PERFORMANCE REPORT

Health Canada

For the
period ending
March 31, 1997

Improved Reporting to Parliament —
Pilot Document

Canada

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Foreword

On April 24, 1997, the House of Commons passed a motion dividing what was known as the *Part III of the Estimates* document for each department or agency into two documents, a *Report on Plans and Priorities* and a *Departmental Performance Report.* It also required 78 departments and agencies to table these reports on a pilot basis.

This decision grew out of work by Treasury Board Secretariat and 16 pilot departments to fulfil the government's commitments to improve the expenditure management information provided to Parliament and to modernize the preparation of this information. These undertakings, aimed at sharpening the focus on results and increasing the transparency of information provided to Parliament, are part of a broader initiative known as "Getting Government Right".

This ***Departmental Performance Report*** responds to the government's commitments and reflects the goals set by Parliament to improve accountability for results. It covers the period ending March 31, 1997 and reports performance against the plans presented in the department's *Part III of the Main Estimates* for 1996-97.

Accounting and managing for results will involve sustained work across government. Fulfilling the various requirements of results-based management – specifying expected program outcomes, developing meaningful indicators to demonstrate performance, perfecting the capacity to generate information and report on achievements – is a building block process. Government programs operate in continually changing environments. With the increase in partnering, third party delivery of services and other alliances, challenges of attribution in reporting results will have to be addressed. The performance reports and their preparation must be monitored to make sure that they remain credible and useful.

This report represents one more step in this continuing process. The government intends to refine and develop both managing for results and the reporting of the results. The refinement will come from the experience acquired over the next few years and as users make their information needs more precisely known. For example, the capacity to report results against costs is limited at this time; but doing this remains a goal.

This report is accessible electronically from the Treasury Board Secretariat Internet site: http://www.tbs-sct.gc.ca/tb/key.html

Comments or questions can be directed to the TBS Internet site or to:

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Health Canada

Pilot Performance Report

For the period ending
March 31, 1997

Allan Rock
Minister of Health

This Report

Health Canada takes pride in presenting to Parliament and all Canadians this report on the 1996-97 performance of Health Canada.

The aim of this document is to provide a general overview of how Health Canada has used the resources given to it by the Canadian taxpayer. The department is large and complex, with a wide variety of specific programs. To report on every achievement of each of those programs would occupy much space and would risk losing the audience. We have chosen instead to look at significant achievements, ones that we feel Parliamentarians and the public would be interested in. We have concentrated on making the report realistic and reader-friendly, rather than following a rigid structure that might fit one program but not another.

Starting in 1998-99, Health Canada's programs will be managed by business line. During the fiscal year 1996-97, the department was still operating under an activity structure, and so this report is organized by activity, and its structure should be regarded as interim. Future reports will follow the business line structure.

If you are looking for a specific topic or program and fail to find it here, or want more detail than we have provided, we invite you to contact Health Canada directly for additional information.

Health Canada

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This Report

SECTION I: THE MINISTER'S MESSAGE

I am pleased to present the 1996-97 Performance Report for Health Canada. This document describes Health Canada's objectives and most significant accomplishments for the year.

Since assuming my new responsibilities as federal Minister of Health, I have been impressed by the important work being done in the different programs, directorates and regions of the Department. Health Canada has shown leadership in dealing with a wide range of challenges. Legislation to reduce tobacco use, guidelines to develop a new blood management system, measures to address women's health issues, programs to support healthy child development, strategies to improve Aboriginal health, and completion of the work of the National Forum on Health are just a few of the year's highlights.

One of my primary concerns in my new portfolio is to ensure that all Canadians continue to have access to quality health care when they need it. Canada must continue its long and proud tradition of providing universal, comprehensive, publicly funded health care. Despite the challenges facing Medicare, I am convinced that through innovation we can modernize and strengthen our health care system while supporting the principles of the *Canada Health Act*. I will do my utmost to work with the provinces, the territories and other stakeholders to ensure that we enter the 21st century with a health system that addresses the health needs of Canadians and delivers the highest possible quality care.

I am proud to present the Department's accomplishments and welcome the views of those who are interested in helping the Department carry out its mandate in the best way possible.

The Honourable Allan Rock, P.C., M.P.
Minister of Health

SECTION II: DEPARTMENTAL OVERVIEW

Mandate and Roles

Health Canada's legislative mandate is expressed in the *Department of Health Act* and some 20 other pieces of legislation (see Part IV D). The Department works with the provinces to ensure the long-term sustainability of our national health system, including safeguarding the principles of the *Canada Health Act*.

Our legislative mandate under other Acts includes (among other responsibilities):

- the safety of food, water, drugs, medical devices and consumer products;
- the sale and advertising of tobacco;
- control of narcotics, pest control products and radiation-emitting devices;
- environmental and workplace hazards; and
- the application of quarantine measures.

In addition, Health Canada has responsibility for a range of specific services: providing medical services to visiting dignitaries, overseeing occupational health and safety for federal government workers, supporting disaster and emergency relief operations, and health-related assessment and training services for civil aviation.

The Department provides essential health services to First Nations and Inuit peoples and works with them as they assume responsibility for delivering these services in their communities.

Health is more than the absence of disease. Health Canada provides national leadership and support in population health and well-being. We deliver programs in areas such as child development, social factors affecting health, and nutrition and lifestyle management. We also promote good health by making available the best and latest information for use by governments, health professionals and the public.

Mission

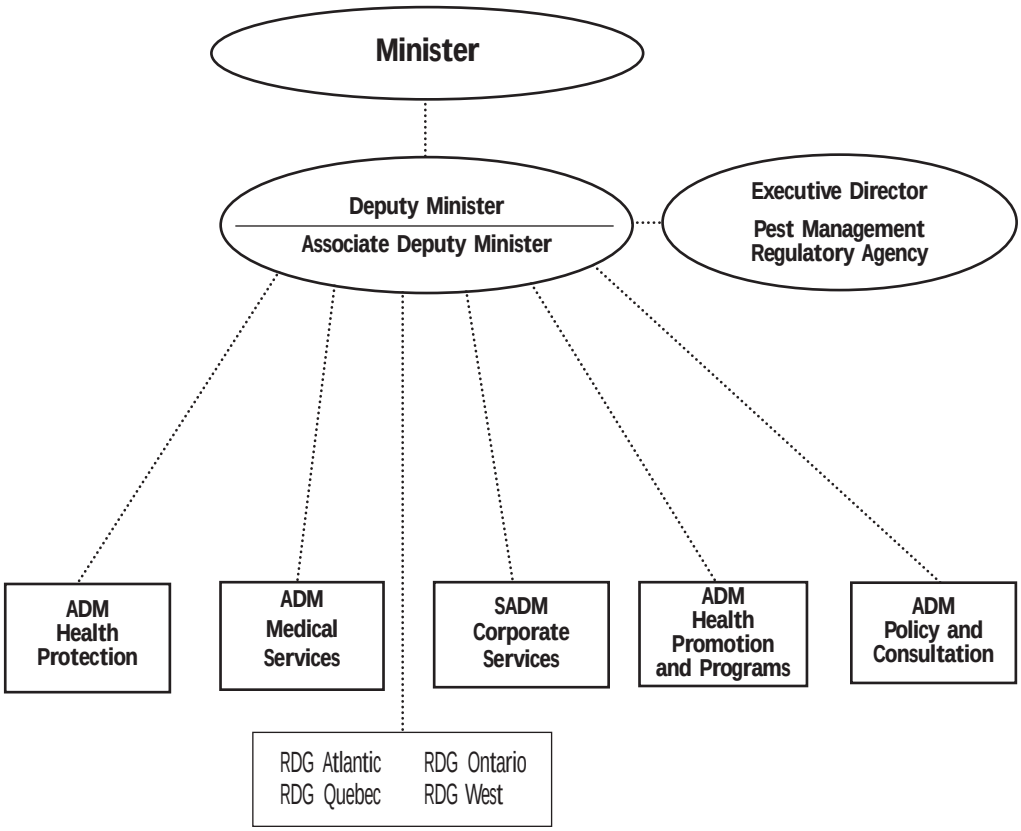
The Department's mission is ***to help the people of Canada maintain and improve their health.***

Strategic Priorities

- To ensure the long-term sustainability of a health system having significant national character.
- To foster strategic and evidence-based decision making in Health Canada and to promote evidence-based decision making in the Canadian health system and by Canadians.
- To anticipate, prevent and respond to health risks.
- To promote a population health approach to health which takes into account the importance of, and linkages among, the determinants of health.
- To assist Aboriginal communities to reach a level of health comparable to that of non-Aboriginal Canadians.

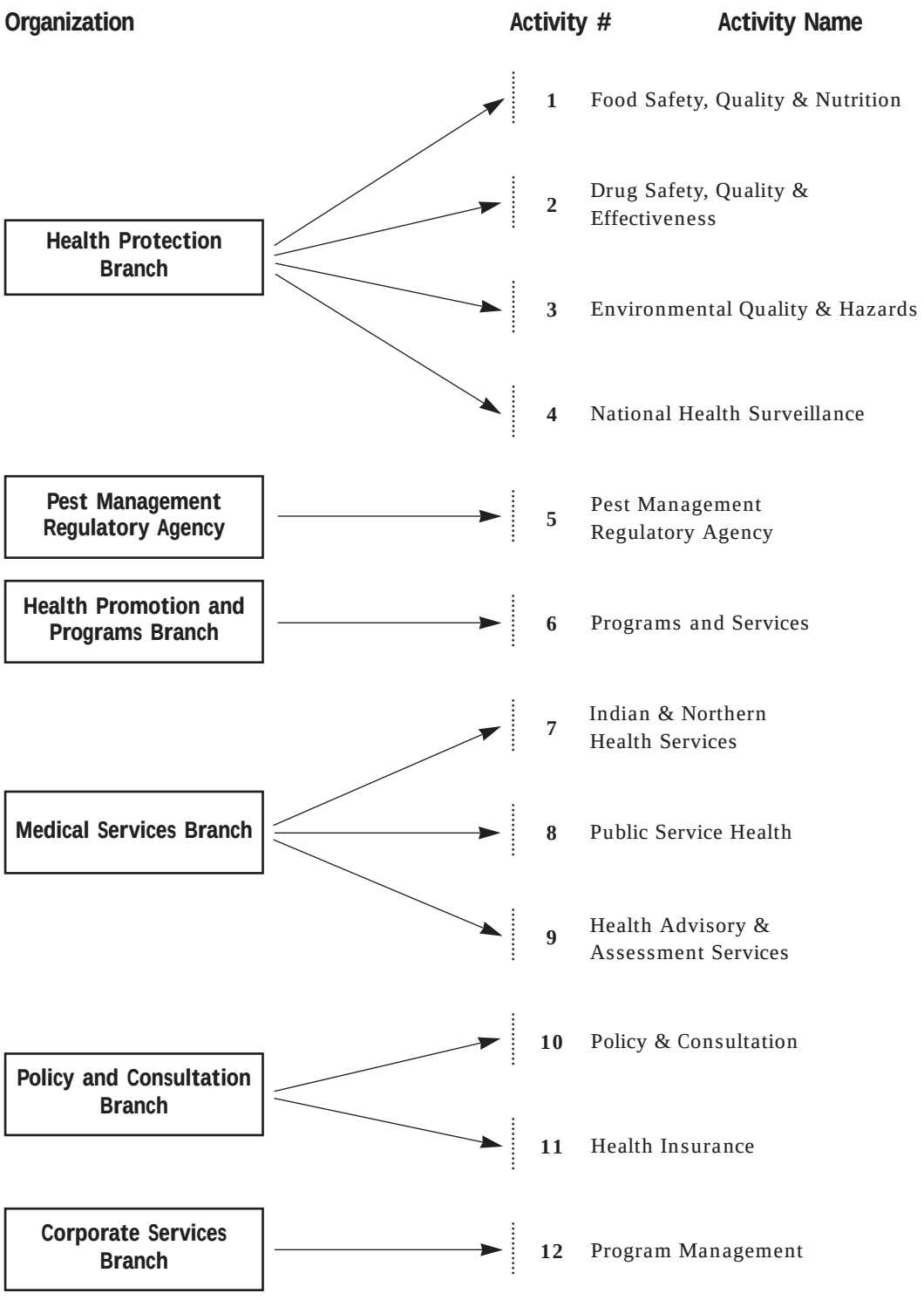
Organizational Structures

FIGURE 1: **Organizational Structure, April 1996**



ADM Assistant Deputy Minister
SADM Senior Assistant Deputy Minister
RDG Regional Directors General

FIGURE 2: **Organizational Relationship to Current Activity**



SECTION 111: DEPARTMENTAL PERFORMANCE

A PERFORMANCE EXPECTATIONS

Planned versus Actual Spending Tables

FIGURE 3: Comparison of Total Planned Spending to Actual Expenditures, 1996-97 by Branch and Activity

($ millions)

Note: Shaded numbers denote actual expenditures in 1996-97.

Organization	Health Protection Branch	Pest Management Regulatory Agency	Health Promotion and Programs Branch	Medical Services Branch	Policy and Consultation Branch	Corporate Services Branch	TOTALS
Activity							
Food Safety, Quality	57.9						57.9
and Nutrition	42.5						42.5
Drug Safety, Quality	20.0						20.0
and Effectiveness	26.2						26.2
Environmental Quality	43.9						43.9
and Hazards	43.0						43.0
National Health	42.4						42.4
Surveillance	42.4						42.4
Pest Management		24.9					24.9
Regulatory Agency		25.6					25.6
Programs and Services			219.0				219.0
			227.7				227.7
Indian and Northern				1,046.5			1,046.5
Health Services				983.6			983.6
Public Service Health				24.9			24.9
				22.7			22.7
Health Advisory and				5.1			5.1
Assessment Services				4.8			4.8
Policy and Consultation					19.0		19.0
					34.4		34.4
Health Insurance [1]					1.7		1.7
					(94.5)		(94.5)
Program Management	0.0					71.5	71.5
	18.3					135.1	153.4
TOTALS	164.2	24.9	219.0	1,076.5	20.7	71.5	1,576.8
	172.4	25.6	227.7	1,011.1	(60.1)	135.1	1,511.8
Percent of Total	11.4	1.7	15.1	66.9	(4.0)	8.9	100.0

[1] the Health Insurance activity actual expenditures includes a statutory adjustment of $96.0M in payments for Insured Health Services and Extended Health Care Services.

FIGURE 4: **Comparison of Total Planned Spending to Actual Expenditures, 1996-97 by Activity** (continued on facing page)

($ millions)

Note: Shaded numbers denote actual expenditures in 1996-97.

Activity	FTE's	Operating [1]	Capital	Voted Grants and Contributions
Food Safety, Quality and Nutrition	762	58.2	1.8	–
	481	42.7	0.7	–
Drug Safety, Quality and Effectiveness	782	45.3	2.2	–
	646	50.5	0.5	–
Environmental Quality and Hazards	532	45.9	2.2	0.1
	516	44.2	1.2	1.3
National Health Surveillance	287	41.0	1.4	–
	327	40.4	1.9	0.1
Pest Management Regulatory Agency	343	23.6	1.5	–
	326	25.8	0.1	–
Programs and Services	564	53.3	0.3	165.4
	561	58.6	0.1	169.0
Indian and Northern Health Services	1,724	637.5	12.0	413.3
	1,550	567.0	9.4	416.8
Public Service Health	357	23.7	1.2	–
	300	23.0	0.6	–
Health Advisory and Assessment Services	77	5.3	0.1	–
	61	5.0	0.1	–
Policy and Consultation	165	12.8	–	6.2
	188	17.7	0.5	16.2
Health Insurance [2]	23	1.7	–	–
	22	1.5	–	–
Program Management	746	61.5	10.4	–
	1,191	101.8	16.0	36.6
TOTALS	6,362	1,009.8	33.1	585.0
	6,169	978.2	31.1	640.0
Other Revenues and Expenditures				
Revenue credited to the Consolidated Revenue Fund				
Cost of services provided by other departments [3]				
Net cost of the program				

[1] Operating includes Contributions to Employee Benefit Plans.

[2] The Health Insurance activity includes an actual statutory adjustment of $96.0M in payments for Insured Health Services and Extended Health Care Services.

[3] Estimated amount.

FIGURE 4: **Comparison of Total Planned Spending to Actual Expenditures 1996-97 by Activity,** (continued)

($ millions)

Note: Shaded numbers denote actual expenditures in 1996-97.

Activity	Subtotal: Gross Voted Expenditures	Statutory Grants and Contributions	Total Gross Expenditures	Less: Revenues Credited to the Vote	Total Net Expenditures
Food Safety, Quality	60.0	–	60.0	2.1	57.9
and Nutrition	43.4	–	43.4	0.9	42.5
Drug Safety, Quality	47.5	–	47.5	27.5	20.0
and Effectiveness	51.0	–	51.0	24.8	26.2
Environmental	48.2	–	48.2	4.3	43.9
Quality and Hazards	46.7	–	46.7	3.7	43.0
National Health	42.4	–	42.4	–	42.4
Surveillance	42.4	–	42.4	–	42.4
Pest Management	25.1	–	25.1	0.2	24.9
Regulatory Agency	25.9	–	25.9	0.3	25.6
Programs and	219.0	–	219.0	–	219.0
Services	227.7	–	227.7	–	227.7
Indian and Northern	1,062.8	–	1,062.8	16.3	1,046.5
Health Services	993.2	–	993.2	9.6	983.6
Public Service Health	24.9	–	24.9	-	24.9
	23.6	–	23.6	0.9	22.7
Health Advisory and	5.4	–	5.4	0.3	5.1
Assessment Services	5.1	–	5.1	0.3	4.8
Policy and	19.0	–	19.0	–	19.0
Consultation	34.4	–	34.4	–	34.4
Health Insurance [2]	1.7	–	1.7	–	1.7
	1.5	(96.0)	(94.5)	–	(94.5)
Program	71.9	0.1	72.0	0.5	71.5
Management	154.4	–	154.4	1.0	153.4
TOTALS	1,627.9	0.1	1,628.0	51.2	1,576.8
	1,649.3	(96.0)	1,553.3	41.5	1,511.8

Other Revenues and Expenditures	
Revenue credited to the Consolidated Revenue Fund	(6.7)
	(7.1)
Cost of services provided	51.1
by other departments [3]	51.1
Net cost of the program	1,621.2
	1,555.8

FIGURE 5: **Departmental Planned versus Actual Spending by Activity**

($ millions)

Activity	Actual 1993-94	Actual 1994-95	Actual 1995-96	Total Planned 1996-97	Actual 1996-97
Food Safety, Quality and Nutrition	63.1	57.8	48.3	57.9	42.5
Drug Safety, Quality and Effectiveness	69.5	73.5	61.7	20.0	26.2
Environmental Quality and Hazards	45.5	56.4	49.4	43.9	43.0
National Health Surveillance	59.5	38.9	35.9	42.4	42.4
Pest Management Regulatory Agency	–	–	21.2	24.9	25.6
Programs and Services	179.5	216.0	237.9	219.0	227.7
Indian and Northern Health Services	824.6	917.2	1,015.2	1,046.5	983.6
Public Service Health	25.8	30.3	22.6	24.9	22.7
Health Advisory and Assessment Services	7.9	6.2	5.0	5.1	4.8
Policy and Consultation	18.1	20.4	22.8	19.0	34.4
Health Insurance [1]	7,233.4	7,567.7	7,242.0	1.7	(94.5)
Program Management	96.0	130.7	120.2	71.5	153.4
Total	8,622.9	9,115.1	8,882.2	1,576.8	1,511.8

[1] 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. However, Health Canada will make both positive and negative adjustments with respect to the 1995-96 EPF payments until they are final. For 1996-97, a negative adjustment of $96.0M is reported.

Health Canada's Main Estimates were $1,576.8 million in 1996-97. During the year this amount was adjusted to reflect the following changes:

- a decrease of 96.0 million due to a statutory adjustment in the Health Insurance Activity;
- an increase of $24.3 million as a result of Supplementary Estimates A;

- an increase of $20.2 million as a result of Supplementary Estimates B;
- a statutory increase of $1.8 million in Employee Benefit Plan costs;
- an increase of $0.9 million from the proceeds of disposal of surplus crown assets; and
- an increase of $0.8 million from revenues received in prior years but applicable to 1996-97.

The remainder being $1,528.8 million represents the maximum amount that Health Canada could have spent during 1996-97. However actual expenditures amounted to $1, 511.8 million, a 98.9% utilization rate, thus creating a lapse (unspent amount) of $17.0 million.

Summary of Performance Expectations

Starting in 1998-99, Health Canada's programs will be managed by Business Line. During 1996-97, the Department was still operating under an activity structure, and the 1996-97 Part III Estimates reflect this structure. This performance report is organized by activity, not business line. Succeeding performance reports (1998 onward) will reflect the new business line structure, using the key results and performance indicators appearing in Part C of Section IV.

The following table summarizes the key activities and major performance measures for each Activity. More detail will be found under each Activity section.

To provide Canadians with:	as demonstrated by:
Food Safety, Quality and Nutrition: definition of, and advice on, and management of, the risks and benefits associated with foods.	◗ set up policies for food safety and nutrition that respond to the needs of all Canadians; ◗ providing advice and leadership to the Canadian food safety system; ◗ identifying significant health threats or benefits, as well as better analytical methods; ◗ participating in harmonization discussions, domestic and international; and ◗ reviewing for approval new foods and food additives.

To provide Canadians with:	as demonstrated by:
Drug Safety, Quality and Effectiveness: plans, priorities and actions to manage the risks from therapeutic products.	◗ quick access to safe, effective and high-quality therapeutic products; ◗ providing national and international leadership to ensure the safety and effectiveness of therapeutic products; and ◗ managing, disseminating and exchanging information and concerns with stakeholders and clients.
Environmental Quality and Hazards: protection from risks caused by natural and human environments.	◗ identifying, assessing and managing risks; ◗ developing and disseminating scientific knowledge and expertise; and ◗ managing risks from sources such as radiation-emitting devices, chemicals and consumer products
National Health Surveillance: national leadership and coordination in identifying, investigating, monitoring, controlling and preventing human diseases.	◗ conducting national surveillance and disease control programs; ◗ using key information sources (such as Public Health Intelligence Networks) as the basis for effective decisions for health systems; and ◗ collecting, analysing and disseminating critical information on such topics as the change in HIV infection rates.
Pest Management Regulatory Agency: reduced risks from pest control products, proper public access to good pest management tools, and environmentally responsible pest management strategies.	◗ introducing amendments to the *Pest Control Products Act*; ◗ streamlining the regulation of minor uses of, and alternatives to, traditional chemical agents; ◗ accepting more public input into the regulatory system for pest control products; ◗ establishing a cost-recovery process linked to service standards; and ◗ harmonizing standards and sharing research with other regulatory systems to speed the regulatory process.

To provide Canadians with:	as demonstrated by:
Programs and Services: policies, programs, information and strategies to help Canadians maintain and improve their health and avoid health risks.	◗ creating and supporting programs, in partnership with the provinces and others, to improve the health of Canadians; ◗ focussing on health and well-being of Canadians at different life stages; ◗ addressing specific health concerns such as AIDS and breast cancer; and ◗ collecting and disseminating information and supporting public awareness and education.
Indian and Northern Health Services: support for Status Indians on reserve, Inuit people and Yukon residents, to reach a level of health comparable to that of other Canadians.	◗ closing the gap between Aboriginal health indicators and those for non-Aboriginal Canadians; and ◗ increasing the transfer of responsibility for health services to First Nations and Inuit communities and organizations.
Public Service Health: occupational and health services for federal public servants.	◗ workplace health and safety inspections; ◗ health evaluations of public service employees and job candidates; ◗ providing essential and emergency health care for visiting dignitaries; and ◗ establishing service standards and activity indicators for Public Servant Health Program services.

To provide Canadians with:	as demonstrated by:
Health Advisory and Assessment Services: professional advice and assistance to civil aviation medicine, emergency services, quarantine services and regulatory services.	◗ assessing the fitness of all civil aviation medical personnel in Canada, and providing lectures, seminars and training to the aviation community and Civil Aviation Medical Examiners; ◗ providing support to health care and social service systems during peacetime disasters; ◗ carrying out quarantine services; and ◗ enforcing health regulations for common carriers and international vessels.
Policy and Consultation: advice and direction on policies and programs, to ensure the provision of appropriate health services across Canada.	◗ supporting the National Forum on Health; ◗ providing advice and leadership for international discussions on health; ◗ responding to the health needs and concerns of women; and ◗ advising on federal-provincial health issues.
Health Insurance: reasonable access for all residents of Canada to insured health care services on a pre-paid basis and to extended health care services.	◗ monitoring provincial health insurance plans to ensure that they meet the conditions of the *Canada Health Act*; ◗ issuing authorization certificates to qualified provincial/territorial health care plans; and ◗ making deductions, if necessary, from health care transfer payments to provinces whose plans are not in accordance with the Act.

B PERFORMANCE ACCOMPLISHMENTS

Activity 1: Food Safety, Quality and Nutrition

Health Canada works to protect and improve the health and well-being of the Canadian public. It defines, advises on, and manages the risks and benefits associated with the food supply. Areas of work include food additives, chemical and microbiological contaminants, nutrients, novel foods (e.g., bio-engineered foods), food components and processes, and veterinary drugs.

Health Canada

- identifies significant health threats and benefits from foods;
- works to improve food characterization and testing;
- establishes food safety and nutrition policies that respond to the needs of Canadians;
- participates in international and domestic fora;
- regulates new foods and food additives; and
- provides advice and leadership to the Canadian food safety system.

Achievements in 1996-97

In the area of health threats:

- Health Canada undertook a number of initiatives in the area of food allergies. It established a task force to review the "Allergy Alert" procedure and a committee to determine which common allergens should always be labelled. Both groups have prepared reports and recommendations. In addition, Health Canada researchers developed a method for detecting trace amounts of peanut protein. This analysis has been put on the market and is being used by the Canadian Food Inspection Agency and the food industry.
- "Hamburger disease" has received widespread attention. In collaboration with Agriculture and Agri-Food Canada (AAFC) and the University of Waterloo, Health Canada identified three areas for assessing the risk of *E. coli* O157:H7 in hamburgers: the concentration of the bacteria in cattle feces, the storage temperature of beef patties before cooking, and cooking practices. These results should influence management practices.

In food safety and nutrition policies:

- Food science and biotechnology are introducing new types of food, and food processed with new processes. To ensure the safety of these foods and address public concern, Health Canada has held extensive consultations and developed regulations that will be promulgated early in 1997-98. The regulations will provide for advance notification to the Health Department of the sale of foods that have not been previously sold in Canada or have been substantially modified from their traditional composition. They will protect consumers while allowing the sale of these novel products in Canada.
- The Food Program is working with provincial health departments to carry out food consumption and nutrient intake surveys. These surveys are the first collection of such data since the Nutrition Canada Survey 25 years ago and will form a national database. To date, nine of the ten provinces have completed their surveys or are working on them. The surveys will give information on the levels of chemical contaminants or nutrients in food and on the quantity of food consumed. These data will allow the Health Protection Branch to carry out risk assessments on chemical contaminants and nutrients in food. The information will also help in the revision of nutrition recommendations and for setting policy in nutrition education programs such as Canada's Food Guide.
- Proposals to require the addition of folic acid (a B vitamin) to flour and enriched pasta were issued in June 1996. Adequate levels of folic acid during pregnancy reduce the incidence of spina bifida in newborns. In addition, Health Canada proposes to harmonize its standards for all nutrients in flour with U.S. standards in order to eliminate trade barriers that would ensue from differing enrichment standards.
- Most foodborne illnesses result from bacterial contamination of food, especially of raw food of animal origin (eggs, meat). Usually this contamination results from improper handling. The Health Promotion Branch/Food Industry Liaison Committee and the federal/provincial/territorial Committee on Food Safety have endorsed a national food safety education program, an important step in developing a plan to control enteric diseases caused by contaminated foods.

- Research shows that Canadians consume more *trans* fatty acids than any other country in the world. *Trans* fatty acids increase blood cholesterol, a major risk factor for cardiovascular disease, and are suspected to have detrimental effects on the growth of infants. Canadian margarine manufacturers have acted to reduce the *trans* fatty acid content in their products. Health Canada allows food manufacturers to list the content of *trans* fatty acids on food labels and in advertising.

In the area of international affairs and harmonization of standards:

- The CUSTA and NAFTA Technical Working Group on Food Additives and Contaminants is making progress on harmonizing standards (for example) for food additives. Canada and the U.S. are discussing the joint review of food additive petitions and cost recovery/user fees and their approaches to such food contaminants as aflatoxins.
- Health Canada has undertaken a review of current policy on the addition of micronutrients to foods, considering health, safety, and trade issues, the nutritional needs of Canadians, and industry competitiveness.
- Health Canada undertook a major international consultation on rewriting the regulations and tables for food additives. It has started work on an overview document summarizing the comments received.

Regulating Foods, Food Additives and Veterinary Drugs

Health Canada is responsible for evaluating and setting standards for foods, food additives and veterinary drugs. In this area:

- The department made almost 200 pre-market evaluations of food additives.
- It handled 2,377 voluntary submissions involving food packaging materials and incidental additives.

- It handled more than 26,000 actions, from public enquiries to media briefings, in all areas involving chemicals in foods.
- It handled 402 new veterinary drug evaluations, 138 reviews of already approved drugs, 215 Drug Number Identification applications, 80 mandatory reviews of applications for Experimental Studies Certificates (for research) and 1,050 Emergency Drug Release requests.
- It handled 32 submissions, reviewing and evaluating 18 novel food notifications and 14 submissions involving food irradiation, genetically altered enzymes, food additives or ingredients and pesticides.
- The Department's target for revenue for these activities was $2.1 million; the Department actually recovered $0.9 million, or 42.9 percent of the target.

Canadian Food Inspection Agency

The 1996 federal budget announced the government's intention to create a single food inspection agency, consolidating activities from AAFC, Health Canada, and Fisheries and Oceans Canada. Responsibility for food inspection was transferred first to AAFC and then to this new independent agency. Health Canada retains responsibility for food safety policy, standard-setting, risk assessment, analytical testing research, and audit of the agency's food safety activities. Bill C-60, the *Canadian Food Inspection Agency Act,* was promulgated on March 20, 1997.

ACTIVITY 2: Drug Safety, Quality and Effectiveness

The Drug Safety, Quality and Effectiveness activity works to ensure that the drugs and therapeutic products available in Canada are safe, effective and of high quality.

Drugs and medical devices must be approved by Health Canada before they can be put through clinical trials or marketed. Health Canada collects and analyses reports of adverse reactions or problems throughout the product's life cycle. It conducts inspections, product analyses and special investigations to ensure that manufacturing processes meet Canadian standards. Under the *Controlled Drugs and Substances Act*, Health Canada also has responsibility for the control and restriction of drugs (including narcotics) and for analysing illicit drugs on behalf of police forces. It helps to foster harmonization and global trade. Finally, it distributes up-to-date information to stakeholders and the general public.

Risk Management

All drugs and medical devices present risks. The regulatory process is designed to weigh these risks relative to the benefits claimed by the products. The process also ensures that sufficient information is generated to enable quick, effective regulatory decisions and proper use of the products. When necessary, Health Canada takes appropriate action to protect the public. Risk management involves such activities as regulatory action (e.g., licensing and inspection) and public information, to allow informed decision making.

Achievements in 1996-97

- A new regulatory framework and policies will allow minimal controls in cases where risk is low, and will reserve regulation for situations in which it is necessary for risk control. A new four-level risk categorization scheme for drugs and medical devices, currently being developed, may allow for earlier release of drugs under certain conditions.

- Health Canada will rely on its Expert Advisory Committees (e.g., on New Active Substances, Non-prescription Drugs, HIV Therapies and Blood Regulation) and the Canadian Adverse Drug Reaction Advisory Committee (CADRAC) to weigh as many factors as possible in the decision-making process.
- National Standards for tissue and organ transplantation are being developed.

Safe, Effective High-Quality Products

The Therapeutic Products Program carries out risk-management of therapeutic products available to Canadians.

Achievements in 1996-97

- The Program has decreased the median review time for New Active Substance Submissions from 38.1 months in 1994, to 18.4 months in 1996, a 52 percent change. In the same period, it has handled an increase in the number of submissions from 28 to 34. The Program also reduced the median approval time for all New Drug Submissions by over 16 months (21.2 months, compared to 37.5 months in 1994). Canadians now have faster access to more new therapies than at any time in the past 10 years.
- In the area of those medical devices (which must be approved before they are marketed), the program completed 81.5 percent of evaluations within the performance standard of 60 calendar days.
- The Program evaluated some 4,000 reports of adverse drug reactions and 200 reports of problems with medical devices. As of January 1, 1996, manufacturers are required to report adverse reactions.
- Health Canada has undertaken a major review of more than 1,200 drug-related operations that will fall under the new Establishment Licensing Regulations, in order to assess their compliance with Good Manufacturing Practices (GMPs) Regulations.

- The Program handled 1,000 reports of incidents (non-adverse reactions) with the use of therapeutic products. As a result, 52 products were recalled and three public alerts were issued to warn the public about safety problems related to drug products.
- The Department's target for revenues for these activities was $27.5 million; the Department actually recovered $24.7 million, or 89.9 percent of the target.

National and International Leadership and Credibility

Health Canada is recognized nationally and internationally as one of the world's most effective regulators of drugs, medical devices and other therapeutic products. It works with other national regulatory agencies to improve and facilitate harmonization and global trade.

Achievements in 1996-97

- In the spring of 1997, Health Canada negotiated the Mutual Recognition Agreements (MRAs) on Good Manufacturing Practices (GMPs) with the European Union to reduce the overall cost of regulation.
- In the area of international standards, Health Canada has led in international efforts to define appropriate controls on Active Pharmaceutical Ingredients (APIs) and to develop an international standard for GMPs for medical devices.
- Talks with Taiwan are under way to reach a Memorandum of Understanding on traditional herbal products, many of which are imported from that country.

Information Management, Dissemination and Exchange

Risk/benefit management depends on having up-to-date and accurate information. The Therapeutic Products Program encourages timely, open communication between management and staff, with other sectors of Health Canada and the federal government, and with stakeholders and clients.

Achievements in 1996-97

- The Program issued two Information Letters, two "Dear Doctor" letters, and six warning statements, as well as publishing four public newsletters on drug safety. These newsletters also appear as inserts in the *Canadian Medical Association Journal*.
- Health Canada developed annexes to the GMP Guidelines for herbal and homeopathic products, biological products, radiopharmaceuticals and cosmetic-like drugs. These documents advise manufacturers on acceptable manufacturing practices.
- A new computerized Drug Product Database will facilitate public access to basic information on all drugs.
- Health Canada's Vancouver-based regional liaison group on traditional medicines will provide a forum for the exchange and development of ideas. Its successes include: a new course run by University of British Columbia for manufacturers, growers and regulators; successful voluntary removal from sale of an extensive list of unacceptable herbal products; and the introduction of new authoritative references for the approval process.
- Health Canada held 29 meetings with 16 national stakeholder groups to keep abreast of emerging issues, provide a balanced perspective, bring forth issues of concern and to discuss the potential impacts of various options. In addition, consultative workshops, focussing on draft issue papers, allowed the discussion of proposed regulatory changes.
- Health Canada established a Therapeutic Products Program Internet Web site.

ACTIVITY 3: Environmental Quality and Hazards

Health Canada helps the people of Canada maintain and improve their health by identifying, assessing and managing environmental risks to health and safety in the living and working environment.

In support of this primary objective, Health Canada develops and disseminates scientific knowledge on health risks arising from the natural environment and from human activities. It helps Canadians understand how they can minimize and cope with environmental hazards. It has built and maintains an environmental health protection infrastructure, including processes to coordinate the federal government's response to nuclear and chemical accidents affecting Canada and Canadians.

Achievements in 1996-1997

Air Quality

- Health Canada studies have shown a strong correlation between air pollution and hospitalizations, cardio-respiratory illness and other health problems. The Department is working on safety standards for exhaust (fine particles) and ozone, two serious air pollutants.
- Health Canada provided scientific background for revising national air quality safety standards.

Drinking Water

- Health Canada provided supporting information on four contaminants in drinking water (aluminum, bromate, microcystin-LR and protozoa). The Federal-Provincial Subcommittee on Drinking Water will use this information to set safety limits.
- The Health Canada Web site has been updated to include a summary of the current drinking water safety standards, activities of the Subcommittee, and a list of drinking water publications.

- Health Canada researchers identified harmful bacteria and disinfection by-products in drinking water samples from across the country.
- The proposed *Drinking Water Materials Safety Act*, introduced in the House of Commons on December 11, 1996, would give Health Canada the authority to regulate drinking water materials using consensus health standards and third-party certification. The bill was awaiting second reading when Parliament was dissolved in April 1997.

Toxic Substances

Health Canada carries out risk assessments for existing and new toxic substances and biotechnology products, and provides guidance for the management of associated human health risks.

- The backlog of 5,000 transitional notifications (made by industry shortly after the New Chemicals Notification Regulations came into force under *Canadian Environmental Protection Act* [CEPA]) has been substantially reduced. Some 3,370 transitional notifications have been reviewed for their impact on health. Of these, 2,250 were reviewed in fiscal year 1996-97. In addition, 400 new substances were assessed in the last fiscal year and Health Canada imposed conditions on three new substances.
- A new CEPA, emphasizing pollution prevention and the protection of the environment and human health, was introduced in the House of Commons on December 10, 1996. It was awaiting second reading when Parliament was dissolved in April 1997.
- The effect of environmental chemicals on human hormones has emerged as an issue of major international concern. Health Canada has developed an inventory of research being carried out in Canada on such chemicals, identified gaps in the data and established research priorities.

Tobacco

The federal government has set a high priority on reducing tobacco use. Its focus in 1996-97 was to prevent the sale of tobacco products to young people, to discourage them from starting to smoke.

- The second stage of a national survey on the sale of tobacco to minors has been completed and the results released.
- The enforcement program was audited in 1996-97. The report is still being reviewed, but a major finding is that the program is working: from 1995 to 1996, non-compliance among retailers dropped from 50 percent to 40 percent.
- The Tobacco Program monitored the toxic constituents of tobacco products and smoke to provide information on cigarette packages to increase users' awareness and developed more realistic test conditions to assess tobacco smoke.

Consumer Products

Consumer products are involved in 230,000 accidents per year, resulting in 2,000 deaths, 47,000 cases of illness and 219,000 injuries. Health Canada issues consumer alerts to warn the public of potential dangers associated with certain consumer products.

- Health Canada conducted an extensive investigation of the public risk from lead levels in imported PVC blinds and widely publicized its findings. Similar warnings were issued for decorative Halloween candles, lighters and children's products.
- Health Canada completed amendments to the Hazardous Products Liquid Coating Materials Regulations, Hazardous Product Glazed Ceramics Regulations and the Hazardous Products Ice Hockey Helmets Regulations, to reduce product-related accidents or improve injury prevention.
- As products from developing countries come onto the Canadian market, Canada has begun to develop Memoranda of Understanding (MOUs) to deal with health and safety concerns about these products. Formal collaboration with China was initiated in 1996.

Worker Safety

The Workplace Hazardous Materials Information System (WHMIS) controls the sale and importation of workplace chemicals and provides information on hazardous workplace materials. Health Canada collaborates with the Canadian Centre for Occupational Health and Safety to review safety information on hazardous products. Chemical safety profiles were produced in 1996-97; some 59 toxicological profile summaries have been produced to date.

Radiation

The National Dosimetry Service provides radiation monitoring services to over 100,000 workers in 12,000 organizations across Canada by issuing and evaluating more than 500,000 personal dosimeters (devices worn by workers to determine exposure to radiation). Radiation exposure records, many dating from 1951, for over 500,000 Canadian workers are maintained on the National Dose Registry. This information has been used for several current large-scale epidemiology studies on such issues as cancer incidence, trend and risk estimates. In addition:

- The service established that electromagnetic radiation (power lines) might affect the progression of a tumour to a more malignant state and completed a major study on cancer mortality from occupational exposure to ionizing radiation.
- Health Canada revised the National Radiation Safety Code 6 to set the standards for exposure of workers and the public to radio frequency fields emitted by electronic devices.
- In collaboration with the provinces and territories, Health Canada completed a survey of mammography facilities across Canada, using the U.S. FDA protocol to assess their performance, their ability to diagnose tumours and the radiation dose delivered to patients. The data can be used both to evaluate Canadian mammographic equipment and facilities, and make comparisons with U.S. facilities.
- Canada has harmonized the X-ray Diagnostic Device Regulations, which cover all X-ray diagnostic devices including mammography equipment, with international requirements to improve diagnosis of breast cancer.

Regional Health Effect Program

Health Canada's bioregional health effects programs provide distinct areas of Canada with integrated and relevant environmental health information. The programs communicate new risk information. They provide health advice, expertise and policy support for governments, individuals and communities. For example, they are integrating departmental policies and guidelines into Remedial Action Plans for cleaning up polluted areas around the Great Lakes.

- Health Canada published Canada's first "Community Self Assessment Guide" books and the first "Public Health Professionals Handbooks" for environmental contaminants.
- Under the *Entente Saint-Laurent Vision 2000*, Health Canada completed: a pilot study investigating the impact of prenatal exposure to organochlorines and heavy metals on the infant immune system; a study evaluating the health risk associated with fish consumption for the Mohawk community of Kahnawake; and a risk assessment of air pollution in the Bécancour area.
- The Department's communication activities included a press conference in the summer of 1996, funding of eight community-level projects and the publication of four priority intervention zone technical reports on human health.
- Five years of cooperative work with Aboriginal, federal and territorial partners and several universities has led to the publication of the *Canadian Arctic Contaminants Assessment Report*, the first comprehensive assessment of health and environment risks in the Arctic. Several pollutants, including radioactive contaminants, are present in high levels (two to ten times the southern Canadian norm) in human tissues in parts of the Arctic bioregion. These pollutants pose a significant threat to health. The department has also been part of the international negotiating team to arrest the use of persistent toxic chemicals that migrate to the Arctic and accumulate in traditional foods.

Intergovernmental Cooperation and Collaboration

Health Canada is involved in the development of regional and global instruments for the control of persistent organic pollutants (POPs) and metals under the NAFTA Commission for Environmental Cooperation, the UN Economic Commission for Europe and the UN Environmental Program. These activities, designed to reduce or eliminate the long-range transport and deposition of POPs in Canada, have resulted in integrated action plans which are now being implemented for four contaminants (PCB, mercury, DDT and chlordane) in North America. A clear and transparent process for the selection of substances for tripartite action in North America was developed in 1996-97 through stakeholder consultations.

Health Canada co-hosted the Second Intergovernmental Forum on Chemical Safety (IFCS) in February 1997. The IFCS promotes the coordination of chemical safety at the national and international levels. The Forum recognized the need to coordinate international research on the effects of chemicals on human hormones.

Cost Recovery

If government activities confer specific benefits on identifiable parties, government policy is to consider recovering the costs of such activities, rather than funding them entirely from tax dollars. In keeping with this policy, Health Canada has implemented a cost-recoverable Label Review Service for consumer chemical products. This non-mandatory service became effective April 1, 1996.

The Department's target for revenues for this service was $4.3 million; the Department actually recovered $3.7 million, or 86.7 percent of the target.

Sustainable Development

Canada is committed to ensuring that today's use of resources and the environment does not unduly damage prospects for future generations. Health Canada is responsible for assessing the potential impact on health of projects or actions that: receive federal funding, occur on federal lands, or require a federal permit. In addition to its ongoing assessment work, Health Canada is working with the provinces and territories to develop a health impact assessment guide. Volume 1, "The Beginner's Guide," was published in May 1997. Volume 2, "The Practitioner's Guide," is currently under development. Internationally, Health Canada, in collaboration with the International Development Research Centre, is providing health impact assessment training to universities in the Amazon Basin.

ACTIVITY 4: National Health Surveillance

National Health Surveillance, carried out by the Laboratory Centre for Disease Control (LCDC), provides national identification, investigation, monitoring, prevention, and management of human diseases through surveillance and disease control programs. Its activities allow diseases to be identified promptly and monitored over time. It helps to develop, implement and evaluate disease control measures, allowing Canada's health care system to direct its limited resources effectively.

LCDC's programs follow changing patterns in health and disease, using ongoing surveillance programs that range from community hospitals to international networks. It has major microbiology and genetics research facilities. It tracks the incidence and spread of notifiable diseases such as AIDS and tuberculosis. The provinces provide the essential infrastructure for surveillance, but only LCDC has the ability to synthesize this information at the national level, providing the information needed for effective disease control. Its aims are to:

- identify disease outbreaks in a timely fashion so that control measures can be implemented;
- monitor trends in disease occurrence over time; and
- detect emerging or re-emerging diseases so that prevention and control strategies can be developed, implemented and evaluated.

Disease Surveillance

The need for continued vigilance, prevention and control efforts is underlined by disturbing trends in a number of disease areas that threaten the health of Canadians. Chronic diseases such as cancer and cardio-respiratory disease remain the leading cause of death in Canada. With an aging population on the rise, work in these areas will become even more urgent. The increase in HIV infections in Canada in all segments of the population, the appearance of multiple drug-resistant bacteria in Canadian hospitals and the appearance of a new strain of hepatitis all have important implications for public health.

Achievements in 1996-97

- Cost-effective national surveillance networks have been strengthened and expanded through considerable provincial investment in surveillance infrastructure to create a picture of health risks, patterns and trends across Canada. This national surveillance and disease control capacity cannot be duplicated in any single province or territory. Surveillance of national notifiable disease is only possible through the presence of these networks.

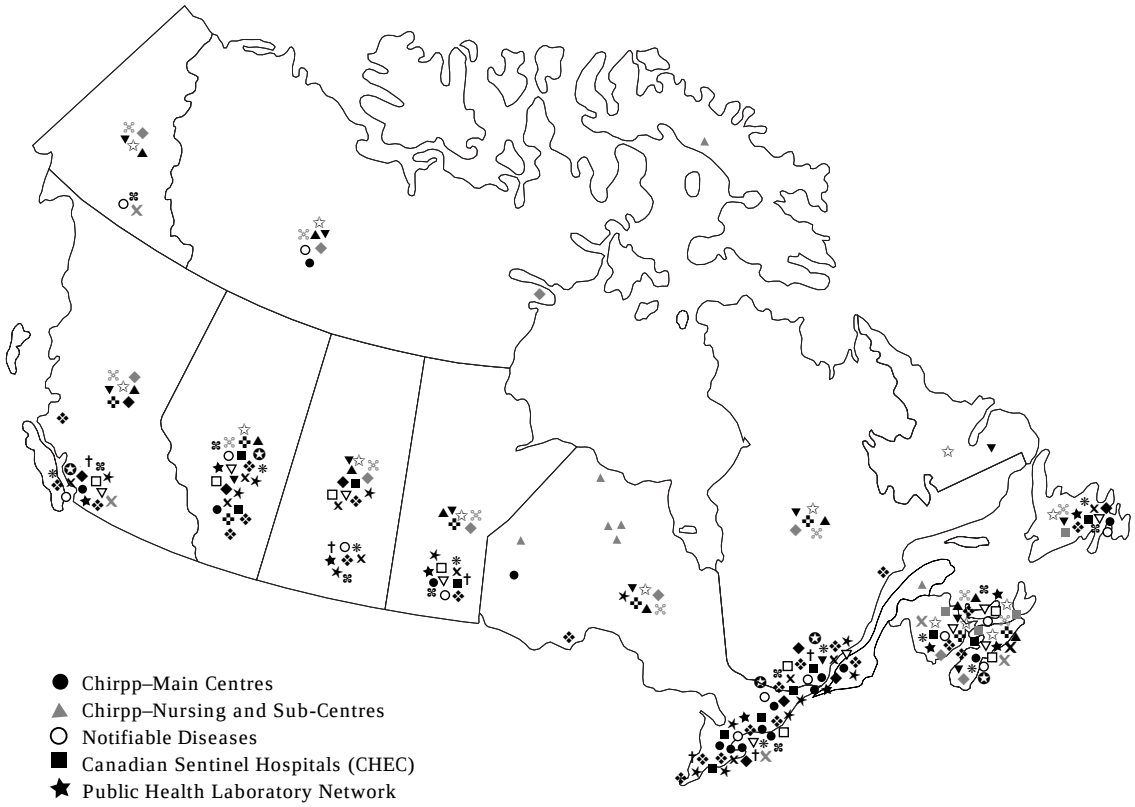
- Despite childhood immunization programs, vaccine-preventable diseases continue to pose a threat to Canadians. LCDC identified an imminent large-scale outbreak of measles, promoting a proactive measles elimination strategy. The strategy, which aims at eliminating the disease by 2005, relies on a two-dose immunization schedule and mass catch-up campaigns. Health Canada contributed health information to the provinces for the strategy.

- As a result of population and environmental changes and the ease of global travel, new communicable diseases such as the Ebola virus have become a serious potential threat. LCDC provides travel health information to Canadians through its FAXlink system and Health Canada's Web site. The Committee to Advise on Tropical Medicine and Travel provides guidelines related to the prevention and treatment of infectious diseases Canadians may encounter abroad, while the Travel Medicine Program works with the Department of Foreign Affairs and International Trade to assess the risks in specific countries. LCDC also maintains a list of national travel restrictions for people with HIV.

- In the area of blood safety, 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. Funding has been provided to provinces, health care facilities, researchers and non-governmental organizations (NGOs) to define risk factors for hepatitis C and the long-term consequences of hepatitis C. Considerable attention was paid to assessing the risk of Creutzfeldt Jakob Disease transmission in the blood supply.

- Health Canada is active in the identification of diseases. Through the Bureau of Microbiology and its network of External Laboratory Centres, laboratory support and expertise were provided to the Public Health Network to identify and monitor the emergence of diseases and their causative agents (e.g., tuberculosis, hepatitis, hanta virus and drug resistant organisms) and to control outbreaks of disease (e.g., enteric diseases).

FIGURE 6: **Laboratory Centre for Disease Control Surveillance Networks 1996**



- ● Chirpp–Main Centres
- ▲ Chirpp–Nursing and Sub-Centres
- ○ Notifiable Diseases
- ■ Canadian Sentinel Hospitals (CHEC)
- ★ Public Health Laboratory Network
- □ Sentinel Health Unit Surveillance System
- ▼ Pediatricians
- ▽ Cancer Registries
- ◆ Impact Registries
- ❖ Oncology Centres and Clinics for Adults
- ✕ Pediatric Oncology Centres (Canadian Childhood Surveillance Network)
- ☆ Neurologists
- ■ Atlantic Health Units (20)
- ✜ National Asthma Control Task Force
- ✶ Acute Coronary Syndrome Extended Surveillance Network
- ✪ Pediatric HIV Surveillance Database
- ⌘ AIDS Case Reporting Surveillance System
- ● Aboriginal HIV Research Network
- ✕ Canadian Breast Cancer Screening Surveillance Network
- ◆ Disease Prevalence-Incidence Surveillance Network
- ▲ Risk Factor Surveillance Network
- ⁂ Canadian Network of Asthma Care
- ✳ National TB Reporting System
- ✶ Antibiotic-Resistant Neisseria Gonorrhea Surveillance System
- † Field Epidemiology Network

Health Intelligence

In April 1995, with strong support from the provinces, Health Canada decided to strengthen and expand the national surveillance, monitoring and disease prevention networks and capacity (Public Health Intelligence). The plan was to target such public health "blind spots" as blood-borne pathogens, cancer control, tuberculosis, reproductive health, children's health, infectious diseases, sexually transmitted diseases (STDs), cardiovascular disease, respiratory diseases, diabetes and antibiotic resistant infections. This major commitment will help health-care decision makers establish well-informed public health policies. Public health intelligence pays significant dividends through early detection of emerging health threats and cost-effective targeting of interventions.

Achievements in 1996-97

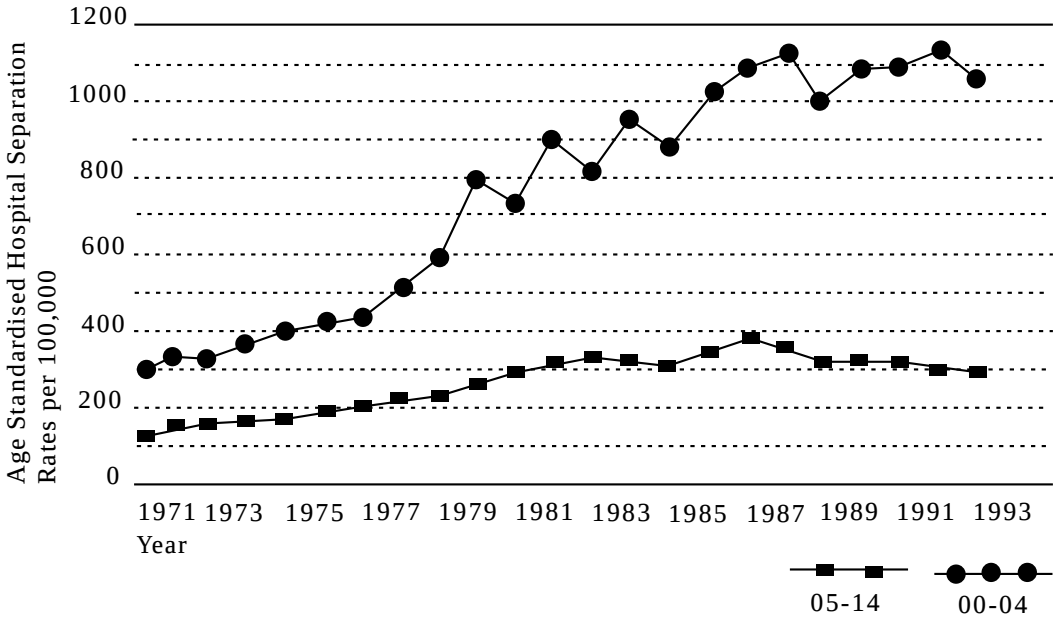
- The collection of data on children's health has been expanded. Previous data collection has focussed on diseases in infants and young children, including birth defects and Sudden Infant Death Syndrome (SIDS). This field has now been expanded to include accidental injury and death, now monitored through the Canadian Hospital Injuries Reporting and Prevention Program and the coroners' database. Surveillance and control of children's illnesses has been expanded for diabetes, childhood cancers, cardiac abnormalities, group B streptococcal infections and pneumonia. Asthma rates have increased fourfold in children under the age of 4 (Figure 7), indicating a need for investigations into the reasons for the increase and for possible preventive and control measures. Finally, Health Canada has collaborated with other government agencies, health professionals, child welfare agents, NGOs and academics to set up a Child Maltreatment Surveillance Program.

- Integrated cancer surveillance can help identify the needs, priorities and gaps in current cancer prevention and treatment programs. The Canadian Coalition on Cancer Surveillance (CCOCS), representing cancer organizations and advocacy groups, cancer survivors and health-care professionals, will oversee the development and implementation of this surveillance. CCOCS aims to further the exchange of information and improve data collection. Its goal is to reduce the economic and health burdens of cancer and the stress suffered by patients and their families. In addition, a national environmental

cancer surveillance system has been established to monitor potential environmental risks, focussing on air and water quality and on specific cancers.

- Communication is crucial to public health partners and clients, across Canada and abroad. For this reason, Health Canada has expanded its FAXLink services to client groups. It has also set up a Web site, part of Health Canada's Canadian Health Network, which provides the public with surveillance data, research findings, evaluation results, national publications and results of LCDC workshops and conferences.

FIGURE 7: **Asthma Hospital Separations in Canada ages 1-14, 1971-1993**



HIV Epidemiology

The incidence of HIV infections is the highest in Canada since the mid-1980s. More and different subtypes of the virus are emerging, and the epidemic is clearly affecting more and different populations, (i.e., it is affecting a younger population). There is an increased requirement for new surveillance strategies, new targeted investigation capacity, new networks and newer laboratory technologies to effectively track the epidemic.

Achievements in 1996-97

- Results of the National HIV Database were published in collaboration with the provinces. Data collection is becoming more standardized while remaining confidential.
- LDCD has tracked the spread of HIV into new populations (women and Aboriginal people, for example) and has monitored changes in the nature of the epidemic. This has allowed planning for care and treatment, and for shifts in the prevention program.
- LCDC continues to disseminate its findings through journals, conferences and health partners, such as the Canadian Hemophilia Society. Among the findings disseminated was information that the median age of HIV infection had dropped from 32 to 23 years of age by 1990. This meant that new infections were occurring in persons aged 23 years or less. This dramatic information has changed the focus of prevention programs to a younger population.

ACTIVITY 5: Pest Management Regulatory Agency

The Pest Management Regulatory Agency (PMRA) protects human health and the environment while helping to ensure that agriculture, forestry, manufacturing and other business sectors remain competitive. PMRA's regulatory decisions take into account both the need for a particular product and its potential risks. The agency is dedicated to integrating the principles of sustainable development into Canada's pest management regulatory regime.

PMRA was established in April 1995 in response to the recommendations of the Pesticide Registration Review. In regulating pest control products, PMRA balances potential risks to human health and the environment, against the real need for these products.

Achievements in 1996-97

- New amendments to the *Pest Control Products Act* take into account public and government input. The revised bill introduces concepts of risk management and sustainable development; ensures that the life cycles of pesticides are considered before they are registered; strengthens post-registration control of pesticides; opens up the process to public input; and provides stronger enforcement and inspection powers.
- Cost-recovery linked to service standards developed after extensive consultations will allow PMRA to recover 44 percent ($12 million) of its $27.3 million operating budget. The effects of these changes on product prices and availability will be monitored over the next year. PMRA also established new performance standards for turnaround times. It will, in future, take advantage of industry expertise through an Economic Management Advisory Committee. The committee will advise on measures to improve efficiency and cost-effectiveness without compromising health and environmental protection.

- Public input into the pest management regulatory system has improved greatly. PMRA now makes its regulatory documents available to the public for a 60-90 day comment period. It maintains two 1-800 lines for public information on pest control products and has set up a home page on the Web. It consulted with stakeholders on cost recovery and legislative amendments.
- Harmonizing international initiatives will help reduce the duplication of data and review processes. Harmonization activities (for example, data requirements and residue zone maps) are ongoing through working groups under NAFTA and the OECD. International efforts are also under way to consider sustainable and integrated pest management projects for pests such as late potato blight, Colorado potato beetle and sea lice in salmon aquaculture.
- Streamlining the process for minor users will put more pest-management products into the hands of farmers.
- PMRA has also reduced the backlog of over 900 complex submissions by 60 percent, to an all-time low of about 360.
- Initial development of a risk-reduction policy and a risk-management approach to decision making that will keep pesticides that pose an unacceptable risk to people or the environment off the market. Under the existing *Pest Control Products Act*, new products must pass detailed review of their safety, value and merit.
- In February 1997 the Department agreed to rationalize jurisdiction over hard surface disinfectant regulations. This will reduce the regulatory burden on manufacturers of these products.

ACTIVITY 6: PROGRAMS AND SERVICES

Many of the programs offered by Health Promotion and Programs Branch (HPPB) focus on health and well-being at different stages in life, from infancy to old age. Others target specific concerns or diseases or behaviour choices (such as smoking) that have serious effects on health. Programs offer education, resources and other support for non-profit organizations, service providers, voluntary sector and educators in a wide variety of areas, from child development to palliative care.

Children's Programs

Support for prenatal care includes information on factors that affect maternal and perinatal health. The Canadian Prenatal Nutrition Program, with the Community Action Program for Children (see below), provides support for some 748 projects in 500 communities across Canada. These programs, aimed at women at risk for having unhealthy babies, cover nutrition and food supplements, smoking, substance abuse, stress and domestic violence.

Community Action Program for Children: Meeting Real Needs Where People Live

CAPC projects across Canada are visited weekly by approximately 30,000 parents and children. More than 75 percent of CAPC families earn less than $30,000 per year. Of these families, 10 percent have neither French nor English as a mother tongue; another 10 percent are Aboriginal (off-reserve First Nations, Metis or Inuit). CAPC projects have created more than 1,000 jobs, with 200 projects staffed by parents. Volunteers give nearly 7,500 hours weekly. Over a six-month period, CAPC attracted more than $3 million in donations and $2 million in goods and services.

The Community Action Program for Children (CAPC) is designed to help local community groups address the needs of children 0-6 who live in conditions of risk such as poverty, poor nutrition, neglect and abuse. The initial funding for most CAPC projects ended in 1996-97. HPPB has assessed projects, using a national evaluation framework. Those projects that met their objectives have been renewed for up to three years.

Aboriginal Head Start (AHS), an early intervention initiative, addresses the needs of young Aboriginal children living in urban centres and large Northern communities. It focuses on preschool children and is designed to meet the spiritual, emotional, intellectual and physical needs of the child.

Achievements in 1996-97

- HPPB developed a national evaluation framework through consultations with local Aboriginal Head Start projects leaders, regional and national committees and Health Canada staff.
- The second national AHS training workshop, held in February 1997 for more than 200 AHS project staff and parents, covered such subjects as culturally based curriculum, techniques for preschoolers and parent involvement.
- Most of the AHS projects officially opened in 1996-97, and nearly 100 sites were fully operational.

HPPB aims to improve the well-being of Canada's children, by:

- Coordinating programs included in the Child Development Initiative;
- Developing national goals for healthy child development; and
- Establishing through consultation, a unified framework for action to improve the health of children and youth in Canada.

Achievements in 1996-97

- A "Joint Statement on the Prevention of Fetal Alcohol Syndrome and Fetal Alcohol Effects in Canada," was developed in consultation with 19 stakeholders and aimed at helping health professionals treat and counsel pregnant women, their partners and families.
- The Postpartum Parent Support Program, designed to educate parents of newborns and help them and family members develop feelings of competence, during the first six months after birth, was provided to more than 600 hospital and community health sites.
- Release of a comprehensive, easy-to-read resource on reducing the risk of injury, for parents of children aged 1 to 6.

- Issuance of 185,000 safety calendars (Safe Seasons 1996/97).
- Production of "Welcome to Parenting: the First Six Years" a video series aimed at increasing parental knowledge and understanding of their child's health, safety, development and behaviour.

The Canadian Active Living Challenge (CALC) has four program components, each targeted to different age groups of children and youth. The program encourages children and youth to make physical activity a regular part of their lives. Almost 80 percent of community leaders surveyed acknowledged that this approach to active living has helped promote physical activity among Canadians.

Achievements for 1996-97

- CALC "spread the message" about physical activity through more than 50,000 newsletters and through community newspapers, with a readership of more than 5 million.
- A report commissioned by Health Canada found that the physical activity component of the five-year National Integration Strategy for Persons with Disabilities produced net benefits of $90 million over 20 years, far exceeding the public cost of the program.

Programs for Seniors

In the area of seniors' initiatives, HPPB can report the following:

- Federal, provincial and territorial Ministers endorsed the National Framework on Aging and a strategy for action on medication use. National Round Tables were held on seniors and medication use, injury prevention, healthy aging and the International Year of Older Persons.
- The National Advisory Council on Aging (NACA) presented position papers on the *Principles of Pension Reform*, and of the *Reform of the Canada Pension Plan (CPP)*, three issues of its newsletter *Expression*, and three statistical fact sheets (*Vignettes*) on Canada's retirement income system, on barriers to autotomy and on dementia. It distributed approximately 85,000 NACA publications and responded to approximately 8,000 information or publication requests.

- Senior community programs, including New Horizons: Partners in Aging (NHPA), have supported 2,562 projects worth $63.5 million since 1994-95.
- The Seniors Independence Research Program supported 31 innovative research projects aimed at strengthening national research on the social, economic and health determinants of healthy aging. These projects included the Canadian Study on Healthy Aging and the Canadian Multicentre Osteoporosis Study. A national symposium on Bridging Policy and Research on Aging was held in 1996.
- Three national roundtables were held on seniors and medication, planning for the International Year of Older Persons, and Understanding the Broader Determinants of Healthy Aging.
- The Division of Aging and Seniors launched an Internet site specifically on seniors, medication and alcohol use (October 1996), developed new publications *The Safe Living Guide: A Guide to Home Safety for Seniors* and the Mortality Atlas of Canada: Seniors' Mortality, and distributed over 100,000 copies of the *Seniors Guide to Federal Programs and Services*.

In the Health System Renewal, two areas of improvement included:

- National standards for home care have been developed, tested in pilot projects, and released in May 1997 as "Standards for Home Care Organizations – A Client-Centred Approach."
- The development of a framework for supporting self-care led to the publication of "Supporting Self-Care: The Contribution of Nurses and Physicians, An Exploratory Study." The study enhances awareness and professional practices regarding self-care in order to reduce demand for health services.

Specific Public Health Concerns

Canadian Heart Health is a national cardiovascular prevention strategy, in partnership with federal and provincial governments and over 300 organizations in the public, private and voluntary sectors. Federal-provincial heart health programs are now under way in six provinces and will be launched in the other four in 1997-98.

Achievements in 1996-97

- The Canadian Heart Health Datatrieve, available on CD-ROM, has been assembled from cost-shared provincial health surveys. The database is the largest and most comprehensive of its kind in the world.
- The Second Nova Scotia Heart Health Survey, comparing (for the first time) trends in heart disease risks in 1986 and 1995, shows that targeted interventions in smoking and fitness have made a difference in Nova Scotians' cardiac health. Obesity, particularly in younger groups, continues to be a problem.
- More than 300 projects in the Provincial Heart Health Programs have been evaluated. Since 1988, 10 heart health teams have been formed in the provinces to carry out epidemiological research and program implementation. More than 1,000 organizations and community coalitions in the voluntary, professional and private sectors have participated in the initiative, which can reach more than six million Canadians. For each $1 invested by the federal government, another $2 has come from the provinces and $1 from other sources.
- Health Canada helped to organize the 4th International Conference in Preventative Cardiology, which attracted over 2,500 delegates from 90 countries. At the conference, the Canadian Heart Health Initiative received the World Health Organization's recognition as an outstanding example.
- HPPB distributed the monograph "Cardiovascular Disease and Obesity in Canada" to more than 50,000 professionals. The monograph documents the problem and identifies key target groups for interventions and approaches.
- A TV film documentary sponsored by Health Canada, "Wisdom of the Heart," highlights cardiovascular disease issues for women. The film was broadcast on TVO, CBC Newsworld, Women's Television Network and educational networks across Canada. The program received three international awards and reached an estimated five million viewers.

Workplace Health

This program gives individuals the knowledge, skills and resources they need to improve and maintain their health and to create safe, healthy, supportive work and school environments.

Achievements in 1996-97

In the area of resources for Workplace Health, HPPB has:

- Completed "Developing a Comprehensive Health Policy: Why and How: A Guide for the Workplace";
- Started the development of a resource to motivate individuals and groups to take action and to address psychosocial issues;
- Planned a National Workplace Health Promotion Consortium/Coalition; and
- Created a WHS Certification Training Program for Health Professionals in the public and private sectors.

Cervical Cancer

The Cervical Cancer Prevention Network (CCPN) is a national working group formed in 1995 with representation from all provinces and the relevant professional societies. It is working toward the development of provincially-based organized quality cervical cancer-screening programs. Six of the eight provinces currently without organized programs have submitted or are developing submissions to their provincial ministries for funding for organized programs.

Achievements in 1996-97

- National consensus on and development of programmatic guidelines for screening for cervical cancer;
- Consensus on core data items for the development of information systems that will allow recruitment, follow-up, quality assurance and evaluation to take place within organized programs; and
- Financial support for the Cervical Cancer Prevention Network.

Canadian Breast Cancer Initiative

The Canadian Breast Cancer Initiative, a partnership among breast cancer survivors, health care professionals, policy makers, researchers and support groups, is developing new approaches to improving both breast cancer prevention, care and treatment, and the quality of life for women with breast cancer.

Achievements in 1996-97

- The Canadian Breast Cancer Screening Initiative released: the first report of the Canadian Breast Cancer Screening Database; a Guide on Quality Determinants of an organized screening program; and a pamphlet on the practice of breast examinations. It also held a national workshop on organized breast cancer screening programs.
- The Professional Education Strategy produced: a national newsletter; annual workshops on improving the training of communication skills; Talking Tools I, an interactive workshop kit designed to raise physicians' awareness of the importance of good communication with patients and to improve communication; an audio cassette entitled "Enhancing Communication Skills and Your Practice"; and a self-assessment program for physicians.
- The Canadian Breast Cancer Research Initiative provided 75 percent more funding per year to breast cancer research, with special initiatives on alternative therapies and health services research.

AIDS

The National AIDS Strategy, Phase II, is a five-year initiative begun in 1993 to: stop the spread of HIV; provide care, treatment and support for people with HIV/AIDS and for their caregivers, families and friends; and search for effective vaccines, drugs and therapies.

The strategy involves:

- Carrying out epidemiological monitoring, international collaboration, regulations and regulatory processes, departmental and extramural research, and resource development; and
- Disseminating knowledge and awareness of HIV/AIDS, facilitating community action, supporting national NGOs and private sector involvement, planning the national research process and promoting supportive environments for those living with HIV/AIDS.

The XIth International Conference on AIDS, hosted by Canada, highlighted new developments in prevention, education, care, treatment and support, and discussed social and economic costs.

Achievements in 1996-97

HPPB supported:

- The development of HIV prevention action plans targeted at high-priority groups such as injected-drug users and adolescents;
- Important prevention research initiatives, including an ongoing study of the economic burden of HIV/AIDS in Canada;
- NGOs and provincial/territorial governments to support leading-edge demonstration projects;
- HIV/AIDS initiatives undertaken by other federal departments in their areas of responsibility;
- Approximately 200 HIV/AIDS-related community-based initiatives, aimed at prevention and education, creating supportive social environments and reducing barriers for people living with HIV/AIDS, and targeted to women, youth, substance abusers, homeless people, ethno-cultural communities in large cities, people at risk in remote

regions of Canada, Aboriginal populations, young adult service industry workers, immigrants and persons with alternate life styles;

- Broad-based initiatives to improve the quality of life of HIV/AIDS victims, partners, families and friends, including caregiver training and innovative models of cost-effective and culturally appropriate HIV/AIDS care;
- Research on psychosocial and quality of life issues; and
- The HIV/AIDS Treatment Information Network and the Canadian HIV Clinical Trials Network.

Tobacco Demand Reduction Strategy (TDRS)

This strategy employs education, legislative, research and enforcement initiatives to prevent tobacco use among young Canadians and other major users. It has substantially increased our understanding of the cultural, social, behavioural, age and gender factors associated with tobacco use in Canada.

In cooperation with other levels of government and the private sector, Health Canada has supported new approaches and resources intended to help all Canadians to live tobacco-free. Smoking is now widely banned in schools, workplaces and other public institutions. As a result, Canadians are becoming better informed of the consequences of tobacco use on their own health and the health of others. Health professionals, parents, teachers, coaches and other community leaders have become more actively involved and trained to provide effective tobacco prevention and cessation advice and counselling to youth.

Family Violence

HPPB supports ongoing community-based projects, programs and services for families facing domestic violence and those who work with them.

Achievements in 1996-97

- In 1996-97, the National Clearinghouse on Family Violence provided 99,240 Canadians with information and materials – an increase of 13 percent compared to 1995-96 and almost 200 percent since 1992-93.

- HPPB allocated resources to address risk factors and conditions and the gaps identified in consultations on the 1991-95 Family Violence Initiative. A review of initiative-supported models and approaches to preventing domestic violence has helped to develop best-practice reports and fact sheets which will be distributed through the Clearinghouse. This information deals with such subjects as adolescent sex offenders, dating violence and emotional abuse. The National Crime Prevention Council and the Canadian Association of Broadcasters also produced fact sheets for the Clearinghouse.

Canada's Drug Strategy (CDS)

CDS coordinates information sharing, leads a comprehensive evaluation process, provides corporate visibility, facilitates networking among CDS partners, and has put together a strategic framework for program and policy development.

Achievements in 1996-97

- Health Canada released a cross-Canada survey of attitudes and behaviours related to alcohol and other drugs, to help direct program and policy development and implementation.
- In partnership with the Canadian Centre on Substance Abuse, Health Canada established the Canadian Community Epidemiology Network on Drug Use (CCENDU) to provide local information on the extent and consequences of substance abuse, foster networking, improve data collection and serve as an early warning network on emerging trends.
- The Health and Enforcement in Partnership Steering Committee, which includes both governments and NGOs representing health and enforcement sectors, has been established to encourage broader cooperation between health and enforcement groups at national, provincial and local levels. National symposia were held in March 1996 and May 1997.

- With 18 national associations representing medical, nursing and midwifery disciplines, and Aboriginal and multicultural groups, Health Canada developed a "Joint Statement on the Prevention of Fetal Alcohol Syndrome and Fetal Alcohol Effects in Canada."
- Health Canada contributed to the development of a hemispheric anti-drug strategy with the Inter-American Drug Abuse Control Commission of the Organization of American States.

National Health Research and Development Program (NHRDP)

This extramural research funding program supports studies in areas relevant to current and emerging national policy and program issues. NHRDP works with other federal agencies (e.g., Medical Research Council of Canada, Social Sciences and Humanities Research Council) to address research gaps and to build a sustained national research response to health issues. NHRDP supports the training of researchers to maintain and enhance Canada's research infrastructure.

Achievements for 1996-97

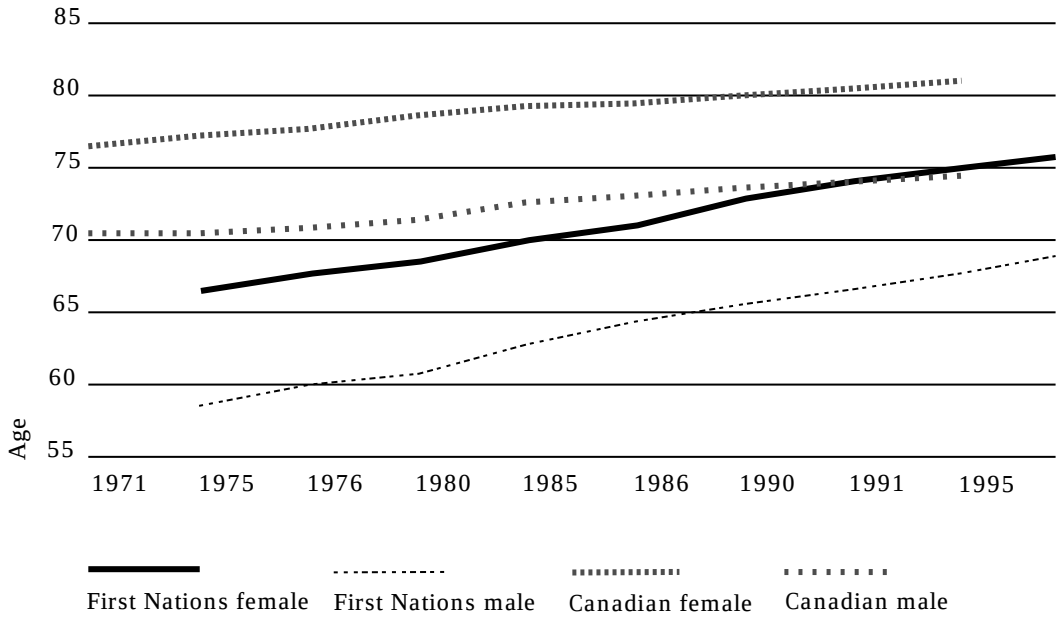
- NHRDP provided funding to over 300 research projects and supported the training and development of 175 Canadian researchers.
- NHRDP solicited research proposals in the areas of population health, health impact of public policies, renewal and restructuring of the health system, research on new methodologies, and research on transfer and uptake of knowledge.

ACTIVITY 7: Indian and Northern Health Services

Indian and Northern Health Services (INHS) provides health-related services to registered First Nations peoples and to the Inuit. These services include programs in community and family health, prevention and treatment of substance abuse, injury prevention, disease prevention and control, environmental health, health research and analysis, and non-insured health benefits. Health Canada's aim is to help ensure that Canada's First Nations and Inuit peoples and residents of the Yukon have a level of health comparable to that of other Canadians living in similar locations.

Increasingly, Health Canada is moving away from directly providing health services and toward supporting community-based programs. Three-quarters of community health services funding is now directly administered by First Nations and Inuit communities and organizations. Aboriginal self-government is one of the government's highest priorities. This principle is supported by INHS's programs and activities that encourage First Nations and Inuit to assume control of their health programming.

FIGURE 8: **Life Expectancy at Birth**
First Nations and Total Canadian Population



Community-based Programs

The National Native Alcohol and Drug Abuse Program (NNADAP) helps First Nations and Inuit communities establish and operate on-reserve prevention and treatment programs aimed at combatting alcohol and other drug abuse. More than 500 prevention programs now exist with some 700 workers. NNADAP coordinates a network of 49 treatment centres with about 700 beds for in-patient treatment. Of NNADAP's $53 million budget, 96 percent is now managed by First Nations through direct contribution or transfer agreements.

Achievement in 1996-97:

- In 1996-97, 9,070 First Nations and Inuit people were treated at NNADAP treatment centres. The issue of prescription drugs misuse was addressed through the development of community education and resource materials which were made available through regional offices.

The Aboriginal component of the national Child Development Initiative (Brighter Futures) helps First Nations and Inuit communities develop mental health and child development programs that are community based and managed. Such programs help improve parenting skills, prevent childhood injury, develop youth activities and community mental health programs, and address the problem of solvent abuse.

Achievements in 1996-97

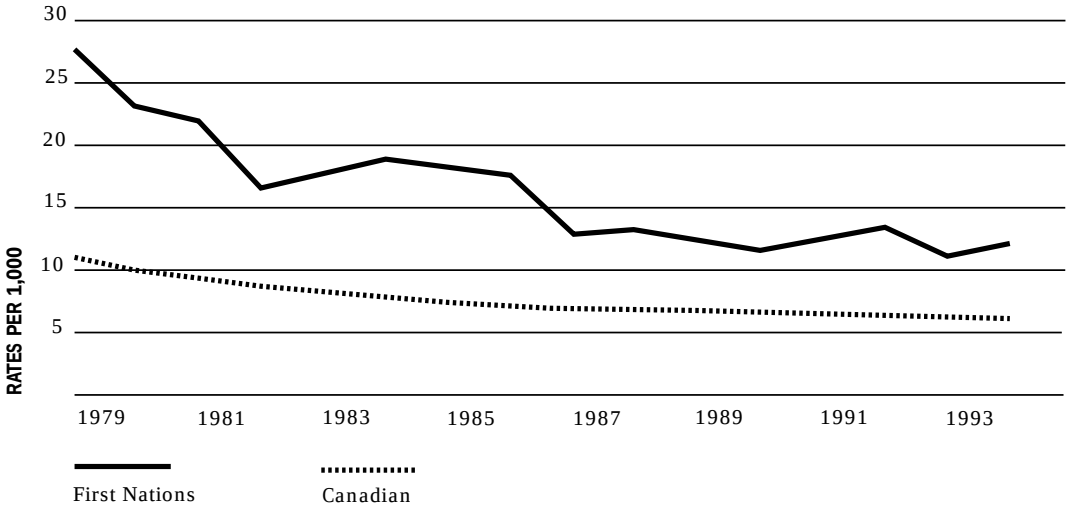
- As part of the $16-million solvent abuse prevention and treatment program, Brighter Futures helped set up six new Aboriginal treatment programs across the country;
- Training was provided to community health representatives and nurses on health promotion and injury prevention, and resource materials were developed in cooperation with the province of Alberta; and
- An Injury Surveillance pilot project was initiated in three Saskatchewan First Nations communities.

The Building Healthy Communities initiative, launched in 1995-96, addresses the mental health, solvent abuse and home care nursing needs of First Nations and Inuit people.

Oral health care and dental disease prevention programs use trained Aboriginal workers to carry out basic oral health care services in their communities. These services include fillings and extractions, as well as routine dental preventative care.

The Canada Prenatal Nutrition Program (CPNP) is a Canada-wide initiative to improve the health of pregnant women and that of babies under 6 months of age. In consultation with First Nations and Inuit, the department has produced versions of *Building Healthy Babies: A Prenatal Nutrition Resource Book* for each cultural group. While infant mortality among Indian and Inuit people is still higher than among other Canadian groups, the rate has dropped dramatically.

FIGURE 9: **Infant Mortality Rate First Nations and Total Canadian Populations**



The Tobacco Demand Reduction Strategy (TDRS) provided $6.8 million in 1994-97 for anti-smoking programs in First Nations and Inuit communities. Health Canada administers the Aboriginal component of the TDRS, in partnership with First Nations and Inuit organizations and associations.

Achievements in 1996-97

Indian and Northern Health Services has:

- Supported an anti-smoking program for Aboriginal women, as well as workshops on smoking prevention;
- Funded and participated through the TDRS in Regional Health Surveys carried out by First Nations;
- Completed a First Nations Youth Smoking Survey, in partnership with WUNSKA (a network of Aboriginal social workers) and *CIET (Community Information Epidemiological Technology)* International, collecting information on the knowledge, attitudes and practices of First Nations youth (age 10-14); and
- Started a ground-breaking initiative to combine modern epidemiological approaches with traditional First Nations practices in anti-smoking campaigns.

The Health Careers program focuses on building health-care capacity in Aboriginal communities and supporting training for Aboriginal health professionals. To help correct the under-representation of Aboriginal people in the health professions, Health Canada actively encourages people of Aboriginal ancestry to enter post-secondary programs leading to health careers, including environmental health and health administration. Health Canada now provides $500,000 in scholarships and bursaries under the Indian and Inuit Health Careers Program. Last year, it awarded 35 scholarships and 53 bursaries.

Achievement in 1996-97

- The Department increased the bursary and scholarship budget by $200,000 and added Health Administration to the list of health disciplines for which bursaries and scholarships are provided.

Disease Prevention and Control

The tuberculosis (TB) rate among First Nations and Inuit people has dropped steadily over the past several decades, but it is still almost seven times higher than the Canada-wide rate. Health Canada's commitment under the Tuberculosis Elimination Plan (established in 1995) is to reduce the tuberculosis rate in Aboriginal communities from today's rate of 49 cases per 100,000 people to less than 1 case per 100,000 people by the year 2010. The program now has a $3.8 million annual budget for case identification, contact tracing, therapy, treatment and prevention activities.

Diabetes is a major health hazard for Aboriginal people. Health Canada helped fund 11 research projects to identify those most at risk and to provide public information about the nature and management of diabetes.

HIV/AIDS is a serious concern in Aboriginal communities. Health Canada is working closely with First Nations and Inuit communities to stop the spread of this disease. AIDS funding for First Nations and Inuit communities began with $300,000 in 1988-89 and increased to $12 million for 1993-97.

Achievements in 1996-97

Health Canada funding supported activities such as:

- The Fourth Canadian Aboriginal Conference on HIV/AIDS and Related Issues;
- The Indigenous Peoples' Gathering Satellite Conference at the 11th International Conference on AIDS;
- An Assembly of First Nations (AFN) HIV/AIDS Economic Evaluation Study;
- A training session by the Association of Iroquois and Allied Indians on AIDS and TB; and
- Projects by the National Indian and Inuit Community Health Representatives Organization and the Native Women's Association of Canada.

Environmental Health and Related Research

INHS carries out comprehensive environmental health programs 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 consultation, education and promotion of environmental health to First Nations and Inuit communities. This program is mandatory under the Transfer Initiative.

INHS also works with First Nations and Inuit communities to ensure the continuation of the initiatives under the Action Plan on Health and the Environment (APHE) that were aimed at groups at greater risk from exposure to environmental contaminants.

Health Canada has committed permanent funding to ensure that the programs established as part of this initiative will continue. These include the Drinking Water Safety Program (Natives), Pregnancy and Child Development, Effects on Aboriginals from the Great Lakes Environment (EAGLE) and Northern and Arctic Pollution.

In 1991, Health Canada launched a six-year $25-million Drinking Water Safety Program for water monitoring, training, education and local capacity-building. This program complements the $250 million allocated over 1991-97 by the Department of Indian Affairs and Northern Development (DIAND) to upgrade water facilities.

Achievement in 1996-97

- In addition to its water quality monitoring programs, INHS evaluated and approved a commercial test, *Colilert*, now used by more than 150 First Nations communities to monitor fecal contamination of drinking water. It also worked with DIAND and the AFN to develop and pilot the Circuit Rider Training Program, which trains First Nations people to operate and maintain water and sewage treatment facilities. This training program has been implemented in Ontario, Manitoba and Alberta.

The EAGLE Project is a partnership between the Assembly of First Nations and Health Canada to investigate the effects of contaminants on the Great Lakes First Nation communities. The program surveys eating patterns, contamination of fish and game, and levels of contaminants in human tissues. It includes a

health survey and socio-cultural program.

Achievement in 1996-97

- In 1996-97, the EAGLE Project completed a Great-Lakes Basin-wide health survey, collected several hundred blood and hair samples, and undertook an extensive wild meat sampling program. The fish consumption program (sampling, guidelines and risk assessment) has been completed.

The National Northern and Arctic Pollution Program, which is managed at the regional level, helps communities address environmental contamination issues.

Achievement in 1996-97

- The Northern and Arctic Pollution Program supported a large number of community projects across the country. These included baseline health surveys, various environmental assessment projects, and public consultations on environmental health issues.

The Pregnancy and Child Development Program is a research program geared to responding to the growing concerns about prenatal and neonatal exposure to contaminants.

Achievement in 1996-97

- A study on mercury and child development collected and analysed information on 200 children in First Nations communities in north-western Ontario, where mercury contamination may be a problem.

Health Research and Analysis

Information gathering helps Aboriginal organizations, field workers and funding bodies, and is important for policy and program development.

Achievements in 1996-97

- INHS has created an Indian Health database with information from DIAND and Statistics Canada. The database contains information on a wide range of health indicators.

- INHS has worked with First Nations and Inuit to develop the Health Information System (HIS), a community-based information system. The implementation of HIS began in Ontario and Atlantic Canada in the spring of 1997 and will be extended across the country.
- INHS published *Trends in First Nations Mortality 1979-93*, showing national and regional trends in First Nations deaths.
- INHS also worked with First Nations to develop and carry out a health-data survey that is both culturally appropriate and scientifically sound. (The results of the survey are currently being analysed.)

Non-Insured Health Benefits

The Non-Insured Health Benefits (NIHB) program provides supplementary health benefits to approximately 640,000 registered Indians, recognized Inuit and Innu clients. These benefits meet medical or dental needs that are not covered by provincial services or other health plans. Benefits include prescription and over-the-counter drugs, dental services, eyeglasses, mental health counselling and transportation to access medically required services.

Achievements in 1996-97

The cost of administering the NIHB program encountered an overall decrease in 1996-97, from $505.3 million in 1995-96 to $489.3 million, a 3.2% reduction. This was accomplished by:

- Reviewing the frequency of dental benefits;
- Applying the Best Price Alternative drug policy;
- Conducting a major review of the drug benefit list;
- Negotiating lower premiums in Alberta; and
- Renegotiating provider pricing agreements.

Unexpended NIHB resources remained in the regional envelopes to be used in other program activities.

Transfer

In the past, Health Canada was responsible for providing direct health services and resources to First Nations and Inuit communities south of the 60th parallel and to Northwest Territories and Yukon residents. Through the Health Transfer Initiative, First Nation and Inuit communities have shown themselves ready and able to assume management of their own health programs. The Health Transfer Initiative, approved by the Government in 1988, is now the policy basis for INHS's activities.

To quote Medical Services Branch's vision statement, "First Nations and Inuit people will have autonomy and control of their health programs and resources within a time frame to be determined in consultation with First Nations and Inuit people."

First Nations and Inuit are assuming greater control over their health programs, and regional First Nations health authorities are being established and are taking over the provision of services at the second (zone) and third (regional) levels of departmental organization.

Achievements in 1996-97

To date, Health Canada has signed 81 transfer agreements and 65 integrated agreements with First Nations and Inuit communities. These agreements cover 262 (41%) of 634 First Nations. In addition:

- Health Canada conducted a long-term review of the Transfer Initiative and signed a joint initiative with DIAND to find ways to simplify funding processes to First Nations.
- In line with the policy direction of Health Canada whereby the department is to divest itself of its role in administering hospitals, the administration of federal Indian hospitals are either being transferred to Aboriginal communities, regional health authorities to be administered as part of local hospital systems or being closed. Plans are well under way for the transfer of hospitals at Moose Factory, Fort Qu'Appelle and Sioux Lookout. The Blood Indian Hospital will be closed.
- As of March 31, 1997, the Department completed the transfer of universal health care programs to the Yukon Territorial Government. In accordance with the 1993 Self-Government Agreement signed with the Council of Yukon First Nations, Health Canada is currently negotiating transfer agreements related to community-based health programs.

ACTIVITY 8: Public Service Health

Public Service Health (PSH) protects and preserves the health of public servants in the federal workplace. It provides a program of occupational and environmental health services under authority delegated by the Treasury Board. It also provides health care services for Very Important Persons (VIPs) during their official visits to Canada.

Health Canada's strategy in the area of public service occupational safety and health is to provide advice and services that help to reduce workplace injuries, occupational illness and the effects of stress by:

- advising senior management on occupational safety and health initiatives;
- conducting public service workplace surveillance and investigations;
- carrying out pre-employment and occupational health evaluations of public service employees;
- providing health education and promotion, and advice and consultation services for Occupational Health Services (OHS); and
- providing traumatic stress management and employee assistance services.

The VIP program's objective is to provide essential health care services for visiting dignitaries.

Occupational Health Services

Occupational Health Services (OHS) provides occupational safety and health services for federal public servants and employees in federally regulated industries. It also deals with public health for the travelling public and with VIP services. Services to federal employees include: health evaluation; employee assistance; workplace surveillance and investigations; health education and promotion; and traumatic stress management. OHS also provides advice and consultation to Treasury Board and departments on occupational safety and health issues.

Achievements in 1996-97

- Established hourly service costs, service standards, performance indicators and a new more customer-focused management structure;
- Piloted a Health Information Management System for use with customers; and
- Studied the feasibility of adding disability management and workplace risk assessment to its service lines.

Very Important Person (VIP) Services

Under the Geneva Convention, a host country is responsible for arranging and providing appropriate medical and health care for visiting foreign dignitaries (VIPs) during official visits to Canada. OEHS plans and coordinates medical contingency and emergency plans, determines the level, extent and availability of medical care, and provides food inspection services.

Achievement in 1996-97

- In addition to dealing with some 50 VIP visits, including the summer Royal visit, VIP Services planned for the Summit of the Asia Pacific Economic Community, scheduled for the fall of 1997.

In November 1996, the new Occupational and Environmental Health Services Agency became a provisional Special Operating Agency (SOA). OEHS will incorporate Occupational Health Services, Civil Aviation Medicine and Quarantine Services. It will operate on a cost-recovery basis. It hopes to achieve full SOA status in April 1998—the first SOA in Health Canada.

ACTIVITY 9: Health Advisory and Assessment Services

Health Advisory and Assessment Services (HAAS) provides medical assessments and advice to Canadian civil aviation personnel licensed by Transport Canada, as well as emergency, quarantine and regulatory services.

It does this by:

- assessing the fitness of all civil aviation personnel in Canada and promoting aviation safety (Civil Aviation Medicine);
- supporting health care and social service systems when peacetime disasters occur (Emergency Services); and
- meeting the requirements of the *Canadian Quarantine Act* and the World Health Organization (WHO) International Health Regulations (Quarantine and Regulatory Services).

Civil Aviation Medicine (CAM)

CAM conducts health and safety lectures, seminars and training sessions for the aviation community. It appoints, trains and monitors Civil Aviation Medical Examiners, who must assess all aviation personnel as part of Transport Canada's licensing and renewal process. CAM advises the Canadian Transportation Accident Investigation and Safety Board in the investigation of aircraft accidents and investigates human factors associated with aviation accidents. Finally, CAM is responsible for policy and development of new standards.

In 1996-97, CAM faced a 37 percent ($1 million) cut to its operating budget, which is to be cut by another $1 million in 1997-98. The reductions, stemming from Program Review, were based on expectations that licence fees could be recovered. Health Canada carries out the medical assessment program as part of the Transport Canada licensing process. The implementation of cost recovery was to be managed by Transport Canada. Since this was not achieved during the fiscal period, CAM and other sections of the Occupational and Environmental Health Services Agency managed the total $1 million reduction internally. An operational review carried out on behalf of both Transport and Health recommended that Transport Canada should take over complete control of this program.

Achievements in 1996-97

- CAM completed an operational review with Transport Canada and the aviation industry which recommended a number of changes to streamline licensing, as well as the use of improved automated systems, reduction of size and the transfer of the CAM program to Transport Canada. These recommendations have been received and are being acted upon by both departments.
- CAM conducted 58,000 medical assessments of which 1,200 were considered borderline and were referred to the Aviation Medical Review Board for final decision.

Emergency Services

Emergency Services works with all levels of government to support health care and social services systems when peacetime disasters such as floods or earthquakes occur. The program provides training for frontline provincial and municipal health and social services workers. It helps provincial and municipal governments establish and update emergency planning, and maintains the Federal Nuclear Emergency Plan. It runs a national stockpile of emergency materials and medical supplies.

Achievements in 1996-97

- Initiated a review, with the provinces, of the national emergency medical and pharmaceutical stockpile;
- Met revenue targets for the sale of emergency materials; and
- Worked with the Radiation Protection Bureau on the Federal Nuclear Response Plan and the development of a test of the revised plan, to be held in April 1998.

Quarantine and Regulatory Services

The Quarantine Program enforces the provisions of the *Canadian Quarantine Act* and the WHO International Health Regulations. It inspects ships arriving in Canada from international waters and carries out shipboard rat eradication programs (derattification). It also takes steps to prevent the spread of dangerous diseases such as the Ebola virus or plague. It helps protect the health of the travelling public by ensuring that common carriers, national parks and historic sites meet proper standards for food handling, drinking water safety and sanitation.

Achievements in 1996-97

- Conducted discussions with the cruise vessel industry and the American government to develop a common inspection protocol for the industry;
- Completed the first joint Canada-U.S. training program for front line inspection staff;
- Revised proposals for recovering the costs of cruise vessel inspection, using feedback from the industry; and
- Recovered all costs of the derattification program and met the cost-recovery target of $250,000.

ACTIVITY 10: Policy and Consultation

Policy and Consultation Branch (PCB) advises and supports the Minister, Departmental Executive and program branches in policy development, intergovernmental affairs, strategic planning and review, communications and consultation, and international affairs. This includes conducting research and analyses, developing and proposing health policies and programs, and providing advice on health policy issues.

Achievements in 1996-97

- PCB developed legislation to prohibit unacceptable practices in new reproductive and genetic technologies. The Minister submitted the draft bill to Parliament in December 1996.
- In response to Justice Krever's Interim Report, PCB completed the initial design of a new blood agency for Canada.
- PCB worked closely with the World Health Organization (WHO) on the WHO health policy development initiative and on the development of a Framework Convention on Tobacco.
- PCB managed 80 international visits of health officials wanting to learn about Canada's health system, including several visits at the ministerial level, and signed international health cooperation agreements with China and France.
- PCB played a leading role in the Directing Council of the Pan American Health Organization and the World Health Assembly. The decisions of these meetings reflected such Canadian priorities as improved international disease surveillance, international cooperation to reduce tobacco consumption and improved performance and management by international health organizations.

- Health Canada has established an Office of Health and the Information Highway to provide a focal point for activities related to the Information Highway. Increased access to health information has the potential to improve the health of Canadians and to improve the quality of health care and the cost-effectiveness of its delivery.
- The first five Centres of Excellence for Women's Health, with federal funding, were announced in June 1996. These centres will conduct interdisciplinary policy-oriented research on key women's health concerns. In addition, Health Canada hosted the Canada–USA Women's Health Forum in August 1996 and signed an agreement concerning women's health with the U.S. in such areas as breast cancer, smoking cessation and information clearinghouses and networks.

With regard to **Health System Renewal**, in October 1994, Prime Minister Chrétien launched the National Forum on Health. The Forum, with the Prime Minister as chair, the Minister of Health as vice-chair, and 24 volunteer members, advised the federal government on new ways to improve our health system and the health of all Canadians. It addressed four key areas: values, striking a balance, determinants of health and evidence-based decision making.

The Forum conducted a national consultation process involving public discussion groups, conferences, meetings with stakeholders and experts, and research. The result, a two-volume report published in February 1997 and entitled *Canada Health Action: Building on the Legacy* has been well received. Its recommendations fall under three themes:

- preserving our health care system by doing things differently;
- transforming our knowledge about health into action; and
- using better evidence to make better decisions.

A number of recommendations have already been acted on in the 1997 budget or have been included in the 1997 Red Book. The Forum completed its work a year ahead of schedule and within its original $12-million budget.

ACTIVITY 11: Health Insurance

The Health Insurance activity ensures that all residents of Canada have reasonable access to insured health care services on a pre-paid basis, and supports extended health care services.

Health Canada administers the *Canada Health Act*. Its Health Insurance activity:

- establishes criteria and conditions for federal contributions to the provinces and territories in support of insured health services and certain extended health care services;
- determines whether provincial and territorial health care insurance plans are compatible with the *Act*;
- provides advice and assistance to health insurance plans and programs; and
- provides policy advice on the role of the *Canada Health Act* in the overall direction of the Canadian health care system.

Under the Act, the Minister of Health is responsible to Parliament for ensuring that payments made in support of provincial health insurance plans meet national program criteria and conditions. If provincial or territorial programs fail to meet the provisions of the Act, their transfer payments may be cut. Health Insurance monitors these programs, determines if they meet program criteria and conditions under the Act, and issues payment authorization certificates to the Department of Finance, which administers the payments.

Achievement in 1996-97

- Penalties against Alberta ended in June 1996 when the province eliminated user charges to patients for medically necessary services at private clinics. Total penalties of more than $2 million were deducted from Alberta's Health and Social Transfer payments in 1996-97.

ACTIVITY 12: Program Management

Program Management provides management services and functional direction, to help executive and business line managers set priorities, plan and achieve their goals, and effectively administer the public resources entrusted to them.

Program Management carries out these responsibilities by aligning departmental objectives with ministerial and government priorities, setting goals and monitoring results, and managing allocated resources effectively and efficiently.

Departmental Planning and Financial Administration

Departmental Planning and Financial Administration is responsible for the implementation, interpretation, and administration of the acts, regulations, policies and processes that govern Health Canada's financial resources. Its provides such services as financial planning, accounting, functional and advisory assistance on cost recovery initiatives, and financial systems support.

Achievements in 1996-97

- Selected a new Departmental Financial System that will allow for better financial and material management in Health Canada; and
- Helped develop and implement departmental policies, procedures and systems related to cost recovery.

Assets and Facilities Management

Assets and Facilities Management develops and implements departmental policies and systems for the procurement and use of real property, materiel, accommodations and security of the Health Canada workplace. It also advises and assists the Departmental Executive Committee and branch managers on all matters related to physical assets and departmental security.

Assets Management coordinated the construction of the Federal Microbiology Laboratory in Winnipeg. The project is a joint venture between Health Canada and Agriculture and Agri-food Canada. This state-of-the-art facility will house the only laboratory in Canada with the capacity to contain highly dangerous biological materials. The facility will also house animal holding areasand training and research facilities.

Information Management Services

Information Management Services provides comprehensive informatics and information management services and support to the department. These include coordination, advisory and technical services on Information Management/ Information Technology (IM/IT) issues, and the development and operation of corporate electronic applications and automated systems. Other activities include the management of records, forms, mail and library services.

Achievements in 1996-97

- Information Management Services has completed the installation of a single corporate electronic mail/work group computing tool. Departmental information systems underwent hardware upgrades and the installation of software to improve internal communication and Internet access. This software gives all Health Canada employees access to common departmental databases, directories and electronic mail.
- Information Management Systems also started the pilot phase of the Automated Procurement Initiation Commitment System (APICS). This will facilitate the work of program support, financial and procurement staff and will speed up the negotiation and payment of contracts with suppliers of services to the Department.

Human Resources

Human Resources is responsible for providing support for the effective management of the department's personnel. It fosters practices that promote fairness, recognize competence and encourage opportunities for growth and development. It implements such federal initiatives as La Relève action plan, designed to build a modern and vibrant Public Service for the future.

In 1996-97, Human Resources implemented measures to improve representation of visible minority employees, as well as designated group members, as a result of the Human Rights Tribunal Order decision of March 19, 1997.

Internal Audit and Review

The Internal Audit Directorate conducts independent reviews of the department's operations, activities, systems and functions to ensure that they support the delivery of departmental programs in an economic, efficient and effective manner.

Achievements in 1996-97

- Initiated audits in the key areas of Workforce Adjustment and Records Management; and
- Reviewed the integrity of departmental systems related to travel expenditures, and the use of acquisition cards and temporary help services.

C KEY REVIEWS

In 1996-97, Health Canada completed five key reviews of its programs and services for Canadians. Three of these reviews dealt with interdepartmental initiatives or strategies led by Health Canada. All reports are publicly available on request.

Action Plan on Health and the Environment (Final Evaluation, Inter-activity Initiative within Health Canada)

The Action Plan on Health and the Environment (APHE) was announced by the Minister of Health and Welfare Canada (HWC) in 1992 as part of the Green Plan. APHE funding ended in 1996-97. The plan initially included 16 initiatives and a budget of $175 million, to be administered by six branches in the department. A series of funding cuts reduced the original budget to actual expenditures of $127 million, or about 73 percent of the original allocation. As a result of these funding cuts, two of the originally announced 16 initiatives were never implemented, and planned activities in many of the surviving initiatives were reduced or eliminated. The initiatives were intended to collect and provide information on, establish standards and regulations for, and give advice on the management of environmental health risks to Canadians.

The final evaluation of APHE was completed in November 1996. It detailed a number of achievements:

- improved inter-branch cooperation;
- increased understanding of relationships between the environment and health;
- improved infrastructure, databases and research techniques; and
- progress in the department's ability to work with communities on health and environment issues.

On the other hand, there was little public knowledge of APHE. Implementation of the initiative was hampered by the lack of a strategic plan, lack of overall responsibility and coordination of the plan, and funding cuts.

Among the key lessons suggested in the evaluation report are the following:

- Health Canada should ensure that future action plans have appropriate organizational structures and accountability, as well as more comprehensive and consistent reporting of progress and results;
- funding should be stabilized for scientific programs, and Health Canada must consider the long-term sustainability of scientific activities initiated with short-term funds; and
- five-year action plans are too short to achieve tangible results from health and environment activities.

Child Development Initiative (CDI) Final Interdepartmental Evaluation

CDI was an initiative led by Health Canada, involving five other federal departments and agencies (Human Resources Development Canada, Canadian Heritage, Justice Canada, the Solicitor General of Canada and the Royal Canadian Mounted Police). The initiative was designed to address conditions that put children at risk. CDI had an original five-year budget of $500 million, cut through a number of changes to $479 million and ending in March 1997. An interdepartmental evaluation of CDI in April 1996 examined the relevance and success of CDI, as well as its resoursing, cost-effectiveness and alternatives to it. The evaluation found that CDI's objectives and mandate are still relevant. There is a continuing need for a coordinated interdepartmental initiative to address conditions that put children at risk. The evaluation had too little data to report major findings on such macro-level issues as promoting the value of children in society or increasing public awareness regarding risks faced by children. The evaluation did, however, report that CDI had:

- contributed knowledge to the professional community on serious illnesses and injuries to children;
- helped to protect children from threats to their well-being;
- provided intervention and compensatory services in communities for at-risk pregnancies, babies and young children; and
- facilitated the development of partnerships among levels of government and between a variety of organizations.

Little data was available on the satisfaction of beneficiaries of CDI products. CDI achievements were more closely linked to the efforts of individual departments than to coordinated efforts among participating departments.

The evaluation concluded that the manner in which the initiative was implemented interdepartmentally limited its potential impact. Interdepartmental aspects were seen as weak and ineffective. The evaluation noted similar findings and concerns in other evaluations of interdepartmental initiatives, citing some lessons to be learned in meeting the challenges inherent to managing interdepartmental initiatives.

Canada's Drug Strategy (CDS) Interdepartmental Mid-term Review

CDS was an initiative led by Health Canada and involved nine other federal departments and agencies (the Solicitor General of Canada, the Royal Canadian Mounted Police, Human Resources Development Canada, Correctional Service Canada, Revenue Canada, Labour Canada, Foreign Affairs and International Trade Canada, Justice Canada and Canadian Heritage). CDS had an original five-year budget of $270 million, which was cut by more than $31 million over the course of the five years, ending in March 1997. CDS was designed to coordinate various federal programs dealing with drug and alcohol issues. The strategy attempted to improve existing programs through stronger coordination, by targeting programs to specific sub-populations, and by improving the information upon which policy and program decisions are made.

The mid-term review focused mainly on the management and administration of the strategy up to 1994. The review identified strengths and weaknesses in the planning and coordination of the strategy, the targeting of funding, and the collection and management of information for performance measurement and priority-setting. An update on these process issues, and an examination of the accomplishments of the strategy, will be addressed in the final evaluation of the strategy, being completed in 1997-98.

National AIDS Strategy Interdepartmental Mid-term Review

The National AIDS Strategy is a Health Canada-led initiative involving two other federal Departments and agencies (Medical Research Council and Correctional Service Canada). The strategy has a five-year budget of more than $200 million, ending in March 1998. The strategy was designed to coordinate national efforts to stop the spread of AIDS through such steps as prevention and education-related activities, to provide care, treatment and support to persons living with HIV/AIDS, and to search for effective vaccines, drugs and therapies.

Health Canada conducted a mid-term review to assess whether the strategy was on target and to identify any mid-course corrections required. This review represents a stocktaking of whether essential elements and processes are in place, rather than an assessment of achievements and success to this point. The review identified strengths and weaknesses in the coordination of the strategy, the implementation of its programs, the process of resource allocation within the strategy, and in the information being collected to evaluate the strategy's performance and success. An evaluation of the accomplishments of the strategy will be completed in 1997-98.

Transfer of Indian Health Services to Community Control (Indian and Northern Health Services Activity)

In 1996, the Medical Services Branch (MSB), working with the First Nations and Inuit people, completed an evaluation of the initiative to transfer health programs and resources, previously directly delivered by MSB, to those communities who identified themselves as ready to assume greater responsibility for these programs and resources. The main focus of the evaluation was to assess the overall success of the Transfer Initiative in facilitating First Nations control of health services, and its impact on the health of Indian people. Transfer is a community-based program delivery process.

The report assessed the achievement of Transfer objectives and identified alternatives to the Transfer process. It looked at the effect of transfer of health services on management capacity at the community level and on awareness of health issues among community members. The report provided 25 recommendations which are currently being implemented. As a result of this evaluation:

- The Department allocated $10.7 million to bring all communities up to a base level of funding, based on community population. This increase provided resources for nurses, clerks and community health representatives.
- MSB has developed a *Guide for First Nations Health Directors*. The guide includes information and advice on issues such as the role and authority of community health boards, management information systems, staff and financial issues, quality assurance and accountability.

SECTION IV: SUPPLEMENTARY INFORMATION

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B FINANCIAL SUMMARY TABLES

Summary of Voted Appropriations Authorities for 1996-97 – Part 11 of the Estimates Financial Requirements by Authority

($ millions)

Vote	Health Department	Main Estimates 1996-97	Actual 1996-97
1	Operating expenditures	914.7	895.5
5	Capital Expenditures	31.0	22.9
10	Grants and contributions	585.0	639.9
(S)	Minister of Health – Salary and motorcar allowance	0.1	0.1
(S)	Payments for insured health services and extended health care services	–	(96.0)
(S)	Contributions to employee benefit plans	46.0	47.8
(S)	Spending of proceeds from the disposal of surplus Crown assets	–	0.7
(S)	Refunds of amounts credited to revenues in previous years	–	0.9
Total Department		1,576.8	1,511.8

Revenues to the Consolidated Revenue Fund (CRF) by Activity

($ millions)

Activity	Actual 1993-94	Actual 1994-95	Actual 1995-96	Total Planned 1996-97	Actual 1996-97
Drug Safety, Quality and Effectiveness	5.2	6.2	3.6	–	–
Environmental Quality and Hazards	1.3	–	–	–	–
Indian and Northern Health Services	32.7	6.7	6.2	6.7	7.1
Total Revenues to the CRF	39.2	12.9	9.8	6.7	7.1

Revenues to the Vote by Activity

($ millions)

Activity	Actual 1993-94	Actual 1994-95	Actual 1995-96	Total Planned 1996-97	Actual 1996-97
Food Safety, Quality and Nutrition	–	–	0.2	2.1	0.9
Drug Safety, Quality and Effectiveness	–	–	10.6	27.5	24.8
Environmental Quality and Hazards	–	2.7	2.7	4.3	3.7
Pest Management Regulatory Agency	–	–	–	0.2	0.3
Indian and Northern Health Services	–	15.9	15.0	16.3	9.6
Public Service Health	–	–	–	–	0.9
Health Advisory and Assessment Services	–	–	0.1	0.3	0.3
Program Management	–	–	0.6	0.5	1.0
Total Revenues to the Vote	–	18.6	29.2	51.2	41.5

Capital Expenditures by Activity

($ millions)

Activity	Actual 1993-94	Actual 1994-95	Actual 1995-96	Total Planned 1996-97	Actual 1996-97
Food Safety, Quality and Nutrition	3.6	3.3	4.1	1.8	0.7
Drug Safety, Quality and Effectiveness	3.0	3.1	2.0	2.2	0.5
Environmental Quality and Hazards	4.9	5.0	2.8	2.2	1.2
National Health Surveillance	1.6	1.8	1.3	1.4	1.9
Pest Management Regulatory Agency	–	–	–	1.5	0.1
Programs and Services	1.2	1.4	1.3	0.3	0.1
Indian and Northern Health Services	17.6	15.2	12.3	12.0	9.4
Public Service Health	0.9	0.8	0.3	1.2	0.6
Health Advisory and Assessment Services	0.1	0.1	0.1	0.1	0.1
Policy and Consultation	0.4	0.2	0.2	–	0.5
Health Insurance	–	–	–	–	–
Program Management	21.0	53.8	26.5	10.4	16.0
Total Capital Expenditures	54.3	84.7	50.9	33.1	31.1

Major Capital Projects

($ millions)

Health Programs	Current Estimated Total Cost	Actual Spending 1993-94	Actual Spending 1994-95	Actual Spending 1995-96	Total Planned Spending 1996-97	Actual Spending 1996-97
Microbiology Laboratory Winnipeg (EPA)	65.8[1]	8.3	22.9	14.4	4.8	6.0
Pelican Narrows (EPA)	3.5	0.0	0.2	1.4	0.1	1.9

[1] Expenditures totalling $9.9 for 1988 to 1993 are included in this currently estimated total cost. Forecast for 1997-98 is $4.3

Transfer Payments by Activity[1]

($ millions)

Activity	Actual 1993-94	Actual 1994-95	Actual 1995-96	Total Planned 1996-97	Actual 1996-97
GRANTS					
Food Safety, Quality and Nutrition	–	–	–	–	–
Drug Safety, Quality and Effectiveness	–	–	–	–	–
Environmental Quality and Hazards	0.1	0.1	0.1	0.1	0.1
National Health Surveillance	–	–	–	–	–
Pest Management Regulatory Agency	–	–	–	–	–
Programs and Services	13.6	13.0	14.8	16.0	11.6
Indian and Northern Health Services	0.1	0.3	0.3	0.3	0.3
Public Service Health	–	–	–	–	–
Health Advisory and Assessment Services	–	–	–	–	–
Policy and Consultation	1.3	1.9	1.9	2.0	12.9
Health Insurance	–	–	–	–	–
Program Management	–	–	–	–	–
TOTAL GRANTS	15.1	15.3	17.1	18.4	24.9

[1] does not include statutory payments

Transfer Payments by Activity[1]

($ millions)

Activity	Actual 1993-94	Actual 1994-95	Actual 1995-96	Total Planned 1996-97	Actual 1996-97
CONTRIBUTIONS					
Food Safety, Quality and Nutrition	0.3	–	–	–	–
Drug Safety, Quality and Effectiveness	3.4	0.3	0.5	–	–
Environmental Quality and Hazards	–	0.3	1.6	–	1.2
National Health Surveillance	–	–	–	–	0.1
Pest Management Regulatory Agency	–	–	–	–	–
Programs and Services	101.9	131.1	145.0	149.4	157.4
Indian and Northern Health Services	244.0	311.4	398.7	413.0	416.5
Public Service Health	–	–	–	–	–
Health Advisory and Assessment Services	–	–	–	–	–
Policy and Consultation	2.0	1.5	2.1	4.2	3.3
Health Insurance	–	–	–	–	–
Program Management	–	–	–	–	36.6
TOTAL CONTRIBUTIONS	351.6	444.6	547.9	566.6	615.1
Total Transfer Payments	366.7	459.9	565.0	585.0	640.0

[1] does not include statutory payments

C Objectives and Key Results by Business Line for 1997-98 Reporting

Starting in 1998-99, Health Canada's programs will be managed by Business Line. Performance in 1998 and in future years will be reported by Business Line, using the objectives and key results identified in the following table.

HEALTH CANADA has a budget of $1.5 billion

to provide Canadians with:	to be demonstrated by :
Health System Support and Renewal A long-term, sustainable health system with significant national character.	◗ Access to health services consistent with the principles of the *Canada Health Act*: universality, portability, accessibility, public administration and comprehensiveness. ◗ Innovations to improve the national Medicare system. ◗ National collaboration on health system issues.
Management of Risks to Health – Products and Disease Control Health surveillance that anticipates, prevents and responds to health risks posed by diseases, food, water, drugs, pesticides, medical devices, environmental hazards, consumer goods and other socio-economic determinants of health.	◗ Reduced illness, injury and death from identified health risks. ◗ Scientific knowledge on risks and benefits to human health and the environment. ◗ A public informed about specific risks and benefits to their health. ◗ Modern surveillance systems, laws and regulations responsive to risks and benefits to human health and the environment, which also take into account globalization, the economy and sustainable development.
Aboriginal Health A level of health in Aboriginal communities comparable to that of other Canadians.	◗ Life expectancy for First Nations to match Canadian levels. ◗ Rate of infant mortality to match Canadian levels. ◗ Rates of communicable disease, chronic disease, injury and suicide not exceeding Canadian levels. ◗ Effective and sustainable Aboriginally managed health services.

to provide Canadians with:	to be demonstrated by:
Promotion of Population Health An approach to health which takes into account, and acts on, social, behavioural and economic determinants of health.	◗ Information about what determines health and on the actions to take to maintain and improve health. ◗ Improvements in the health status of the population or of specific groups targeted by the Promotion of Population Health. ◗ Tools and mechanisms, developed in collaboration with other federal government departments, to assess the health impacts of federal policies and programs.
Health Policy, Planning and Information Evidence-based health-related decision making that promotes health as part of a knowledge-based society and economy.	◗ A Health Canada decision-making system that uses the best available knowledge and relevant health information. ◗ A well functioning national health information and health research infrastructure.

D Acts Administered in Whole or in Part by the Department of Health

1. *Canada Health Act*, R.S.C. 1985, c. C-6
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.)
5. *Controlled Drugs and Substances Act*, S.C. 1996, c. 19
6. *Department of Health Act*, S.C. 1996, c. 8
7. *Federal-Provincial Fiscal Arrangements Act*, R.S.C. 1985, c. F-8
8. *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
   - – Regulations Prescribing Fees to be Paid for a Pest Control Product SOR/97-173
9. *Fitness and Amateur Sport Act*, R.S.C. 1985, c. F-25
10. *Food and Drugs Act*, R.S.C. 1985, c. F-27
11. *Hazardous Materials Information Review Act*, S.C. 1985, c. H-2.7
12. *Hazardous Products Act*, R.S.C. 1985, c. H-3 as amended
13. *Medical Research Council Act*, R.S.C. 1985, c. M-4
14. *Patent Act*, R.S.C. 1985, c. P-4
15. *Pest Control Products Act*, R.S.C. 1985, c. P-9
16. *Pesticide Residue Compensation Act*, R.S.C. 1985, c. P-10

17. *Quarantine Act*, R.S.C. 1985, c. Q-1

18. *Queen Elizabeth II Canadian Research Fund Act*, R.S.C. 1970, c. Q-1

19. *Radiation Emitting Devices Act*, R.S.C. 1985, c. R-1

20. *Tobacco Act*, S.C. 1997, c. 13

E Acts and Regulations in which the Department is Involved or has a Special Interest

1. *Aeronautics Act*, R.S.C. 1985, c. A-2
2. *Atomic Energy Control Act*, R.S.C. 1985, c. A-16
3. *Broadcasting Act*, R.S.C. 1985, c. B-9
4. Canada Labour Code, R.S.C. 1985, c. L-2
5. *Canada Shipping Act*, R.S.C. 1985, c. S-9
6. *Canadian Food Inspection Agency Act*, S.C. 1997, c. 6
7. *Emergency Preparedness Act*, R.S.C. 1985, c. 6 (4th Supp.)
8. *Energy Supplies Emergency Act*, R.S.C. 1985, c. E-9
9. *Excise Tax Act*, R.S.C. 1985, c. E-15
10. *Feeds Act*, S.C. 1985, C. F-9
11. *Immigration Act*, R.S.C. 1985, c. I-2
12. *Income Tax Act*, S.C. 1970-71-72, c. 63
13. *National Parks Act*, R.S.C. 1985, c. N-14
14. *National Transportation Act*, 1987, R.S.C. 1985, c. 28 (3rd suppl.), Railway Act, R.S.C. 1985, c. R-3
15. *Trade Marks Act*, R.S.C. 1985, c. T-13

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