Equivalents*	1994-95 Actuals	1995-96 Actuals	1996-97 Estimates	**1997-98 Estimates**	1998-99 Planned	1999-00 Planned
Food Safety, Quality and Nutrition	756	704	762	**552**	552	552
Drug Safety, Quality and Effectiveness	716	718	782	**652**	646	646
Environmental Quality and Hazards	533	555	532	**526**	523	523
National Health Surveillance	294	324	287	**298**	251	238
Pest Management Regulatory Agency	0	0	343	**202**	197	197
Programs and Services	544	580	564	**430**	358	359
Indian and Northern Health Services	1,861	1,829	1,724	**1,396**	1,394	1,394
Public Service Health	356	318	357	**395**	351	351
Health Advisory and Assessment Services	81	62	77	**93**	63	63
Policy and Consultation	192	193	165	**191**	179	179
Health Insurance	26	23	23	**23**	23	23
Program Management	835	856	746	**910**	862	862
Total Department	6,194	6,162	6,362	**5,668**	5,399	5,387

* Full time equivalents (FTE) are a measure of human resource consumption based on average levels of employment. FTEs are not subject to Treasury Board control but are disclosed in Part III of the Estimates in support of personnel expenditure requirements specified in the Estimates.

Figure 51: Summary by Professional Category

Full Time Equivalents*	1994-95 Actuals	1995-96 Actuals	1996-97 Estimates	**1997-98 Estimates**
OIC Appointments[1]	1	2	2	**2**
Executive[2]	131	126	123	**110**
Scientific and Professional	2,268	2,154	2,463	**2,098**
Administrative and Foreign Service	1,381	1,444	1,412	**1,301**
Technical	576	625	591	**600**
Administrative Support	1,508	1,499	1,485	**1,280**
Operational	329	312	286	**277**
Total Department	6,194	6,162	6,362	**5,668**

[1] This includes all those at the DM level and all GICs.
[2] This includes all those in the EX-1 to EX-5 range inclusive.

3. Capital Expenditures

The Health Program's capital costs of $11.417 million account for 0.7% of the Program's total Main Estimates. Information on capital costs by Activity is provided in Figure 52.

Figure 52: Capital Expenditures by Activity

(thousands of dollars)	1994-95 Actuals	1995-96 Actuals	1996-97 Estimates	**1997-98 Estimates**	1998-99 Planned	1999-00 Planned
Food Safety, Quality and Nutrition	3,300	4,114	1,790	**2,062**	2,232	2,232
Drug Safety, Quality and Effectiveness	3,076	2,031	2,206	**1,580**	2,811	2,811
Environmental Quality and Hazards	4,968	2,769	2,197	**1,848**	1,990	1,990
National Health Surveillance	1,763	1,314	1,419	**1,310**	1,310	1,310
Pest Management Regulatory Agency	—	—	1,500	**—-**	—	—
Programs and Services	1,411	1,303	264	**—-**	—	—
Indian and Northern Health Services	15,210	12,254	12,032	**560**	560	560
Public Service Health	838	345	1,257	**—-**	—	—
Health Advisory and Assessment Services	65	57	107	**—-**	—	—
Policy and Consultation	230	172	8	**—-**	—	—
Health Insurance	30	12	—	**—-**	—	—
Program Management	53,814	26,471	10,442	**4,057**	4,057	4,057
Total Department	84,705	50,842	33,222	**11,417**	12,960	12,960

Definitions Applicable to Controlled Capital and Major Crown Projects

Controlled capital, formerly called major capital, has been defined to include budgeted resources for:

- acquisition of land, buildings, engineering structures and works;
- alterations or modifications to assets which extend the useful life or change performance and agreed limits; and
- other investments exceeding limits to be agreed on for each department.

Minor capital is the residual after the determination of major capital.

Government Projects - A departmental undertaking which is not a regular program activity, but involves the design and development of new programs, equipment, structures, or systems, and has above normal risk, is deemed to be a government project when:

a. its estimated expenditure exceeds the project approval authority granted to the department by the Treasury Board; or

b. it is particularly high risk, regardless of estimated expenditure.

When a high risk government project exceeds $100 million in estimated expenditure, it is deemed to be a Major Crown Project.

All major capital projects are displayed with information on the class of the estimate (Substantive (S) or Indicative (I)) and the extent of Treasury Board authority, i.e. delegated to the Department (DA), Preliminary Project Approval (PPA) or Effective Project Approval (EPA). The following definitions apply:

Substantive Estimate - This estimate is one of sufficiently high quality and reliability so as to warrant Treasury Board approval as a Cost Objective for the project phase under consideration. It is based on detailed system and component design and taking into account all project objectives and deliverables.

Indicative Estimate - This is a low quality, order of magnitude estimate that is not sufficiently accurate to warrant Treasury Board approval as a Cost Objective. It replaces the classes of estimates formerly referred to as Class C or D.

Preliminary Project Approval (PPA) - This is Treasury Board's authority to initiate a project in terms of its intended operational requirement, including approval of the objectives of the project definition phase and any associated expenditures. Sponsoring departments submit for PPA when the project's complete scope has been examined and costed, normally to the indicative level, and when the cost of the project definition phase has been estimated to the substantive level.

Effective Project Approval (EPA) - This is Treasury Board's approval of the objectives (project baseline), including the Cost Objective, of the project implementation phase and provides the necessary authority to proceed with implementation. Sponsoring departments submit for EPA when the scope of the overall project has been defined and when the estimates have been refined to the substantive level.

Departmental Approval (DA) - Treasury Board approval is not required. Medical Services Branch has delegated authority for projects up to a total of $2 million.

4. Transfer Payments

Figure 53: Details of Grants

(dollars)	1994-95 Actuals*	1995-96 Actuals*	1996-97 Estimates	**1997-98 Estimates**
Grants				
Health Protection				
Food Safety, Quality and Nutrition				
National Food Distribution Centre	—	—	15,000	**15,000**
Environmental Quality and Hazards				
World Health Organization	100,000	100,000	100,000	**100,000**
International Commission on Radiological Protection	5,000	5,000	5,000	**5,000**
Health Promotion and Programs				
National Voluntary Health Organizations	2,298,250	2,662,175	2,749,000	**—-**
Health Promotion Grants Program	7,306,232	6,913,514	8,929,000	**9,450,000**
Canadian Centre on Substance Abuse	1,420,000	1,420,000	500,000	**500,000**
National Cancer Institute of Canada	2,000,000	2,000,000	2,000,000	**2,000,000**
Aboriginal Head Start	—	1,764,423	1,840,000	**400,000**
Medical Services				
Grants to Individuals of Indian and Inuit ancestry in the form of bursaries to assist them in their health career studies	246,655	264,250	300,000	**500,000**
Policy and Consultation				
Membership fees to International Organizations	75,000	93,000	—	**—-**
World Health Organization and Pan American Health Organization	80,000	—	—	**—-**
International Agency for Research on Cancer	1,281,451	1,359,291	1,100,000	**—-**
Grants to eligible non-profit international organizations in support of their projects or programs on health	500,000	515,000	922,000	**97,000**
Health Services Research Fund	—	—	—	**11,000,000**
Total Grants	15,312,588	17,096,653	18,460,000	**24,067,000**
Statutory Payments**				
Health Insurance				
Insured Health Services Program	6,063,956,000	5,721,260,000	—	**—-**
Extended Health Care Services Program	1,502,133,000	1,519,266,000	—	**—-**
Total Statutory Payments	7,566,089,000	7,240,526,000	—	**—-**

* Some figures may not agree with Public Accounts due to rounding.

** Payments under the Federal-Provincial Fiscal Arrangements and Post-Secondary Education and Health Contributions Act, 1977. 1996-97 and future Statutory contributions have been replaced by transfers to provinces under the Canada Health and Social Transfer (CHST). CHST transfers appear in the Department of Finance Estimates.

Figure 54: Details of Contributions

(dollars)	1994-95 Actuals	1995-96 Actuals	1996-97 Estimates	**1997-98 Estimates**
Contributions				
Health Protection				
Food Safety, Quality and Nutrition				
Contributions made to non-profit organizations engaged in activities related to Health Protection	—	7,000	—	**—-**
Drug Safety, Quality and Effectiveness				
Canadian Coordinating Office for Health Technology Assessment	305,874	—	—	**—-**
Contributions made to non-profit organizations engaged in activities related to Health Protection	—	514,070	—	**—-**
Environmental Quality and Hazards				
Province of New Brunswick-Minister of Finance	19,390	—	—	**—-**
Province of Newfoundland-Minister of Finance	33,333	—	—	**—-**
Province of PEI-Minister of Finance	5,066	—	—	**—-**
Province of BC-Minister of Finance	160,000	—	—	**—-**
University of Waterloo	10,000	—	—	**—-**
World Health Organization	100,000	—	—	**—-**
Contributions made to non-profit organizations engaged in activities related to Health Protection	—	1,549,980	—	**—-**
National Health Surveillance				
Contributions made to non-profit organizations engaged in activities related to Health Protection	—	90,000	—	**—-**
Health Promotion and Programs				
National Health R&D Program	30,510,226	35,174,139	28,462,000	**21,209,000**
Health Promotion Contributions Program	15,958,472	22,645,573	13,432,000	**14,215,000**
Alcohol and Drugs Education and Research Programs	800,000	800,000	—	**—-**
National AIDS Program	13,512,646	12,422,243	12,238,000	**12,038,000**
Family Violence	7,010,980	1,310,684	—	**—-**
New Horizons	4,227,451	10,861,838	18,000,000	**7,016,000**
Seniors Independence Program	9,550,636	—	—	**—-**
Ventures in Independence	1,224,780	—	—	**—-**
Partners for Children Fund	4,451,748	5,566,114	—	**—-**
Community Action Program for Children and Prenatal Nutrition	35,255,345	44,665,213	57,960,000	**42,185,000**
Contributions to national fitness/recreation associations and agencies	7,237,243	6,658,808	3,965,000	**1,737,000**
Contributions to ParticipACTION	1,423,000	1,250,000	900,000	**700,000**
Aboriginal Head Start	—	3,648,836	14,435,000	**18,645,000**

Figure 54: Details of Contributions (cont'd)

(dollars)	1994-95 Actuals	1995-96 Actuals	1996-97 Estimates	**1997-98 Estimates**
Medical Services				
Indian and Northern Health Services				
Contributions for Integrated Indian and Inuit Community-based Health Care Services	155,085,922	180,929,421	203,666,800	**200,873,000**
Payments to Indian bands, associations or groups for the control and provision of health services	51,260,635	74,924,827	75,415,000	**93,000,000**
Contributions for National Indian and Inuit time-limited special initiatives	18,407,000	21,521,011	9,466,000	**12,500,000**
Contributions to Indian Bands, Indian and Inuit associations or groups or local governments and the Governments of the Yukon and NWT for Non-insured Health Services	55,995,133	66,824,176	70,125,000	**70,125,000**
Payments to Indian bands, associations or groups for the control and provision of non-insured health benefits	—	—	10,000,000	**10,000,000**
Contributions towards the cost of Indian and Inuit health facilities and health care equipment.	18,793,291	36,477,010	—	**—-**
Contributions to universities, colleges and other organizations to increase the participation of Indian and Inuit students in academic programs leading to professional health careers	2,163,035	2,200,926	2,426,000	**2,226,000**
Contribution to the Government of of Newfoundland toward the cost of health care delivery to Indian and Inuit communities	901,988	907,000	907,000	**907,000**
Contributions to Indian and Inuit associations or groups for consultation on Indian and Inuit Health	1,055,045	943,519	1,053,000	**1,053,000**
Contribution to the Government of the Yukon for the construction of the Whitehorse General Hospital	7,700,000	13,970,000	18,587,000	**2,700,000**
Contributions on behalf of, or to, Indians or Inuit towards the cost of construction, extension or renovation of hospitals and other health care delivery facilities and institutions as well as of hospital and health care equipment	—	—	1,200,000	**1,100,000**
Policy and Consultation				
Health or welfare information systems	389,396	297,742	1,458,600	**3,058,600**
Canadian Corporation for the IYF	1,074,259	—	—	**—-**
Contribution to the Canadian Institute for Health Information	—	1,781,600	2,672,400	**2,672,400**
Program Management				
Contributions for Integrated Indian and Inuit Community-based Health Care Services	—	—	4,073,200	**4,073,200**
Contributions towards the cost of Indian and Inuit health facilities and health care equipment	—	—	16,128,000	**15,940,400**
Total Contributions	444,621,894	547,941,730	566,570,000	**537,973,600**
Total Grants, Contributions, and Statutory Payments	8,026,023,482	7,805,564,383	585,030,000	**562,040,600**

5. Revenue

Program revenues for 1993-94 were credited directly to the Consolidated Revenue Fund and were not available for use by the Program. Hospital revenues result from payments for service provided in Medical Services Branch hospitals which are covered under provincial or territorial plans. Cost sharing revenues are received primarily from the Yukon territorial government for health stations operated in the Yukon. Revenues are also generated through fees, fines and disposal of seized assets. For 1994-95, the Department introduced net-voting for Dosimetry Services and for MSB hospital services.

Figure 55: Revenue Sources

(thousands of dollars)	1994-95 Actuals	1995-96 Actuals	1996-97 Estimates	**1997-98 Estimates**	1998-99 Planned	1999-00 Planned
Revenue Credited to the CRF						
Drug Safety, Quality and Effectiveness						
Import/export and other license fees	2,490	11	—			
Fines and seizures	3,727*	3,548	—			
Indian and Northern Health Services						
Cost Sharing	3,925	3,080	3,950			
Professional Services	1,126	1,631	1,130			
Other	1,624	1,545	1,630			
Total Revenue Credited to the CRF	12,892	9,815	6,710	**0**	0	0
Revenue Credited to the Vote						
Food Safety, Quality and Nutrition	—	231	2,082	**2,306**	2,179	2,179
Drug Safety, Quality and Effectiveness	—	10,626	27,529	**35,935**	31,181	31,181
Environmental Quality and Hazards	2,655	2,746	4,321	**4,303**	4,303	4,303
Pest Management Regulatory Agency	—	—	185	**185**	185	185
Indian and Northern Health Services	15,873	14,955	16,300	**11,364**	11,364	11,364
Public Service Health	—	—	0	**4,472**	0	0
Health Advisory and Assessment Services	—	85	250	**1,799**	250	250
Program Management	—	563	466	**1,338**	682	682
Total Revenue Credited to the Vote	18,528	29,206	51,133	**61,702**	50,144	50,144
Total Revenue	31,420	39,022	57,843	**61,702**	50,144	50,144

* This revenue is generated primarily from the sale of seized property. Effective September 1st, 1993, the responsibility for the disposal of seized assets was transferred to Public Works and Government Services Canada under the Seized Property Management Act.

6. Net Cost of Program

The Program's Estimates only include expenditures charged to its voted and statutory authorities. The net cost of the Program takes into account other cost items as well as revenue. Details are as follows:

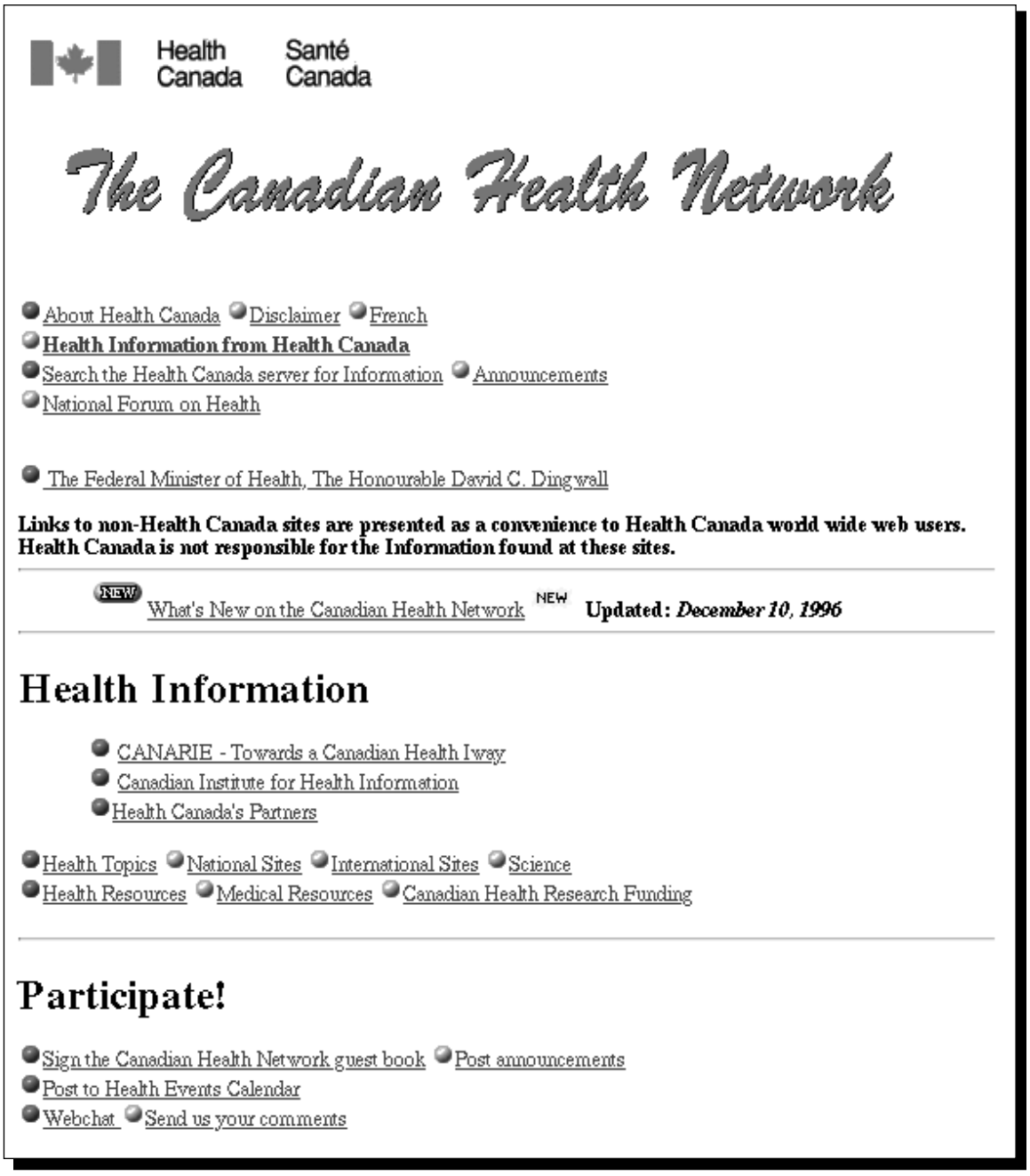
Figure 56: Net Cost of Program

(thousands of dollars)	1994-95 Actuals	1995-96 Actuals	1996-97 Estimates	**1997-98 Estimates**
Operating expenditures	1,024,829	1,054,962	1,011,928	**1,022,302**
Controlled Capital	82,603	50,842	31,024	**11,417**
Transfer Payments	8,026,024	7,805,564	585,030	**562,041**
Less: Receipts & revenues	(18,528)	(29,206)	(51,133)	**(61,702)**
Total Budgetary	9,114,928	8,882,162	1,576,849	**1,534,058**
Services received without charge				
Accommodation	29,987	29,987*	29,987	**29,987***
Cheque issue services	705	669*	679	**684***
- from Public Works and Government Services				
Employer's share of employee benefits covering insurance premiums and costs				
- from Treasury Board Secretariat	14,316	19,761*	18,739	**18,872**
Airport Space				
- by Department of Transport	54	146*	150*	**15**
Legal services				
- from Department of Justice	461	186*	660	**641**
Workmen's Compensation coverage				
- from Human Resources Development	858	867*	876	**1,009**
Sub-total	46,381	51,616	51,091	**51,208**
Total Program cost	9,161,309	8,933,778	1,627,940	**1,585,266**
Less: Revenues credited to the CRF	(12,892)	(9,815)	(6,710)	**—**
Estimated net Program cost	9,148,417	8,923,963	1,621,230	**1,585,266**

* Estimated amount

B: Other Information

Figure 57: Health Canada World Wide Web Home Page



http://www.hwc.ca/

Figure 58: Medical Services Branch Regional Health Facilities

Region	Atlantic	Quebec	Ontario	Manitoba	Sask.	Alberta	B.C.	Yukon	Total
Hospitals			2	2	1	1			6
Nursing Stations		11	18	21	10	3	9	4	76
Health Centres	12	13	26	11		30	12	10	114
Health Stations			41		67	13	67	1	189
Health Offices	19		31	27	1	1	17		96
NNADAP TCs	7	5				6	8		26

Hospitals: Hospitals are facilities operated for medical surgical obstetrical care of in-patients and out-patients usually located in or near a populated centre.

Nursing Station: A nursing station is a field unit located in an isolated/remote community where there is no year round road access to other health care facilities. It houses field unit staff of two or more community health nurses and other support and primary health care staff organized to carry out primary health care services including urgent care, short-term in-patient care and public/community health. Access for urgent health needs is available on a 24-hour basis. Physician services and dental services are provided on a visiting basis.

Health Centre: A health centre is a field unit staffed by one or more community health nurses and support personnel to carry out disease prevention and health promotion activities in the community. Services for primary/urgent care are provided by physicians residing in the area or on a visiting basis. A Health Centre is normally located in non-isolated and semi-isolated communities.

Health Station: A health station is a field unit in a small building or trailer in an isolated or semi-isolated community. It houses field unit staff consisting of community health nurse(s) and other health care support staff to carry out disease prevention and health promotion activities in the community. A Health Station may include primary care services for urgent health needs of the community which is available on weekdays only and not on a 24-hour basis. Physician services and dental services are provided on a visiting basis.

Health Office: A health office is leased space or space funded through a contribution agreement within a multi-purpose building (ie., Band office, Community Centre, etc.). This arrangement supports the work of Community Health Representatives, visiting Community Health Nurses and other transient health care providers.

NNADAP TCs: These are facilities for the prevention and treatment of alcohol and drug abuse including treatment, residential, recreational, social, administrative and training components.

Figure 59: Health Protection Branch Regional Headquarters and Laboratories, and District Offices

Atlantic Region - Dartmouth	
District offices	Dartmouth
	St. John's
	Saint John
	Charlottetown
Quebec Region - Montreal (Longeuil)	
District offices	Québec
	Sherbrooke
	Trois-Rivières
	Hull
Ontario Region - Toronto (Scarborough)	
District offices	Toronto West
	Hamilton
	London
	Ottawa
Central Region - Winnipeg	
District offices	Brandon
	Regina
	Saskatoon
Western Region - Vancouver	
District offices	Vancouver Island (Victoria)
	B.C. Interior (Kelowna)
	B.C. Lower Mainland (Burnaby)
	Northern Alberta (Edmonton)
	Southern Alberta (Calgary)

Mandate: Acts administered in whole or in part by the Department of Health

1. Canada Health Act, R.S.C. 1985, c. C-6
   - Extra-Billing and User Charges Information Regulations SOR/84-503, SOR/85-274, SOR/86-259

2. Canada Medical Act, R.S.C. 1952, c. 27

3. Canadian Centre on Substance Abuse Act, R.S.C. 1985, c. C-13.4

4. Canadian Environmental Protection Act, R.S.C. 1985, c. 16 (4th Supp.)
   - Ozone-depleting Substances Regulations, SOR/95-576
   - Ozone-depleting Substances Products Regulations, SOR/95-584
   - Prohibition of Certain Toxic Substances Regulations, SOR/96-237

5. Department of Health Act, S.C. 1996, c. 8
   - Order fixing July 12, 1996 as the Date of the Coming into Force of the Act, SI/96-69

5.1. Department of Health Act, S.C. 1996, c. 8
   - Potable Water on Common Carriers, C.R.C. 1978, c. 1105

5.2. Department of Health Act, S.C. 1996, c. 8
   - Human Pathogens Importation Regulations, SOR/94-558

6. Federal-Provincial Fiscal Arrangements Act, R.S.C. 1985, c. F-8
   - Public Service Re-arrangement and Transfer of Duties Act, SI/95-52

7. Financial Administration Act, R.S.C. 1985, c. F-11
   - Minister of National Health and Welfare Authority to Prescribe Fees Order, SI/88-98
   - Dosimetry Services Fees Regulations, SOR/90-109, SOR/94-279
   - Authority to Sell Drugs Fees Regulations, SOR/95-31
   - Drug Evaluation Fees Regulations, SOR/95-424
   - Medical Devices Fees Regulations, SOR/95-585
   - Veterinary Drug Evaluation Fees Regulations, SOR/96-143

8. Fitness and Amateur Sport Act, R.S.C. 1985, c. F-25
   - Fitness and Amateur Sport Regulations, C.R.C. 1978, c. 868
   - Order Designating the Minister of Health as Minister for Purposes of the Act Respecting Fitness and the Minister of Canadian Heritage as Minister for Purposes of the Act, SOR/96-74

9. Food and Drugs Act, R.S.C. 1985, c. F-27
   - Cosmetic Regulations, C.R.C. 1978, c. 869
   - Food and Drug Regulations, C.R.C. 1978, c. 870
   - Order Transferring Food Safety Policy Activities from the Department of Agriculture and Agri-Food to the Department of Health, SI/96-52

10. Hazardous Materials Information Review Act, S.C. 1985, c. H-2.7
    - Hazardous Materials Information Review Regulations, SOR/88-456
    - Hazardous Materials Information Review Act Appeal Board Procedures Regulations, SOR/91-86

11. Hazardous Products Act, R.S.C. 1985, c. H-3 as amended
    - Hazardous Products Regulations:
    - Carbonated Beverage Glass Containers Regulations, SOR/80-831
    - Carriages and Strollers Regulations, SOR/85-379
    - Consumer Chemicals and Containers Regulations, SOR/88-556
    - Controlled Products Regulations, SOR/88-66
    - Cribs and Cradles Regulations, SOR/86-962
    - (Booster Cushions), SOR/89-446
    - (Carpet), CRC, Vol. IX, c. 923, p. 6995
    - (Cellulose Insulation), SOR/79-732
    - (Charcoal), CRC, Vol. IX, c. 924, p. 6997
    - (Child Restraint Systems), SOR/88-151
    - (Children's Sleepwear), SOR/87-443
    - (Crocidolite Asbestos), SOR/89-440
    - (Expansion Gates and Expandable Enclosures), SOR/90-39
    - (Glazed Ceramics), CRC, Vol. IX, c. 925, p. 6999
    - (Ice Hockey Helmets), SOR/89-257
    - (Infant Feeding Bottle Nipples), SOR/84-271
    - (Kettles), CRC, Vol. IX, c. 927, p. 7029
    - (Lighters), SOR/89-514
    - (Liquid Coating Materials), CRC, Vol. IX, c. 928, p. 7031
    - (Matches), CRC, Vol. IX, c. 929, p. 7033
    - (Mattresses), SOR/80-810
    - (Pacifiers), CRC, Vol. IX, c. 930, p. 7039
    - (Tents), SOR/90-245
    - (Toys), CRC Vol. IX, c. 931, p. 7045
    - Ingredient Disclosure List, SOR/88-64
    - Playpens Regulations, CRC Vol. IX, c. 932, p. 7073
    - Safety Glass Regulations, CRC Vol. IX, c. 933, p. 7081
    - Science Education Sets Regulations, CRC, Vol. IX, c. 934, p. 7083

12. Medical Research Council Act, R.S.C. 1985, c. M-4
    - Designation Order of the Responsible Minister, SI/77-207

13. Narcotic Control Act, R.S.C. 1985, c. N-1
    - Narcotic Control Regulations, C.R.C. 1978, c. 1041
    - Narcotic Control Regulations, amendment, SOR/85-588
    - Narcotic Control Regulations, amendment, SOR/85-930
    - Narcotic Control Regulations, amendment, SOR/86-173
    - Narcotic Control Regulations, amendment, SOR/86-882
    - Narcotic Control Regulations, amendment, SOR/88-279
    - Schedule to the Act, amendment, SOR/96-258

14. Patent Act, R.S.C. 1985, c. P-4
    - Order designating the Minister, SI/93-114
    - Patented Medicines (Notice of Compliance) Regulations, SOR/93-133
    - Patented Medicines regulations, SOR/88-474
    - Payments to each Province for Research and Development (Medicine) Regulations, SOR/88-167
    - Patent Cooperation Treaty Regulations, SOR/89-453
    - Patent Cooperation Treaty Regulations, amendment, SOR/94-284
    - Patent Rules, amendment, SOR/94-30
    - Patented Medicines Regulations, 1994, SOR/94-688
    - Miscellaneous Amendments Regulations (Department of National Health and Welfare), SOR/95-172

15. Pest Control Products Act, R.S.C. 1985, c. P-9
    - Pest Control Product Regulations, R.S.C. 1978, c. 1253
    - Order designating the Minister, SI/95-44 (P.C. 1995-525), March 28, 1995

16. Pesticide Residue Compensation Act, R.S.C. 1985, c. P-10
    - Assessor's Rules of Procedure, SOR/87-65
    - Pesticide Residue Compensation Regulations, Amendment, SOR/78-865
    - Order designating the Minister, SI/95-44 (P.C. 1995-525), March 28, 1995

17. Quarantine Act, R.S.C. 1985, c. Q-1
    - Quarantine Regulations, C.R.C. 1978, c. 1368

18. Queen Elizabeth II Canadian Research Fund Act, R.S.C. 1970, c. Q-1
    - Order designating the Minister, SI/82-46
    - Order fixing Certain Dates as the Coming into Force of Certain Sections of the Government Organization Act (Federal Agencies), SI/95-115

19. Radiation Emitting Devices Act, R.S.C. 1985, c. R-1
    - Radiation Emitting Devices Regulations, C.R.C. 1978, c. 1370
    - Radiation Emitting Devices Regulations Amendment, SOR/93-210, SOR/94-40

20. Tobacco Products Control Act, R.S.C. 1985, c. 14 (4th Supp.)
    - Tobacco Products Control Regulations, SOR/89-21, SOR/89-248, SOR/93-389, SOR/94-5

21. Tobacco Sales to Young Persons Act, S.C. (1993) c. 5
    - Tobacco Sales to Young Persons Regulations, SOR/94-163, SOR/94-191

Abbreviations

AAFC	Agriculture and Agri-Food Canada
ACAP	AIDS Community Action program
AIDS	Acquired Immune Deficiency Syndrome
ALEP	Active Living Environment Program
APHE	Action Plan on Health and the Environment
ATIS	AIDS Treatment and Information Service
CAPC	Community Action Program for Children
CDAB	Canadian Diabetes Advisory Board
CDC	Centres for Disease Control
CDS	Canada's Drug Strategy
CDSS	Canada's Drug Strategy Secretariat
CEPA	Canadian Environmental Protection Act
CHA	Canada Health Act
CHIRPP	Canadian Hospitals Injury Reporting and Prevention Program
CIDA	Canadian International Development Agency
CRF	Consolidated Revenue Fund
CSB	Corporate Services Branch
CSH	Comprehensive School Health
CTFPHE	Canadian Task Force on the Periodic Health Examination
CUSTA	Canada-United States Trade Agreement
DSQE	Drug Safety, Quality and Effectiveness
EPF	Established Programs Financing
EQH	Environmental Quality and Hazards
ERPD	Extramural Research Programs Directorate
FSQN	Food Safety, Quality and Nutrition
FTE	Full Time Equivalent
G&C	Grants and Contributions
GLHEP	Great Lakes Health Effects Program
GMP	Good Manufacturing Practices
GNP	Gross National Product
HAAS	Health Advisory and Assessment Services
HEP	Healthy Environments Program
HI	Health Insurance
HIV	Human Immuno-suppressive Virus
HPB	Health Protection Branch
HPSB	Health Programs and Services Branch
HRD	Human Resources Development Canada
HTLV	Human T-Lymphotrophic Virus
ICH	International Commission on Harmonization
INHS	Indian and Northern Health Services
ISO	International Standards Organization
IYF	International Year of the Family
LCDC	Laboratory Centre for Disease Control
MMIS	Materiel Management Information System
MRC	Medical Research Council
MSB	Medical Services Branch
NACA	National Advisory Council on Aging
NCFV	National Clearinghouse on Family Violence

Abbreviations (continued)

NCR	National Capital Region
NDR	National Dose Registry
NDS	National Dosimetry Services
NGO	Non-Governmental Organization
NHRDP	National Health Research and Development Program
NHS	National Health Surveillance
NIHB	Non-Insured Health Benefits
NNADAP	National Native Alcohol and Drug Abuse Program
NPSS	National Perinatal Surveillance System
NVHO	National Voluntary Health Organization
PAHO	Pan-American Health Organization
PC	Policy and Consultation
PCB	Policy and Consultation Branch
PCB	Poly-Chlorinated Bi-phenyl
PM	Program Management
PMIS	Personnel Management Information System
PS	Programs and Services
PSH	Public Service Health
SIDS	Sudden Infant Death Syndrome
SIRP	Seniors Independence Research Program
SLHEP	St. Lawrence Health Effects Program
STD	Sexually Transmitted Disease
TBS	Treasury Board Secretariat
TDRS	Tobacco Demand Reduction Strategy
TPCA	Tobacco Products Control Act
TSYPA	Tobacco Sales to Young Persons Act
UNICEF	United Nations International Children’s Emergency Fund
WHMIS	Workplace Hazardous Materials Information System

Topical Index

Topical Index, continued