Health Canada Santé Canada

Your health and safety… our priority. *Votre santé et votre sécurité… notre priorité.*

Departmental Performance Report

Health Canada
2005–2006

For the period ending
March 31, 2006

Canada

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Section I

Overview

Minister's Message

Canada's New Government knows that accountability and transparency are keys to earning the trust of Canadians. As Minister of Health, I am proud that this *Departmental Performance Report* (DPR) stands as yet another contribution to this Government's track record of improved accountability and commitment in delivering results that reflect the priorities of Canadians.

Health Canada plays an extensive and unique range of roles in Canada's health system. Many of them are critical, ongoing responsibilities, such as the delivery of health services to First Nations people living on reserves and to Inuit; reviewing and approving drugs, medical devices and other health-related products for use in Canada; safeguarding consumer product and food safety; and pest control product approvals and monitoring. Throughout these and the Department's many other responsibilities, this DPR showcases the continuing efforts to improve results and use newly gained knowledge of what works best to improve health outcomes for Canadians.

This *Departmental Performance Report* also underlines the work that has taken place to move forward on the health priorities that are of fundamental importance to Canadians. The centrepiece of those recent efforts has been the work that we began with provincial and territorial governments in February 2006 to develop and implement a Patient Wait Times Guarantee. Our goal is to provide Canadians with a health care system that is responsive, fair, transparent, and accountable – one that provides them with certainty. Canadians want a system that is easier to navigate, one that delivers timely, quality care, and one that doesn't result in added anxiety. Canada's New Government is committed to delivering on this patient-centred approach.

We have also increased our emphasis on preparing for the potential of pandemic influenza. Having learned from our 2003 experience with Severe Acute Respiratory Syndrome (SARS), this DPR demonstrates the many ways that the federal government has helped to expand Canada's capacity to track and respond to such a threat. For example, we launched a new web-based resource on pandemic influenza (www.influenza.gc.ca) that gives Canadians access to a one-stop source of information on pandemic influenza and Canada's preparedness. These actions will grow even further, on the basis of the Budget 2006 commitment of $1 billion over five years to further improve Canada's pandemic preparedness.

Canada's New Government made a commitment to improve the quality of health care in this country. This *Departmental Performance Report* shows our initial efforts to honour that commitment to Canadians.

The Honourable Tony Clement
Minister of Health
Government of Canada

Management Representation Statement

I submit for tabling in Parliament the 2005–2006 Departmental Performance Report for Health Canada.

This document has been prepared based on the reporting principles contained in the *Guide for the Preparation of Part III of the 2005–2006 Estimates: Reports on Plans and Priorities and Departmental Performance Reports*:

- adheres to the specific reporting requirements outlined in the Treasury Board Secretariat guidance;
- is based on the Department's approved Program Activity Architecture as reflected in its Management, Resources and Results Structure (MRRS);
- presents consistent, comprehensive, balanced and reliable information;
- provides a basis of accountability for the results achieved with the resources and authorities entrusted to it; and
- reports finances based on approved numbers from the Estimates and Public Accounts of Canada.

Morris Rosenberg
Deputy Minister

Summary Information

About Health Canada

Health Canada develops, implements and enforces legislation, regulations, policies, programs and services and works with other federal partners, the provinces and territories to maintain and improve the health of Canadians. As administrator of the *Canada Health Act*, we ensure that the principles of Canada's universal health care are respected, allowing Canadians to be confident in the services they receive from the public health care system. The Minister of Health is also responsible for the direct administration of another 18 statutes including the *Food and Drugs Act*, the *Pest Control Products Act* and the *Controlled Drugs and Substances Act*.

We provide policy leadership and portfolio co-ordination among our partners in the Government of Canada's Health Portfolio, each of which produces its own *Departmental Performance Report*, namely:

- the Public Health Agency of Canada;
- the Canadian Institutes of Health Research;
- the Hazardous Materials Information Review Commission;
- the Patented Medicine Prices Review Board; and
- the new Assisted Human Reproduction Agency of Canada which came into being on January 12, 2006.

Our Vision

Health Canada is committed to improving the lives of all of Canada's people and to making this country's population among the healthiest in the world as measured by longevity, lifestyle and effective use of the public health care system.

Our Mission

Health Canada is the federal department that helps the people of Canada maintain and improve their health.

Our Objectives

By working with others in a manner that fosters the trust of Canadians, Health Canada strives to:

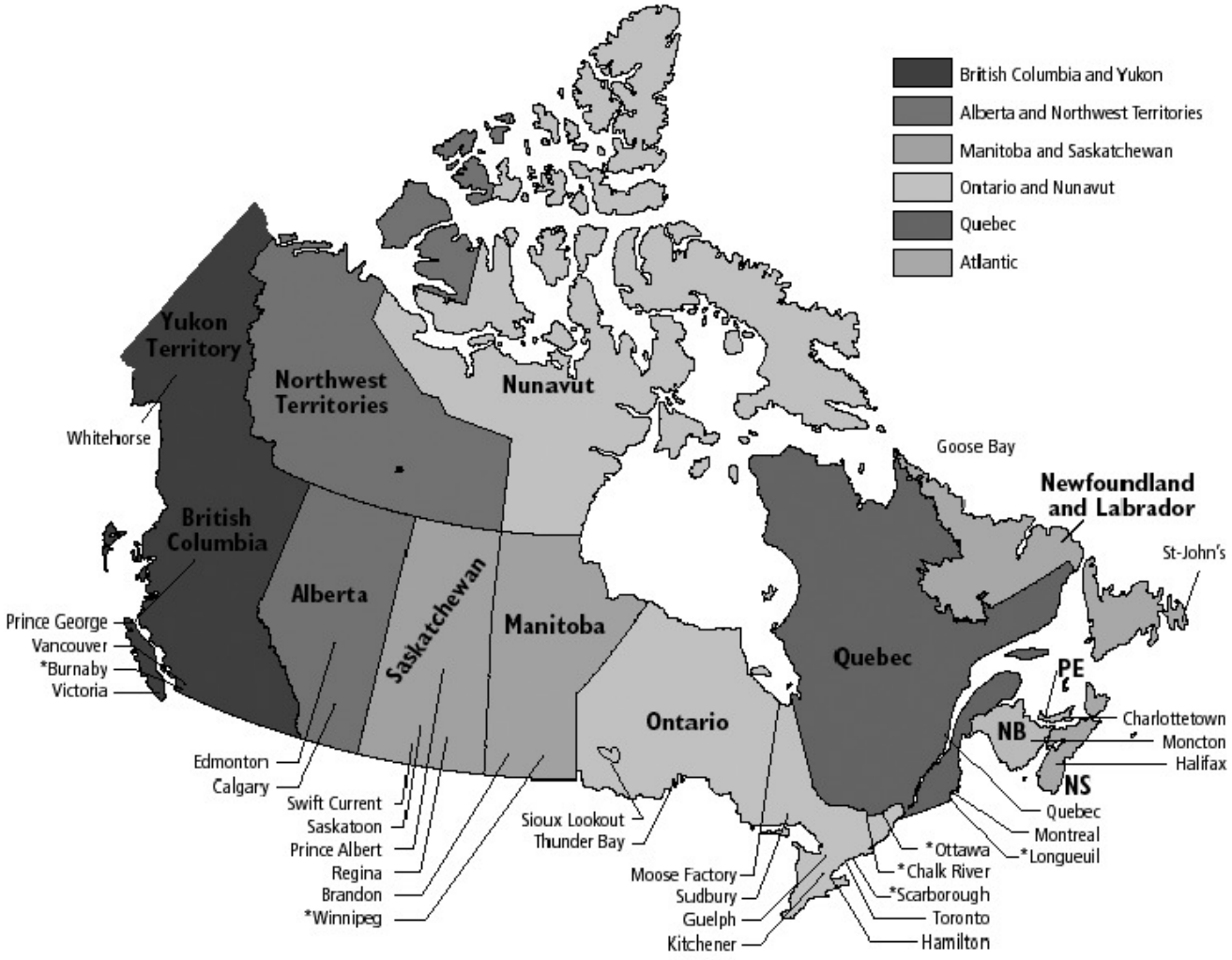
- prevent and reduce risks to individual health and the overall environment;
- promote healthier lifestyles;
- ensure high quality health services that are efficient and accessible;
- integrate renewal of the health care system with longer term plans in the areas of prevention, health promotion and protection;
- reduce health inequalities in Canadian society; and
- provide health information to help Canadians make informed decisions.

Our Roles

Health Canada operates in all regions of Canada as indicated on the accompanying map. The Department plays key roles in promoting, protecting and improving the health of Canadians — roles that assist other stakeholders working towards the same goals.

Innovators — As a science-based department, Health Canada employees are innovators, providing leading-edge science, sound policy research, and effective program and service development. Keeping abreast of global developments on diseases enabled Health Canada to play a leading role in Canada's response to the SARS, BSE and West Nile virus outbreaks.

Health Canada at Work Across the Country



Note: This map indicates only where Health Canada has significant presence.
* Indicates location of Health Canada's laboratories

Knowledge Brokers — Through research, risk assessments and surveillance, Health Canada provides knowledge to Canadians and others working in the health care field to enable them to make sound choices to protect health. The Department also monitors and researches the health threats from environmental factors such as toxic substances, air and water pollution, climate change and other threats. This work fosters sound decision making and policy development at all levels to help reduce health risks.

Enablers — In all program areas, Health Canada brings stakeholders together, as well as provides information, research and education. The work of Health Canada enables Canadians to be up-to-date and informed about the issues that can impact their health.

Trustees/Stewards — Health Canada, through the administration of the *Canada Health Act*, aims to ensure that all eligible residents of Canada have reasonable access to medically necessary insured services. The Department's broad regulatory responsibilities to protect Canadians and promote health and safety range from prescription drugs and vaccines to toxic substances, from cardiac pacemakers to natural health products and food, from consumer goods to pesticides.

Proponents of Transparency — All work at Health Canada, from the assessment of products under the *Canadian Environmental Protection Act* to the regulation and approval of thousands of products, is conducted transparently. Health Canada has committed to be accountable in delivering results to Canadians. The public had an opportunity to be involved in consultations on major regulatory initiatives such as the new *Pest Control Products Act* and will continue to be consulted in other areas as part of the Department's consultations framework.

Financial Resources

(MILLIONS OF DOLLARS)

Planned Spending	Total Authorities*	Actual Spending**
2,878.9	2,959.1	2,892.0

Actual Spending is reported on the basis of appropriations used, as shown in the departmental financial statements (see Table 13, page 115).

Human Resources

(FTEs)

Planned	Actual***	Difference
8,123	8,544	421

* *The increase from Planned Spending to Total Authorities is due mainly to funding provided under the Governor General Special Warrants and from the Treasury Board (TB) Government Contingencies Vote e.g. for the Territorial Medical Travel and Health Access Funds.*

** *The difference between TotalAuthorities and Actual Spending is mainly the result of lapses in the TB Special Purpose and Frozen Allotments, including the reprofiling of the Primary Health Care Transition Fund.*

****The actual FTEs were higher because of an increase in the authorized budget over the planned.*

Overall Departmental Performance

Our Operating Environment and Context

Health is a fundamental priority of the Government of Canada and Health Canada is the focal point for much of the federal health agenda. During 2005–2006, as in previous years, Health Canada worked closely with our Health Portfolio partners. We also collaborated with other federal departments on issues of shared responsibility such as environmental health, child care, and agriculture.

Health Canada continued to consult with a wide spectrum of partners: provincial and territorial governments, First Nations and Inuit organizations and communities, professional associations, consumer groups, universities and research institutes, international organizations and volunteers.

The Department used a mix of policy development and program delivery activities to carry out its responsibilities. Health Canada's grants and contributions programs funded partners in the health sector and at the community level to pursue shared goals, such as health system modernization and support services for parents to encourage the healthy development of young children. To support greater control over their health services, Health Canada continued to transfer funding and responsibilities to First Nations and Inuit for the provision of many programs and services.

Health Canada's operating context in 2005–2006 evolved largely as projected in the *Report on Plans and Priorities* (RPP). In addition to work to address federal-provincial-territorial agreements, we supported the Government's commitment to develop and implement Patient Wait Times Guarantees with the provinces and territories.

The Department continued to work on key priorities that attracted additional public and Parliamentary attention during the year. These included improving Canada's readiness to identify, monitor and act on a possible pandemic influenza outbreak and the monitoring of water and waste water systems.

Summarizing Health Canada's Performance — Our Medium-Term Corporate Priorities

During 2005–2006, Health Canada continued to address four medium-term corporate priorities established in 2004 which have been further articulated and revised in the 2006–2007 RPP. These are based on the Department's vision, mission, and mandate, as well as on government directions and commitments, including First Ministers' Agreements. The priorities integrated activities across all strategic outcomes.

Maintain Confidence in a Publicly-funded Health Care System

This priority recognizes both the Government's commitment to an effective, responsive health care system and its importance to Canadians. It has been revised as "Working with others to strengthen the efficiency and effectiveness of the publicly-funded health care system."

In response to the RPP commitments, Health Canada supported the provinces and territories as they created a common set of 10 evidence-based wait time benchmarks in the areas of radiation therapy, cardiac surgery, cancer screening, hip and knee replacements and cataract

surgery. The Department also provided support to specific provincial and health organization projects and to the Federal Advisor on Wait Times. We funded organizations' initiatives to apply information technologies, research results and other evidence to improve health system performance, including wait times.

The Department played a critical collaborative role in efforts by provincial and territorial governments and other health system partners to address health human resource (HHR) challenges. The goal is to ensure that all Canadians, including those in rural and remote communities and those in official language minority communities, have reasonable access to health professionals. We were also actively involved in the federal-provincial-territorial decision to approve a new Framework for Collaborative Pan-Canadian Health Human Resources Planning and to implement its Action Plan.

More specifically, Health Canada's work was targeted to such areas as improving the amount of information available on HHR supply and demand, as well as enhancing tools that governments and health system partners can use to gather and analyze data. We supported activities to improve access to physicians in rural communities and many projects to enhance the quality of workplaces in the health system.

As projected in the 2005–2006 RPP, we also contributed to positive changes in the primary health care system and in expanded access to home care services, particularly those for First Nations, Inuit and veterans.

In collaboration with the Public Health Agency of Canada, we addressed emerging concerns about the potential for an influenza pandemic which would have serious implications for health care services. New investments announced in Budget 2006 will build significantly on expanded international co-operation on pandemic influenza this year. In particular, Canada hosted a major meeting that led to the adoption of the "Ottawa Statement" by representatives of 30 countries and nine international organizations. The Statement established a commitment and priorities to guide domestic and international work for preparedness and response.

Improve the Quality of Life of Canadians

As noted in the RPP for 2005–2006, this priority synthesizes the ongoing leadership roles Health Canada plays toward the improvement of the health of Canadians. This priority has been revised as "Contributing to the improvement of the health of Canadians."

Many departmental roles and responsibilities support the achievement of this priority, such as initiatives that address health issues including diabetes, HIV/AIDS, and tobacco. Health Canada responsibilities for environmental health are increasingly important, as are specialized functions such as funding for community initiatives within Canada's Drug Strategy.

Health Canada responsibilities for First Nations and Inuit health are particularly important under this priority. The Department works to improve the health status of First Nations and Inuit in partnership with other federal departments, provincial and territorial governments, as well as Aboriginal organizations and communities. To achieve our goals, we continue to deliver programs and services such as the Non-Insured Health Benefits program, public health and other health initiatives at the community level.

The Department expanded community programs targeting Aboriginal mothers, children and families. For example, we enhanced the Aboriginal Head Start On-Reserve Program and the First Nations and Inuit component of the Canada Prenatal Nutrition Program. In addition, we developed and enhanced health promotion and disease prevention programs including the Aboriginal Diabetes Initiative, the National Aboriginal Youth Suicide Prevention Strategy and Maternal and Child Health programming.

We also expanded our public health efforts for First Nations and Inuit. For example, we provided access to additional vaccines as a step in reducing the incidence of vaccine-preventable diseases and related complications. We also increased drinking water quality monitoring in First Nations communities and the number of community workers under the First Nations Water Management Strategy. Through the Nursing

Transformation Strategy, we increased the number of Health Canada nurses and significantly improved professional resources and training. In addition, improvements were made to many departmental health facilities.

Health Canada made progress in implementing the Aboriginal Health Human Resources Initiative. In collaboration with our partners, we expect to increase the number of Aboriginal people in health careers, improve the retention of health care workers in Aboriginal communities and enhance education curricula in health professions to make them more culturally appropriate. In addition, the implementation of the Aboriginal Health Transition Fund was designed to improve access to quality health services for all Aboriginal people.

Reduce the Risks to the Health of Canadians

This priority centred largely on Health Canada's many legislative and regulatory responsibilities in areas such as drugs, food, consumer products and pesticides. We also play leadership and knowledge generation roles in emerging health issues, particularly those related to environmental factors influencing human health. The wording of this medium-term priority has been revised as "Reducing the risks to the health of the people of Canada."

The Department increased its efforts aimed at strengthening the safety of drugs, medical devices and other therapeutic products being proposed for sale and use in Canada and those already on the market. We made progress in eliminating or reducing significant backlogs in our reviews of new product submissions in many areas. Health Canada also worked with foreign counterparts, such as Australia and the European Union, to harmonize the guidance we provide to industry and to share data needed to make informed, timely, transparent and science-based decisions. We expanded the tools available to track cases of adverse reactions to health products and to better alert health professionals and consumers about potential concerns.

During the year, Health Canada carried out many initiatives addressing specific potential health risks facing Canadians including Bovine Spongiform Encephalopathy (BSE) and the presence of trans fatty acids in food products. The Department also pursued implementation of both the Federal Tobacco Control Strategy and Canada's Drug Strategy, aimed at reducing further tobacco use and limiting the negative impact of drugs on health. Departmental tobacco control work, in particular, applied lessons learned to improve the effectiveness of initiatives.

Health Canada's responsibilities for product safety were carried out through research, testing, surveillance and monitoring, as well as by ensuring that potentially unsafe products, once identified, were removed in a timely fashion from the Canadian market. For example, as part of our Lead Risk Reduction Strategy, Canadians were protected from specific products that we found had the potential to release lead.

The Department also carried out initiatives related to health and the environment. We continued to assess the health risks of new chemicals and biotechnology products under the *Canadian Environmental Protection Act* (CEPA). We met the targets under our CEPA obligation to categorize substances on the Domestic Substances List. To date, 520 substances have been identified as high health priorities and 680 have been identified as moderate priorities to be addressed with health protection measures. We piloted a Canadian Air Quality Health Index that better informs Canadians about links between local air quality and their health. We carried out studies of air quality in Canada-United States border areas to examine the health impacts of cross-border air pollution. The Department also made progress on the Canadian Climate Change and Health Vulnerability Assessment.

Health Canada continued to enhance transparency in decision making and to widen consultation, as well as to provide more information to Canadians. For example, work to update *Canada's Food Guide to Healthy Eating* included consultations with many communities. In support of the new *Pest Control Products Act* coming

into force, we established the infrastructure and processes to meet the requirements of the Act while ensuring greater openness to Canadians. Also, new regulations were created that required nutrition labelling to provide shoppers with more information.

Improve Accountability to Canadians

In line with the Government's priority, Health Canada contributed to enhanced accountability to Canadians and modernization of the public service. This priority has been revised as "Strengthening accountability to Parliament and the public."

Health Canada has implemented a series of activities to respond to new and/or enhanced government-wide initiatives such as the *Federal Accountability Act*, the *Public Service Modernization Act* (PSMA) and the Management Accountability Framework (MAF).

As one of our departmental management priorities, in May 2005 Health Canada launched an exercise to articulate a vision for health, with the aim of strengthening policy coherence and communication throughout the Health Portfolio.

The 2004–2007 Health Canada Sustainable Development Strategy was another RPP commitment. We made considerable progress during 2005–2006 towards completion of the Strategy's 20 target commitments. These commitments covered three themes: helping to create healthy social and physical environments; integrating sustainable development into departmental decision making and management processes; and minimizing the environmental health effects of the Department's physical operations and activities. We developed a framework for key departmental planning and reporting activities. With this framework, we began to identify opportunities for integrating sustainable development considerations into departmental legislation, regulations, policies, operations and contracting.

The Department was an early adopter of the MAF. Health Canada earned "best practice" recognition in the 2005–2006 MAF assessment by government central agencies for success in satisfying PSMA implementation requirements. The Department was recognized for improving financial analysis, decision making and integration of human resource planning and business planning. Also cited was our continued progress in measuring client satisfaction and external service delivery partnerships.

Stewardship and accountability were being strengthened as we proceeded with the implementation of our comprehensive Financial Management Control Framework, including departmental operational planning and financial management training for managers. Health Canada introduced improvements in the monitoring, review and management of contracts and contribution agreements. We have been an active participant supporting the work of the Blue Ribbon Panel on Grants and Contributions. The progress in these areas has placed the Department in a good position to meet the requirements of the *Federal Accountability Act*.

Health Canada continued to implement workplace health programs. Human resource planning and staffing were modernized to support managers and employees in their assumption of new roles, responsibilities and delegated authorities under the PSMA, *Financial Administration Act* and *Public Service Labour Relations Act*.

Summarizing Health Canada's Performance — Our Strategic Outcomes and Program Activities

This Departmental Performance Report represents the first opportunity for Health Canada to apply the new Program Activity Architecture (PAA) as the basis for reporting on performance. The PAA defines departmental strategic outcomes, program activities, and program results and provides explicit linkages between these elements.

Health Canada has four strategic outcomes and five program activities under the new PAA. The table below summarizes the 2005–2006 departmental performance by strategic outcome and program activity and displays associated budgets and expenditures.

All Health Canada strategic outcomes align with one Government of Canada Outcome: *Healthy Canadians with access to quality health care.*

1 STRATEGIC OUTCOME #1:

Strengthened Knowledge Base to Address Health and Health Care Priorities

(MILLIONS OF DOLLARS)		PLANNED SPENDING (1)	AUTHORITIES (2)	ACTUAL SPENDING (2)
		456.3	416.6	375.1
PROGRAM ACTIVITY	**EXPECTED RESULTS**	**PERFORMANCE STATUS**		
Health Policy, Planning and Information	Goals and objectives identified for specific strategies and initiatives Collaboration with and engagement of government and stakeholders Knowledge development and transfer of specific health policy issues	**Satisfactorily Met** **Major commitments met included:** Support for actions to implement recent federal-provincial-territorial commitments such as wait time benchmarks, access to home and community care, pharmaceutical issues, health human resources and use of new technologies. Development of policy approaches to emerging issues such as human genetics, research involving human biological materials and nanotechnology. Leadership in the development of internationally-accepted approaches to dealing with pandemic influenza. Work with provinces, territories and non-governmental organizations to address issues such as improved access to health services for official language minority communities. **Challenges included:** Slow progress on work with Human Resources and Social Development Canada to develop a government-wide approach to support family members who care for seniors and people with disabilities.		

(1) From the 2005–2006 RPP

(2) From the 2005–2006 Public Accounts

2 STRATEGIC OUTCOME #2:

Access to Safe and Effective Health Products and Food and Information for Healthy Choices

(MILLIONS OF DOLLARS)	PLANNED SPENDING (1)	AUTHORITIES (2)	ACTUAL SPENDING (2)
	234.0	260.7	256.9

PROGRAM ACTIVITY	EXPECTED RESULTS	PERFORMANCE STATUS
Health Products and Food	Access to safe and effective health products and food and information for healthy choices	**Satisfactorily Met** **Major commitments met included:** Under the Therapeutics Access Strategy, major reductions in backlogs of reviews of biologic and genetic therapies, veterinary drugs and medical devices. Achievement of performance standard targets for reviews of new pharmaceutical drug submissions. Updated safety assessment processes in fields such as natural health products and novel foods. New nutrition labelling requirements and regulations in effect. More surveillance of health products now on the market through inspections of manufacturers and reporting on adverse reactions. Quick response to rising concerns over presence of trans fatty acids in prepared foods. **Challenges included:** The call on departmental resources and expertise in response to growing and complex litigation related to health products and food.

(1) From the 2005–2006 RPP

(2) From the 2005–2006 Public Accounts

3 STRATEGIC OUTCOME #3:

Reduced Health and Environmental Risks from Products and Substances, and Safer Living and Working Environments

(MILLIONS OF DOLLARS)		PLANNED SPENDING (1)	AUTHORITIES (2)	ACTUAL SPENDING (2)
		273.7	284.0	277.9
PROGRAM ACTIVITY	**EXPECTED RESULTS**	**PERFORMANCE STATUS**		
Healthy Environments and Consumer Safety	Reduced risks to health and safety and improved protection against harm associated with workplace and environmental hazards and consumer products, including cosmetics Reduced health and safety risks associated with tobacco consumption and the abuse of drugs, alcohol and other substances	**Satisfactorily Met** **Major commitments met included:** Completion of regulatory initiatives on lead exposure related to children's jewellery and surface coatings of products. Testing of the National Air Quality Health Index and implementation of border air quality studies. On target towards meeting the deadline for health-related testing required under the *Canadian Environmental Protection Act* by 2006. Further work on the Canadian Climate Change and Health Vulnerability Assessment. Continued support for the health protection of travellers, transport workers, and the public. Continued leadership of the Federal Tobacco Control Strategy, with results in reduced tobacco consumption and compliance with "sales to youth" laws. **Challenges included:** Despite progress under Canada's Drug Strategy, continued increases in the use of marijuana, speed, LSD and heroin. In addition, there is anecdotal evidence that methamphetamine use may be increasing in some provinces. Canadian emergency preparedness exercises identifying gaps and issues that need to be addressed. Monitoring a very dynamic Canadian marketplace for safety of consumer products.		

(1) From the 2005–2006 RPP

(2) From the 2005–2006 Public Accounts

3 STRATEGIC OUTCOME #3:

Reduced Health and Environmental Risks from Products and Substances, and Safer Living and Working Environments *(continued)*

(MILLIONS OF DOLLARS)	PLANNED SPENDING (1)	AUTHORITIES (2)	ACTUAL SPENDING (2)
	51.4	55.9	54.6

PROGRAM ACTIVITY	EXPECTED RESULTS	PERFORMANCE STATUS
Pest Control Product Regulation	Access to safer pesticides Strengthened compliance with Pest Control Products Act and Regulations User informed of reduced-risk practices Transparency of pesticide regulation Improved regulatory efficiencies and cost effectiveness Informed public and stakeholders	**Satisfactorily Met** **Major commitments met included:** Preparations for the new *Pest Control Products Act* (PCPA) to come into force included pre-publication of revised Pest Control Product Regulations and publications of the List of Formulants and Contaminants of Concern. Procedures developed along with the electronic infrastructure to support increased transparency in the new Act. Work began on a public registry of information on pesticide activities and possible regulations and revisions to the Agriculture and Agri-Food Administrative Monetary Penalties Regulations. Continued harmonization of pest control product analysis and processes with the United States, Mexico, European countries and other major trading partners. Expanded information to pesticide users of practices to reduce risks. **Challenges included:** Workload pressures; public demands for new lower risk products; increasingly complex applications for review; and commitments to re-evaluate older pesticides.

(1) From the 2005–2006 RPP

(2) From the 2005–2006 Public Accounts

4 STRATEGIC OUTCOME #4:

Better Health Outcomes and Reduction of Health Inequalities Between First Nations and Inuit and Other Canadians

(MILLIONS OF DOLLARS)		PLANNED SPENDING (1)	AUTHORITIES (2)	ACTUAL SPENDING (2)
		1,863.6	1,942.0	1,927.5
PROGRAM ACTIVITY	**EXPECTED RESULTS**	**PERFORMANCE STATUS**		
First Nations and Inuit Health	Strengthened community programs Better health protection and improved primary health care Access to Non-Insured Health Benefits	**Satisfactorily Met** **Major commitments met included:** Expanded community programs targeting Aboriginal mothers, children and families. Introduction of a new National Aboriginal Youth Suicide Prevention Strategy, Maternal and Child Health programming and preparations for an enhanced Aboriginal Diabetes Initiative. Expanded public health efforts to provide access to new vaccines. New efforts under the First Nations Water Management Strategy for increased drinking water quality monitoring in First Nations communities and more trained personnel. Implementation of the Nursing Transformation Strategy with more Health Canada nurses, significantly improved professional resources and training and improved health facilities. Progress in implementing the Aboriginal Health Human Resources Initiative and Aboriginal Health Transition Fund. The evolution of the Fetal Alcohol Spectrum Disorder program from a focus on education and awareness to one of community capacity building, prevention and intervention. **Challenges included:** General, ongoing systemic challenges to the programs, including health human resource shortages and increasing costs for Aboriginal health care services.		

(1) From the 2005–2006 RPP

(2) From the 2005–2006 Public Accounts

Section II

Analysis of Performance by Strategic Outcome

Health Canada's Program Activity Architecture (PAA)

This Section reports on our results in detail based on our PAA, which links budgets to expenditures and, in turn, to performance.

Planned and Actual Spending by Strategic Outcome, Program Activity and Sub-Activity

(MILLIONS OF DOLLARS)

PROGRAM ACTIVITY	PLANNED SPENDING	AUTHORITIES	ACTUAL SPENDING	PROGRAM SUB-ACTIVITIES
Strategic Outcome #1: Strengthened Knowledge Base to Address Health and Health Care Priorities				
Health Policy, Planning and Information	**456.3**	**416.6**	**375.1**	
	369.5	292.3	275.1	Health Care Policy
	7.8	7.9	5.1	Intergovernmental Affairs
	14.0	13.5	11.4	Strategic Health Policy
	24.1	24.6	5.6	International Affairs
	5.3	5.4	5.1	Women's Health
	13.0	30.1*	30.1	Applied Research, Dissemination and Accountability
	1.5	1.5	1.2	Nursing
	21.1	41.4*	41.4	Official Languages Minority Community Development
	* *Authorities have been increased temporarily through internal reallocations in the following areas: Applied Research Analysis ($0.7 million); and Official Languages, Minority Community Development ($19.9 million).*			
Strategic Outcome #2: Access to Safe and Effective Health Products and Food and Information for Healthy Choices				
Health Products and Food	**234.0**	**260.7**	**256.9**	
	112.3	125.1	123.3	Pre-market Regulatory Evaluation and Process Improvement
	11.7	13.0	12.8	Information, Education and Outreach on Health Products, Food and Nutrition
	93.6	104.3	102.8	Monitoring Safety and Therapeutic Effectiveness and Risk Management
	16.4	18.3	18.0	Transparency, Public Accountability and Stakeholder Relationships

PROGRAM ACTIVITY	PLANNED SPENDING	AUTHORITIES	ACTUAL SPENDING	PROGRAM SUB-ACTIVITIES
Strategic Outcome #3: Reduced Health and Environmental Risks from Products and Substances, and Safer Living and Working Environments				
Healthy Environments and Consumer Safety	**273.7**	**284.0**	**277.9**	
	68.1	70.4	65.1	Safe Environments
	27.1	28.9*	28.9	Product Safety
	70.5	72.9	72.6	Tobacco Control
	80.2	74.1	73.6	Drug Strategy and Controlled Substances
	27.9	37.7*	37.7	Workplace Health and Public Safety
Pest Control Product Regulation	**51.4**	**55.9**	**54.6**	
	23.8	25.9	25.3	New Pest Control Product Registration and Decision Making
	9.3	10.0	9.8	Registered Pest Control Product Evaluation and Decision Making
	7.8	8.5	8.3	Compliance
	3.3	3.5	3.5	Pesticide Risk Reduction
	7.2	7.9	7.7	Regulatory Improvement
	* *Authorities have been increased temporarily through internal reallocations in the following areas: Product Safety ($0.5 million); and Workplace Health and Public Safety ($8.8 million).*			
Strategic Outcome #4: Better Health Outcomes and Reduction of Health Inequalities between First Nations and Inuit and Other Canadians				
First Nations and Inuit Health	**1,863.6**	**1,942.0**	**1,927.5**	
	209.3	296.1*	296.1	First Nations and Inuit Community Health Programs
	69.4	71.6	65.4	First Nations and Inuit Health Protection
	244.1	252.0	245.8	First Nations and Inuit Primary Health Care
	925.3	925.3*	925.3	Non-Insured Health Benefits (NIHB) for First Nations and Inuit
	415.5	396.9	394.9	Governance and Infrastructure Support to First Nations and Inuit Health System
	* *Authorities have been increased temporarily through internal reallocations in the following areas: First Nations and Inuit Community Health Programs ($33.8 million); and Non-Insured Health Benefits (NIHB) ($13.8 million).*			
Planned Spending is as reported in the 2005–2006 RPP *Authorities and Actual Spending are as reported in the 2005–2006 Public Accounts*				

STRATEGIC OUTCOME #1:
Strengthened Knowledge Base to Address Health and Health Care Priorities

Program Activity Name:

Health Policy, Planning and Information

Expected Results:

- Goals and objectives identified for specific strategies and initiatives
- Collaboration with and engagement of government and stakeholders
- Knowledge development and transfer of specific health policy issues

Financial Resources

(MILLIONS OF DOLLARS)

Planned Spending	Authorities	Actual Spending
456.3	416.6	375.1

Human Resources

(FTEs)

Planned	Actual	Difference
681	717	36

Variances between planned spending versus authorities are mainly due to:

- reprofiling of funding for the Primary Health Care Transition Fund from 2005–2006 to 2006–2007
- funding for the grant to the Canadian Institute for Health Information
- additional funding for initiatives related to federal-provincial-territorial commitments to strengthen health care
- compensation for salary adjustments

The actual spending is $41.5 million lower than authorities mainly due to:

- lapse in frozen allotment of a portion of the Primary Health Care Transition Fund Reprofile
- lapse in the Health Council special purpose allotment
- year end adjustments of Department of Justice expenditures

The objective of this ongoing program activity is to provide policy advice and support to the Minister in making decisions to improve the health of Canadians. The expected long-term outcomes within the health system are successful and appropriate adaptation to change and a strengthened knowledge base to address health and health care priorities.

Under this program activity, Health Canada had three ongoing sub-activities, as defined in the Program Activity Architecture.

Intergovernmental Affairs

As part of this ongoing activity, the Department advances the Health Portfolio mandate by providing strategic advice on intergovernmental issues and by maintaining effective relationships with provinces and territories. We co-ordinated support on intergovernmental health-related issues and activities, including the annual meeting of federal, provincial and territorial (F/P/T) Ministers of Health.

Health Canada continued to administer the *Canada Health Act*. This included investigation of potential cases of non-compliance and analysis of emerging issues of relevance to the Act, such as insured persons being charged out of pocket for insured services in private clinics. As well, the Department analyzed issues related to the June 2005 Supreme Court of Canada decision on private health insurance in *Chaoulli v. Quebec (Attorney General)*.

In general, we continued to see the traditionally high level of provincial and territorial compliance as detailed in the *Canada Health Act Annual Report* to Parliament. Health Canada worked with provincial and territorial health departments to improve the report by streamlining the process and by increasing collaboration and communication.

Intergovernmental Affairs Directorate

http://www.hc-sc.gc.ca/ahc-asc/branch-dirgen/hpb-dgps/igovad-daigov/index_e.html
http://www.hc-sc.gc.ca/ahc-asc/branch-dirgen/hpb-dgps/igovad-daigov/index_f.html

Canada Health Act Annual Report

http://www.hc-sc.gc.ca/hcs-sss/medi-assur/index_e.html
http://www.hc-sc.gc.ca/hcs-sss/medi-assur/index_f.html

Women's Health and Gender-based Analysis

Under this ongoing activity, we continued to focus on gender and diversity issues related to health throughout the Department and the Health Portfolio. One component was the application of the Department's Gender-based Analysis (GBA) Policy. This involved providing expertise, training, tools and resources to facilitate GBA within policy projects in mental health, HIV/AIDS and Aboriginal women's health, and to develop and support a network of GBA focal points within the Department. In addition, we facilitated the application of gender- and diversity-sensitive advice to initiatives such as the revision of *Canada's Food Guide to Healthy Eating* and the development of reports and papers for departmental, national and international audiences.

Through our Women's Health Contribution Program, we supported policy-relevant research, advice, networking and information dissemination on: addictions and mental health; women and urban environments; women and poverty; gender and HIV/AIDS; Aboriginal women's

health issues and health status; indicators of women's health; and emergency contraception. This included a submission on gender issues related to mental health and addictions that was requested by the Standing Senate Committee on Social Affairs, Science and Technology as part of development of its report to Parliament, *Out of the Shadows at Last: Transforming Mental Health, Mental Illness and Addiction Services in Canada* and an addendum on gender-based analysis in the *Final Report of the Federal Advisor on Wait Times*.

Bureau of Women's Health and Gender Analysis

http://www.hc-sc.gc.ca/ahc-asc/branch-dirgen/hpb-dgps/pppd-dppp/bwhga-bsfacs/index_e.html
http://www.hc-sc.gc.ca/ahc-asc/branch-dirgen/hpb-dgps/pppd-dppp/bwhga-bsfacs/index_f.html

Women's Health Contribution Program

http://www.hc-sc.gc.ca/hl-vs/women-femmes/contribution_e.html
http://www.hc-sc.gc.ca/hl-vs/women-femmes/contribution_f.html

Gender-based Analysis

http://www.hc-sc.gc.ca/hl-vs/women-femmes/gender-sexe/index_e.html
http://www.hc-sc.gc.ca/hl-vs/women-femmes/gender-sexe/index_f.html

Nursing

The focus of the Office of Nursing Policy (ONP) is to influence the health of Canadians by optimizing the contribution of nursing knowledge and practice. It is intended to link the agendas of Health Canada and the nursing community in a complementary and transparent manner.

In 2005–2006, ONP addressed nursing-related issues in three major areas: enhanced access to health care services through work force stability; improved quality of health care through work force development and capacity building; and improved health care through sustainable health system transformation.

Policy development activities to improve nursing work force stability focused on effective recruitment and retention strategies. Examples where ONP provided advice and shared expertise include: participation and financial support to the National Nursing Sector Study; co-chair position and participation on F/P/T Task Force on Internationally Educated Nurses; co-chair position and involvement in the Canadian Nurse Practitioner Initiative funded by Health Canada's Primary Health Care Transition Fund (PHCTF); and secretariat support and participation on the F/P/T Principal Nursing Advisor Group.

Development and utilization of evidence for retention strategies was accomplished by funding background policy papers on: mandatory nurse/patient ratios for staffing; new nursing roles such as nurse anaesthetist; patient safety in mental health settings; employee turnover; optimizing scopes of practice; and future visions for nursing.

Policy development activities to improve both workplace capacity building and system transformation centred on work led by ONP under the Pan-Canadian Health Human Resources (HHR) Strategy, the Healthy Workplace Initiative (HWI) under Recruitment and Retention and Interprofessional Education for Collaborative Patient-Centred Practice (IECPCP).

HWI accomplishments have been: 11 local healthy workplace projects funded; four complementary projects funded to address knowledge gaps in the home and community care sector; retention of experienced nurses; and co-ordination of quality workplace action at the national level (Quality of Worklife/Quality of Health Care Collaboration). Further details are provided in the Health Care Policy section.

IECPCP includes: funding of $19.7 million for 20 projects through two call for proposal processes; complementary priority projects totalling $1.895 million in areas of legislative and regulatory mechanisms (which will include scope of practice issues) to facilitate inter-professional collaboration; mechanisms to address liability issues for collaborative practice; academic barriers to interprofessional education; accreditation for Interprofessional Education (IPE); models of clinical placement that facilitate IPE; and engagement of a National Expert Committee that provides strategic direction for the initiative. It is composed of researchers, academics, practitioners, students and patients.

ONP leadership in the development of global nursing and health policy was provided through interaction with the Pan American Health Organization, the World Health Organization (WHO), the Commonwealth Nurses Federation and the International Council of Nurses. The issue of migration of health care workers, and more specifically nurses, was discussed on many fronts, and ONP worked closely with the International Affairs Directorate and other federal departments on this issue.

Nursing Policy
http://www.hc-sc.gc.ca/hcs-sss/nurs-infirm/index_e.html http://www.hc-sc.gc.ca/hcs-sss/nurs-infirm/index_f.html

The combined resources for these three responsibilities were:

Financial Resources

(MILLIONS OF DOLLARS)

Planned Spending	Authorities	Actual Spending
14.6	14.8	11.4

In addition to the above ongoing responsibilities, the Department worked towards this strategic outcome through five other program sub-activities in our Program Activity Architecture.

Health Care Policy

Financial Resources

(MILLIONS OF DOLLARS)

Planned Spending	Authorities	Actual Spending
369.5	292.3	275.1

Our policy work involved analytical, research and policy leadership on issues related to the health care system. The expected results are: improved policy coherence and research capacity; consensus among well-informed governments and stakeholders; and implementation of ongoing activities. During 2005–2006, the Department followed through on two broad RPP commitments.

Building on Federal-Provincial-Territorial agreements, including action toward Patient Wait Times Guarantees

Health Canada continued implementing strategies to address priorities established by the federal, provincial and territorial partners in recent years, as well as the additional commitment of the new Government to improve the quality of health care, in particular, through a commitment to work with provincial and territorial governments to develop and implement Patient Wait Times Guarantees.

Governments are improving how they measure, monitor and manage wait times. In December 2005, the provincial and territorial governments announced a first set of 10 common evidence-based benchmarks in the areas of: radiation therapy; cardiac surgery; cancer screening; hip and knee replacements and cataract surgery. In addition, Health Canada is supporting the Canadian Institute for Health Information (CIHI) which released its first comprehensive report on wait times, *Waiting for Health Care in Canada*, in March 2006, and is working with governments to develop comparable indicators of access to these benchmarked services.

There are other innovative initiatives under way. For example, in partnership with Manitoba Health and the Canadian Association of Radiologists, Health Canada is supporting a pilot project to help physicians order the appropriate diagnostic tests, which could lead to shorter wait times for Magnetic Resonance Imaging (MRI) and Computed Tomography (CT) scans.

Health Canada is also supporting the Western Canada Waiting List Project to develop and implement tools to assist in the management of waiting lists.

The Department played a central role in supporting extensive consultations by the Federal Advisor on Wait Times with governments, stakeholders, health care providers, experts, researchers and patients. The Federal Advisor's Final Report addressed the role of research, innovation, information technology, public education, surge capacity, and culture change in the reduction of wait times.

In addition, to facilitate information sharing, the Department supported workshops and conferences on initiatives in the measurement, monitoring and management of wait times. We also provided funding to the Canadian Institutes of Health Research, Canada Health Infoway and the Canadian Health Services Research Foundation to support provinces in maxi-mizing the use of information technology and research evidence to improve health system performance.

In British Columbia, we led initiatives to facilitate knowledge transfer and to strengthen relationships with partners and stakeholders. For example, in partnership with the B.C. Arts Council, we developed a prototype of an internet-based network for creating a national network for arts to capture the positive effects of arts and culture on health. In cooperation with other levels of government, we also organized a policy forum on the topic of youth suicide to foster knowledge transfer across various interested parties.

Advancing the National Pharmaceuticals Strategy (NPS) in collaboration with the provinces and territories was a health policy priority in 2005–2006. Under the NPS, participating governments are developing and implementing policies, programs and initiatives in support of equitable and affordable access to safe, effective and appropriately used medicines. During the year, the F/P/T Health Ministers called for accelerated work on the NPS, and agreed to expand the Common Drug Review (CDR) process to all drugs and to mandate the Patented Medicine Prices Review Board (PMPRB) to monitor and report on non-patented drug prices.

A new Framework for Collaborative Pan-Canadian Health Human Resources Planning was put in place to ensure Canadians have timely access to the health professionals they need. It outlines a vision, goals, objectives and an Action Plan to improve all jurisdictions' capacity to: plan for the optimal number, mix and distribution of health providers; work closely with the education system to develop an appropriately qualified health work force; deploy health providers in service delivery models that make full use of their skills; and build and maintain a sustainable work force in healthy, safe work environments.

Much of our HHR role supported the planning, enhanced data collection, standardization and improved forecasting modelling necessary to achieve the shared goals of governments. In 2005–2006, this included work with the CIHI on HHR demand data development for specific health professions and collaboration with provinces and territories to share information and assess gaps in HHR modelling and forecasting capacities. We also supported the development of a labour relations database that will provide information on compensation, benefits and other terms and conditions of health professional collective agreements across Canada.

The Department also funded specific initiatives to address HHR challenges. For example, we provided funding to the Society of Rural Physicians of Canada for development of a research agenda for rural surgical services as well as preliminary work towards new strategies to educate, recruit and retain the physicians needed in rural communities. As part of the Recruitment and Retention Initiative, the Healthy Workplace Initiative (HWI) supports action by health care organizations to create and maintain healthy work environments. In 2005–2006, the HWI implemented 15 contribution projects for a total of $4.2 million that will contribute to improved recruitment and retention, patient safety and quality of care and operational excellence in health care facilities.

Health Canada provided $13 million to 11 projects under the Interprofessional Education for Collaborative Patient-Centred Practice Initiative, which is contributing to health system renewal, increased health system efficiency and sustainability and reduced wait times.
We completed a selection process to allocate an additional $6.7 million in funding for nine projects to begin in 2006–2007.

In February 2005, $75 million over five years was announced for the Internationally Educated Health Professionals (IEHP) Initiative and includes both pan-Canadian and provincial/territorial funding. Multi-year contribution agreements are in place with most provinces and territories for initiatives to assess and integrate these health professionals. Pan-Canadian initiatives were also launched. For example, six professions are collaborating to develop an interdisciplinary orientation program for IEHPs.

We made strides in 2005–2006 in improving health outcomes for women by consulting with health researchers, practitioners and Non-Government Organizations (NGOs) in Alberta. Recommendations were developed that focus on the importance of gender-based analysis and women's health centres, as well as on the need to build capacity to address the health of women through research, networking, multi-sectoral collaborations and involvement of all levels of government.

The recommendations of the Canadian Task Force on International Medical Graduates (IMG) were either fully implemented or were well under way. Examples include: the successful launch of a faculty development program for teachers of IMGs; an increased number of IMG assessments across the country; and a well utilized central website of information for IMGs. A formative and summative evaluation of the IMG initiatives was launched in 2005 and the formative reports have been completed.

Primary health care was another F/P/T priority. During 2005–2006, the Department continued work to improve primary health care services for populations under federal jurisdiction, such as First Nations people on reserves and Inuit. In addition, under the Primary Health Care Transition Fund (PHCTF), for which $800 million was allocated between 2000 and 2006, we supported the development and implementation of new ways of providing and managing primary health care. Eighteen initiatives concluded in March 2006, including those in British Columbia, Saskatchewan and Nunavut; the remaining 50 will wind down in September 2006 and all results will be shared during the rest of that fiscal year.

Our national leadership responsibilities led to funding and support for the first two meetings of the Best Practices Network for primary health care. The inaugural meeting, held in Winnipeg in November 2005, examined physician participation in innovative primary health care models. The second, held in St. John's in February 2006, discussed interprofessional approaches to health care.

In the area of home care, the Department continued to support implementation of commitments including provision of first dollar coverage for certain home care services, based on assessed need, by 2006. We continued to work with federal partners to meet these commitments for First Nations, Inuit and veterans. All jurisdictions have made progress and will report by December 2006.

Maintaining Public Confidence in Health Care

Health Canada continues efforts that strengthen public confidence in the publicly-funded health care system. Examples of our work during 2005–2006 include progress made in implementing the PHCTF, palliative care, home care and pharmaceuticals.

In addition to the initiatives described previously, the PHCTF, supported 14 national workshops on broader issues such as physician remuneration, chronic disease management, telehealth and collaborative care models. We were also part of the development and launch of the National Primary Health Care Awareness Strategy which used national print and television coverage to inform Canadians of the benefits of primary health care and changes under way to improve it.

We continued to support initiatives to improve Canadians' access to quality palliative and end-of-life care and to work with partners to promote awareness of palliative care, improve the education of health providers and foster networks for palliative care research. A major achievement was our support of the Canadian Council on Health Services Accreditation in developing national health services accreditation standards on palliative and end-of-life care.

Under the Canada Health Portal initiative, negotiations took place with the Government of Ontario and Toronto Public Health to test the feasibility of inter-jurisdictional partnerships. Bilateral meetings were conducted with municipal and provincial representatives respectively in order to assess the readiness and capability of their respective websites. It soon became clear that owing to different infrastructures and varying degrees of readiness, coupled with competing priorities for all three parties, the timing was inappropriate. As such, plans for the feasibility study were abandoned.

Family and informal caregivers provide the majority of care that seniors receive in their homes. Human Resources and Social Development Canada (HRSDC), which has the federal policy lead for family caregiving, has conducted consultations on initiatives to assist caregivers. We work closely with HRSDC to pursue a possible national strategy to support family caregivers for seniors and people with disabilities.

Recognizing that pharmaceuticals are an essential component of the health care system, Health Canada worked with partners and stakeholders to address regulatory and coverage issues. Initiatives such as the Common Drug Review process for new prescription drugs, information initiatives such as the Canadian Optimal Medication Prescribing and Utilization Service and the National Prescription Drug Utilization Information System contribute to better integration of drugs into health care. The federally-sponsored Best Practices Contribution Program funded the evaluation of six optimal drug prescribing and utilization initiatives in 2005–2006 to encourage uptake of best practices across jurisdictions.

Health Care Policy Directorate
http://www.hc-sc.gc.ca/ahc-asc/branch-dirgen/hpb-dgps/hcpd-dpmss/index_e.html http://www.hc-sc.gc.ca/ahc-asc/branch-dirgen/hpb-dgps/hcpd-dpmss/index_f.html

Strategic Health Policy

Financial Resources

(MILLIONS OF DOLLARS)

Planned Spending	Authorities	Actual Spending
14.0	13.5	11.4

Strategic health policy work involves analysis and action on issues that affect or are likely to have an increasing impact on health care. For example, we began to implement the *Assisted Human Reproduction Act*. In particular, we supported the activities that led to an Order-in-Council establishing the Assisted Human Reproduction Agency of Canada in Vancouver, effective January 12, 2006. We also moved forward on creating the governance and infrastructure frameworks for that Agency, developing regulations under the Act and critical information systems such as the Personal Health Information Registry as mandated by the Act.

Since the dissolution of Parliament in November 2005 meant that the Supplementary Estimates could not be voted on, Health Canada had to allocate $4.1 million from departmental resources to fund the operations of the Assisted Human Reproduction Implementation Office. That office was established to perform functions including: licensing; inspecting and compliance activities; collecting and analyzing health reporting information; and providing advice to the Minister on assisted human reproduction issues.

We carried out preparatory work to replace and update the existing *Food and Drugs Act*, *Radiation Emitting Devices Act*, *Quarantine Act* and parts of the *Hazardous Products Act* and to subsume the Human Pathogens Importation Regulations administered by the Public Health Agency of Canada. While we had originally envisioned a single piece of health protection legislation, we decided to pursue results through a number of acts that would form a comprehensive framework of health protection laws for Canada. The new *Quarantine Act*, which received Royal Assent in May 2005, was the first part of this framework.

Much of the work set out in the RPP involved long-term policy research and development to address broad health sciences questions, such as issues related to gene patenting and quality assurance of genetic testing. This included work with international organizations such as the Organization for Economic Co-operation and Development (OECD) and information sharing, targeted policy research and consultations with the provinces, territories and relevant Canadian stake-holders. A major international symposium was held on the licensing of genetic inventions and contributions made to the development of OECD Guidelines on Quality Assurance in Molecular Genetic Testing and the OECD Licensing Guidelines for Genetic Inventions.

We also analyzed regulatory issues with respect to pharmacogenomic data for drug test approvals and drugs for "orphan populations." Health Canada was active in the Canadian initiative to advance HIV/AIDS vaccine research and development. We also produced a discussion paper on global access issues related to pandemic influenza vaccines.

The Department had identified research ethics policies as a priority for the year. As part of this, we worked with partners to examine how best to protect human research participants. This led to the creation of a website for an accreditation initiative and nominations to the Experts Committee for Human Research Participant Protection in Canada. Health Canada was also involved in internationally harmonized research ethics practices as shown in the UNESCO Declaration on Bioethics adopted in October 2005.

The Department participated with partners in early identification and monitoring of policy issues related to the health, safety and societal impacts of nanotechnology. We also took part in policy research and development on issues of concern to vulnerable populations, such as health research involving Aboriginal people.

Assisted Human Reproduction Agency Implementation Office
http://www.hc-sc.gc.ca/ahc-asc/branch-dirgen/hpb-dgps/pppd-dppp/ahrio-bmpra/index_e.html http://www.hc-sc.gc.ca/ahc-asc/branch-dirgen/hpb-dgps/pppd-dppp/ahrio-bmpra/index_f.html

Health Sciences Policy Division
http://www.hc-sc.gc.ca/ahc-asc/branch-dirgen/hpb-dgps/pppd-dppp/hspd-dpss/index_e.html http://www.hc-sc.gc.ca/ahc-asc/branch-dirgen/hpb-dgps/pppd-dppp/hspd-dpss/index_f.html

International Affairs

Financial Resources

(MILLIONS OF DOLLARS)

Planned Spending	Authorities	Actual Spending
24.1	24.6	5.6

Given the increasingly global nature of many health issues and other countries' interest in Canadian health initiatives, Health Canada has an important international role, consistent with government-wide policies and domestic health priorities.

As in previous years, the Department has been active in the work of international health organizations, particularly the WHO and the Pan American Health Organization. We agreed with European partners through the Canada-EU Summit to further work on regulatory co-operation. We also collaborated with the health ministries of other governments, particularly the U.S. Department of Health and Human Services, on issues of common interest. Health Canada was called upon by international organizations and developing countries for technical expertise, especially in areas such as the health of indigenous peoples, HIV/AIDS and health human resources.

Over the year, Health Canada received 44 foreign delegations on health issues, including some involving ministers from other countries. The Department supported international health research through conferences and consultations. A new paper, "Comparison of Canadian and U.S. Health Systems" was completed for distribution in the U.S. in response to regular requests for information from the Canadian Embassy and Consulates in the United States and the general public.

An important new area of focus was our contribution in partnership with the Public Health Agency of Canada to heightened international preparations to address avian influenza and a possible pandemic influenza. The Global Pandemic Readiness Conference was a milestone. Canada hosted this first international health ministerial meeting on pandemic influenza on October 24–25, 2005 in Ottawa. The "Ottawa Statement" that was finalized at the Conference was adopted by delegates from 30 countries and nine international organizations. It identified policy priorities that are now guiding both our work and international efforts.

This was complemented by our role as chair of the Asia-Pacific Economic Cooperation (APEC) Health Task Force, which made "enhancing avian and pandemic influenza preparedness and response" one of the three priorities in its 2006–2007 work plan. The leaders of Canada, the U.S. and Mexico made a similar commitment through the Security and Prosperity Partnership at their summit in Cancun in March 2006.

Attention to avian and pandemic influenza was also an important element of the Global Health Security Initiative, agreed to at a November 2005 Ministerial Meeting in Rome. Ministers agreed to address global health security related to pandemic influenza, risk management and coordination, chemical events, laboratory capacity and collaboration, field epidemiology and capacity building in epidemic alert and response.

Canada continued to be active in global HIV/AIDS activities, particularly through our work under the Global Engagement Component of the Federal Initiative to Address HIV/AIDS. As part of this, Health Canada continued to co-ordinate global engagement activities and to serve as the secretariat for the Consultative Group on Global HIV/AIDS and the Interdepartmental Forum on Global HIV/AIDS Issues. The Consultative Group acts as a forum for dialogue between government and civil society on Canada's response to the global epidemic. The Interdepartmental Forum meets to discuss ongoing issues and provides coordination and coherence in the federal government's approach. We also provided grants to support activities that will increase Canada's contribution to the global response to HIV/AIDS and promote learning from both domestic and global responses.

As the lead department for the XVI International AIDS Conference (August 13–18, 2006 in Toronto), we established the Federal AIDS 2006 Secretariat, an interdepartmental committee that meets regularly to address policy, operational and communications issues related to the Conference. Funding was also directed to support core conference costs.

The Department successfully led Canada's negotiations on the International Health Regulations (IHRs) which are to come into force in June 2007. These regulations will help to ensure a clear and scientifically-based assessment and review process for determining public health emergencies of international concern. The IHRs also better define the roles and responsibilities of the WHO, as well as member countries, and commit countries to establishing core capacities for responding to such emergencies.

Health Canada contributed to policy coherence by co-ordinating departmental input on health-related issues in major trade negotiations, including the World Trade Organization General Agreement on Trade in Services and Canada-Korea negotiations on a possible free trade agreement. The Department also led the federal government's response to the report of the WHO Commission on Intellectual Property, Innovation and Public Health. The aim was to support international initiatives to promote access by developing countries to safe and effective medicines while respecting the integrity of Canada's intellectual property regime and ensuring that its international obligations are respected.

As a major supporter of the initiative to create a WHO Framework Convention on Tobacco Control (FCTC), the Department worked with other countries after the FCTC came into force on February 27, 2005. The first Conference of Parties in February 2006 resolved issues enabling the FCTC to be implemented. We supported tobacco control capacity building activities internationally.

International Affairs Division
http://www.hc-sc.gc.ca/ahc-asc/branch-dirgen/hpb-dgps/iad-dai/index_e.html http://www.hc-sc.gc.ca/ahc-asc/branch-dirgen/hpb-dgps/iad-dai/index_f.html

Applied Research, Dissemination and Accountability

Financial Resources

(MILLIONS OF DOLLARS)

Planned Spending	Authorities	Actual Spending
13.0	30.1	30.1

This activity centres on Health Canada's development and implementation of a strategic policy research agenda for medium and long-term issues. It contributes to our commitment to achieve a performance-based and outcome-oriented culture by developing the tools and information base for increased accountability and through policy research dissemination.

The Department's research management and dissemination activities include the Health Policy Research Program, which funds academic research that is directly relevant to health policy issues and promotes the use of that research. In 2005–2006, we funded research proposals under three priority themes: Healthy Communities; Innovation in the Health System; and Regulation. We continued to post executive summaries of the project results on our website.

We continued to publish the *Health Policy Research Bulletin* to aid policy development and decision making by providing in-depth evidence on important health policy concerns. Issues were published on "Changing Fertility Patterns: Trends and Implications" and on "Climate Change and Health."

The Health Supply and Demand Analysis research program supports policy making in the Department

related to topics including pharmaceuticals, information technologies, underlying influences on health system utilization and costs of specific diseases, as well as the net benefit of new treatments for those diseases. Through applications of advanced methods, departmental researchers assessed the relative importance of health-related factors, such as the environment, community level variables and individual behaviours. In 2005–2006, we continued work on three policy research priority themes: First Nations and Inuit Health Sustainability; Health Innovation; and Healthy Communities. We also undertook research on wait times and public health care models. The results of this research were presented to audiences inside and outside of Health Canada.

To get accurate estimates of costs and benefits for proposed policy interventions, the Department used microsimulation modelling and data analysis. With quantitative tools and unique databases we were able to create impact analyses of proposed policy changes relating to issues such as physician and nursing shortages and combatting obesity (e.g., a possible physical activity tax credit), which we shared with federal policy makers as well as other health policy researchers in Canada and internationally.

A final area of Health Canada's research-related work was the ongoing effort to identify gaps in health data and prioritize possible responses. We identified data needs and undertook activities to acquire and disseminate reliable health data and advice in a timely fashion.

Applied Research and Analysis Directorate
http://www.hc-sc.gc.ca/ahc-asc/branch-dirgen/hpb-dgps/arad-draa/index_e.html http://www.hc-sc.gc.ca/ahc-asc/branch-dirgen/hpb-dgps/arad-draa/index_f.html

Health Policy Research Program
http://www.hc-sc.gc.ca/sr-sr/finance/hprp-prpms/index_e.html http://www.hc-sc.gc.ca/sr-sr/finance/hprp-prpms/index_f.html

Official Languages Minority Community Development

Financial Resources

(MILLIONS OF DOLLARS)

Planned Spending	Authorities	Actual Spending
21.1	41.4	41.4

As part of the government-wide commitment to foster Canada's linguistic duality and to make it easier for Canadians to receive health services in the official language of their choice, we administer two contribution programs to improve access to health services for English-speaking residents of Quebec and Francophones outside of Quebec. Both programs were established under the five-year federal Action Plan for Official Languages (2003–2004 to 2007–2008).

Through the Contribution Program to Improve Access to Health Services for Official Language Minority Communities, the Department continued to manage the implementation of projects for training and retention of health professionals and the creation of community networks.

In 2005–2006, the Francophone Training and Retention Program generated 533 new student registrations for training as French-speaking health care professionals in 10 post-secondary institutions, up from 493 registrations in 2004–2005, for a three-year total of 1,428 new registrations. There were also 208 program graduates reported in 2005–2006, for a two-year total of 296. Program sponsors indicated that both the number of registrations and graduates have exceeded expectations. These efforts were supported by the Francophone Networking Activities Program which funded the production of information materials relating to health in French and eight vignettes that promoted French-language health care services.

Departmental support for English-speaking minority communities in Quebec involved a Language Training for French Speakers in Quebec program that supplied training for 1,427 workers during its first year of operation. The Anglophone Networking Activities Program provided renewed funding to all 10 previously-participating organizations. They carried out activities such as producing bilingual newsletters, translating health and social service documents, training volunteers to provide translation services in emergency situations, conducting surveys, assessing and addressing access needs and improving availability of English information and signage in public institutions. This program was reinforced by two professional development conferences that enabled participants to network, discuss current research related to the vitality of English-speaking communities across Quebec and share best practices on innovative health and social service access initiatives.

The Primary Health Care Transition Fund, described earlier in this section, includes an Official Languages Envelope to support projects to improve access, accountability and integration of primary health care services for French- and English-speaking minority communities across Canada. Of 70 Francophone community projects, nine were completed in 2005–2006 including: production and distribution of the French version of the British Columbia Health Guide to 23,500 Francophone households in British Columbia and to 500 Francophone households in the Yukon; the set-up of a central coordination point to improve access to health care services in French in Saskatchewan and to implement workshops and self-help groups primarily for children and seniors; a Francophone provincial health information line in Manitoba; and the development of a Nova Scotia inventory of primary care services provided in French.

All 37 projects under this envelope for English-speaking minority communities in Quebec were launched in January 2005 and completed by March 2006. Seven projects supported a major reorganization of Quebec's Info-Santé help line to make those services available in English in all regions of Quebec. Four projects addressed long-term care needs of Anglophones in Quebec. Twenty-six projects improved front line health and social services.

Official Languages Community Development Bureau

http://www.hc-sc.gc.ca/ahc-asc/branch-dirgen/hpb-dgps/igovad-daigov/olcdb-baclo/index_e.html
http://www.hc-sc.gc.ca/ahc-asc/branch-dirgen/hpb-dgps/igovad-daigov/olcdb-baclo/index_f.html

Consultative Committee for French-Speaking Minority Communities

http://www.hc-sc.gc.ca/ahc-asc/public-consult/consultations/col/ccfsmc-cccfsm/index_e.html
http://www.hc-sc.gc.ca/ahc-asc/public-consult/consultations/col/ccfsmc-cccfsm/index_f.html

Consultative Committee for English-Speaking Minority Communities

http://www.hc-sc.gc.ca/ahc-asc/public-consult/consultations/col/ccesmc-cccasm/index_e.html
http://www.hc-sc.gc.ca/ahc-asc/public-consult/consultations/col/ccesmc-cccasm/index_f.html

STRATEGIC OUTCOME #2:
Access to Safe and Effective Health Products and Food and Information for Healthy Choices

Program Activity Name:
Health Products and Food

Expected Result:

- The call on departmental resources and expertise in response to growing and complex litigation related to health products and food.

Financial Resources
(MILLIONS OF DOLLARS)

Planned Spending	Authorities	Actual Spending
234.0	260.7	256.9

Human Resources
(FTEs)

Planned	Actual	Difference
2,380	2,503	123

Variances between planned spending versus authorities are mainly due to:

- funding to ensure the safety of therapeutic products
- additional funding for Bovine Spongiform Encephalopathy (BSE) risk assessment and targeted research
- additional funding for the Access to Medicines Program
- funding to launch an integrated public health strategy to reduce the impact of chronic disease
- compensation for salary adjustments

The actual spending is $3.7 million lower than authorities mainly due to:

- year end adjustments of Department of Justice expenditures

The objective of this ongoing program activity is to provide a broad range of health protection and promotion activities that affect the daily lives of Canadians through an integrated, science-based approach to managing risks and benefits relating to health products, food and nutrition.

Through partnerships with provincial and territorial governments, other departments and international health organizations, the Department carries out activities such as conducting pre-market evaluations and harmonizing domestic regulatory policies with international approaches. We develop standards and conduct inspections and enforcement activities, as well as research and post-market surveillance. This work enhances public confidence and contributes to maintaining and improving the health of Canadians.

Recent media attention, for example, global withdrawal of COX-2 inhibitors, allegations of industry non-disclosure of negative clinical trial results, adverse reactions to anti-depressants in children, has heightened public concerns about the safety of therapeutic products and revealed limitations in current legislative and regulatory instruments. These events illustrate the need to continue modernizing legislative and regulatory frameworks to keep pace with changing science, consumer expectations, international developments and other pressures.

As a response, in 2005 Health Canada received $170 million over five years to strengthen the safety of drugs, medical devices and other therapeutic products. These new investments allowed the Department to embark on initiatives including increased oversight of the safety of therapeutics in real world use through post-market surveillance and risk communication.

Under this program activity, Health Canada had four sub-activities as defined in our Program Activity Architecture.

Pre-market Regulatory Evaluation and Process Improvement

Financial Resources

(MILLIONS OF DOLLARS)

Planned Spending	Authorities	Actual Spending
112.3	125.1	123.3

Health Canada conducts pre-market regulatory scientific review of human and veterinary drugs, pharmaceuticals, biologics, genetic therapies, medical devices and natural health products, as well as novel foods including genetically modified foods, and the chemical and microbial safety and nutritional quality of food. Through the Therapeutics Access Strategy, we continue to improve the timeliness, transparency and predictability of our pre-market reviews of therapeutic products for human use by benchmarking them against leading international practices, while maintaining Health Canada's high safety standards. This program supports the Department's ongoing responsibility to improve product regulation as part of the larger federal commitment to "smart regulation."

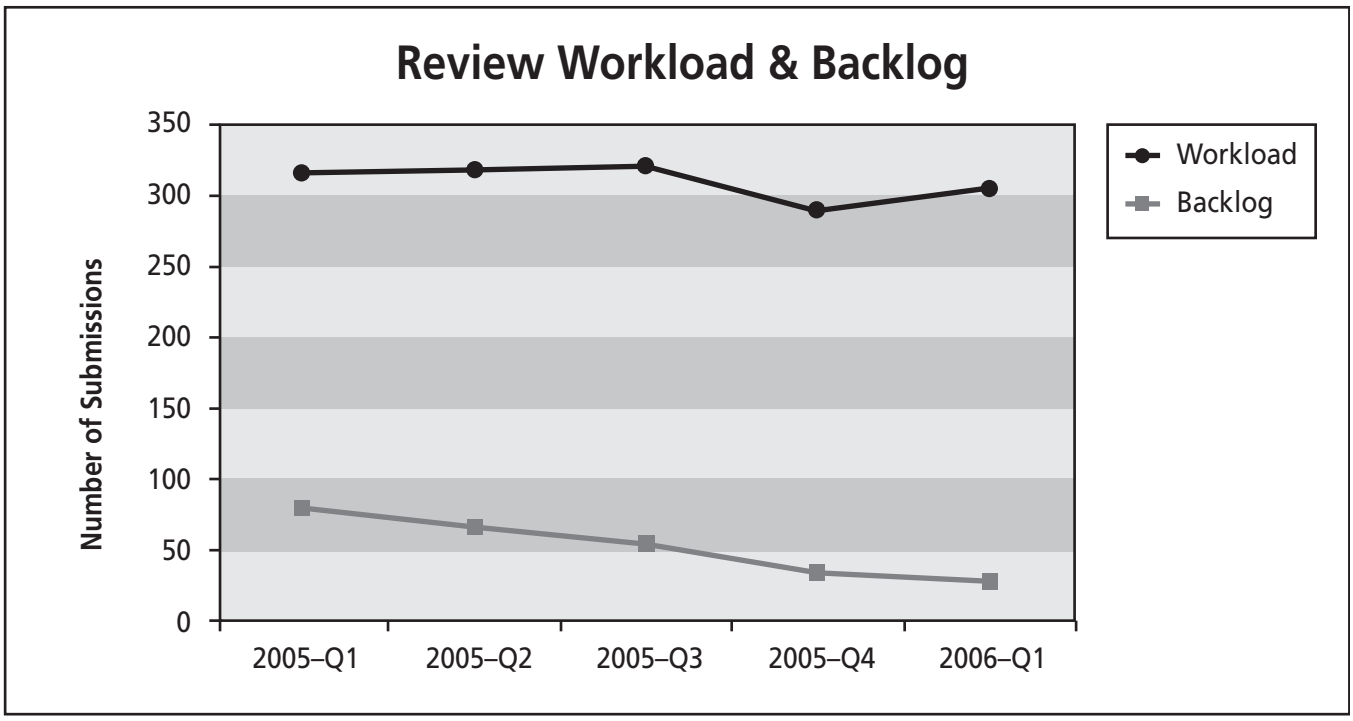
In 2005–2006, the Department made progress in reducing the submission review backlog and introduced initiatives to make the evaluation process more efficient. We eliminated 64 percent of the submission backlog for biologic and genetic therapies. We achieved a 98 percent reduction in the backlog of veterinary drug submissions older than 12 months, exceeding our target of a 90 percent reduction.

By September 2005, we achieved our target of reviewing 90 percent of new pharmaceutical drug submissions within our performance standard. We also reduced the number of pharmaceutical drug and biologic and genetic therapy submissions in queue and their duration in queue.

Progress on reviews of medical devices was also impressive. The backlog for Class III and IV device submissions was reduced from 25 percent in January 2005 to 1.1 percent by March 31, 2006. These results have been achieved through a combination of process improvements and an increase in capacity. Maintaining or improving this performance is a challenge because of new product development driven by science and technology advances. Stable and adequate funding in the future will be key to sustaining performance.

Health Canada is continuing to implement the electronic transmission of human drug submissions by adopting the internationally-developed electronic Common Technical Document (eCTD) format for the registration of pharmaceuticals for human use. After public consultation, in May 2005 we released a Guidance for Industry on preparation of drug submissions in the eCTD format.

During 2005–2006, Heath Canada's review workload for all submission types of human pharmaceuticals and biologics remained relatively steady at an average of 308 submissions per quarter. Between the first quarter of 2005 and the first quarter of 2006, we reduced the submission backlog from 79 submissions to 28 submissions as shown in the chart.



Quarterly Drug Submission Performance Report Part I

http://www.hc-sc.gc.ca/dhp-mps/alt_formats/hpfb-dgpsa/pdf/prodpharma/tpd_dpt_06q1_e.pdf
http://www.hc-sc.gc.ca/dhp-mps/alt_formats/hpfb-dgpsa/pdf/prodpharma/tpd_dpt_06q1_f.pdf

Quarterly Drug Submission Performance Report Part II

http://www.hc-sc.gc.ca/dhp-mps/alt_formats/hpfb-dgpsa/pdf/prodpharma/bgtd_dpbtg_06q1_e.pdf
http://www.hc-sc.gc.ca/dhp-mps/alt_formats/hpfb-dgpsa/pdf/prodpharma/bgtd_dpbtg_06q1_f.pdf

In the RPP, Health Canada committed to continue updating the ways in which we conduct safety assessments of health products to prevent and mitigate risks. We re-engineered the product assessment process for natural health products with a focus on risk-based management. We also developed new technology for efficient and effective review and assessment of natural health products. During the year, 1,191 Product Licences were issued, a 305 percent increase over the previous year; 212 Site Licences issued, a 404 percent increase; and 46 clinical trials authorized, a 92 percent increase. With over 40,000 natural health products that may require

evidence-based review, the ongoing challenge will be to find ways and means to process these applications in a timely manner and at a sustainable level of performance.

The Department is working to address the growing public health challenge of antimicrobial resistance, to continue to ensure that drugs are effective in killing or inhibiting the growth of targeted micro-organisms. In 2005–2006, we made progress in developing science-based policies and measures to prevent and control the spread of antimicrobial resistant bacteria, including establishment of an Expert Advisory Committee on Antimicrobial Resistance Risk Assessment. The Committee will provide Health Canada with advice on risk management issues; its work will help inform policy development and regulatory decisions.

Following the report of the Krever Commission in 1997 and the report by the Office of the Auditor General in 2000 on the regulatory regime for biologics, various stakeholder groups have endorsed standards-based regulations on cells, tissues and organs as therapeutic products used in transplantation. In response, in 2005–2006, the Department proposed a pioneering approach through our regulatory framework which will be implemented in two phases.

Phase I focuses on safety regulations. The proposed regulations for cells, tissues and organs were published in *Canada Gazette*, Part I in December 2005 and are being revised to address comments. This regulatory approach has been recognized as a world-first which establishes flexible rules to accommodate the rapid evolution of transplantation science, while ensuring the safety of Canadians. Health Canada has also developed an education strategy for stakeholders and released a revised interim guidance document. Phase II of the framework focuses on adverse event reporting and establishment compliance. We completed consultations with provincial and territorial health officials on this phase in October 2005.

To foster development of the regulatory framework for natural health products, Health Canada continued to develop linkages with international organizations and regulatory agencies. Collaborating with the World Health Organization (WHO), we contributed to the decision to create the Secretariat for International Regulatory Cooperation for Herbal Medicines, a global collaborative network of authorities responsible for the regulation of herbal medicines.

The Department carried out extensive consultations on a draft Health Canada-European Union guidance document to assist pharmaceutical companies in meeting regulatory requirements for developing products for the Canadian market. We expect use of the same guidance by the European Union and Canada to facilitate global development of pharmaceuticals and to make products available to Canadians in a more timely fashion. Release of the final version of the guidance document and full implementation is to take place during 2006–2007.

The Access to Medicines Program facilitates access to pharmaceutical products to treat HIV/AIDS, malaria, tuberculosis and other epidemics in least-developed and developing countries. The regulatory regime came into force in May 2005. Throughout the year, Health Canada completed the work needed to implement this program. For example, system enhancements were made to administer submissions and track products; work related to the registration of a trademark was completed; and processes and procedures were implemented to support the timely review of the Canada's Access to Medicines Regime (CAMR) submissions. At year end, three submissions were in review on a priority basis. We initiated an outreach strategy to provide information about the Regime to eligible countries and manufacturers in order to facilitate uptake. In spite of this progress, international uptake of CAMR remains a challenge due to the complexity of the international agreement that the Regime implements.

The Department completed revised guidelines for safety assessment of novel foods derived from plants and micro-organisms that are consistent with international guidelines adopted by the Codex Alimentarius Commission. We also continued to work at the international level, participating in efforts to refine the safety assessment approach for genetically modified and other novel foods. Jointly with the Canadian Food Inspection Agency (CFIA) and Croplife Canada, Health Canada initiated a Notice of Submission

pilot project that will lead to the posting on our website of notices and information on all novel food submissions received by the Department.

Health Canada continued to develop analytical methods to increase scientific capacity for safety assessments of novel foods. This included our work on a guideline for the conduct of safety assessments of foods derived from recombinant DNA animals. We also supported international efforts related to the conduct of safety assessments of foods derived from plants modified for nutritional or health benefits. These kinds of initiatives support continuous improvement of the scientific underpinnings of the regulation of foods derived from biotechnology and other novel foods. They also contribute to transparency and openness of the regulatory process and enhance international harmonization of the approach to safety assessments of novel foods available to Canadians.

Information, Education and Outreach on Health Products, Food and Nutrition

Financial Resources

(MILLIONS OF DOLLARS)

Planned Spending	Authorities	Actual Spending
11.7	13.0	12.8

Health Canada supports informed decisions and healthy choices by consumers, patients and health professionals through a broad range of activities linked to health products, food and nutrition, including the development of policies and standards such as Canada's Food Guide to Healthy Eating.

In addition, Health Canada published the *Issuance of Health Professional Communications and Public Communications by Market Authorization Holders* in November 2005. This guideline is intended to ensure consistent and effective risk communication materials to Canadians about regulated therapeutic health products.

The Department also published four regulatory amendments to the Food and Drug Regulations in the *Canada Gazette*. The proposed amendments dealt with nutrition labelling, nutrient content claims and health claims. Others addressed Maximum Residue Limits for veterinary drugs and carrageenan in infant formula and food additives. In addition, we completed a policy on the addition of vitamins and minerals to food and four separate food-related guidelines. This has all contributed to providing consumers with reliable information to make better choices for improved health outcomes and to manage risks related to food safety.

Canada Gazette Publishings

http://canadagazette.gc.ca/partI/2005/20050507/html/index-e.html
http://canadagazette.gc.ca/partI/2005/20050507/html/index-f.html

1994 Report of the Auditor General of Canada, Chapter 13

www.oag-bvg.gc.ca/domino/reports.nsf/html/9413ce.html
http://www.oag-bvg.gc.ca/domino/rapports.nsf/html/9413cf.html

Promoting and supporting healthy eating helps Canadians to maintain and improve their health. In 2005–2006, Health Canada released a draft of key components of *Canada's Food Guide to Healthy Eating*, designed to promote a pattern of eating that meets nutrient needs, promotes health and minimizes the risk of nutrition-related chronic disease. We conducted national, regional and online consultations, through which more than 7,500 stakeholders shared their views. Related work involved research into the needs of multicultural communities and further development of supporting materials for the *Food Guide*, including a guide for intermediaries and an interactive web-based tool. The Department worked on a guide tailored for Aboriginal people as well.

Food Guide Revision
http://www.hc-sc.gc.ca/fn-an/food-guide-aliment/revision/index_e.html http://www.hc-sc.gc.ca/fn-an/food-guide-aliment/revision/index_f.html

Nutrition labelling became mandatory for most prepackaged foods on December 12, 2005. Smaller businesses have until December 12, 2007 to make the information available. To help Canadians better understand and use the nutrition information on food labels, Health Canada launched the Interactive Nutrition Label and Quiz. This new online tool assists consumers to make more informed choices about the foods they eat.

Monitoring Safety and Therapeutic Effectiveness and Risk Management

Financial Resources

(MILLIONS OF DOLLARS)

Planned Spending	Authorities	Actual Spending
93.6	104.3	102.8

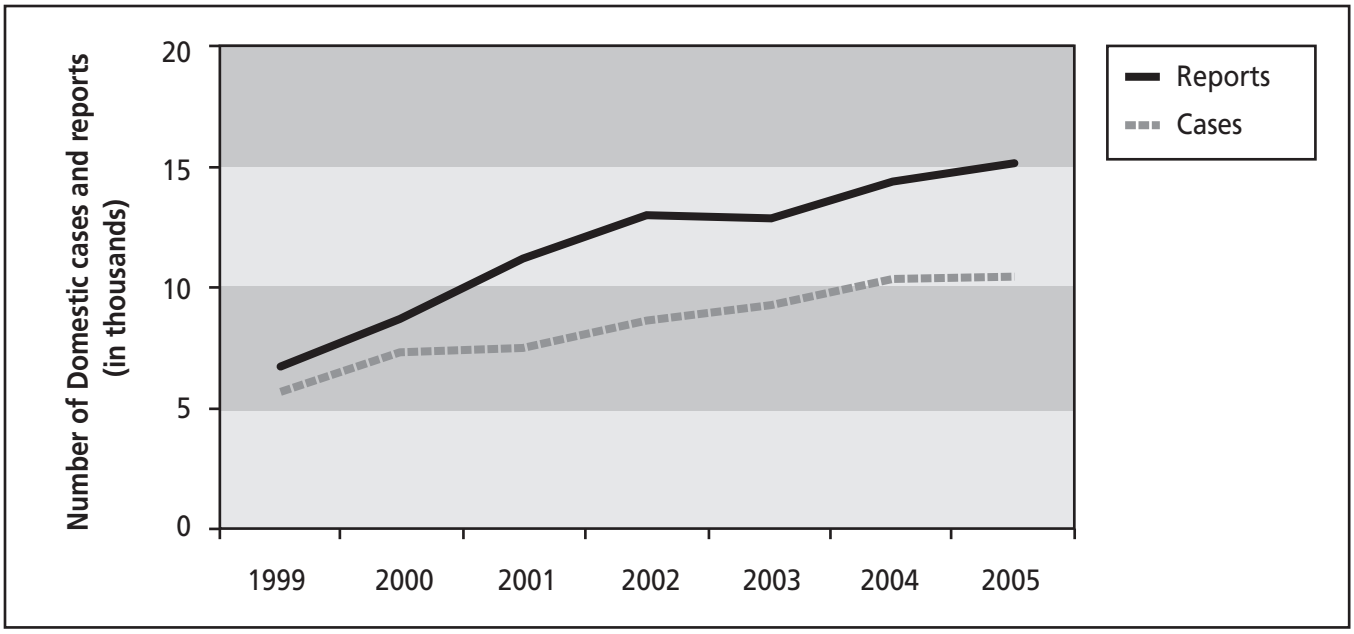
Health Canada conducts post-market surveillance on safety and therapeutic effectiveness. This is done by collecting information on adverse reactions to health products in Canada and abroad. Our Department also identifies and assesses health and safety risks and alerts the public to any such issues. Further, we conduct compliance activities so that health products available in Canada meet Canadian and international standards for safety, quality and efficacy.

In a March 2005 progress report on the Therapeutics Access Strategy (TAS), the Department committed to conducting post-market inspections of up to 25 percent of manufacturers. We met this target through our Post-Market Reporting Compliance inspection program which assessed compliance of manufacturers[1] with the *Food and Drugs Act* and Regulations pertaining to the reporting of adverse drug reactions and the reporting of failures in efficacy of new drugs.[2] In 2005–2006, our 71 post-market reporting compliance inspections met the target and demonstrated that all manufacturers were in compliance with requirements.

1. Regulation and Beyond: Progress on Health Canada's Therapeutics Access Strategy, March 2005, page 14.

2. Food and Drugs Act and Food and Drug Regulations, Justice Canada http://laws.justice.gc.ca/en/F-27/index.html

Number of domestic reports and cases of adverse reactions (ARs) received by Health Canada from 1999 to 2005. (Reports include follow-up, duplicate and unenterable reports. Cases result from the merge of initial, follow-up and duplicate reports.)



Compliance and Enforcement

http://www.hc-sc.gc.ca/dhp-mps/compli-conform/index_e.html
http://www.hc-sc.gc.ca/dhp-mps/compli-conform/index_f.html

As seen in the attached figure, the reporting of domestic adverse reactions (ARs) to health products in Canada has increased over the past seven years *(Canadian Adverse Reaction Newsletter, Vol. 16, Issue 2, April 2006)*.

The Department supported the commitment to provide information to the public about adverse reactions through quarterly publication of the *Canadian Adverse Reaction Newsletter* (CARN) on the new Health Canada MedEffect website. These were also published in the *Canadian Medical Association Journal* (CMAJ) reaching 67,000 physicians in Canada and 1,700 more in other countries. Another 28,000 copies were distributed to 25,000 pharmacists.

In August 2005, six months ahead of schedule, Health Canada launched the MedEffect web portal, which provides access to relevant and reliable health product safety information. It also enables easy reporting by consumers and health professionals of adverse reactions to drugs and other health products.

During 2005–2006, the Department continued to work closely with officials in other countries to share data. In addition to work through Canadian delegations to international committees and working groups, in April 2005, Health Canada signed a Memorandum of Understanding with the Australian Pesticides and Veterinary Medicines Authority. The supporting implementation plan will lead to the sharing of data and policies, and a policy on joint reviews.

Adverse Reaction Reporting — 2005

http://www.hc-sc.gc.ca/dhp-mps/medeff/bulletin/carn-bcei_v16n2_e.html#2
http://www.hc-sc.gc.ca/dhp-mps/medeff/bulletin/carn-bcei_v16n2_f.html#2

MedEffect

http://www.hc-sc.gc.ca/dhp-mps/medeff/index_e.html
http://www.hc-sc.gc.ca/dhp-mps/medeff/index_f.html

More information is available at:

http://www.hc-sc.gc.ca/dhp-mps/intactivit/veterin/index_e.html
http://www.hc-sc.gc.ca/dhp-mps/intactivit/veterin/index_f.html

In 2005–2006, Health Canada opened the Office of Paediatric Initiatives to serve as a focal point for an integrated approach to children's health and safety issues related to health products and food. The Department expects that the Office may also serve as a model for dealing with health and safety issues of other vulnerable populations such as seniors.

Our Department took action on Bovine Spongiform Encephalopathy/Transmissible Spongiform Encephalopathy (BSE/TSE) issues during 2005–2006. Two federal government-wide meetings provided a forum for exchange of new research and findings, promoted collaboration and minimized duplication of effort on BSE/TSE issues.

Health Canada conducted a collaborative research project with the world reference centre for BSE. The project tested more than 10,000 cattle tissue samples to improve the scientific knowledge of specified risk material (SRM). The Department conducted a research study to determine markers for the detection of SRM in food. We also completed a comprehensive peer reviewed risk assessment that evaluated options for Canada's BSE food risk management policies and associated human risks. As well, we validated SRM test kits based on Canadian situations for frozen, fresh and processed products and tested commercial food samples for the presence of SRM.

The Department received funding for two years (2004–2006) to support scientific research projects as part of the Augmenting Health Canada's Response to BSE Initiative. These projects enhanced understanding of the science underpinning BSE/TSE, and in particular, transmission of the agent from animals to humans. We then used this knowledge to develop rigorous risk assessment tools. However, certification of the laboratory needed for much of this work took longer than anticipated. By the end of the year, we developed a test to identify cell lines used in vaccine and biologics production that are susceptible to TSE infection. Other research sought to understand the biological conditions that lead to prion diseases.

While Canadians have reduced their total fat intake over the last two decades, their consumption of trans fatty acids remains among the highest in the world. In consultation with the public, industry, government and non-governmental food and nutrition organizations,

Health Canada remains committed to ensuring that the food supply in Canada is free of or contains nominal levels of trans fatty acids derived from partially hydrogenated fats.

In 2005–2006, we established a Trans Fat Task Force, co-chaired by representatives of Health Canada and the Heart and Stroke Foundation of Canada. Its interim report focussed on public education, labelling and possible immediate opportunities for food service and food processing industries to reduce trans fats. In collaboration with industry, Health Canada has taken steps to help Canadians reduce their trans fat consumption since the release of that interim report. Effective December 12, 2005, new nutrition labelling regulations required most prepackaged food to identify the content of 13 core nutrients, including trans fats. Health Canada also continued to monitor levels of trans fatty acids in the Canadian diet.

News Release on Trans Fat Task Force

http://www.hc-sc.gc.ca/ahc-asc/media/nr-cp/2006/2006_50_e.html
http://www.hc-sc.gc.ca/ahc-asc/media/nr-cp/2006/2006_50_f.html

In 1999 the Auditor General identified a lack of federal public health legislation and a national framework to link public health activities in the provinces and territories. To provide an integrated approach to food safety issues, enhance national decision making and ensure the same level of protection for all consumers, Health Canada, in collaboration with the Canadian Food Inspection Agency (CFIA), Agriculture and Agri-Food Canada, and the provinces and territories, contributed to the development of the National Food Policy Framework.

Although planned governmental and non-governmental consultations on the Framework in 2005–2006 were delayed because of multiple priorities among the partners, this group was able to achieve progress in other areas. This included: involvement of key players within the federal Health Portfolio; engagement of the provinces and territories through the Canadian Food Inspection System Implementation Group; and completion of version 2 of Canada's Proposed Strategy for Safe Food. Another step forward was the formation of expert panels for pathogens, chemical contaminants and nutritional safety which developed rationales for performance measures related to public health outcomes.

In collaboration with CFIA, the Canadian restaurant and food service industry, and allergy and asthma consumer information associations, Health Canada continued to ensure that Canadians are informed about allergens in food. The Department participated in the newly formed Precautionary Labelling Working Group (PLWG), which will develop options and advice for allergen labelling. Regulatory options for allergen labelling continue to be discussed and amendments are to be finalized. We also published Government of Canada Food Allergens pamphlets.

Allergen Labelling

http://www.hc-sc.gc.ca/fn-an/label-etiquet/allergen/index_e.html
http://www.hc-sc.gc.ca/fn-an/label-etiquet/allergen/index_f.html

Completing the Biotechnology Regulatory Framework

http://cbac-cccb.ca/epic/internet/incbac-cccb.nsf/en/ah00437e.html
http://cbac-cccb.ca/epic/internet/incbac-cccb.nsf/fr/ah00437f.html

Expert Panel on the Future of Food Biotechnology

http://www.rsc.ca/index.php?lang_id=1&page_id=119
http://www.rsc.ca/index.php?lang_id=2&page_id=119

Genetically Modified (GM) Foods and Other Novel Foods

http://hc-sc.gc.ca/fn-an/gmf-agm/index_e.html
http://hc-sc.gc.ca/fn-an/gmf-agm/index_f.html

With stakeholders, Health Canada has been working to find a solution to the use of the veterinary drug *SLICE™* to treat infestations of sea lice in farmed salmon — a solution that will meet the needs of industry while ensuring that fish going to market are safe for consumers. To do so, we worked closely with CFIA, Department of Fisheries and Oceans (DFO), the farmed salmon industry and provincial governments.

Questions and Answers on Emamectin Benzoate (SLICE™)

http://www.hc-sc.gc.ca/dhp-mps/vet/faq/faq_slice_e.html
http://www.hc-sc.gc.ca/dhp-mps/vet/faq/faq_slice_f.html

Transparency, Public Accountability and Stakeholder Relationships

Financial Resources

(MILLIONS OF DOLLARS)

Planned Spending	Authorities	Actual Spending
16.4	18.3	18.0

Health Canada continues to strengthen its transparency, openness and accountability to Canadians. We have increased public involvement initiatives related to health products, food and nutrition policy and regulatory decisions, as well as improved annual plans and reports.

The transparency of clinical trials for health products has become an important issue in Canada and abroad. Patients, prescribers, researchers and regulators want greater access to information on clinical trials to support informed decisions. In 2005–2006, the Department worked on a proposed approach for the registration and disclosure of clinical trial information. In June 2005, Health Canada held consultations with stakeholders to identify what "end-users" want from clinical trial registrations. Phase I consultations included an online questionnaire and workshops in Ottawa, Halifax and Vancouver. We published the results of the consultations and used the feedback as we began policy development. An External Working Group was created to develop and advise on options for improving public access to clinical trial information on health products in Canada.

Registration and Disclosure of Clinical Trial Information

http://www.hc-sc.gc.ca/dhp-mps/prodpharma/activit/proj/enreg-clini-info/index_e.html
http://www.hc-sc.gc.ca/dhp-mps/prodpharma/activit/proj/enreg-clini-info/index_f.html

Another initiative is the Health Products and Food Branch Public Advisory Committee. This Committee is composed of citizens who participate as public advisors to the Branch. During 2005–2006, the Committee deliberated on such issues as: Innovation in Drug Regulation; Public Involvement Models in Drug Regulatory Decisions; Use of Foreign Reviews; and Blood Donor Deferral. They also were part of focus testing of the MedEffect portal for information about adverse drug reactions, described earlier in this section and other consultation mechanisms.

Health Canada held two Stakeholder Committee meetings on veterinary drug issues in the past year, in addition to several meetings of advisory committees on specific issues. These allowed experts from government, academia and industry to participate in development of policies on Extra Label Drug Use, Minor Uses/Minor Species and Antimicrobial Resistance.

Veterinary Drugs

http://www.hc-sc.gc.ca/dhp-mps/consultation/vet/index_e.html
http://www.hc-sc.gc.ca/dhp-mps/consultation/vet/index_f.html

Stakeholder Information for Veterinary Drugs

http://www.hc-sc.gc.ca/dhp-mps/vet/part/index_e.html
http://www.hc-sc.gc.ca/dhp-mps/vet/part/index_f.html

Single-use devices (SUDs) are medical devices manufactured for one-time use. Because these devices can be expensive, evidence suggests some health care institutions have reused them. While there may be cost savings and reduced environmental and waste disposal costs, this practice may result in risks to patients. In response to a recommendation in the 2004 Audit of the Medical Devices Program, Health Canada established the Scientific Advisory Panel on the Reprocessing of Medical Devices (SAP-RMD). Provincial and territorial representatives met in February and October 2005 and January 2006. The SAP-RMD recommended that the reuse of single-use devices (SUDs) not be allowed unless regulated by Health Canada. Stakeholder consultations, including provinces and territories, took place in June 2005. Consensus emerged that Health Canada should regulate the reprocessing of SUDs. Legislative and policy options are being developed on this issue.

In 2005–2006, we conducted more than 120 public and stakeholder involvement activities. This was fewer than the previous year because many activities were suspended or deferred due to the federal election.

STRATEGIC OUTCOME #3:
Reduced Health and Environmental Risks from Products and Substances, and Safer Living and Working Environments

Program Activity Name:

Healthy Environments and Consumer Safety

Expected Results:

- Reduced risks to health and safety and improved protection against harm associated with workplace and environmental hazards and consumer products (including cosmetics)
- Reduced health and safety risks associated with tobacco consumption and the abuse of drugs, alcohol and other substances

Financial Resources

(MILLIONS OF DOLLARS)

Planned Spending	Authorities	Actual Spending
273.7	284.0	277.9

Human Resources

(FTEs)

Planned	Actual	Difference
1,832	1,927	95

Variances between planned spending versus authorities are mainly due to:

- additional funding for health risk assessments and protection measures related to the *Canadian Environmental Protection Act*
- funding related to the assessment, management and remediation of federal contaminated sites
- compensation for salary adjustments

The actual spending is $6.1 million lower than authorities mainly due to:

- lapse of a frozen allotment for Drug Treatment Court Funding
- year end adjustments of Department of Justice expenditures

Health Canada reduces health and environmental risks from products and substances, contributes to safer living and working environments and to improved health-related decision making on the part of Canadians, health practitioners and industry and fosters increased confidence in health-related programs and strategies.

The broad scope of the mandate under this program activity includes elements such as drinking water safety, air quality, radiation exposure, substance use and abuse (including alcohol), consumer product safety, tobacco and second-hand smoke, workplace health, and chemicals in the environment and the workplace.
We are also engaged in other health and safety-related activities, including the Government's public safety and anti-terrorism initiatives, inspection of food and

potable water for the travelling public, and health contingency planning for visiting foreign dignitaries. Health Canada's mandate is founded in legislation that includes the *Food and Drugs Act*, the *Controlled Drugs and Substances Act*, the *Hazardous Products Act*, the *Radiation Emitting Devices Act*, the *Canadian Environmental Protection Act* and the *Tobacco Act*.

We work to accomplish our objectives through: enhanced compliance with regulations, standards and guidelines; increased awareness and knowledge of major health and regulated products issues relating to healthy and safe living, working and recreational environments; enhanced involvement of stakeholders; and improved scientific knowledge and capacity in order to support evidence-based decision making.

Under this program activity, Health Canada had five sub-activities, as defined in the Program Activity Architecture. These encompassed work defined in the RPP under two broad priorities:

- Reduce risks to health and safety, and improve protection against harm associated with workplace and environmental hazards, consumer products (including cosmetics), radiation-emitting devices, new chemical substances, and products of biotechnology; and
- Reduce health and safety risks associated with tobacco consumption and the abuse of drugs, alcohol and other controlled substances.

During the year, we continued to carry out our responsibilities, generally meeting or exceeding commitments made in the RPP, consistent with planned resources. We undertook science, research, policy, regulatory and prevention/promotion initiatives to achieve results. We collaborated extensively with partners and stakeholders inside and outside of the country, and had an active presence in every region. We fulfilled our responsibilities in accordance with principles of sustainable development to promote economic, social, cultural and environmental objectives. Many achievements are the result of our science and research activities.

Our 2005–2006 achievements and challenges in each of the five sub-activities are described below.

Detailed status of our achievements with respect to specific commitments
http://www.hc-sc.gc.ca/ahc-asc/performance/estim-previs/dpr-rmr/2005-2006a_e.html http://www.hc-sc.gc.ca/ahc-asc/performance/estim-previs/dpr-rmr/2005-2006a_f.html

Safe Environments

Financial Resources

(MILLIONS OF DOLLARS)

Planned Spending	Authorities	Actual Spending
68.1	70.4	65.1

Under the Safe Environments sub-activity in 2005–2006, Health Canada helped Canadians maintain and improve their health by reducing harm caused by environmental contaminants in air, water and soil. We contributed to healthy living, working and recreational environments by identifying and assessing health risks posed by environmental factors, and through developing national risk management strategies that are supported by scientific research and aligned with Health Canada's Sustainable Development Strategy. As a result of our surveillance, monitoring, communication, and outreach activities, Canadians were better able to make informed decisions about limiting their exposures to environmental contaminants.

There were many areas of continuing work, such as the Canadian Climate Change and Health Vulnerability Assessment to be completed by 2007, and provision of risk assessments and training to managers to help federal departments manage the human health risks associated with federal contaminated sites. Work progressed on guidelines for drinking water quality and collaboration with the United States on nuclear emergency preparations.

The Department built on earlier work to address the health risks associated with air pollutants in both indoor and outdoor environments, with an emphasis on vulnerable populations such as children, seniors and people with heart or lung conditions.

Significant progress took place in the development of a new National Air Quality Health Index (AQHI), which is a tool to communicate links between air quality and human health. Unlike previous indices, the new AQHI puts health first. It will help Canadians better understand how to protect their health from the negative effects of air pollution on a daily, or even hourly basis, much as Canadians use the UV Index to assess risks of sun exposure. This index was piloted in autumn 2005 under the leadership of the British Columbia Ministry of Environment and the Interior Health Authority. The results of the pilot led to further refinement of the technology, formulation and health messaging of the AQHI, in preparation for additional testing in 2006–2007.

Models for the new Air Health Indicator were developed and testing began. This indicator will serve to link trends in ambient air quality to changes in the daily rates of death or hospitalization, something missing from previous assessment methodologies. The indicator will provide a means to evaluate the effectiveness of air quality management programs in reducing the health impact of air pollution.

Border Air Quality Studies continued to examine the impacts of air pollution on health, with special emphasis on children and other vulnerable populations, and also to examine region-specific issues of concern to health, such as transportation emissions, seasonality and unique regional exposures. Most of the data collection and preliminary data analyses for the Great Lakes Basin pilot were completed; the other pilot in British Columbia's Georgia Basin and Puget Sound neared completion as well. These studies will fill knowledge gaps about health issues related to pollution sources such as transportation, marine and wood smoke emissions.

A key area of work in 2005–2006 involved our responsibilities under the *Canadian Environmental Protection Act* (CEPA). CEPA's intended outcomes include reducing the amount and release of toxic substances in the environment, reducing human exposure to toxic substances, and enhancing awareness, openness and collaboration across sectors.

We continued our participation in the Federal Prairie Water Committee (FPWC) to develop a common federal approach to water issues in the Prairies. In October 2005, a two-day meeting was held with broad representation from a number of federal departments to facilitate information exchange, establish ongoing contacts, promote interdepartmental interaction and establish and confirm a three-year plan for the Committee including the identification of goals, objectives and project initiatives. Funding was secured such that a Secretariat was established to support and advance the Committee's work in relation to a number of proposed prairie water projects.

We worked toward completion of the health-related components of the categorization of substances on the CEPA Domestic Substances List (DSL). The immediate goal of this process is to guide the priorization of substances that merit health protective measures. Ongoing categorization work has so far resulted in about 520 substances being identified as high health priorities, and 680 substances identified as moderate health priorities, all listed for further action. We will complete this process by the September 2006 legislated time frame. The Department also released draft health assessments on nine existing substances for public comment. We implemented a system and process under a Results-Based Management and Accountability Framework (MAF) to measure our CEPA activities.

Safe Environments Programme

http://www.hc-sc.gc.ca/ahc-asc/branch-dirgen/hecs-dgsesc/sep-psm/index_e.html
http://www.hc-sc.gc.ca/ahc-asc/branch-dirgen/hecs-dgsesc/sep-psm/index_f.html

Air Quality

http://www.hc-sc.gc.ca/ewh-semt/air/index_e.html
http://www.hc-sc.gc.ca/ewh-semt/air/index_f.html

Radiation

http://www.hc-sc.gc.ca/ewh-semt/radiation/index_e.html
http://www.hc-sc.gc.ca/ewh-semt/radiation/index_f.html

Water Quality

http://www.hc-sc.gc.ca/ewh-semt/water-eau/index_e.html
http://www.hc-sc.gc.ca/ewh-semt/water-eau/index_f.html

Environmental Contaminants

http://www.hc-sc.gc.ca/ewh-semt/contaminants/index_e.html
http://www.hc-sc.gc.ca/ewh-semt/contaminants/index_f.html

Product Safety

Financial Resources

(MILLIONS OF DOLLARS)

Planned Spending	Authorities	Actual Spending
27.1	28.9	28.9

Through Product Safety initiatives we identified and reduced risks to the health and safety of Canadians associated with consumer products (including cosmetics), new chemical substances, radiation-emitting devices, workplace and environmental hazards and products of biotechnology. We achieved this through regulatory monitoring and compliance activities and through information, education and guidance aimed at both industry and the public.

Health Canada protected Canadians against risks posed by consumer products (including cosmetics) through a multi-pronged approach. We identified unsafe products and product-related risks through research, Product Safety Laboratory testing, surveillance and monitoring activities. The Department developed regulations and policies to address product-related risks.

Our monitoring, compliance and enforcement activities encouraged compliance with consumer product regulations and standards and reduced the number of unsafe consumer products on the market. The Department used communications and education to raise awareness of product safety and informed decisions on the part of both manufacturers and consumers. This included consumer awareness of product-related hazards and the safe use of products and encouraging the design of safer products by providing hazard and technical information to importers and manufacturers.

The Lead Risk Reduction Strategy (LRRS) was an important aspect of our consumer protection responsibilities during 2005–2006. The purpose of the LRRS is to protect Canadians, and in particular children, against exposure to lead, by developing and implementing regulations to limit lead content in consumer products. Lead exposure is most serious for young children, because they absorb lead more easily and are more susceptible to its harmful effects. The LRRS proposes to regulate, under the *Hazardous Products Act*, the lead content of five categories of consumer products that children are likely to come into contact with. In the past year, regulations were published for surface coating materials and children's jewellery. Public consultations were held to update glazed ceramics and glassware regulations. A public opinion survey was completed to address comments on regulations related to lead in candles.

The Department also conducted inspection and sampling surveys for lead on children's jewellery, surface coating materials, pencils and artist brushes, glazed ceramics and glassware. More than 900 products were inspected; almost 300 samples tested and noncompliant products were removed from the market. We issued three public advisories: two concerning lead in children's jewellery and one concerning the lead content of some Moroccan cooking vessels (tajines). Eighteen recalls of products containing lead were issued and monitored to ensure the products in question were removed from the Canadian market.

Health Canada continued to assess the potential health risks of new chemicals such as fabric dyes and fuel additives, as well as biotechnology products. Our Department imposed control measures on substances suspected to pose significant risks to reduce the presence of toxic substances in the environment.

The Department received approximately 500 new chemical notifications in 2005–2006. Our risk-based prioritization resulted in the completion of assessment reports on the roughly 300 new notifications that presented relatively higher threats to health. While the remainder, which represented relatively lesser threats to health, went into a backlog of uncompleted notifications, we made significant progress in reducing that backlog as well.

Risk management actions were recommended for five new chemical substances and additional information-gathering conditions were imposed on eight others. None of the five new living organisms of which we were notified required risk management actions. Screening assessments were completed for three living organisms on the Domestic Substances List, all of which will require risk management actions. Additionally, the Department received 96 notifications under the *Food and Drugs Act* and completed 83 risk assessment reports, although most were not completed as quickly as required.

The appropriate classification and labelling of substances to communicate potential hazards is important to protect consumers and workers. Canada has committed to implement the Globally Harmonized System of Classification and Labelling of Chemicals (GHS), which is an international initiative for a harmonized system of classification and labelling of chemicals. Our Department, which chairs the United Nations GHS Sub-Committee, continued to work toward the legislative and regulatory changes necessary for domestic GHS implementation.

The Globally Harmonized System of Classification and Labelling of Chemicals (GHS)

http://www.hc-sc.gc.ca/ahc-asc/intactiv/ghs-sgh/index_e.html
http://www.hc-sc.gc.ca/ahc-asc/intactiv/ghs-sgh/index_f.html

Product Safety Program

www.hc-sc.gc.ca/ahc-asc/branch-dirgen/hecs-dgsesc/psp-psp/index_e.html
www.hc-sc.gc.ca/ahc-asc/branch-dirgen/hecs-dgsesc/psp-psp/index_f.html

Update on proposed amendments to the Hazardous Products (Glazed Ceramics and Glassware) Regulations

www.hc-sc.gc.ca/cps-spc/legislation/acts-lois/ceramic-modification-ceramique_e.html
www.hc-sc.gc.ca/cps-spc/legislation/acts-lois/ceramic-modification-ceramique_f.html

Chemical Hazards

www.hc-sc.gc.ca/ahc-asc/branch-dirgen/hecs-dgsesc/psp-psp/cps-spc/chem-chimie_e.html
www.hc-sc.gc.ca/ahc-asc/branch-dirgen/hecs-dgsesc/psp-psp/cps-spc/chem-chimie_f.html

Tobacco Control

Financial Resources

(MILLIONS OF DOLLARS)

Planned Spending	Authorities	Actual Spending
70.5	72.9	72.6

Through the Tobacco Control Program, Health Canada continued in 2005–2006 to lead the Federal Tobacco Control Strategy (FTCS). We worked to reduce the health and safety risks associated with tobacco consumption, still Canada's most significant single cause of preventable death and disease. We carried out this work through initiatives supporting the four pillars: prevention; cessation; protection; and harm reduction. The Department developed and administered programs, and partnered with provinces, territories and stakeholder groups. Together, we reached individual Canadians with tools, information and resources to help them limit and

reduce tobacco use. We developed, implemented and enforced regulations pursuant to the Tobacco Act. Our research, monitoring, surveillance and reporting activities added to the knowledge base essential to the development, implementation and evaluation of effective policies, programs and regulations to reduce the health harms associated with tobacco.

The 10-year objectives of the FTCS, commencing in 2001, are to:

- reduce smoking prevalence to 20 percent, from 25 percent in 1999;
- reduce the number of cigarettes sold by 30 percent (from 45 billion to 32 billion);
- increase retailer compliance regarding youth access to sales from 69 percent to 80 percent;
- reduce the number of people exposed to environmental tobacco smoke in enclosed public spaces; and
- explore how to mandate changes to tobacco products to reduce hazards to health.

The Canadian Tobacco Use Monitoring Survey (CTUMS), based on data collected between February and December 2005, provided insights in the tobacco use and trends. It reported that slightly fewer than five million people, representing 19 percent of the population aged 15 years and older, were current smokers and 15 percent of the population smoke daily. Those smokers reported smoking an average of 15.7 cigarettes per day during 2005. These results indicate a continued downward trend in smoking prevalence among Canadians aged 15 years and older.

Cigarette sales also declined from nearly 42 billion cigarettes in 2001 to 34.2 billion in 2004, a decrease of approximately 18 percent.

The FTCS goal of 80 percent compliance with sales-to-youth laws was achieved for the first time in 2004 and continued to be met in 2005. The 2005 survey found that the national rate of retailers refusing to sell tobacco products to youth was 80.8 percent, a vast improvement over the rate of 47.9 percent in 1995 when this was first measured.

Work during 2005–2006 recognized that maintaining or improving smoking prevalence levels from the current 19 percent of the over-15 population requires sustained and focussed attention on segments of the population. People aged 20–24 are important since young adult males report the highest prevalence of current smoking (32 percent), with 24 percent smoking daily. The Tobacco Control Program focussed on activities to identify and implement appropriate interventions to reduce smoking among youth and young adults. Nineteen community consultations took place across the country and we began to develop a Framework for Action for Youth and Young Adults, with input from various levels of government, non-governmental organizations and members of the community at large, including youth and young adults.

An assessment of our Youth Action Committee (YAC) helped the Department to identify lessons learned and best practices in engaging youth in tobacco control activities. We will review its recommendations in order to make the most of the YAC. Those recommendations included suggestions to maximize the group's productivity, recruit marginalized segments of the youth community and measure the effectiveness of the program. At the November 2005 meeting, YAC participants received training in evaluation and consultation to prepare them to participate in consultations regarding the second phase of the FTCS.

We also developed and focus tested Young Adult Cessation modules for parents, students and workers aged 20–34. These sixteen modules were written and reviewed by leading Canadian experts. They address topics such as nicotine addiction and withdrawal, meeting the challenges of quitting, life stage specific information, relapse and smoking during pregnancy.

Tobacco Control Programme

http://hc-sc.gc.ca/ahc-asc/branch-dirgen/hecs-dgsesc/tcp-plct/index_e.html
http://hc-sc.gc.ca/ahc-asc/branch-dirgen/hecs-dgsesc/tcp-plct/index_f.html

Drug Strategy and Controlled Substances

Financial Resources

(MILLIONS OF DOLLARS)

Planned Spending	Authorities	Actual Spending
80.2	74.1	73.6

In 2005–2006, Health Canada reduced the health and safety risks associated with abuse of drugs, alcohol and other controlled substances through our Drug Strategy and Controlled Substances sub-activity. This Strategy takes a balanced approach to reducing drug demand and supply. It contributes to a healthier, safer Canada through prevention, enforcement, treatment and harm reduction initiatives. Departmental activities included:

- managing the *Controlled Drugs and Substances Act* (CDSA) and its Regulations;
- providing national leadership for Canada's Drug Strategy (CDS);
- regulating access to controlled substances and preventing diversion of these substances for illegal purposes;
- managing programs that reduce and prevent harm associated with controlled substances;
- providing Canadians with information to facilitate knowledgeable health and lifestyle decisions;
- partnering with provinces and territories to facilitate access to treatment and rehabilitation services; and
- delivering drug analysis services and materials in support of the criminal justice system.

Alcohol consumption and the illegal use of drugs continue to pose serious threats to the health of Canadians. Twenty-three percent of past-year drinkers reported risky drinking practices in 2004. The use of marijuana, cocaine/crack, and LSD, Speed and heroin, all continued to increase. More than 14 percent of Canadians surveyed, aged 15 and older, reported past-year use of marijuana in 2004, up from 12 percent in 2002, and more than double the 6.5 percent reported in 1989.

The Department continued to administer the CDSA, and completed several amendments to update and strengthen its regulations. In addition, we continued our provision of exemptions and authorizations, such as those for methadone and the use of marijuana for medical purposes. Our drug analysis services continued to support law enforcement agencies with expert scientific advice and drug analysis. Our laboratories worked with law enforcement agencies to identify and analyze more than 100,000 seized samples of controlled substances, an increase of 10 percent over the previous year. We provided expert advice and aid in dismantling 47 illicit laboratories in 2005.

Health Canada continued to fund programs to increase the capacity of communities to address substance abuse issues and to provide appropriate and effective addiction services and treatment. We supported communities with the full implementation in 2005–2006 of the Drug Strategy Community Initiatives Fund (DSCIF). A total of 115 projects received contributions of approximately $9.5 million, all designed to facilitate the development of national and community-based solutions to substance abuse problems, and to promote public awareness.

The Alcohol and Drug Treatment and Rehabilitation (ADTR) Program continued to fund improved treatment for women and youth. The Department also negotiated and monitored cost-shared funding agreements with all provincial governments based on new terms of reference for ADTR, including enhanced performance reporting requirements. We co-funded, with the Department of Justice, drug treatment courts in Toronto, Ottawa, Winnipeg, Edmonton, Regina and Vancouver. These specialized courts are intended to offer treatment as an alternative to incarceration to non-violent offenders who are addicted to cocaine or opiates.

To combat the continuing problem of substance abuse, our Department is directing resources toward enhancing research and partnerships and the development and implementation of a national framework for action and a national research agenda. In 2005–2006, we conducted a forum with participation of all major stakeholders, completed the National Framework for Action to Reduce the Harms Associated with Alcohol and Other Drugs and Substances in Canada, and initiated the endorsement process with provincial and territorial governments and other stakeholder groups. We also formed a National Alcohol Working Group, which is developing a National Alcohol Strategy. We started to develop a Strategy on the Misuse/Abuse of Pharmaceuticals, initiated work on the CDS Interim Evaluation and completed a report on the progress of the CDS.

Knowledge development continues to be vital to making progress against substance abuse and the presence of illegal drugs. A National Research Agenda was established as was a National Co-ordination and Advisory Committee to implement it. We also analyzed and reported on the results of the Canadian Addiction Survey (CAS), and initiated specific reports on youth and gender-related issues.

Canada's Drug Strategy

http://www.hc-sc.gc.ca/ahc-asc/activit/strateg/drugs-drogues/index_e.html
http://www.hc-sc.gc.ca/ahc-asc/activit/strateg/drugs-drogues/index_f.html

Medical Use of Marihuana

http://www.hc-sc.gc.ca/dhp-mps/marihuana/index_e.html
http://www.hc-sc.gc.ca/dhp-mps/marihuana/index_f.html

Controlled Substances and Precursor Chemicals

http://www.hc-sc.gc.ca/dhp-mps/substancontrol/index_e.html
http://www.hc-sc.gc.ca/dhp-mps/substancontrol/index_f.html

Health Canada's Marihuana Supply

http://www.hc-sc.gc.ca/dhp-mps/marihuana/supply-approvis/index_e.html
http://www.hc-sc.gc.ca/dhp-mps/marihuana/supply-approvis/index_f.html

Drug Analysis Service

http://www.hc-sc.gc.ca/dhp-mps/substancontrol/analys-drugs-drogues/index_e.html
http://www.hc-sc.gc.ca/dhp-mps/substancontrol/analys-drugs-drogues/index_f.html

National Framework for Action to Reduce the Harms Associated with Alcohol and Other Drugs and Substances in Canada

http://www.hc-sc.gc.ca/ahc-asc/activit/strateg/drugs-drogues/nfa-can/index_e.html
http://www.hc-sc.gc.ca/ahc-asc/activit/strateg/drugs-drogues/nfa-can/index_f.html

Treatment and Rehabilitation
http://www.hc-sc.gc.ca/dhp-mps/substan/treat-trait/index_e.html http://www.hc-sc.gc.ca/dhp-mps/substan/treat-trait/index_f.html
Drug Strategy Community Initiative Fund
http://www.hc-sc.gc.ca/dhp-mps/substan/fond-comm-fund/index_e.html http://www.hc-sc.gc.ca/dhp-mps/substan/fond-comm-fund/index_f.html
Be Drug Wise
http://drugwise-droguesoisfute.hc-sc.gc.ca/index_e.asp http://drugwise-droguesoisfute.hc-sc.gc.ca/index_f.asp
Canada's Drug Strategy Publications
http://www.hc-sc.gc.ca/ahc-asc/pubs/drugs-drogues/index_e.html http://www.hc-sc.gc.ca/ahc-asc/pubs/drugs-drogues/index_f.html
Overview of Alcohol and Other Drug Use in Canada
http://www.hc-sc.gc.ca/dhp-mps/substan/alc-can/overview-apercu/index_e.html http://www.hc-sc.gc.ca/dhp-mps/substan/alc-can/overview-apercu/index_f.html

Workplace Health and Public Safety

Financial Resources

(MILLIONS OF DOLLARS)

Planned Spending	Authorities	Actual Spending
27.9	37.7	37.7

In 2005–2006, Health Canada continued to enhance productivity and quality of life by contributing to the health and safety of federal and other workers, the travelling public and visiting dignitaries and improving protection against harm associated with the workplace through:

- administration of the Public Service Health Program (PSHP) on behalf of Treasury Board, providing occupational health and safety services in federal departments and agencies;
- provision of Employee Assistance Services (EAS) to public sector employees and their families in Canada and abroad and support in the form of psycho-social services to emergency responders and federal workers who provide services during and immediately after public health emergencies;
- providing tools to federal departments to assist in the management of risks related to drinking water and to facilitate compliance with the Canadian Guidelines for Drinking Water Quality;

- developing the regulatory framework for health issues related to "conveyances" such as passenger aircraft, ships and trains, and providing public health inspections and audits related to safe food, drinking water and general sanitation on those conveyances, including emergency response;
- providing health services and contingency planning for Internationally Protected Persons and their families while on official visits to Canada, and preparing comprehensive health contingency plans for international events hosted by Canada; and
- developing and implementing workplace health strategies through the provision of advice, guidance and tools for employers.

The Department contributed to the health and safety of federal workers by responding to thousands of requests for occupational health and safety services under the PSHP, including 13,550 service requests related to communicable diseases (10,089 immunizations/screenings and 3,461 consultations), 4,353 ergonomic service requests (3,573 individual assessments, 575 training sessions and 205 Employee Assistance Program (EAP) consultations), 11,852 health assessments (9,798 pre-placement and periodic evaluations, 1,992 fitness-to-work evaluations and 62 hazardous exposure evaluations), 607 workplace investigations and consultations (417 investigations and 190 consultations), and 512 educational sessions.

The Department's EAS Bureau provided counselling and/or advice as well as crisis response and referrals to employees and their families in 122 public sector organizations, in response to 27,115 calls for assistance. During 2005–2006, in response to trauma in the workplace, Health Canada provided 21 on-site group interventions and 249 individuals received direct post-trauma services. Survey results show that 98 percent of clients of the EAS Bureau indicated that they would use the service again if the need arose, and all clients indicated that they would recommend the service to a colleague. In December 2005, the Bureau was recognized for its service excellence by the Council on Accreditation through a prestigious Quality Assurance Accreditation for its Employee Assistance Services. The Department also continued its ongoing activities related to drinking water risk management in federal departments, and held its first annual workshop for federal drinking water providers, to increase awareness on best practices and due diligence requirements.

Health Canada continued to inspect passenger conveyances (ships, aircraft and passenger trains) and ancillary services and recorded no gastrointestinal outbreaks. Health Canada is also engaged in collaborative efforts with the U.S. Centres of Disease Control to deal with the spread of norovirus amongst travellers. The Department began to address the gaps in the regulatory framework by including food, air and sanitation on conveyances. The World Health Organization (WHO) has indicated that updating domestic legislation and regulations to comply with revised International Health Regulations is critical to preventing communicable disease transmission across international borders.

Emergency preparedness and response was a key area of achievement under this sub-activity in 2005–2006. In several respects, we improved the level of preparedness for emergencies such as a pandemic or natural disaster. A national conference and workshop for occupational emergency response personnel contributed to ongoing development of protocols and guidelines for emergency response. These are linked to national plans, including the Pandemic Preparedness Plan. The Department developed special materials on the psycho-social impacts of a pandemic, as part of the Government's readiness initiatives.

Health Canada made extensive progress in staffing and equipping the Emergency Preparedness and Response Unit and in planning preparedness activities involving federal, provincial and municipal authorities and agencies. These actions have helped to improve our preparedness for terrorist acts of a chemical, biological, radiological or nuclear nature. Work with clients and stakeholders included participation in "table-top" and live emergency response exercises.

Despite progress in physical and psycho-social emergency preparedness, analysis of the results of these exercises and the conference highlighted areas where work remains to be done to enhance preparedness for major emergencies. These include formalizing and streamlining preparedness and response infrastructures, building alternative response networks, and training people to ensure surge capacity for emergencies that could simultaneously affect multiple areas across the country or those which might last for a substantial amount of time, such as a pandemic.

Workplace Health and Public Safety Programme

http://www.hc-sc.gc.ca/ahc-asc/branch-dirgen/hecs-dgsesc/whpsp-psstsp/index_e.html
http://www.hc-sc.gc.ca/ahc-asc/branch-dirgen/hecs-dgsesc/whpsp-psstsp/index_f.html

Employee Assistance Program

http://www.hc-sc.gc.ca/ewh-semt/occup-travail/empl/eap-pae_e.html
http://www.hc-sc.gc.ca/ewh-semt/occup-travail/empl/eap-pae_f.html

Critical Incident Stress Management Services

http://www.hc-sc.gc.ca/ewh-semt/occup-travail/empl/stress_e.html
http://www.hc-sc.gc.ca/ewh-semt/occup-travail/empl/stress_f.html

Workplace Health

http://www.hc-sc.gc.ca/ewh-semt/pubs/occup-travail/work-travail/index_e.html
http://www.hc-sc.gc.ca/ewh-semt/pubs/occup-travail/work-travail/index_f.html

Inspection Programs

http://hc-sc.gc.ca/hl-vs/travel-voyage/general/inspection/index_e.html
http://hc-sc.gc.ca/hl-vs/travel-voyage/general/inspection/index_f.html

Deratification Programs

http://hc-sc.gc.ca/hl-vs/travel-voyage/general/inspection/deratification-deratisation_e.html
http://hc-sc.gc.ca/hl-vs/travel-voyage/general/inspection/deratification-deratisation_f.html

Program Activity Name:

Pest Control Product Regulation

Expected Results:

- Access to safer pesticides
- Strengthened compliance with *Pest Control Products Act* and Regulations
- Users informed of reduced-risk pesticides
- Transparency of pesticide regulation
- Improved regulatory efficiencies and cost effectiveness
- Informed public and stakeholders

Financial Resources

(MILLIONS OF DOLLARS)

Planned Spending	Authorities	Actual Spending
51.4	55.9	54.6

Human Resources

(FTEs)

Planned	Actual	Difference
642	675	33

Variances between planned spending versus authorities are mainly due to:

- funding for the regulatory system for pesticides
- compensation for salary adjustments

The actual spending is $1.3 million lower than authorities mainly due to:

- year end adjustments of Department of Justice expenditures

To help prevent unacceptable risks to people and the environment, Health Canada regulates, under the *Pest Control Products Act* (PCPA) and Regulations, pesticides that are imported, sold or used in Canada.

All five of the program sub-activities as defined in the Program Activity Architecture consisted of ongoing operations during 2005–2006.

Our main priority was to make the necessary preparations for the coming into force of the new *Pest Control Products Act* (PCPA) that will direct future activities. The new PCPA modernizes the legal framework for pesticide regulation. It provides additional authorities to improve health and environmental protection; make the registration system more transparent; and strengthen post-registration controls and compliance.

The most significant change in the *Act* is the provision for increased transparency and public participation in the pesticide regulatory system. The public will be able to better understand how we arrive at regulatory decisions through access to evaluation reports and scientific studies. Members of the public can now participate in the decision-making process through consultations on major decisions and requests to reconsider decisions or initiate special reviews. Health Canada will also disclose some information when applications are received to register a new pesticide or amend an existing registration. This will allow pesticide users to consider how these new products may be integrated into their pest management strategies.

The Department reached the goals outlined in the 2005–2006 RPP to enable the Government to bring the new *Act* into force, focussing on the significant input from preliminary consultations. Revised Pest

Control Products Regulations were prepublished, the List of Formulants and Contaminants of Concern was published and we developed procedures necessary to implement the new *Act*.

Health Canada established the electronic infrastructure needed to support the legislation, particularly to achieve increased transparency. Our Department created a public registry that will contain extensive information on pesticide activities including applications and registrations, publications, sales information, and adverse effects/incident reports. We also prepared to provide a reading room for Canadians to review the confidential test data submitted by pesticide companies. Finally, to support the new authorities, work began that will lead to review panel regulations and revisions to Agriculture and Agri-Food Administrative Monetary Penalties Regulations.

In addition to the general effort to support implementation of the new *Pest Control Products Act*, Health Canada worked towards this strategic outcome through the five program sub-activities defined in our Program Activity Architecture, all of which represented ongoing activities for us. Ongoing activities under this program activity generated workload pressures for our Department. Those pressures related to factors such as the coming into force of the new legislation; the need for lower risk pest control products; our need to review increasingly complex product applications; commitments to re-evaluate older pesticides and the importance of maintaining the momentum of international cooperation on pest control product regulation.

New Pest Control Product Registration and Decision Making

Our ongoing responsibilities for assessing and registering new products for the Canadian market had many facets. We conducted human health, safety and environmental risk assessments, efficacy and value assessments, established Maximum Residue Limits (MRLs) and made regulatory decisions within specified performance standards on applications to register new pest control products.

Under this program sub-activity, Health Canada drew upon work with other science-based federal departments (Environment Canada, Fisheries and Oceans Canada, Agriculture and Agri-Food Canada, Natural Resources Canada and the Canadian Food Inspection Agency) to improve the co-ordination of pesticide research and regulatory actions, develop risk reduction strategies for the agricultural sector and improve access to specialized pesticides for Canadian growers.

The Department also worked closely with the United States Environmental Protection Agency (USEPA), the Government of Mexico and member countries of the Organization for Economic Co-operation and Development (OECD). All these partners are seeking harmonized approaches for evaluating pesticides and improved efficiencies through expanded international regulatory co-operation. We pursued international joint reviews and work-sharing agreements that contribute to access to new pesticide technologies for Canadians, while maintaining health and environmental protection. Five of the 12 new active ingredients being proposed for use in Canada are now being evaluated jointly with the USEPA or through work-sharing agreements.

Registered Pest Control Product Evaluation and Decision Making

The Department has an ongoing responsibility to determine if older pesticides that have been approved for Canadian use meet modern safety standards. As part of this, Health Canada re-evaluated older pesticides on the basis of updated data and information, to determine whether, and under what conditions, their continued registration was acceptable in meeting modern safety standards. In the past year, we made 30 re-evaluation decisions, bringing our cumulative totals to 136 finalized decisions, 32 proposed decisions and 44 decisions pending publication. Consistent with the international collaboration described above, up to 80 percent of our decisions on the re-evaluations of older pesticides are based on USEPA science-based risk assessments. We also developed post-registration controls to be used under the new PCPA, such as regulations requiring pesticide companies to report adverse effects and incidents related to their pesticides and those requiring registrants to submit pesticide sales data.

Compliance

This past year, we promoted, maintained and enforced compliance with the PCPA through investigations and inspections coordinated with provincial and territorial governments and other federal departments. We conducted 14 inspection programs and 459 investigations. We also worked on four projects: revisions of compliance policy and guidance based on an integrated risk management model; enhancing compliance coordination among the federal, provincial and territorial governments; and development of performance indicators for reporting outcomes of our compliance efforts. Another example of our increasing commitment to international collaboration was preparation for the June 2006 OECD Workshop on Pesticide User Compliance Issues.

Pesticide Risk Reduction

Because Canadians are interested in reducing pesticide use and risks, we continued efforts including sustainable pest management (SPM) approaches. This included the development and implementation of SPM policies, guidelines and partnerships to address SPM opportunities. Our increased emphasis on communications included publication of new documents on pesticide risk reduction and distribution of information on healthy lawn practices.

Regulatory Improvement

During 2005–2006, we pursued initiatives related to information technology, policy development, legislative and regulatory change and communication. These support our commitment to improved performance and transparency with reduced costs, while maintaining a high level of protection of health and the environment.

The Department informed, consulted with, and involved Canadians on pest control product-related issues. We increased communication and engagement with stakeholders such as agricultural groups and other governments with activities, to better understand their pesticide registration concerns.

We recognized that some applicants seeking to register new pesticides would benefit from more guidance on our registration requirements. In response, our Department launched pre-submission consultations and training sessions for potential applicants that help improve submissions. Our broader outreach to Canadians included a Pest Management Information Service that handled 6,157 queries from the public.

STRATEGIC OUTCOME #4:
Better Health Outcomes and Reduction of Health Inequalities between First Nations and Inuit and Other Canadians

Program Activity Name:

First Nations and Inuit Health

Expected Results:

- Strengthened community programs
- Better health protection and improved primary health care
- Access to non-insured health benefits.

Financial Resources

(MILLIONS OF DOLLARS)

Planned Spending	Authorities	Actual Spending
1,863.6	1,942.0	1,927.5

Human Resources

(FTEs)

Planned	Actual	Difference
2,588	2,722	134

Variances between planned spending versus authorities are mainly due to:

- funding for the Territorial Medical Travel Fund
- funding for the Territorial Health Access Fund and Operational Secretariat
- additional funding in support of Aboriginal health further to the Special Meeting of First Ministers and Aboriginal Leaders in September 2004
- funding to enhance Early Learning and Child Care program for First Nations on-reserve
- funding for the Labrador Innu Comprehensive Healing Strategy
- compensation for salary adjustments

The actual spending is $14.5 million lower than authorities mainly due to:

- delays in the Indian Residential Schools Program
- lapse of frozen allotment for transfer to Indian and Northern Affairs to make payments for self government agreements
- year end adjustments of Department of Justice expenditures

The objectives of Health Canada's First Nations and Inuit health program activity are improving health outcomes; ensuring the availability of, and access to, quality health services; and supporting greater control of the health system by First Nations and Inuit.

To achieve these goals, the Department must face many of the same challenges as other Canadian health

providers, such as increasing costs, health human resources shortages and an aging population. The First Nations and Inuit health system has unique challenges due to rapidly growing populations, including a large population under 20 years of age, high rates of illness and injury, and a population living largely in rural and remote areas. Improving First Nations and Inuit health outcomes also requires action on the broader determinants of health, such as economic development, education, housing and culture so that communities can become sustainable, culturally strong and economically viable.

In partnership with First Nations and Inuit, Health Canada provided primary health care services, including home care, in approximately 200 remote communities. We employed directly or funded 761 nurses to deliver health services for more than 600 First Nations communities through nursing stations and community health centres. Our regional offices also delivered community programs that focussed on children and youth, mental health and addictions, chronic diseases, environmental health, and disease prevention and management. These services supplemented and supported services that provincial, territorial and regional health authorities provided.

Under this program activity, Health Canada had one ongoing sub-activity, as defined in the Program Activity Architecture.

Non-Insured Health Benefits for First Nations and Inuit

Non-Insured Health Benefits (NIHB) coverage of drugs, dental care, vision care, medical supplies and equipment, short-term crisis intervention mental health services, and medical transportation was available to approximately 765,000 registered Indians and recognized Inuit in Canada, regardless of residency. Health care premiums are also paid on behalf of First Nations and Inuit in Alberta and British Columbia.

Non-Insured Health Benefits
http://www.hc-sc.gc.ca/fnih-spni/nihb-ssna/index_e.html http://www.hc-sc.gc.ca/fnih-spni/nihb-ssna/index_f.html

NIHB Annual Report
http://www.hc-sc.gc.ca/fnih-spni/pubs/nihb-ssna_e.html http://www.hc-sc.gc.ca/fnih-spni/pubs/nihb-ssna_f.html

Financial Resources

(MILLIONS OF DOLLARS)

Planned Spending	Authorities	Actual Spending
925.3	925.3	925.3

In addition to the above ongoing responsibility, the Department worked towards this strategic outcome through four other program sub-activities in our Program Activity Architecture.

First Nations and Inuit Community Health Programs

Financial Resources

(MILLIONS OF DOLLARS)

Planned Spending	Authorities	Actual Spending
209.3	296.1	296.1

Community Programs support community-based and community-delivered programs that aim to improve health outcomes and reduce health risks in three targeted areas: Children and Youth; Chronic Disease and Injury Prevention; and Mental Health and Addictions.

Children and youth programs and services improve the health of mothers, infants and families and support the development of children in an effort to address the gap in health status between Aboriginal and non-Aboriginal children. The Department delivers services that aim to reduce the rate of type-2 diabetes and other chronic diseases as well as injuries among Aboriginal people to levels consistent with other Canadians. Health Canada also delivers services to improve mental health outcomes of First Nations and Inuit.

Funding announced in 2004 helped to enhance Health Canada's growing continuum of services that support Aboriginal mothers, children and families from before pregnancy to the time a child enters school. In 2005–2006, the Department, through the Aboriginal Head Start On-Reserve (AHSOR) program, continued to create new sites, expand existing ones and purchase new equipment and supplies in order to serve more children and families. It is anticipated that this will result in approximately 750 new AHSOR spaces and about 25 new community projects. Health Canada, Human Resources and Social Development Canada and Indian and Northern Affairs Canada (INAC) worked together to identify and prioritize capital and training needs for the co-location of AHSOR sites with those funded through the First Nations and Inuit Child Care Initiative.

In order to assist in capacity building among First Nations, we promoted the Environmental Health Officer Program at the New Brunswick Community College (NBCC) to Francophone First Nations in Quebec. We worked with the Conseil d'Éducation des Premières Nations (CEPN) to develop a promotion strategy. A more intense strategy that utilizes synergies with First Nations education organizations will be used to better cover the target population.

Through the Canada Prenatal Nutrition Program — First Nations and Inuit Component, we developed educational tools and resources to help program workers enhance service delivery to mothers and children. In addition, a plan to improve program delivery in the North was created with partners.

Drawing on lessons learned from previous programming, the Fetal Alcohol Spectrum Disorder (FASD) program evolved from its former focus on education and awareness to one of capacity building, prevention and intervention. This was primarily achieved through development and implementation of approximately 30 community-based Mentorship Programs, of which one-third are already delivering services.

Health Canada also developed and began implementing the Maternal Child Health (MCH) program, which will provide home visits, case management, and increased access to health promotion services for pregnant First Nations women and families with infants and/or young children who live on-reserve. In the North, the MCH program will enhance existing health promotion programs

for Inuit and other Aboriginal people. Planning took place in 2005–2006 with plans to introduce the program in between five and ten communities per Health Canada region in 2006–2007.

Preparations for the enhancement of the Aboriginal Diabetes Initiative (ADI) took place in 2005–2006 while programming was maintained in more than 600 communities. Our Department began baseline data collection that will enable us to measure the impact of the enhanced ADI. Increased expertise on nutrition and physical activity was used to strengthen the emphasis on behaviour change in local ADI programming. Health Canada embarked on summer and winter public education and mobilization campaigns and developed education and resource materials and tools to support effective diabetes programming. Further, the competencies of diabetes lay workers were identified and educational institutions were engaged to train workers. At least 40 to 60 workers will be trained in 2006–2007.

In partnership with the Nova Scotia Government, Indian and Northern Affairs Canada, and the Nova Scotia First Nations Chiefs, we supported the Mi'kmaq Youth, Recreation and Active Circle of Living (MYRACL) initiative that promotes physical activity in 13 Nova Scotia First Nations communities. We helped develop a toolkit and an Aboriginal role model package that can be used by community health staff to promote active living and healthy eating among children and youth.

In 2005–2006, Health Canada, through the First Nations and Inuit Tobacco Control Strategy (FNITCS), funded more than 200 community-based projects. These continued to increase awareness of the harms of tobacco misuse and second-hand smoke. The projects consisted of youth initiatives, community advisories and capacity training for health and cessation workers. A social marketing campaign was developed, which consisted of television and radio ads, fact sheets, facilitator guides and presentations for people wanting to quit smoking.

Aboriginal Head Start On-Reserve

http://www.hc-sc.gc.ca/fnih-spni/famil/develop/ahsor-papa_intro_e.html
http://www.hc-sc.gc.ca/fnih-spni/famil/develop/ahsor-papa_intro_f.html

Fetal Alcohol Spectrum Disorder

http://www.hc-sc.gc.ca/fnih-spni/famil/preg-gros/intro_e.html
http://www.hc-sc.gc.ca/fnih-spni/famil/preg-gros/intro_f.html

Aboriginal Diabetes Initiative

http://www.hc-sc.gc.ca/fnih-spni/diseases-maladies/diabete/index_e.html
http://www.hc-sc.gc.ca/fnih-spni/diseases-maladies/diabete/index_f.html

Injury Prevention

http://www.hc-sc.gc.ca/fnih-spni/promotion/injury-bless/index_e.html
http://www.hc-sc.gc.ca/fnih-spni/promotion/injury-bless/index_f.html

Indian Residential Schools — Mental Health Support
http://www.hc-sc.gc.ca/fnih-spni/services/indiresident/index_e.html http://www.hc-sc.gc.ca/fnih-spni/services/indiresident/index_f.html

National Native Alcohol and Drug Abuse Program
http://www.hc-sc.gc.ca/fnih-spni/substan/ads/nnadap-pnlaada_e.html http://www.hc-sc.gc.ca/fnih-spni/substan/ads/nnadap-pnlaada_f.html

First Nations and Inuit Tobacco Control Strategy
http://www.hc-sc.gc.ca/fnih-spni/substan/tobac-tabac/index_e.html http://www.hc-sc.gc.ca/fnih-spni/substan/tobac-tabac/index_f.html

First Nations and Inuit Health Protection

Financial Resources

(MILLIONS OF DOLLARS)

Planned Spending	Authorities	Actual Spending
69.4	71.6	65.4

Health Canada's work with the provinces and First Nations communities supports public health services on-reserve: communicable disease control and surveillance; immunization; environmental health services (drinking water testing, public health inspections of buildings, drinking water systems, and food). In the absence of federal public health legislation that applies to reserves, the Department tries to ensure that standards applied on reserves are generally equivalent to those found in the surrounding jurisdictions.

In the 2003 federal budget, $605 million was allocated over five years to implement the First Nations Water Management Strategy, of which $116 million was designated for upgrading, maintaining and monitoring water and waste water systems on reserves. Health Canada used these resources to raise the frequency of drinking water quality monitoring in First Nations communities to nationally recommended standards, to increase the number of First Nations communities with on-site sampling and testing kits and to provide training to increase First Nations communities' capacity to sample and test drinking water quality. Over the past year, 546 communities trained community-based water monitors. This was an increase of nine percent over the previous year. As well, 538 communities had access to portable laboratory kits for testing. Sixteen qualified Environmental Health Officers (EHOs) were hired to assist with drinking water quality monitoring.

As a result of our involvement with the Manitoba Institute for Patient Safety (MIPS) and the Canadian Patient Safety Institute, a Regional Patient Safety Committee in Manitoba and within the First Nations and Inuit Health Branch was created to liaise with Manitoba Health, the Regional Health Authorities, First Nations, MIPS and other health care stakeholders on issues to enhance patient safety for the on-reserve clientele.

The events at Kashechewan, Ontario in October 2005 demonstrated that Health Canada's Drinking Water Safety Program was able to quickly identify contamination in drinking water and advise First Nations communities in order to prevent outbreaks of water-borne illness. The results of health assessments of Kashechewan community members did not indicate the presence of a water-borne illness. However, the assessments did point to the need for increased co-ordination between First Nations communities and the Government of Canada to address underlying problems that may lead to drinking water contamination.

The Department's National First Nations Environmental Contaminants Program funded seven community-based environmental research projects. Funding was also allocated to six human health research projects under the Northern Contaminants Program. Also, 20 training sessions on the Transportation of Dangerous Goods were delivered to Health Canada and Band employees working in the Department's facilities on-reserve. These activities contributed to a reduction in the risk of exposure to environmental hazards in First Nations and Inuit communities and improved community capacity to manage, contain and control those hazards.

To help increase immunization coverage rates for on-reserve children and reduce the incidence of vaccine-preventable diseases and related complications, Health Canada added three vaccines (meningococcal conjugate, pneumococcal conjugate and varicella vaccine) to our routine immunizations of on-reserve populations. We also acted on results of a study that assessed transportation, storage and temperature levels for vaccines. The Department developed vaccine management checklists and tools for health facility staff and public awareness materials concerning the importance of immunization.

In 2005–2006, the Department worked with Aboriginal AIDS organizations in prevention, education and awareness initiatives for First Nations communities. New efforts included updating the HIV/AIDS nursing guidelines for registered nurses working on First Nations reserves, and support for the planning and co-ordination of the International Indigenous Peoples' Satellite, an event to be held in conjunction with the International AIDS Conference in Toronto in August 2006. Health Canada, in partnership with the Public Health Agency of Canada (PHAC), also supported the National Advisory Committee on HIV/AIDS, an advisory body providing policy advice to Health Canada, PHAC and other relevant stakeholders about HIV/AIDS and related issues among Aboriginal peoples in Canada. We also supported the Assembly of First Nations with its HIV/AIDS activities and the Canadian Aboriginal AIDS Network to implement Aboriginal AIDS Awareness Week.

The PHAC coordinates national surveillance and response to West Nile virus (WNv). The Agency works closely with Health Canada on the safety of the blood supply and on providing information and health advice to First Nations groups and federal employees. In 2005–2006, Health Canada distributed public education materials in all First Nations communities and provided education sessions on request. We also provided WNv bird and human surveillance in all First Nations communities, and mosquito surveillance in 80 communities in order to identify in a timely manner those communities at high risk of transmission to humans. Health Canada funded the application of insecticides in six First Nations communities in order to reduce the number of mosquitoes that could potentially transmit WNv to humans.

Communicable Disease Control

http://www.hc-sc.gc.ca/ahc-asc/branch-dirgen/fnihb-dgspni/phcphd-dsspsp/cdcd-dcmt/index_e.html
http://www.hc-sc.gc.ca/ahc-asc/branch-dirgen/fnihb-dgspni/phcphd-dsspsp/cdcd-dcmt/index_f.html

Environmental Health

http://www.hc-sc.gc.ca/ahc-asc/branch-dirgen/fnihb-dgspni/phcphd-dsspsp/ehd-dse/index_e.html
http://www.hc-sc.gc.ca/ahc-asc/branch-dirgen/fnihb-dgspni/phcphd-dsspsp/ehd-dse/index_f.html

Drinking Water Quality

http://www.hc-sc.gc.ca/fnih-spni/promotion/water-eau/index_e.html
http://www.hc-sc.gc.ca/fnih-spni/promotion/water-eau/index_f.html

Immunization Schedule for Infants and Children

http://www.phac-aspc.gc.ca/im/is-cv/index.html
http://www.phac-aspc.gc.ca/im/is-cv/index_f.html

Targeted Immunization (TIS) Program

http://www.hc-sc.gc.ca/ahc-asc/activit/strateg/fnih-spni/immuni_e.html
http://www.hc-sc.gc.ca/ahc-asc/activit/strateg/fnih-spni/immuni_f.html

First Nations and Inuit Primary Health Care

Financial Resources

(MILLIONS OF DOLLARS)

Planned Spending	Authorities	Actual Spending
244.1	252.0	245.8

Comprehensive health care services are provided to remote and/or isolated First Nations and Inuit settlements to supplement and support primary, emergency and acute care services provided by provincial, territorial and/or regional health authorities. Health Canada also ensures links to appropriate care by other health care providers and/or institutions. The continuum of community health care and primary care services includes illness and injury prevention and health promotion activities.

Health Canada's First Nations and Inuit Home and Community Care (FNIHCC) program has enabled the creation of home care services in approximately 92 percent of First Nations and Inuit communities. Part two of a three-part evaluation of FNIHCC was completed, with the series to be finalized in spring 2007 to assist us in improving home and continuing care. The first phase of work with the INAC Assisted Living program and First Nations and Inuit partners to identify gaps ended with completion of a major research project in 2006. Using this research as evidence, work began on the final phase - development of a continuing care policy framework that could address these gaps.

Governance and Infrastructure Support to First Nations and Inuit Health System

Financial Resources

(MILLIONS OF DOLLARS)

Planned Spending	Authorities	Actual Spending
415.5	396.9	394.9

Governance and infrastructure activities aim to increase First Nations and Inuit control over health programs and services and the capacity to generate and use health information and knowledge. These activities include health planning, capacity building of First Nations and Inuit communities to manage and deliver health programs and services, integration and co-ordination of health services, stewardship and health research, knowledge and information management.

Through 2005–2006, we worked with our federal, provincial, territorial and Aboriginal partners on various partnership initiatives as well as ongoing consultation intended to improve health outcomes, ensure access to quality services, and support greater control of the health system by Aboriginal people.

During 2005–2006, Health Canada proceeded with implementation of the Aboriginal Health Transition Fund (AHTF). The AHTF is designed to improve access to and quality of health services for all Aboriginal people through better adaptation and integration of federal, provincial and territorial programs and services. These include public health, and programs in community-based care such as maternal child services, mental health, and chronic disease management. Major activities in 2005–2006 included establishment of the AHTF Secretariat, engagement with First Nations and Inuit communities and regional organizations, planning with National Aboriginal Organizations, and initial discussions with provinces and territories regarding implementation of the AHTF. Contribution agreements with National Aboriginal Organizations enabled them to conduct preliminary work in support of implementation.

Health Canada's Aboriginal Health Human Resources Initiative (AHHRI) aimed to increase the number of Aboriginal people choosing health care professions; to adapt current health professional curricula to provide a more culturally sensitive focus; and to improve retention of health workers serving Aboriginal peoples. In April 2005, Health Canada held a national stakeholder consultation to seek agreement on issues and priorities with respect to Aboriginal health human resources. Subsequent bilateral discussions with National Aboriginal Organizations, provincial and territorial ministries, and other partners, led to creation of AHHRI Strategic Framework. As a result, partnerships were formed that built on work already begun under the Pan-Canadian Health Human Resources Strategy.

In 2005–2006, we provided funding to the Assembly of First Nations, Inuit Tapiriit Kanatami, Métis National Council, Congress of Aboriginal Peoples and Native Women's Association of Canada to develop health indicator frameworks. Through the year and into 2006–2007, Health Canada worked with others to improve data collection and analysis in the area of infant mortality and other vital statistics.

Through work with the National Aboriginal Achievement Foundation, the Department was able to more than double the amount of funding available to Aboriginal post-secondary health career students, improve the process for awarding bursaries and scholarships, and increase the number of students entering these careers. Work on improving educational curricula for medical students was also begun, to ensure that medical students receive training on how to provide culturally safe care to Aboriginal people.

Health Canada continued to implement the comprehensive Nursing Transformation Strategy in order to improve quality, accessibility and integration of health

services. Through $55.4 million committed over the next three years, we were able to staff front line, clinical specialist and nurse manager positions.

Health Canada's Health Facilities and Capital Program continued to support construction, operation and maintenance of on-reserve health facilities and nurse residences. In 2005–2006, we built and/or expanded 27 health facilities and 10 residential units, which contributed to improved living and working conditions for our nursing staff. We also repaired, upgraded and replaced building systems to improve safety and operating efficiency at Health Canada health facilities and nurse residences. These projects included fuel distribution system upgrades, furnace and heating system repairs, installation of efficient lighting systems, and remediation for problems associated with waste water, mold, indoor air quality and air emissions.

Environmental management and sustainable development principles were integrated into the Health Facilities and Capital Program, the Environmental Health and Research Program and other program areas through our Environmental Compliance Audits in 2005–2006. Specifically, 46 Environmental Compliance Audits and Phase One Environmental Site Assessments were conducted at National Native Alcohol and Drug Abuse Program (NNADAP) treatment centres. An asbestos materials survey was conducted at 19 nursing stations in response to concerns raised in the 2004–2005 Environmental Compliance Audits and Phase One Environmental Site Assessments. A comprehensive microbial investigation was completed in 39 nursing stations and NNADAP treatment centres. These led to preventative and remedial measures benefiting the health and safety of building occupants and the surrounding environment. They also met a commitment in Health Canada's Sustainable Development Strategy 2004–2007 and demonstrated continued dedication to a commitment made in the previous Health Canada Sustainable Development Strategy (2000–2004).

The Department demonstrated innovative practices in delivering health care in remote First Nations and Inuit communities by supporting installation of telehealth sites. In 2005–2006, we worked to improve access to broadband Internet connectivity in partnership with the provinces, First Nations and other federal departments such as Industry Canada and Indian and Northern Affairs Canada. These improved connections enable essential access to e-mail, Internet, telehealth, online reporting and e-learning applications for community health professionals. We also funded regional First Nations telehealth information sharing workshops and creation of the Aboriginal Telehealth Knowledge Circle (ATKC), a not-for-profit Aboriginal association with telehealth expertise. These promoted adoption of telehealth technologies by community health practitioners to access more timely treatments and reduce family and community disruption through delivery of in-community services.

Health Canada's Sustainable Development Strategy 2004–2007

http://www.hc-sc.gc.ca/ahc-asc/alt_formats/hecs-sesc/pdf/pubs/sus-dur/strateg/sds2004-2007-sdd/sds2004-2007-sdd_e.pdf
http://www.hc-sc.gc.ca/ahc-asc/alt_formats/hecs-sesc/pdf/pubs/sus-dur/strateg/sds2004-2007-sdd/sds2004-2007-sdd_f.pdf

e-Health

http://www.hc-sc.gc.ca/fnih-spni/services/ehealth-esante/index_e.html
http://www.hc-sc.gc.ca/fnih-spni/services/ehealth-esante/index_f.html

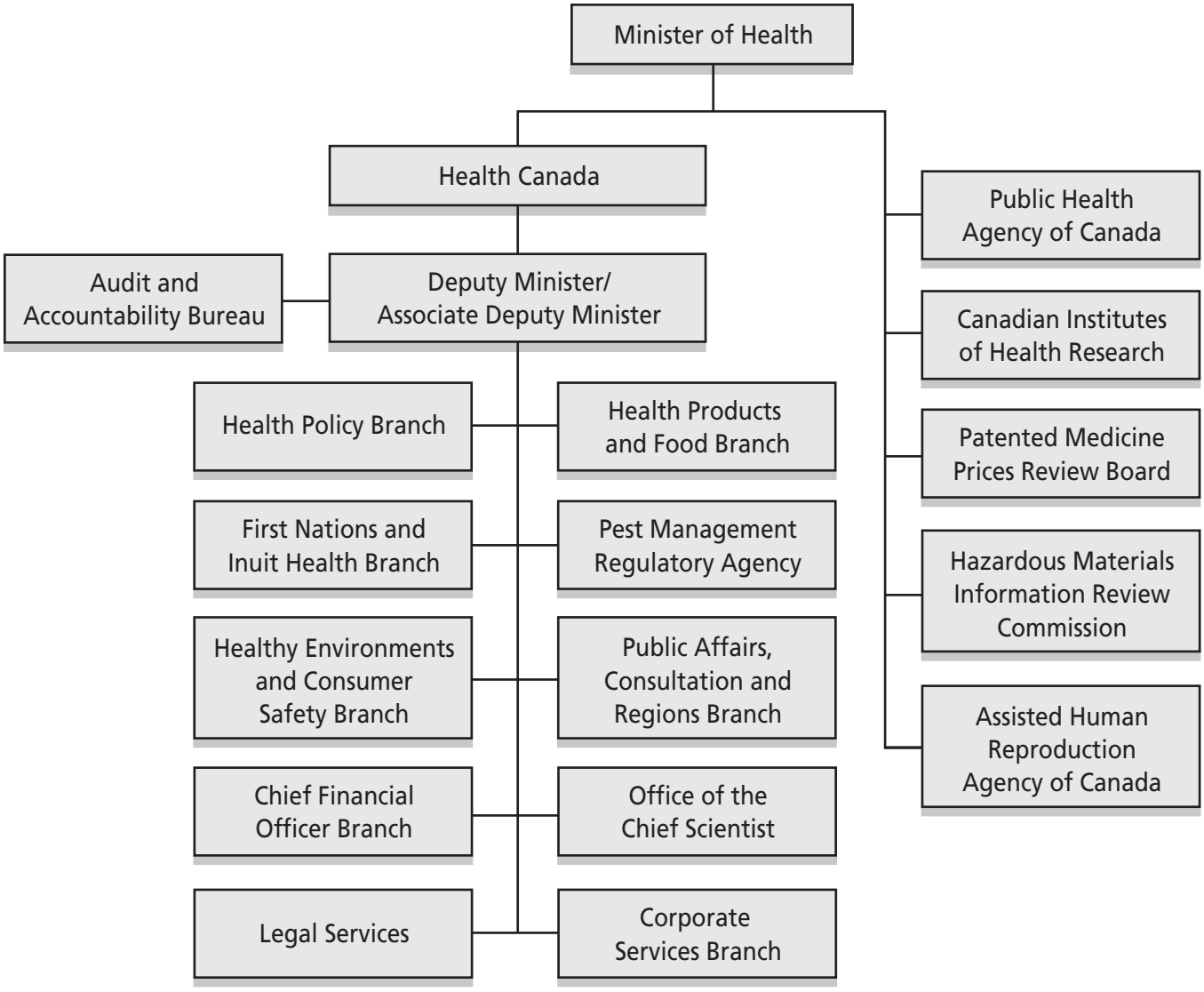
Aboriginal Health Human Resources Initiative

http://www.hc-sc.gc.ca/ahc-asc/activit/strateg/fnih-spni/ahhri-irrhs_e.html
http://www.hc-sc.gc.ca/ahc-asc/activit/strateg/fnih-spni/ahhri-irrhs_f.html

Section III

Supplementary Information

ORGANIZATIONAL CHART



Health Canada also contributes grants and contributions to several health organizations such as Infoway, Canadian Institute for Health Information and Canadian Health Services Research Foundations.

1 TABLE 1:
Comparison of Planned to Actual Spending (incl. FTEs)

This table offers a comparison of the Main Estimates, Planned Spending, Total Authorities and Actual Spending for the recently completed fiscal year, as well as historical figures for Actual Spending.

The $23.2 million increase from Main Estimates to Planned Spending is due to anticipated funding for such initiatives as Health Canada's response to Bovine Spongiform Encephalopathy (BSE), Access to Medicines Program, Federal Initiative to address HIV/AIDS, and Assisted Human Reproduction.

The $80.2 million increase from Planned Spending to Total Authorities is due to new program initiatives and sustainability funding which is usually received through Supplementary Estimates however, in 2005–06 was supported through the Governor General Special Warrants exercise.

The $67.1 million difference between Total Authorities and Actual Spending is mainly the result of:

- lapse in the Health Council special purpose allotment;
- delays in Indian Residential Schools Program;
- frozen allotment which includes:
  - Primary Health Care Transition Fund Reprofile
  - Drug Treatment Court Funding Reprofile
  - Departmental Savings — Expenditure Review
- year end adjustments of Department of Justice (DOJ) expenditures.

TABLE 1:

Comparison of Planned to Actual Spending (incl. FTEs) *(continued)*

(MILLIONS OF DOLLARS)

PROGRAM ACTIVITIES	2003–2004	2004–2005	2005–2006			
	Actual Spending (1)	Actual Spending (1)	Main Estimates	Planned Spending (2)	Total Authorities (3)	Actual Spending (3)
Health Policy, Planning and Information	347.1	385.9	448.4	456.3	416.6	375.1
Health Products and Food	561.7	261.5	221.1	234.0	260.7	256.9
Healthy Environments and Consumer Safety	614.4	289.9	272.6	273.7	284.0	277.9
Pest Control Product Regulation	44.8	59.3	51.3	51.4	55.9	54.6
First Nations and Inuit Health	1,733.1	1,820.0	1,862.3	1,863.6	1,942.0	1,927.5
Total	**3,301.2**	**2,816.6**	**2,855.7**	**2,878.9**	**2,959.1**	**2,892.0**
Less: Non-Respendable Revenue	-56.0	-51.3	0.0	-8.9	-8.9	-19.8
Plus: Cost of services received without charge (4)	89.5	58.9	0.0	76.5	76.5	85.6
Net cost of Department	**3,334.7**	**2,824.2**	**2,855.7**	**2,946.5**	**3,026.7**	**2,957.8**
Full Time Equivalents	**8,119**	**8,026**	**8,018**	**8,123**	**8,421**	**8,544**

(1) Calculation of these amounts are estimated due to the change in reporting structure from Business Line to Program Activity. However, the total number for the department is accurate.

(2) from the 2005–2006 Report on Plans and Priorities

(3) from the 2005–2006 Public Accounts

(4) Services received without charge include accommodation provided by PWGSC, the employer's share of employees' insurance premiums, Workers' Compensation coverage provided by Social Development Canada, and services received from the Department of Justice.

This table excludes amounts related to the Public Health Agency of Canada (PHAC).

2 TABLE 2:

Resources by Program Activity

(MILLIONS OF DOLLARS)

This table reflects how resources are used within Health Canada by appropriation and by program activity.

2005–2006							
	BUDGETARY						
PROGRAM ACTIVITIES	Operating	Capital	Grants	Contributions and Other Transfer Payments	Total Gross Expenditures	Less: Respendable Revenues	Total Net Expenditures
Health Policy, Planning and Information							
(Main Estimates)	95.3		56.4	296.7	448.4		448.4
(Planned Spending)	102.3		57.2	296.7	456.3		456.3
(Total Authorities)	86.0		61.6	268.9	416.6		416.6
(Actual Spending)	84.2		54.6	236.3	375.1		375.1
Health Products and Food							
(Main Estimates)	251.0	1.4	5.9	4.0	262.3	-41.2	221.1
(Planned Spending)	263.9	1.4	5.9	4.0	275.2	-41.2	234.0
(Total Authorities)	290.8	1.4	5.5	4.1	301.9	-41.2	260.7
(Actual Spending)	283.6	1.4	5.5	4.1	294.6	-37.7	256.9
Healthy Environments and Consumer Safety							
(Main Estimates)	236.8	1.0	3.1	46.9	287.8	-15.2	272.6
(Planned Spending)	237.9	1.0	3.1	46.9	288.9	-15.2	273.7
(Total Authorities)	253.9	1.0	1.4	42.9	299.2	-15.2	284.0
(Actual Spending)	245.5	1.0	1.2	42.3	289.9	-12.0	277.9
Pest Control Product Regulation							
(Main Estimates)	58.3				58.3	-7.0	51.3
(Planned Spending)	58.4				58.4	-7.0	51.4
(Total Authorities)	62.8				62.8	-7.0	55.9
(Actual Spending)	60.4				60.4	-5.9	54.6

2 TABLE 2:

Resources by Program Activity *(continued)*

(MILLIONS OF DOLLARS)

2005–2006							
	BUDGETARY						
PROGRAM ACTIVITIES	Operating	Capital	Grant	Contributions and Other Transfer Payments	Total Gross Expenditures	Less: Respendable Revenues	Total Net Expenditures
First Nations and Inuit Health							
(Main Estimates)	1,077.5	1.5	0.0	788.8	1,867.7	-5.5	1,862.3
(Planned Spending)	1,078.6	1.5	0.0	788.9	1,869.0	-5.5	1,863.6
(Total Authorities)	1,082.8	1.5	30.0	833.1	1,947.5	-5.5	1,942.0
(Actual Spending)	1,072.6	1.5	30.0	826.8	1,930.8	-3.4	1,927.5
Total							
(Main Estimates)	1,718.9	3.9	65.4	1,136.4	2,924.6	-68.9	2,855.7
(Planned Spending)	1,741.1	3.9	66.2	1,136.6	2,947.8	-68.9	2,878.9
(Total Authorities)	1,776.4	3.9	98.6	1,149.1	3,028.0	-68.9	2,959.1
(Actual Spending)	1,746.2	3.9	91.3	1,109.5	2,950.9	-58.9	2,892.0

More detailed explanations on all program activities can be found in Section II: Analysis of Performance by Strategic Outcome.

3 TABLE 3:

Voted and Statutory Items

(MILLIONS OF DOLLARS)

		2005–2006			
VOTE OR STATUTORY ITEM	**TRUNCATED VOTE OR STATUTORY WORDING**	Main Estimates	Planned Spending (1)	Total Authorities (2)	Actual Spending (2)
	Health Canada				
1	Operating expenditures	1,552.6	1,573.4	1,601.7	1,581.7
5	Grants and contributions	1,201.8	1,201.8	1,247.7	1,200.8
(S)	Minister's salary and car allowance	0.1	0.1	0.1	0.1
(S)	Payments for insured health services and extended health care services	–	–	0.0	0.0
(S)	Spending of proceeds from the disposal of surplus Crown assets	–	–	0.4	0.1
(S)	Refunds from previous year's revenue	–	–	0.1	0.1
(S)	Collection agency fees	–	–	0.0	0.0
(S)	Court awards	–	–	0.1	0.1
(S)	Contributions to employee benefit plans	101.2	102.7	109.1	109.1
	Total Department	**2,855.7**	**2,878.9**	**2,959.1**	**2,892.0**

(1) from the 2005–2006 Report on Plans and Priorities

(2) from the 2005–2006 Public Accounts

(S) indicates expenditures the Department is required to make that do not require an appropriation act.

4 TABLE 4:

Services Received without Charge

(MILLIONS OF DOLLARS)

	2005–2006
Accommodation provided by Public Works and Government Services Canada	34.5
Contributions covering employer's share of employees' insurance premiums and expenditures paid by Treasury Board Secretariat	48.2
Workers' compensation coverage provided by Social Development Canada	0.9
Salary and associated expenditures of legal services provided by the Department of Justice Canada	2.0
Total Services Received without Charge	**85.6**

5 TABLE 5:

Sources of Respendable and Non-Respendable Revenue

Reflected in this table is the collection of respendable revenues by program activity/branch and of non-respendable revenues by classification and source.

Respendable revenues refers to funds collected for user fees or for the recovery of the cost of departmental services. These revenues include those both external and internal to the government, the majority being external.

A variety of respendable revenues are collected which include Medical Devices, Radiation Dosimetry, Drug Submission Evaluation, Veterinary Drugs, Pest Management Regulation, Product Safety, hospital revenues resulting from payments for services provided to First Nations and Inuit Health hospitals, which are covered under provincial or territorial plans, and for the sale of drugs and health services for First Nations communities.

Non-respendable revenues are shown by source in order to reflect the information in a useful format. The Department is not allowed to respend these revenues.

5 TABLE 5:

Sources of Respendable and Non-Respendable Revenue *(continued)*

(MILLIONS OF DOLLARS)

	2003–2004	2004–2005	2005–2006			
	Actual Revenues (1)(2)	Actual Revenues (1)	Main Estimates	Planned Revenues	Total Authorities	Actual Revenues
RESPENDABLE REVENUES Program Activity/Branch						
Health Products and Food Health Products and Food Branch	34.6	35.1	41.2	41.2	41.2	37.7
Healthy Environments and Consumer Safety Healthy Environments and Consumer Safety Branch	8.7	10.6	15.2	15.2	15.2	12.0
Pest Control Product Regulation Pest Management Regulatory Agency	6.6	6.1	7.0	7.0	7.0	5.9
First Nations and Inuit Health First Nations and Inuit Health Branch	3.5	4.0	5.5	5.5	5.5	3.4
Total Respendable Revenues	**53.4**	**55.8**	**68.9**	**68.9**	**68.9**	**58.9**
NON-RESPENDABLE REVENUES Main Classification and Source						
Non-tax revenues:						
Refunds of expenditures	43.9	41.8				10.0
Sales of goods and services	6.1	2.5				2.6
Other fees and charges	5.8	6.8		8.9	8.9	7.0
Proceeds from the disposal of surplus Crown assets	0.2	0.2				0.2
Miscellaneous non-tax revenues	0.0	0.0				0.0
Total Non-Respendable Revenues	**56.0**	**51.3**	**0.0**	**8.9**	**8.9**	**19.8**
Total Revenues	**109.4**	**107.1**	**68.9**	**77.8**	**77.8**	**78.7**

(1) Excludes amounts related to the Public Health Agency of Canada (PHAC).

(2) Actual Revenues not comparable to previous DPR Revenues because of a change in reporting structure from Planning, Reporting and Accountability Structure (PRAS) to Program Activity Structure (PAA). These amounts are estimated based on the most appropriate crosswalk.

6 TABLE 6:

Resource Requirements by Branch

Comparison of Main Estimates, 2005–2006 (RPP) planned spending and total authorities to actual spending by organization and program activity.

(MILLIONS OF DOLLARS)	PROGRAM ACTIVITY					
ORGANIZATION	Health Policy, Planning and Information	Health Products and Food	Healthy Environments and Consumer Safety	Pest Control Product Regulation	First Nations and Inuit Health	**TOTAL**
Health Policy						
(Main Estimates)	424.4					424.4
(Planned Spending)	432.2					432.2
(Total Authorities)	385.6					385.6
(Actual Spending)	**344.7**					**344.7**
Health Products and Food						
(Main Estimates)		171.8				171.8
(Planned Spending)		184.2				184.2
(Total Authorities)		201.7				201.7
(Actual Spending)		**199.4**				**199.4**
Healthy Environments and Consumer Safety						
(Main Estimates)			222.9			222.9
(Planned Spending)			223.6			223.6
(Total Authorities)			224.4			224.4
(Actual Spending)			**219.9**			**219.9**
Pest Management Regulatory Agency						
(Main Estimates)				40.2		40.2
(Planned Spending)				40.2		40.2
(Total Authorities)				42.2		42.2
(Actual Spending)				**41.3**		**41.3**
First Nations and Inuit Health						
(Main Estimates)					1,756.7	1,756.7
(Planned Spending)					1,757.3	1,757.3
(Total Authorities)					1,798.1	1,798.1
(Actual Spending)					**1,786.4**	**1,786.4**

The Public Affairs, Consultation and Regions Branch was not operational until summer, 2006 and thus is not reported separately.

6 TABLE 6:

Resource Requirements by Branch *(continued)*

Comparison of Main Estimates, 2005–2006 (RPP) planned spending and total authorities to actual spending by organization and program activity.

(MILLIONS OF DOLLARS)	PROGRAM ACTIVITY					
ORGANIZATION	Health Policy, Planning and Information	Health Products and Food	Healthy Environments and Consumer Safety	Pest Control Product Regulation	First Nations and Inuit Health	**TOTAL**
Chief Financial Officer						
(Main Estimates)	3.3	8.2	8.6	2.0	15.2	37.2
(Planned Spending)	3.3	8.3	8.7	2.0	15.3	37.6
(Total Authorities)	3.5	8.7	9.1	2.1	16.0	39.4
(Actual Spending)	**3.4**	**8.5**	**8.9**	**2.1**	**15.7**	**38.5**
Corporate Services						
(Main Estimates)	14.0	22.6	22.5	5.0	38.9	103.0
(Planned Apending)	14.1	22.8	22.7	5.1	39.3	104.0
(Total Authorities)	19.8	29.6	29.8	6.9	51.3	137.3
(Actual Spending)	**19.4**	**28.5**	**28.7**	**6.6**	**49.4**	**132.7**
Departmental Executive						
(Main Estimates)	6.7	18.6	18.6	4.1	51.6	99.5
(Planned Spending)	6.7	18.7	18.6	4.1	51.7	99.7
(Total Authorities)	7.6	20.8	20.8	4.6	76.6	130.4
(Actual Spending)	**7.5**	**20.5**	**20.5**	**4.6**	**76.0**	**129.1**
Total						
(Main Estimates)	448.4	221.1	272.6	51.3	1,862.3	2,855.7
(Planned Spending)	456.3	234.0	273.7	51.4	1,863.6	2,878.9
(Total Authorities)	416.6	260.7	284.0	55.9	1,942.0	2,959.1
(Actual Spending)	**375.1**	**256.9**	**277.9**	**54.6**	**1,927.5**	**2,892.0**
% of Total	**13.0%**	**8.9%**	**9.6%**	**1.9%**	**66.6%**	**100.0%**

7A TABLE 7A:
User Fees Act

Health Products and Food Branch (HPFB)

				2005–06					PLANNING YEARS		
User Fee	Fee Type	Fee Setting Authority	Date Last Modified	Forecast Revenue ($000)	Actual Revenue ($000)	Full Cost ($000)	Performance Standard	Performance Results	Fiscal Year	Forecast Revenue ($000)	Estimated Full Cost ($000)
Authority to Sell Drugs Fees	Regulatory (R)	Financial Administration Act (FAA)	Dec. 1994	7,985	7,965	26,416	120 calendar days to update the Drug Product Database following notification	98% within target	2006–07 2007–08 2008–09	8,039 8,094 8,100	27,119 27,840 28,581
Certificate of a Pharmaceutical Product (Drug Export) Fees	Other (O)	Ministerial authority to enter into contract	May 2000	120	127	354	5 working days	7 working days 90% of the time	2006–07 2007–08 2008–09	120 122 123	363 373 383
Drug Establishment Licensing Fees	R	FAA	Dec. 1997	5,031	5,376	8,167	150 to 250 days to renew(1)	200 days for renewals 90% of the time	2006–07 2007–08 2008–09	5,141 5,195 5,200	8,385 8,608 8,837
Drug Master File Fees	O	Ministerial authority to enter into contract	Jan. 1996	98	144	367	30 calendar days	87% within target	2006–07 2007–08 2008–09	150 151 153	377 387 397

(1) Further consultation on service standards is being planned.

7A TABLE 7A:
User Fees Act *(continued)*

Health Products and Food Branch

				2005–06					PLANNING YEARS		
User Fee	Fee Type	Fee Setting Authority	Date Last Modified	Forecast Revenue ($000)	Actual Revenue ($000)	Full Cost ($000)	Performance Standard	Performance Results	Fiscal Year	Forecast Revenue ($000)	Estimated Full Cost ($000)
Drug Submission Evaluation Fees – **Pharmaceuticals & Biological Products**	R	FAA	Aug. 1995	18,584	18,723	62,271	See separate headings under Pharmaceuticals & Biological Products	See separate headings under Pharmaceuticals & Biological Products	2006–07 2007–08 2008–09	18,693 18,802 18,820	63,928 65,628 67,374
Drug Submission Evaluation — **Pharmaceuticals** (Performance standard and results)							Review time to first decision (calendar days)	Review time to first decision (calendar days)			
							NDS: Priority NAS = 180	191			
							NDS: Priority Clin/C&M = 180	176			
							NDS: NOC-C NAS = 200	144			
							NDS: NOC-C Clin/C&M = 200	106			
							NDS: NAS = 300	261			
							NDS: Clin/C&M = 300	240			
							NDS: Clin only = 300	181			
							NDS: Labeling Only = 60	71			
							ANDS: Comp/C&M = 180	167			
							ANDS: C&M/ Labelling = 180	176			

7A TABLE 7A:
User Fees Act *(continued)*

Health Products and Food Branch

				2005–06					PLANNING YEARS		
User Fee	Fee Type	Fee Setting Authority	Date Last Modified	Forecast Revenue ($000)	Actual Revenue ($000)	Full Cost ($000)	Performance Standard	Performance Results	Fiscal Year	Forecast Revenue ($000)	Estimated Full Cost ($000)
Drug Submission Evaluation — **Pharmaceuticals** (Performance standard and results continued)							ANDS: Labelling Only = 60	86			
							SNDS: Priority Clin Only = 180	157			
							SNDS: Priority Clin/C&M = 180	64			
							SNDS: Clin/C&M = 300	256			
							SNDS: Comp/C&M = 180	189			
							SNDS: Clin only = 300	235			
							SNDS: C&M/Labelling = 180	151			
							SNDS: Rx to OTC (switch) – new indication = 300	194			
							SNDS: Labelling only = 60	48			
							SANDS: Comp/C&M = 180	152			
							SANDS: C&M/Labelling = 180	232			
							SANDS: Labelling only = 60	35			
							DIN with data = 210	201			
							DIN form only = 180	162			

7A TABLE 7A:
User Fees Act *(continued)*

Health Products and Food Branch

				2005–06					PLANNING YEARS		
User Fee	Fee Type	Fee Setting Authority	Date Last Modified	Forecast Revenue ($000)	Actual Revenue ($000)	Full Cost ($000)	Performance Standard	Performance Results	Fiscal Year	Forecast Revenue ($000)	Estimated Full Cost ($000)
Drug Submission Evaluation– **Biological Products** (Performance standard and results)							Review time to first decision (calendar days)	Average review time to first decision			
							NDS: Priority NAS = 180	594			
							NDS: NOC-C NAS = 200	166			
							NDS: NOC-C Clin/C&M = 200	539			
							NDS: NAS = 300	962			
							NDS: Clin/C&M = 300	520			
							SNDS: Priority Clin Only = 180	391			
							SNDS: Clin only = 300	585			
							SNDS: C&M/Labeling = 180	281			
							SNDS: Clin/C&M = 300	708			
							SNDS: COMP/C&M = 180	358			
							DIN with data = 210	251			
							DIN form only = 180	33			

7A TABLE 7A:
User Fees Act *(continued)*

Health Products and Food Branch

				2005–06					PLANNING YEARS		
User Fee	Fee Type	Fee Setting Authority	Date Last Modified	Forecast Revenue ($000)	Actual Revenue ($000)	Full Cost ($000)	Performance Standard	Performance Results	Fiscal Year	Forecast Revenue ($000)	Estimated Full Cost ($000)
Medical Device License Application Fees – **Medical Devices**	R	FAA	Aug. 1998	3,244	3,376	10,716	Review time to first decision (calendar days)	Review time to first decision (calendar days)	2006–07 2007–08 2008–09	3,352 3,460 3,480	11,001 11,293 11,594
							Class II= 15	12			
							Class II Amendment = 15	11			
							Class III Priority = 45	n/a (none reviewed)			
							Class III = 75	61			
							Class III Amendment = 75	67			
							Class IV Priority = 45	23			
							Class IV = 90	68			
							Class IV Amendment = 90	55			
Fees for Right to Sell a Licensed Medical Device	R	FAA	Aug. 1998	1,622	2,092	7,917	15 working days from deadline for receipt of annual notification (Nov. 1) to update the Medical Devices Active License Listing database	100% within target	2006–07 2007–08 2008–09	1,730 1,784 1,786	8,128 8,344 8,566
Medical Device Establishment Licensing Fees	R	FAA	Jan. 2000	2,055	2,076	5,719	75 to 125 days to renew (1)	115 days for renewals 90% of the time	2006–07 2007–08 2008–09	2,163 2,271 2,280	5,871 6,028 6,188

(1) Further consultation on service standards is being planned

7A TABLE 7A:
User Fees Act *(continued)*

Health Products and Food Branch

				2005–06					PLANNING YEARS		
User Fee	Fee Type	Fee Setting Authority	Date Last Modified	Forecast Revenue ($000)	Actual Revenue ($000)	Full Cost ($000)	Performance Standard	Performance Results	Fiscal Year	Forecast Revenue ($000)	Estimated Full Cost ($000)
Veterinary Drug Evaluation Fees — **Veterinary Drug Products**	R	FAA	Mar. 1996	716	768	6,254	Review time to first decision (calendar days)	Review time to first decision (calendar days)	2006–07 2007–08 2008–09	776 806 810	6,420 6,591 6,766
							NDS, ABNDS = 300 SNDS, SABNDS = 240	In keeping with the target, 90% of data packages more than 12 months old were issued decisions as of March 31, 2006. By March 31, 2007, it is expected that 90% of data packages more than six months old will have had decisions issued. Estimated review time: 2005–2006 = 820 days 2006–2007 = 630 days (projected) 2007–2008 = 450 days (projected) 2008–2009 = 270 days (projected)			
							Admin = 90	Data not available. Upgrades are being made to the tracking system to be able to report in next year's DPR.			
							DIN = 120				
							ND = 90				
							IND/ESC = 60	90% within target			
							Labels = 45	90% within target			
							Emergency Drug Release = 2	90% within target			

7A TABLE 7A:
User Fees Act *(continued)*

Health Products and Food Branch

				2005–06					PLANNING YEARS		
User Fee	Fee Type	Fee Setting Authority	Date Last Modified	Forecast Revenue ($000)	Actual Revenue ($000)	Full Cost ($000)	Performance Standard	Performance Results	Fiscal Year	Forecast Revenue ($000)	Estimated Full Cost ($000)
Subtotal	R			39,237	40,376	127,460			2006–07	39,894	130,851
									2007–08	40,412	134,331
									2008–09	40,476	137,905
Subtotal	O			218	271	721			2006–07	270	740
									2007–08	273	760
									2008–09	275	780
Total				**39,455**	**40,647**	**128,181**			2006–07	40,164	131,591
									2007–08	40,685	135,091
									2008–09	40,751	138,685

1. Acronyms

NDS: New Drug Submission
SNDS: Supplemental New Drug Submission
ANDS/ABNDS: Abbreviated New Drug Submission
SANDS/SABNDS: Supplemental Abbreviated New Drug Submission
DIN: Drug Identification Number Application
INDS: Investigational New Drug Submission
ESC: Experimental Studies Certificate
NC: Notifiable Change
NAS: New Active Substance
OTC: Over the Counter
Rx: Prescription
Clin: Clinical
Comp: Comparative Bio, Clinical, or Pharmacodynamic
C & M: Chemistry & Manufacturing
NOC-C: Notice of Compliance with Conditions

2. Detailed performance targets for human and veterinary drugs and medical devices:

(human drugs) http://www.hc-sc.gc.ca/dhp-mps/prodpharma/applic-demande/guide-ld/mgmt-gest/mands_gespd_e.html
(medical devices) http://www.hc-sc.gc.ca/dhp-mps/md-im/applic-demande/pol/mdlapp_demhim_pol_e.html
(veterinary drugs) http://www.hc-sc.gc.ca/dhp-mps/legislation/vet/pol/mors-gspr_pol_e.html

3. Detailed information on performance for human drugs and medical devices:

http://www.hc-sc.gc.ca/ahc-asc/pubs/hpfb-dgpsa/index_e.html
and for human drugs at http://www.hc-sc.gc.ca/dhp-mps/prodpharma/applic-demande/docs/perform-rendement/index_e.html

4. Forecast and actual revenue are reported on a modified cash accounting basis.

5. Under the External Charging Initiative, HPFB is in the process of implementing an external charging framework, which includes an updated costing model. Current year costing was developed using the Program Activity Architecture coding structure as directed through Treasury Board.

7A TABLE 7A:
User Fees Act *(continued)*

Corporate Services Branch (CSB)

				2005–06					PLANNING YEARS		
User Fee	Fee Type	Fee Setting Authority	Date Last Modified	Forecast Revenue ($000)	Actual Revenue ($000)	Full Cost ($000)	Performance Standard	Performance Results[1]	Fiscal Year	Forecast Revenue ($000)	Estimated Full Cost ($000)
Fees charged for the processing of access requests filed under the Access to Information Act (ATIA)	Other products and services (O)	Access to Information Act	1992	See Section C – Other Information, Note 1.	17.4	$1,284	Response provided within 30 days following receipt of request; response time may be extended pursuant to section 9 of the ATIA. Notice of extension to be sent within 30 days of receipt of request. ATIA: http://laws.justice.gc.ca/en/A-1/218072.html	Of 2,115 requests, 1,538 (72.7%) requests were completed during 2005–2006. The Department was able to respond within 30 days or less in 812 (52.8%) of completed cases. Response times for the remaining cases were 328 (21.3%) within 31 days to 60 days, 209 (13.6%) within 61 to 120 days, and 189 (12.3%) in 121 or more days.	2006–07 2007–08 2008–09	20.93 25.12 30.14 See Section C — Other Information, Note 2.	1,770 1,770 1,770 See Section C — Other Information, Note 3.
Sub-Total	R				0	0			Sub-total 2006–07	20.93	1,770
Sub-Total	O				17.44	1,284			Sub-total 2007–08	25.12	1,770
Total					**17.44**	**1,284**			**Sub-total** 2008–09	30.14	1,770
									Total	76.19	5,310

Date Last Modified: N/A

Other Information:

1. *Due to reorganization during 2005–2006, forecast revenue is no longer relevant.*
2. *Projection based on actual revenue received during 2005–2006. Due to the nature and varying complexity of ATI requests, it is unknown what fees may be applicable until a request is processed.Under certain circumstances, fees may be waived.*
3. *Estimated direct cost of administering Health Canada's ATIP.*

7A TABLE 7A:

User Fees Act *(continued)*

Pest Management Regulatory Agency (PMRA)

				2005–06					PLANNING YEARS		
User Fee	Fee Type	Fee Setting Authority	Date Last Modified	Forecast Revenue ($000)	Actual Revenue ($000)	Full Cost ($000)	Performance Standard	Performance Results	Fiscal Year	Forecast Revenue ($000)	Estimated Full Cost ($000)
Fees to be paid for Pest Control Product Application Examination Service	Regulatory (R)	*Pest Control Products Act* (PCPA)	April 1997	2,657	2,037	27,830	Target is 90% of submissions in all categories to be processed within time shown. *www.pmra-arla.gc.ca/english/pdf/pro/pro9601-e.pdf* Category A Standard — 550 days User Request Minor Use Registration (URMUR) — 365 days Joint Reviews — variable Reduced risk — variable Category B Standard/priority — 365 days Reduced risk — variable Category C Standard — 180 or 225 days Category D Standard — variable Category E Standard — variable *Includes deviations from Management of Submission Policy	Category A = 88% Category B = 91% Category C = 84% Category D (Minor Use only) = 74% Category E = 74%	2006–07 2007–08 2008–09	2,657 2,657 2,657	29,300 29,300 27,050

7A TABLE 7A:
User Fees Act *(continued)*

Pest Management Regulatory Agency

				2005-06					PLANNING YEARS		
User Fee	Fee Type	Fee Setting Authority	Date Last Modified	Forecast Revenue ($000)	Actual Revenue ($000)	Full Cost ($000)	Performance Standard	Performance Results	Fiscal Year	Forecast Revenue ($000)	Estimated Full Cost ($000)
Fees to be paid for the right or privilege to manufacture or sell a pest control product in Canada and for establishing a Maximum Residue Limit in relation to a pest control product.	R	*Financial Administration Act* (FAA)	April 1997	5,343	4,469	32,670	100% of all fees for the right or privilege to manufacture or sell a pest control product in Canada will be invoiced within the first 30 days of the fiscal year. (Pending consultation)	See Section C — Other Information, Note 1.	2006–07 2007–08 2008–09	5,343 5,343 5,343	29,300 29,300 27,050
Sub-Total	R			8,000	6,506	60,500			2006–07	8,000	58,600
Sub-Total	O			0	0	0			2007–08	8,000	58,200
TOTAL				**8,000**	**6,506**	**60,500**			2008–09	8,000	54,100
									Total	**24,000**	**170,900**

Date Last Modified: N/A

Other Information:

1. Standard established during current year. Results will be available next year.

7B TABLE 7B:
Policy on Service Standards for External Fees

Healthy Environments and Consumer Safety Branch (HECS)			
EXTERNAL FEE	**SERVICE STANDARD***	**PERFORMANCE RESULT***	**STAKEHOLDER CONSULTATION**
National Dosimetry Services (NDS)	Provide timely, responsive and reliable customer services to 95,000 workers in 13,000 groups: Registration and inspections of incoming dosimeters within 48 hours Exposures over regulatory limits reported within 24 hours Dosimeters leave NDS premises 10–13 working days prior to exchange date Message call backs (phone, e-mail) within 24 hours Updated account information within 48 hours Additional request dosimeters shipped within 24 hours Exposure Reports sent out within 10 days of dosimeter receipt	Provided timely, responsive and reliable customer services to 95,000 workers in 13,000 groups. The standards were met as follows: 99% of incoming dosimeters registered and inspected within 48 hours 100% of exposures over regulatory limits reported within 24 hours 97% of dosimeters leave NDS premises 10–13 working days prior to exchange date 99% of message call backs done within 24 hours 99% of account information updated within 48 hours 99% of additional request dosimeters shipped within 24 hours 90% of Exposure Reports sent out within 10 days of dosimeter receipt	NDS has been maintaining and improving service and performance standards for a number of years. For example, performance in dosimeter mail-out deadlines improved from 65% to 97% in the last three years. As part of the restructuring of its product, service and fee structure in July 2004, client consultations on service quality affirmed the type and level of standards in use. NDS has improved the monitoring of customer feedback (compliments and criticism) using a centralized electronic database directly connected to the Call Centre system. Additional information is obtained during regular contact sessions with the client and, when required, using exit questionnaires.
Deratting Services	Health Canada provides 7-day service in designated ports and all requests are responded to within 48 hours. See Note 1 below.	100% of requests received were responded to within 48 hours or less.	There were no changes to the service standards in 2006–2007. Changes are anticipated within the next two to five years due to new International Health Regulations (WHO). Stakeholders will be consulted in advance.
Cruise Ship Inspection Program	Periodic inspections done a minimum of once a sailing season on ships in Canadian waters. Final reports submitted within 10 working days. Re-inspection on any ships with scores of less than 85%.	See Notes 2 and 3 below. 100%	There were no changes to the service standards in 2006–2007. Health Canada meets with stakeholders on an annual basis to review and discuss any proposed changes to the service standards. The standards are consistent with the CDC/VSP (Vessel Sanitation Program) administrative guideline and criteria for inspections, and any changes would be synchronized to harmonize the process with the U.S.

7B TABLE 7B:

Policy on Service Standards for External Fees *(continued)*

Healthy Environments and Consumer Safety Branch (HECS)			
EXTERNAL FEE	**SERVICE STANDARD***	**PERFORMANCE RESULT***	**STAKEHOLDER CONSULTATION**
Common Carrier Inspection (e.g. trains, ferries, airports/airlines, seaports)	See Note 3 below.	See Note 4 below.	Service standards are negotiated and included in MOUs/contracts; any changes also need to be negotiated. A new MOU/contract was created with Via Rail in 2004–2005 and Rocky Mountaineer in 2005–2006 and these service standards are part of the MOU. All other service standards/MOUs remain unchanged.
Employee Assistance Services (EAS) (Fee is charged through contractual or formally-based agreements between HC and other departments, agencies and federally-regulated organizations.)	As per formal agreement, varies depending on customer organization's requirements, needs and EAS capacity to meet these.	EAS is an Accredited service. Voluntary satisfaction surveys, customer surveys and follow-ups with clients and customers are done on a regular basis. Results are shared at year end with report to each customer, as per formal agreement.	Customer survey and meeting with customer at least once a year. Formal agreement to renew contractual or MOU-type agreement done annually or every two years. Utilization data given at least annually to each customer.
Medical Marihuana Dried marihuana ($5.00 / gram) Cannabis seeds ($20.00 / packet of 30 seeds)	Dried marihuana Quality: Each lot is tested prior to distribution for potency and absence of specific contaminants. Quantity: 14 working days (date of receipt of request to date of shipment.) Cannabis seeds Quality: Each batch is tested for germination rate and mature plants morphological and chemical attributes. Quantity: 5 working days (date of receipt of request to date of shipment.)	Dried marihuana Requirements were met for all four lots distributed to authorized persons (A.P.) (Quality control results posted on Health Canada website). Return rate due to product non-satisfaction = 1.09% (53 pouches out of 4,828 shipped.) Total number dried marihuana shipment orders sent to A.P. = 1412 Cannabis seeds Current cannabis seeds batch distributed since November 2004. Return rate due to product non-satisfaction = 0.89% (3 packets out of 336 shipped.) Total number seeds shipment orders sent to A.P. = 196	As a result of comments received from the first users of marihuana produced under contract for Health Canada, a "bud" only product with increased potency has been distributed by Health Canada since May 2004. Additional changes to the physical attributes of dried marihuana resulting in a marihuana product with higher humidity and larger particle size were made September 2005, thus increasing the quality of the product. Based on feedback received from clients, since August 2004, Health Canada has been offering three different pouch sizes to allow new A.P. to try a smaller size pouch product; therefore allowing clients the opportunity to pay for opened smaller size pouches in the advent the product does not meet their needs. Processing time was calculated and based on historical data accumulated over a period of a year.

7B TABLE 7B:

Policy on Service Standards for External Fees *(continued)*

Note 1: In total, 654 Derat certificates were issued in 2005–2006. See table below for details on service standards.

DAY OF THE WEEK	PRIOR NOTIFICATION REQUIRED
Weekday Service — Designated Ports	24 hours
Weekend Service — Designated Ports	48 hours
Regular Weekend Service Designated Ports	For service on Saturday, notice must be received Thursday by 1300 hours local time.
	For service on Sunday, notice must be received Friday by 1300 hours local time.
Holiday Weekend Service Designated Ports	When Friday is the statutory holiday • for service on Friday, notice must be received Wednesday by 1300 hours local time.
	• for service on Saturday or Sunday, notice must be received Thursday by 1300 hours local time.
	When Monday is the statutory holiday • for service on Saturday, notice must be received Thursday by 1300 hours local time.
	• or service on Sunday or Monday, notice must be received Friday by 1300 hours local time.
Prior Notice for Service — Non-designated Ports	72 hours prior notice is requested for service at non-designated ports.

Note: The fee for short notice service i.e. less than 24 hours for week days, less than 48 hours for weekends, at both designated and non-designated ports, will be the normal fee plus a 25% surcharge.

Note 2: Health Canada publishes scores obtained from the Cruise Ship Inspection Program at: http://www.hc-sc.gc.ca/hecs-sesc/whpsp/shipinsp.htm

Note 3: In regards to service standards, Cruise Ship and Common Carrier Inspections are performed following procedures and protocols that have been published and distributed to clients. Health Canada's protocols are in accordance with international public health inspection protocols. Copies of the inspection protocols for these programs may be requested by e-mail at: phb_bsp@hc-sc.gc.ca.

7B TABLE 7B:
Policy on Service Standards for External Fees *(continued)*

Note 4: Service Standards for Common Carrier Inspection Program

COMMON CARRIER INSPECTION PROGRAM	SERVICE STANDARD	PERFORMANCE RESULT
Passenger Train — On Board	Periodic inspection done on each passenger train line as determined by MOU between Health Canada and passenger train industry. Final periodic inspection report provided to industry within 10 working days.	100% of reports provided within 10 working days.
Passenger Train — Off Board	Sanitation inspection done twice a year. Final sanitation report provided to industry within 10 working days	100% of reports provided within 10 working days.
Flight Kitchen	Scheduled number of periodic announced audits per year based on meals prepared. Final audit inspection report provided within 10 working days of inspection.	100% of reports provided within 10 working days.
Ferry — On Board Food	Unannounced inspections as per predetermined contractual obligations. Final inspection report provided within 10 working days of inspection.	100% of reports provided within 10 working days.
Ferry — Potable Water	Annual inspection as per Potable Water Regulations for Common Carriers. Final annual inspection reports provided within 10 working days of inspection.	100% of reports provided within 10 working days.

Other Information

National Dosimetry Services billed for $5.4 M in 2005–2006, representing $4.5 M in net vote/respendable cash. The product, service and fee structure are being reviewed this year to confirm areas that are proceeding well, and to identify and resolve gaps in financial performance (cost of living), business capacity (competition) and client demands/expectations for enhanced levels of products and services.

7B TABLE 7B:

Policy on Service Standards for External Fees *(continued)*

Corporate Services Branch (CSB)			
EXTERNAL FEE	**SERVICE STANDARD**	**PERFORMANCE RESULT**	**STAKEHOLDER CONSULTATION**
Fees charged for the processing of access requests filed under the *Access to Information Act* (ATIA)	Response provided within 30 days following receipt of request; response time may be extended pursuant to section 9 of the ATIA. Notice of extension to be sent within 30 days of receipt of request. ATIA: *http://laws.justice.gc.ca/en/A-1/218072.html*	Of 2,115 requests, 1,538 (72.7%) were completed during 2005–2006. The Department was able to respond within 30 days or less in 812 (52.8%) of completed cases. Response times for the remaining cases were 328 (21.3%) within 31 to 60 days, 209 (13.6%) within 61 to 120 days, and 189 (12.3%) in 121 or more days.	The service standard is established by the ATIA and the Access to Information Regulations. Consultations with stakeholders were undertaken by the Department of Justice and the Treasury Board Secretariat for amendments done in 1986 and 1992.
Other Information: *N/A*			

Pest Management Regulatory Agency (PMRA)			
EXTERNAL FEE	**SERVICE STANDARD**	**PERFORMANCE RESULT**	**STAKEHOLDER CONSULTATION**
Fees to be paid for Pest Control Product Application Examination Service	Target is 90% of submissions in all categories to be processed within the time shown. www.pmra-arla.gc.ca/english/pdf/pro/pro9601-e.pdf Category A Standard — 550 days User Request Minor Use Registration (URMUR) — 365 days Joint Reviews — variable Reduced risk — variable Category B Standard/priority — 365 days Reduced risk — variable Category C Standard – 180 or 225 days Category D Standard – variable Category E Standard – variable *Includes deviations from Management of Submission Policy	Category A = 88% Category B = 91% Category C = 84% Category D (Minor Use only) = 74% Category E = 74%	Stakeholder consultation conducted annually when required.
Fees to be paid for the right or privilege to manufacture or sell a pest control product in Canada and for establishing a Maximum Residue Limit in relation to a pest control product	100% of all fees will be invoiced within the first 30 days of the fiscal year (pending consultation).	Standard established during the current year. Results will be available next year.	Stakeholder consultation to occur in fall 2006.
Other Information: *N/A*			

7B TABLE 7B:

Policy on Service Standards for External Fees *(continued)*

Health Products and Food Branch (HPFB)			
EXTERNAL FEE	**SERVICE STANDARD**	**PERFORMANCE RESULT**	**STAKEHOLDER CONSULTATION**
The following user fees for the Health Products and Food Branch did not have performance standards or results previously reported. They were developed in consultation with program experts. 1. Authority to Sell Drugs Fees 2. Drug Master File Fees 3. Fees for Right to Sell a Licensed Medical Device The remaining user fees have been previously reported. Stakeholder consultations on all service standards are planned for 2006–2007. 4. Certificate of a Pharmaceutical Product (Drug Export) Fees 5. Drug Establishment Licensing Fees 6. Drug Submission Evaluation Fees — Pharmaceuticals 7. Drug Submission Evaluation Fees — Biological Products 8. Medical Device Application Fees — Medical Devices 9. Medical Device Establishment Licensing Fees 10. Veterinary Drug Evaluation Fees — Veterinary Drug Products	**1. Authority to Sell Drugs Fees** 120 calendar days to update the Drug Product Database following notification **2. Drug Master File Fees** 30 calendar days **3. Fees for Rights to Sell a Licensed Medical Device** 15 working days from deadline for receipt of annual notification (Nov. 1) to update the Medical Devices Active License Listing database **4. Certificate of a Pharmaceutical Product (Drug Export) Fees** 5 working days **5. Drug Establishment Licensing Fees** Data not available. Extensive consultations on service standards are planned for 2006–2007. **6. Drug Submission Evaluation Fees — Pharmaceuticals** Review time to first decision (calendar days) NDS: Priority NAS = 180 NDS: Priority Clin/C&M = 180 NDS: NOC-C NAS = 200 NDS: NOC-C Clin/C&M = 200 NDS: NAS = 300 NDS: Clin/C&M = 300 NDS: Clin only = 300 NDS: Labelling Only = 60 ANDS: Comp/C&M = 180 ANDS: C&M/Labelling = 180 ANDS: Labelling Only = 60 SNDS: Priority Clin Only = 180 SNDS: Priority Clin/C&M = 180 SNDS: Clin/C&M = 300	**1. Authority to Sell Drugs Fees** 98% within target **2. Drug Master File Fees** 87% within target **3. Fees for Rights to Sell a Licensed Medical Device** 100% within target **4. Certificate of a Pharmaceutical Product (Drug Export) Fees** 7 working days 90% of the time **5. Drug Establishment Licensing Fees** Data not available. Extensive consultations on service standards are being planned for 2006–2007. **6. Drug Submission Evaluation Fees — Pharmaceuticals** Average review time to first decision NDS: Priority NAS = 191 NDS: Priority Clin/C&M = 176 NDS: NOC-C NAS = 144 NDS: NOC-C Clin/C&M = 106 NDS: NAS = 261 NDS: Clin/C&M = 240 NDS: Clin only = 181 NDS: Labelling Only = 71 ANDS: Comp/C&M = 167 ANDS: C&M/Labelling = 176 ANDS: Labelling Only = 86 SNDS: Priority Clin Only = 157 SNDS: Priority Clin/C&M = 64 SNDS: Clin/C&M = 256 SNDS: Comp/C&M = 189 SNDS: Clin only = 235 SNDS: C&M/Labelling = 151 SNDS: Rx to OTC (switch) - new indication = 194 SNDS: Labelling only = 48 SANDS: Comp/C&M = 152	The Health Products and Food Branch (HPFB) continues to develop a new external charging framework as a key component of a sustainable regulatory system. In 2005–2006, the Branch undertook to develop a common policy framework. The approach provides coherence across product and business lines within HPFB, consisting of elements which include costing methodology, criteria for excluding or including activities for fees, impact on service standards and their link to fees, annual reporting and dispute management. On June 22, 2005 the first multi-stakeholder consultation was held, where over 40 participants had the opportunity to discuss and provide feedback on the Branch's proposed approach to meeting the requirements of the *User Fees Act* when introducing new or amended fees. The common policy approach is expected to be finalized in 2006–2007 and will provide an overarching framework in which fee proposals for individual product lines will be considered by stakeholders. Extensive consultations on all therapeutic products are planned for 2006–2007.

7B TABLE 7B:

Policy on Service Standards for External Fees *(continued)*

Health Products and Food Branch (HPFB)			
EXTERNAL FEE	**SERVICE STANDARD**	**PERFORMANCE RESULT**	**STAKEHOLDER CONSULTATION**
(continued)	SNDS: Comp/C&M = 180 SNDS: Clin only = 300 SNDS: C&M/Labelling = 180 SNDS: Rx to OTC (switch) — new indication = 300 SNDS: Labelling only = 60 SANDS: Comp/C&M = 180 SANDS: C&M/Labelling = 180 SANDS: Labelling only = 60 DIN with data = 210 DIN form only = 180 **7. Drug Submission Evaluation Fees — Biological Products** Review time to first decision (calendar days) NDS: Priority NAS = 180 NDS: NOC-C NAS = 200 NDS: NOC-C Clin/C&M = 200 NDS: NAS = 300 NDS: Clin/C&M = 300 SNDS Priority Clin Only = 180 SNDS: Clin only = 300 SNDS: C&M/Labeling = 180 SNDS: Clin/C&M = 300 SNDS: COMP/C&M = 180 DIN with data = 210 DIN form only = 180 **8. Medical Device License Application Fees — Medical Devices** Review time to first decision (calendar days) Class II = 15 Class II Amendment = 15 Class III Priority = 45 Class III = 75 Class III Amendment = 75 Class IV Priority = 45 Class IV = 90 Class IV Amendment = 90	SANDS: C&M/Labelling = 232 SANDS: Labelling only = 35 DIN with data = 20 DIN form only = 162 **7. Drug Submission Evaluation Fees — Biological Products** Average review time to first decision NDS: Priority NAS = 594 NDS: NOC-C NAS = 166 NDS: NOC-C Clin/C&M = 539 NDS: NAS = 962 NDS: Clin/C&M = 520 SNDS Priority Clin Only = 391 SNDS: Clin only = 585 SNDS: C&M/Labeling = 281 SNDS: Clin/C&M = 708 SNDS: COMP/C&M = 358 DIN with data = 251 DIN form only = 33 **8. Medical Device License Application Fees** Average review time to first decision Class II = 12 Class II Amendment = 11 Class III Priority = n/a (none reviewed) Class III = 61 Class III Amendment = 67 Class IV Priority = 23 Class IV = 68 Class IV Amendment = 55 **9. Medical Device Establishment Licensing Fees** Data not available. Extensive consultations on service standards are planned for 2006–2007.	

7B TABLE 7B:

Policy on Service Standards for External Fees *(continued)*

Health Products and Food Branch (HPFB)			
EXTERNAL FEE	**SERVICE STANDARD**	**PERFORMANCE RESULT**	**STAKEHOLDER CONSULTATION**
(continued)	**9. Medical Device Establishment Licensing Fees** Data not available. Extensive consultations on service standards are planned for 2006–2007. **10. Veterinary Drug Evaluation Fees — Veterinary Drug Products** Review time to first decision (calendar days) NDS, ABNDS = 300 SNDS, SABNDS = 240 Admin = 90 DIN = 120 ND = 90 IND/ESC = 60 Labels = 45 Emergency Drug Release = 2	**10. Veterinary Drug Evaluation Fees — Average review time to first decision** NDS, ABNDS SNDS, SABNDS In keeping with the target, 90% of data packages more than 12 months old were issued decisions as of March 31, 2006. By March 31, 2007, it is expected that 90% of data packages more than six months old will have had decisions issued. Estimated review time: 2005–2006 = 820 days 2006–2007 = 630 days (projected) 2007–2008 = 450 days (projected) 2008–2009 = 270 days (projected) Admin = Data not available. Upgrades are being made to the tracking system to be able to report in next year's DPR. DIN = 90% within target ND = 90% within target IND/ESC = 90% within target Labels = 90% within target Emergency Drug Release = 90% within target	
Other Information: *N/A*			

8 TABLE 8:
Major Regulatory Initiatives

Health Products and Food Branch			
REGULATIONS	**EXPECTED RESULTS**	**PERFORMANCE MEASUREMENT CRITERIA**	**RESULTS ACHIEVED**
Medical Devices Regulations Exclusion of certain tissues from the Medical Devices Regulations.	Amend the Medical Devices Regulations to exclude certain tissues that will be regulated under the proposed Cells, Tissues and Organs (CTO) Regulatory Framework.	Certain tissues more appropriately regulated under the CTO Regulations (Phase I).	The amendment was published in *Canada Gazette*, Part I on December 10, 2005 at the same time as the CTO Regulations (Phase 1).
Food and Drug Regulations Amendment of the Data Protection provisions of Division 8.	Amend the data protection provisions of the Food and Drug Regulations to provide effective data protection for eight years for innovator drugs that contain medicinal ingredients not previously approved for sale in Canada. An additional six months will be provided for submissions that include pediatric studies.	Publication in *Canada Gazette*, Part I by June 2006.	The amendment to the Food and Drug Regulations (Data Protection) was published in *Canada Gazette*, Part I on June 17, 2006.
Food and Drug Regulations Amendment to Division 8 to allow for the issuance of a Notice of Compliance with Conditions (NOC/c).	Provide a legislative basis on which Health Canada can accelerate access to new life saving drug therapies on the basis of promising evidence of clinical effectiveness. Will also provide the means to monitor and regulate the products effectively in the post-market domain and mitigate legal liability.	N/A	Regulatory development was deferred to the 2006–2007 initiative to renew Canada's health products and food regulatory system.
Food and Drug Regulations Regulations amending the Special Access Program (Block Release).	The current Special Access Program allows for the authorization of a drug for use by an individual patient. This amendment will allow for the release of a drug to a block of patients under certain limited circumstances.	Assessment of options through issue analysis and pre-*Canada Gazette* I consultations Determination of further performance measurement criteria will be finalized once consultation and issue analysis have been completed.	An issue analysis paper with proposed options has been developed. Targeted consultation will be held to further analyze the issue.
Food and Drugs Act Implement Phase I and II of the regulatory framework for Cells, Tissues and Organs (CTO) intended for Transplantation.	Balance the need for safe CTO of high quality with the need to ensure availability of CTO for transplantation. Phase I regulations will focus on basic safety requirements for human CTO. Phase II regulations will include adverse event reporting requirements and a compliance and enforcement strategy.	Improved protection of the health and safety of Canadian transplant recipients Decreased health risks to Canadian recipients of human CTO	Phase I: Proposed regulations were pre-published in *Canada Gazette,* Part I on December 10, 2005. Comments received have being analyzed and responses developed. Revised regulations are in preparation.

8 TABLE 8:

Major Regulatory Initiatives *(continued)*

REGULATIONS	EXPECTED RESULTS	PERFORMANCE MEASUREMENT CRITERIA	RESULTS ACHIEVED
Health Products and Food Branch			
Food and Drugs Act Amendment to Processing and Distribution of Semen for Assisted Conception Regulations (Semen Regulations).	Reflect current safety standards for semen used in assisted conception.	Regulations reflective of current safety standards for semen used in assisted conception.	Significant policy analysis around the changes needed to the regulations has been completed.
Food and Drug Regulations Amendment to provisions respecting Plasmapheresis in Part C, Division 4.	Reflect current methods and practices used to collect human plasma as well as the list of transmissible diseases for which tests must be performed in order to maximize the safety of plasma and plasma donors.	Regulations consistent with current methods and practices used to collect human plasma.	Proposed regulations were pre-published in *Canada Gazette*, Part I on September 3, 2005. Comments received have being analyzed and responses developed. Revised regulations are in preparation.
Food and Drugs Act New Regulations Respecting Blood and Blood Components.	Balance the need for safe blood and blood components with the need to ensure availability of blood and blood components for transfusion. The new regulations will include basic safety requirements, adverse event reporting requirements and a compliance and enforcement strategy.	Regulations reflective of current safety standards, methods and practices used in the collection and testing of human whole blood and blood components. Requirements updated on a timely basis as new technologies/products/ issues emerge.	Draft regulations are in preparation.
Food and Drug Regulations Amendments to Division 3 respecting Positron Emitting Radiopharmaceuticals.	Reduce regulatory burden by simplifying submission requirements for certain basic clinical research studies using positron emitting radiopharmaceuticals, while still ensuring patient safety.	Simplified submission process with appropriately decreased level of clearly defined requirements may lead to fewer questions from sponsors in the long run. Decreased time/resources required to review each submission (compared to a Clinical Trial Application).	Draft regulations are in preparation.

8 TABLE 8:
Major Regulatory Initiatives *(continued)*

REGULATIONS	EXPECTED RESULTS	PERFORMANCE MEASUREMENT CRITERIA	RESULTS ACHIEVED
Health Products and Food Branch			
Food and Drug Regulations Amendment to further restrict "personal use" importation of all drugs to be administered to animals intended for consumption.	Further restrict the importation of veterinary drugs to include the personal importation of drugs intended to be used in food-producing animals to avoid potentially harmful residues in food products from animals treated with these drugs.	Reduced incidence of harmful drug residues being detected in animals treated with veterinary drugs imported under personal use circumstances.	Proposed regulatory amendments restricting the "personal use" importation of all drugs to be administered to animals intended for consumption will be published in *Canada Gazette*, Part I in 2006–2007.
Food and Drug Regulations Further restrictions to the sale of Carbadox in Canada.	Further restrict the sale of products containing Carbadox for sale in Canada to avoid potentially harmful residues in food products from animals treated with this drug.	Reduced availability of food products containing Carbadox residues or its metabolites derived from food-producing animals.	Proposed regulatory amendments restricting the sale of products containing Carbadox will be published in *Canada Gazette*, Part I in 2006–2007.
Food and Drug Regulations Addition of Vitamins and Minerals to Foods.	Revise regulations on the addition of vitamins and minerals to foods.	Improved nutritional quality of the Canadian food supply.	Proposed regulatory amendments are being developed to implement the new policy. Publication of the proposed amendments is anticipated for fall 2006.
Food and Drug Regulations Enhanced Labelling.	Considerations: the role of nutrients; consumer needs and expectations; and industry requests. Mandatory labelling of specific food allergens, gluten sources and sulphites on the labels of prepackaged food products, whether they have been added directly or indirectly.	Reduced number of adverse reactions to prepared and prepackaged foods containing specific allergens, gluten sources and sulphites. Increased consumer awareness of presence of specific allergens, gluten sources and sulphites in prepared and prepackaged foods.	Proposed regulatory amendments are being developed to implement the new policy. Publication of the proposed amendments is anticipated for fall 2006.
Food and Drug Regulations Mandatory Labelling of Raw Ground Meat and Ground Poultry.	Mandatory safe handling labels on raw ground meat and ground poultry.	Reduction of food-borne illness as a result of providing safe handling information on the labels of these products. Increased consumer awareness of the potential microbiological hazards associated with improper handling of ground meat and poultry.	Health Canada continued policy development in order to support the preparation of proposed regulatory amendments to implement this initiative.

TABLE 8:
Major Regulatory Initiatives *(continued)*

REGULATIONS	EXPECTED RESULTS	PERFORMANCE MEASUREMENT CRITERIA	RESULTS ACHIEVED
Health Products and Food Branch			
Food and Drug Regulations Saccharin.	Saccharin permitted as a food additive in a limited number of foods.	Availability of a wider range of dietetic food products for the benefit of this consumer market.	Health Canada continued policy development.
Food and Drug Regulations Caffeine.	Additional beverages containing added caffeine and more information on levels of caffeine in these products to allow consumers to make an informed choice about their caffeine intake.	Increased consumer awareness of the levels of caffeine in beverages sold in Canada.	Health Canada continued policy development in regard to the quantity of caffeine in beverages and the options to provide additional label information to consumers.
Food and Drug Regulations Food Irradiation.	Optional use of irradiation to control pathogens; reduce microbial load and insect infestation; and extend shelf life of ground beef, poultry, shrimp and prawns, and mangoes.	Reduced levels of pathogens and insect infestations in irradiated food products. Extended shelf life for irradiated food products.	Health Canada continued with policy and regulatory development.
Food and Drug Regulations Health Claims.	Addition of a diet-related health claim regarding fruits, vegetables and whole grains and reduced risk of heart disease to list of claims manufacturers can use to promote healthy foods.	Dietary surveys to monitor healthier eating practices. Number of submissions received for the use of product-specific health claims for foods.	Health Canada continued policy development and assessment of additional diet-related health claims for use on foods. Health Canada formed an Interdepartmental Policy Team to develop recommendations for an appropriate framework for these types of health claims.
Food and Drug Regulations Revisions to Division 12 — Prepackaged Water and Ice.	Modernize and expand safety and labelling requirements for prepackaged water and ice products.	Industry compliance with revised regulations.	In April 2005, a targeted consultation with stakeholders was conducted. The results of this consultation are being analyzed. Health Canada and the Canadian Food Inspection Agency continued policy and regu-latory development. Proposed regulations are anticipated for publication in *Canada Gazette*, Part I in spring 2007.

8 TABLE 8:
Major Regulatory Initiatives *(continued)*

REGULATIONS	EXPECTED RESULTS	PERFORMANCE MEASUREMENT CRITERIA	RESULTS ACHIEVED
Health Products and Food Branch			
Food and Drug Regulations — Miscellaneous Amendments to Division 15.	New or revised maximum residue limits (MRLs) for veterinary drugs in foods to ensure the safety of food products from animals treated with the veterinary drugs.	Food products, derived from animals, comply with prescribed MRLs.	Proposed regulatory amendments for MRLs for these veterinary drugs will be published in *Canada Gazette*, Part I in 2006–2007.
Health Policy Branch			
Regulations concerning Section 8 of the Assisted *Human Reproduction Act* (consent) and the definition of an in vitro embryo donor.	Human reproductive material and in vitro embryos are used only with the donor's written consent. The principle of free and informed consent is promoted and applied as a fundamental condition of the use of assisted human reproductive technologies.	Inspections, investigations, tracking of complaints and surveys.	Draft regulations were pre-published in *Canada Gazette*, Part I on September 24, 2005. Comments from readers have been considered and revised draft regulations are being prepared for parliamentary review.
Pest Management Regulatory Agency			
Revision of current Pest Control Products Regulations in light of the new *Pest Control Products Act* (PCPA).	Will ensure that terminology is consistent with the new Act and that any provisions that have been moved to the Act are deleted from the Regulations and, through use of authority in new PCPA, will codify current policy.	Regulations consistent with and supportive of new PCPA.	Pre-published in *Canada Gazette,* Part I on November 12, 2005.
Mandatory Reporting of Incidents Regulations.	Specify types of information that must be reported by registrant/applicant under the new *Pest Control Products Act* and time frames for reporting. This information will be used in the re-evaluation of pesticide products and may be used as a possible trigger for special review, resulting in removal of pesticides posing unacceptable risk. In turn, this will contribute to strengthened health and environmental protection.	Provision of pesticide adverse effects information by all registrants.	Priority was placed on bringing the new *Act* into force. These regulations will follow shortly.

8 TABLE 8:
Major Regulatory Initiatives *(continued)*

REGULATIONS	EXPECTED RESULTS	PERFORMANCE MEASUREMENT CRITERIA	RESULTS ACHIEVED
Pest Management Regulatory Agency			
Review Panel Regulations.	The new *Pest Control Products Act* includes a process for the reconsideration of major registration decisions by a Review Panel. New regulations will specify administrative details necessary to govern the reconsideration process. Will contribute to better public participation in the regulatory process, increased transparency and increased public and stakeholder confidence in pesticide regulation.	Concerned parties with clear understanding of requirements and responsibilities. Smoothly functioning Review Panel process.	Priority was placed on bringing the new Act into force. These regulations will follow shortly.
Revision of Agriculture and Agri-Food Administrative Monetary Penalties Regulations respecting the *Pest Control Products Act* (PCPA) and Regulations.	Reflect additional violations specified in the new PCPA and Regulations.	Regulations consistent with and supportive of new PCPA and Regulations.	Priority was placed on bringing the new Act into force. These regulations will follow shortly.
Healthy Environments and Consumer Safety Branch			
Surface Coating Materials Regulations and Order Amending Schedule I to the *Hazardous Products Act* (Surface Coating Materials).	To reduce adverse health effects due to surface coating materials containing lead and mercury.	Trend in non-compliance by industry to the regulation. Identification of non-compliant products through enforcement activities. Trend in safety complaints with regulated product.	Published in *Canada Gazette*, Part II on May 4, 2005.
Children's Jewellery Regulations and Order Amending Schedule I to the *Hazardous Products Act* (Children's Jewellery).	To prevent children from being exposed to harmful levels of lead through the mouthing of lead-containing jewellery.	Trend in non-compliance by industry to the Regulations. Identification of non-compliant products through enforcement activities. Trend in safety complaints with regulated product.	Published in *Canada Gazette*, Part II on June 1, 2005.

8 TABLE 8:
Major Regulatory Initiatives *(continued)*

REGULATIONS	EXPECTED RESULTS	PERFORMANCE MEASUREMENT CRITERIA	RESULTS ACHIEVED
Healthy Environments and Consumer Safety Branch			
Order Amending Parts I and II of Schedule I to the *Hazardous Products Act* (HPA) (Ice Hockey Helmets).	To prohibit the sale, importation, and advertisement of ice hockey helmets that do not comply with a standard rather than restricting the sale, importation, and advertisement of ice hockey helmets that comply with the standard.	Prohibition of non-compliant hockey helmets (regulation no longer listed in Part I, Schedule 1 of the HPA).	Published in *Canada Gazette,* Part II on November 30, 2005.
Introduction of new tobacco labelling requirements. Tobacco Promotion Regulations prohibiting "light" and "mild" descriptors	Increased awareness of tobacco-related hazards. Increased knowledge of tobacco products and their emissions.	Level of public awareness of health hazards related to tobacco use. Level of knowledge of tobacco products and their emissions.	A first series of potential new health warning messages was developed and focus tested.
Cigarette Ignition Propensity Regulations and Regulations Amending the Tobacco Reporting Regulations.	Reduced confusion among smokers regarding these descriptors. Greater awareness that no class of cigarettes is a "safe" alternative.	Number of smokers who believe that "light" and "mild" cigarettes are less harmful than regular cigarettes.	A cost assessment of the possible impacts of the "light" and "mild" tobacco regulations was conducted as part of the preparation of the regulatory impact assessment statement (RIAS).
Regulations under the *Controlled Drugs and Substances Act* (CDSA) to expand the authority for regulated health professionals to prescribe controlled substances where appropriate.	To decrease the number of cigarette-lit fires and their associated harm and deaths.	Number of death and injuries related to cigarette-lit fires.	Published in *Canada Gazette* Part II, on June 29, 2005 (SOR/2005-178 for the Cigarette Ignition Propensity Regulations and SOR/2005-179 for the Regulations Amending the Tobacco Reporting Regulations). Ignition Propensity Standard came into force on October 1, 2005.
	Federal legislation will not unnecessarily restrict the professional practice of any health profession regulated by provincial or territorial (P/T) authorities, including practitioners of medicine, dentistry, veterinary medicine, podiatric medicine, midwifery, and nurse practitioners, with respect to the use of controlled substances in the treatment of their patients.	Achievement will be measured by improved alignment of federal and P/T regulatory frameworks governing the appropriate use of controlled substances for medical purposes.	Active work on this initiative has resumed and a draft policy framework, which will be distributed to members of the Advisory Committee for comment in summer 2006, is currently under development.

9 TABLE 9:
Details on Project Spending

The following project exceeded the Department's delegated project approval authority:
• The Way Forward

Supplementary information on Project Spending can be found at:

http://www.tbs-sct.gc.ca/est-pre/estime.asp

10A TABLE 10A:
Summary of Transfer Payments by Program Activity
(MILLIONS OF DOLLARS)

	2003–2004	2004–2005	2005–2006			
PROGRAM ACTIVITY	Actual Spending (1)	Actual Spending (1)(2)	Main Estimates	Planned Spending	Total Authorities	Actual Spending
Grants						
Health Policy, Planning and Information	31.9	50.7	56.4	57.2	61.6	54.6
Health Products and Food	352.9	5.4	5.9	5.9	5.5	5.5
Healthy Environments and Consumer Safety	348.6	1.5	3.1	3.1	1.4	1.2
First Nations and Inuit Health	0.0	0.0	0.0	0.0	30.0	30.0
Total Grants	733.4	57.6	65.4	66.2	98.6	91.3
Contributions						
Health Policy, Planning and Information	216.1	222.8	296.7	296.7	268.9	236.3
Health Products and Food	0.0	0.4	4.0	4.0	4.1	4.1
Healthy Environments and Consumer Safety	29.8	35.8	46.9	46.9	42.9	42.3
First Nations and Inuit Health	768.4	858.9	788.8	788.9	833.1	826.8
Total Contributions	1,014.3	1,118.0	1,136.4	1,136.6	1,149.1	1,109.5
Total Transfer Payments	1,747.7	1,175.6	1,201.8	1,202.8	1,247.7	1,200.8

1) Excludes amounts related to the Public Health Agency of Canada (PHAC).

2) Actual Spending not comparable to previous DPR Spending because of a change in reporting structure from Planning, Reporting and Accountability Structure (PRAS) to Program Activity Structure (PAA). These amounts are estimated based on the most appropriate crosswalk.

The increase in First Nations and Inuit Health grant expenditures in 2005–2006 is due to funding for the Territorial Health Access Fund and Operational Secretariat and the Territorial Medical Travel Fund.

10B TABLE 10B:
Details on Transfer Payment Programs (TPPs)

HEALTH POLICY, PLANNING AND INFORMATION

- Northern Health Supplement to the 2003 First Ministers' Accord on Health Care Renewal
- Health Care Strategies and Policy, Federal/ Provincial/Territorial Partnership Grant Program
- Grant to the Health Council of Canada
- Grant to the Canadian Agency for Drugs and Technology in Health, previously named the Canadian Coordinating Office for Health Technology Assessment
- Grant to the Canadian Patient Safety Institute
- Contributions Program to improve access to health services for official language minority communities
- Health Care Strategies and Policy Contribution Program
- Contributions for the Primary Health Care Transition Fund
- Grant to the Canadian Institute for Health Information
- Health Policy Research Program
- Women's Health Contributions Program

HEALTH PRODUCTS AND FOOD

- Grant to the Canadian Blood Services: Blood Safety and Effectiveness and Research and Developement
- Contribution to strengthen Canada's organs and tissues donation and transplantation system

HEALTHY ENVIRONMENTS AND CONSUMER SAFETY

- Payments to provinces and territories to assist in ensuring access for Canadians to effective alcohol and drug treatment and rehabilitation programs and services
- Drug Strategy Community Initiatives Fund
- Contributions in support of the Federal Tobacco Control Strategy
- Contributions in support of the Canadian Centre on Substance Abuse

FIRST NATIONS AND INUIT HEALTH

- Nunavut Medical Travel Fund
- Grant to the Government of Yukon for the Territorial Health Access Fund and Operational Secretariat
- Contributions to Indian bands, Indian and Inuit associations or groups or local governments and the territorial governments for non-insured health services
- Payments to the Aboriginal Health Institute/Centre for the advancement of aboriginal peoples' health
- Contributions for First Nations and Inuit health promotion and prevention projects and for developmental projects to support First Nations and Inuit control of health services.
- Contributions on behalf of, or to, Indians or Inuit towards the cost of construction, extension or renovation of hospitals and other health care delivery facilities and institutions, as well as of hospital and health care equipment
- Contribution towards the Aboriginal Head Start On-Reserve Program
- Capital contributions for non-departmental health facilities for First Nations and Inuit
- Payments to Indian bands, associations or groups for the control and provision of health services
- Contributions for integrated Indian and Inuit community-based health care services
- Contributions to support pilot projects to assess options for transferring the Non-Insured Health Benefits Program to First Nations and Inuit control
- Contributions to Indian and Inuit associations or groups for consultations on Indian and Inuit health

Supplementary information on Transfer Payment Programs can be found at

http://www.tbs-sct.gc.ca/est-pre/estime.asp

11 TABLE 11:
Foundations — Conditional Grants

Name of Foundation:
• Canadian Health Services Research Foundation (CHSRF) • Canada Health Infoway Inc. (Infoway) • The Canadian Institute for Health Information (CIHI)

Supplementary information on Project Spending can be found at:

http://www.tbs-sct.gc.ca/est-pre/estime.asp

12 TABLE 12:
Horizontal Initiatives

Name of Horizontal Initiative:
• Canada's Drug Strategy • Federal Tobacco Control Strategy • Building Public Confidence in Pesticide Regulation and Improving Access to Pest Management Products • Federal Early Childhood Development Strategy for First Nations and Other Aboriginal Children

Supplementary information on Horizontal Initiatives can be found at:

http://www.tbs-sct.gc.ca/rma/eppi-ibdrp/hrdb-rhbd/profil_e.asp

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TABLE 13:

Financial Statements

Statement of Management Responsibility

Responsibility for the integrity and objectivity of the accompanying financial statements and all information contained in this report rests with management. These financial statements have been prepared by management in accordance with accounting standards issued by the Treasury Board of Canada Secretariat which are consistent with Canadian generally accepted accounting principles for the public sector.

Management is responsible for the integrity and objectivity of the information in these financial statements. Some of the information in the financial statements is based on management's best estimates and judgment and gives due consideration to materiality. To fulfil its accounting and reporting responsibilities, management maintains a set of accounts that provides a centralized record of the department's financial transactions. Financial information submitted to the Public Accounts of Canada and included in the department's Departmental Performance Report is consistent with these financial statements.

Management maintains a system of financial management and internal control designed to provide reasonable assurance that financial information is reliable, that assets are safeguarded and that transactions are in accordance with the *Financial Administration Act*, are executed in accordance with prescribed regulations, within Parliamentary authorities, and are properly recorded to maintain accountability of Government funds. Management also seeks to ensure the objectivity and integrity of data in its financial statements by careful selection, training and development of qualified staff, by organizational arrangements that provide appropriate divisions of responsibility, and by communication programs aimed at ensuring that regulations, policies, standards and managerial authorities are understood throughout the department.

The financial statements of the department have not been audited.

Morris Rosenberg
Deputy Minister
Ottawa, Canada
Date August 14, 2006

Chantale Cousineau-Mahoney
Chief Financial Officer
Ottawa, Canada
Date August 14, 2006

13 TABLE 13:

Financial Statements

Statement of Operations (unaudited)

HEALTH CANADA

For the year ended March 31

(in thousands of dollars)

	2006						2005
	First Nations and Inuit Health	Health Policy, Planning and Information	Health Products and Food	Healthy Environments and Consumer Safety	Pest Control Product Regulation	**Total**	(Note 11) **Total**
Expenses							
Transfer payments	847,699	290,565	9,646	43,284	0	**1,191,194**	1,162,600
Salaries and wages	260,258	62,560	236,047	164,977	59,687	**783,529**	705,048
Utilities, material and supplies	373,124	2,031	11,960	12,802	1,884	**401,801**	392,004
Professional and special services	286,171	14,656	35,925	45,260	5,855	**387,867**	369,542
Travel- Non-Insured Health Patient	112,713	0	0	0	0	**112,713**	102,967
Accommodation	16,634	6,123	10,082	13,912	3,447	**50,198**	29,976
Purchased repair and maintenance	16,098	3,193	9,998	11,065	2,216	**42,570**	37,585
Travel and relocation	19,898	3,669	6,476	7,806	899	**38,748**	36,144
Amortization	7,727	44	7,522	6,888	311	**22,492**	21,497
Communications	9,015	1,015	3,628	4,103	681	**18,442**	20,220
Information	4,340	1,033	2,255	6,780	308	**14,716**	21,833
Rentals	1,654	661	973	906	162	**4,356**	4,810
Other	201	522	1,329	1,687	465	**4,204**	3,976
	1,955,532	386,072	335,841	319,470	75,915	**3,072,830**	**2,908,202**
Revenues							
Sales of goods and services							
Rights and privileges	22	0	16,618	54	4,512	**21,206**	19,083
Lease and Use of Public Property	445	0	2	0	1	**448**	485
Services of a regulatory nature	19	0	19,222	48	2,075	**21,364**	22,104
Services of a non-regulatory nature	4,818	0	366	11,706	56	**16,946**	16,533
Gain on sale of assets	92	0	4	20	2	**118**	93
Interest	32	0	144	80	64	**320**	246
Revenues from fines	0	0	0	2,759	0	**2,759**	2,570
Other	1,744	0	3,102	1,455	826	**7,127**	5,442
	7,172	**0**	**39,458**	**16,122**	**7,536**	**70,288**	**66,556**
Net cost of operations	**1,948,360**	**386,072**	**296,383**	**303,348**	**68,379**	**3,002,542**	**2,841,646**

The accompanying notes are an integral part of the financial statements

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TABLE 13:
Financial Statements
Statement of Financial Position (unaudited)

HEALTH CANADA

As at March 31 (in thousands of dollars)	**2006**	2005 (Note 11)
Assets		
Financial assets		
Accounts receivable and advances (Note 4)	**27,360**	55,192
	27,360	55,192
Non-financial assets		
Prepaid expenses	**0**	132
Tangible capital assets (Note 5)	**109,824**	123,538
	109,824	123,670
	137,184	178,862
Liabilities and Equity of Canada		
Liabilities		
Accounts payable and accrued liabilities	**402,718**	641,548
Vacation pay and compensatory leave (Note 6)	**37,205**	34,469
Deferred revenue	**4,944**	4,147
Employee severance benefits (Note 7)	**122,332**	100,476
Other liabilities	**10,684**	13,238
	577,883	793,878
Equity of Canada	**(440,699)**	(615,016)
	137,184	178,862

Contingent Liabilities (Note 8)
Contractual Obligations (Note 10)

The accompanying notes are an integral part of the financial statements

13 TABLE 13:
Financial Statements
Statement of Equity (unaudited)

HEALTH CANADA

For the year ended March 31 (in thousands of dollars)	**2006**	2005 (Note 11)
Equity of Canada, beginning of year	**(615,016)**	(458,238)
Net cost of operations	**(3,002,542)**	(2,841,646)
Current year appropriations used (Note 3)	**2,891,980**	2,816,674
Revenue not available for spending	**(11,234)**	(10,475)
Change in net position in the Consolidated Revenue Fund (Note 3)	**210,538**	(180,204)
Services provided without charge by other government departments (Note 9)	**85,575**	58,873
Equity of Canada, end of year	**(440,699)**	(615,016)

The accompanying notes are an integral part of the financial statements

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TABLE 13:
Financial Statements
Statement of Cash Flow (unaudited)

HEALTH CANADA

For the year ended March 31 (in thousands of dollars)	**2006**	2005 (Note 11)
Operating transactions		
Net cost of operations	**3,002,542**	2,841,646
Non-cash items:		
Amortization of tangible capital assets (Note 5)	**(22,492)**	(21,497)
Gain on disposal of capital and non-capital assets	**1,003**	672
Services provided without charge by other government departments (Note 9)	**(85,575)**	(58,873)
Variations in Statement of Financial Position:		
Increase (decrease) in accounts receivable, advances and prepaids	**(27,964)**	32,870
Decrease (increase) in liabilities	**215,995**	(192,297)
	3,083,509	2,602,521
Capital investment activities		
Acquisitions of tangible capital assets (Note 5)	**7,894**	23,577
Proceeds on disposal of tangible capital assets	**(119)**	(103)
	7,775	23,474
Financing Activities		
Net cash provided by Government of Canada	**(3,091,284)**	(2,625,995)
	(3,091,284)	(2,625,995)

The accompanying notes are an integral part of the financial statements

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TABLE 13:
Financial Statements
Notes to the Financial Statements

HEALTH CANADA

1. Authority and purpose

The Department of Health was established effective July 12, 1996 under the *Department of Health Act* to participate in the promotion and preservation of the health of the people of Canada. It is named in Schedule I of the *Financial Administration Act* and reports through the Minister of Health. Priorities and reporting are aligned under the following program activities:

First Nations and Inuit Health
The First Nations and Inuit Health program activity objectives include improving health outcomes; ensuring availability of, and access to, quality health services; and supporting greater control of the health system by First Nations and Inuit. Together with First Nations and Inuit, the First Nations and Inuit Health Branch through its regional offices, delivers public health and community health programs on-reserve, these include environmental health and communicable and non-communicable disease prevention, and provision of primary health care services through nursing stations and community health centres in remote and/or isolated communities to supplement and support the services that provincial, territorial and regional health authorities provide. The First Nations and Inuit Health program activity also supports targeted health promotion programs for Aboriginal people, regardless of residency (e.g. Aboriginal Diabetes Initiative) as well as counselling, addictions and mental wellness services. The Non-Insured Health Benefits coverage of drug, dental care, vision care, medical supplies and equipment, short-term crisis intervention mental health services, and medical transportation is available to all registered Indians and recognized Inuit in Canada, regardless of residency.

Health Policy, Planning and Information
The Health Policy, Planning and Information program activity provides advice and support to the Minister, the departmental executives and to program branches in the areas of policy development, intergovernmental and international affairs, strategic planning, program delivery and review and the administration of the *Canada Health Act*. It also contributes to improved health outcomes for Canadians by promoting the increased and more effective use of information and communications technologies; by improving access to reliable health information; by providing policy research and analysis to support evidence-based decision-making; by working with official language minority communities and others to improve access to health services in the official language of choice; and by taking into account Canadians' privacy expectations with respect to health information.

Health Products and Food
Health Canada is responsible for a broad range of health protection and promotion activities that affect the everyday lives of Canadians. As the federal authority responsible for the regulation of health products and food, Health Products and Food Branch evaluates and monitors the safety, quality and effectiveness of thousands of drugs (human and veterinary), vaccines, blood and blood products, biologics and genetic therapies, medical devices and natural health products, as well as the safety of the foods Canadians eat. It also provides useful information about risks and benefits related to health products and food so that Canadians can make informed decisions about their health and well-being. Ongoing regulatory responsibilities span the life cycle of health products and food, from clinical trials to surveillance, compliance and enforcement. The branch is also facing challenges associated with rapid advances in technology and scientific breakthroughs that have resulted in the growth of an unprecedented number of biologics, genetic therapies and vaccines and genetically modified and other novel foods. These challenges are met by drawing on sound science and effective risk management in evidence-based decision-making. These disciplines are integrated into daily operations, and together with the branch health promotion activities, they enable timely access to safe and effective health products and food for Canadians.

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TABLE 13:
Financial Statements
Notes to the Financial Statement

1. Authority and purpose (continued)

Healthy Environments and Consumer Safety
Under this Program Activity, Health Canada addresses many elements of day-to-day living that have an impact on the health of Canadians. These include drinking water safety, air quality, radiation exposure, substance use and abuse (including alcohol), consumer product safety, tobacco and second hand smoke, workplace health, and chemicals in the workplace and in the environment. Health Canada is also engaged in other health and safety related activities, including the Government's public safety and anti-terrorism initiatives, inspection of food and potable water for the travelling public, and health contingency planning for visiting foreign dignitaries. The broad national mandate flows from legislation including *the Food and Drugs Act, the Controlled Drugs and Substances Act, the Hazardous Products Act, the Radiation Emitting Devices Act, the Canadian Environmental Protection Act, the Tobacco Act* and others. Results are delivered through partnerships and by an active presence throughout every region of the country.

Pest Control Product Regulation
To help prevent unacceptable risks to people and the environment, Health Canada regulates the importation, sale and use of pesticides under the federal authority of the *Pest Control Products Act* (*PCPA*) and Regulations. The scope of work is extensive with more than 5,000 registered pesticides - including herbicides, insecticides, fungicides, antimicrobial agents, pool chemicals, microbials, material and wood preservatives, animal and insect repellents, and insect- and rodent-controlling devices. Ongoing regulatory responsibilities constitute the majority of the work underthis program activity. Using internationally accepted approaches and protocols; Health Canada conducts science-based health, environmental and value assessments. Pesticides are registered only if the health and environmental risks are considered acceptable, and if the product is effective. Health Canada sets maximum pesticide residue limits for food commodities under *the Food and Drugs Act* . Older pesticides are re-evaluated to determine if their use continues to be acceptable under current scientific approaches. Health Canada facilitates, encourages and maximizes compliance with the *PCPA* and the conditions of registration and also develops and promotes the use of sustainable pest management practices and products in cooperation with stakeholders.

The Department is responsible for the administration and enforcement of the following statutes and/or regulations, for which the Minister of Health is responsible for the Department and remains accountable to Parliament: *Canada Health Act, Canadian Centre on Substance Abuse Act, Canadian Environmental Protection Act, Controlled Drugs and Substance Act, Department of Health Act, Fitness and Amateur Sport Act, Food and Drugs Act, Hazardous Materials Information Review Act, Hazardous Products Act, Patent Act, Pest Control Products Act, Pesticide Residue Compensation Act, Quarantine Act, Queen Elizabeth II Canadian Research Fund Act, Radiation Emitting Devices Act, Tobacco Act,* and the *Human Assisted Reproduction Act.*

2. Significant accounting policies

The financial statements have been prepared in accordance with Treasury Board accounting policies which are consistent with Canadian generally accepted accounting principles for the public sector.

Significant accounting policies are as follows:

(a) Parliamentary appropriations
The Department of Health is financed by the Government of Canada through Parliamentary appropriations. Appropriations provided to the department do not parallel financial reporting according to generally accepted accounting principles since appropriations are primarily based on cash flow requirements. Consequently, items recognized in the statement of operations and the statement of financial position are not necessarily the same as those provided through appropriations from Parliament. Note 3 provides a high-level reconciliation between the two bases of reporting.

(b) Net Cash Provided by Government
The department operates within the Consolidated Revenue Fund (CRF). The CRF is administered by the Receiver General for Canada. All cash received by the department is deposited to the CRF and all cash disbursements made by the department are paid from the CRF. Net cash provided by Government is the difference between all cash receipts and all cash disbursements including transactions between departments of the federal government.

(c) Change in net position in the Consolidated Revenue Fund
The change in net position in the Consolidated Revenue Fund is the difference between the net cash provided by Government and appropriations used in a year, excluding the amount of non respendable revenue recorded by the department. It results from timing differences between when a transaction affects appropriations and when it is processed through the CRF.

(d) Revenues
Revenues are accounted for in the period in which the underlying transaction or event occurred that gave rise to the revenues. Types of revenues collected include medical devices, radiation dosimetry, drug submission evaluation, veterinary drugs, pest management regulation, product safety, hospital revenues resulting from payments for services provided to First Nations and Inuit Health hospitals, which are covered under provincial or territorial plans, and for the sale of drugs and health services for First Nations communities.

Revenues that have been received but not yet earned are disclosed as deferred revenues.

(e) Expenses
Expenses are recorded on the accrual basis:

- Grants are recognized in the year in which the conditions for payment are met. In the case of grants which do not form part of an existing program, the expense is recognized when the Government announces a decision to make a non-recurring transfer, provided the enabling legislation or authorization for payment receives parliamentary approval prior to the completion of the financial statements;
- Contributions are recognized in the year in which the recipient has met the eligibility criteria or fulfilled the terms of a contractual transfer agreement;
- Vacation pay and compensatory leave are expensed as the benefits accrue to employees under their respective terms of employment.
- Services provided without charge by other government departments for accommodation, the employer's contribution to the health and dental insurance plans, salary and associated expenditures of legal services and the worker's compensation coverage are recorded as operating expenses at their estimated cost.

TABLE 13:
Financial Statements
Statement of Operations (unaudited)

2. Significant accounting policies (continued)

(f) Accounts receivable

Accounts receivables are stated at amounts expected to be ultimately realized; a provision is made for receivables where recovery is considered uncertain.

(g) Employee future benefits

i Pension benefits: Eligible employees participate in the Public Service Pension Plan, a multiemployer plan administered by the Government of Canada. The department's contributions to the Plan are charged to expenses in the year incurred and represent the total departmental obligation to the Plan. Current legislation does not require the department to make contributions for any actuarial deficiencies of the Plan.

ii Severance benefits: Employees are entitled to severance benefits under labour contracts or conditions of employment. These benefits are accrued as employees render the services necessary to earn them. The obligation relating to the benefits earned by employees is calculated using information derived from the results of the actuarially determined liability for employee severance benefits for the Government as a whole.

(h) Contingent liabilities

Contingent liabilities are potential liabilities which may become actual liabilities when one or more future events occur or fail to occur. To the extent that the future event is likely to occur or fail to occur, and a reasonable estimate of the loss can be made, an estimated liability is accrued and an expense recorded. If the likelihood is not determinable or an amount cannot be reasonably estimated, the contingency is disclosed in the notes to the financial statements.

(i) Environmental liabilities

Environmental liabilities reflect the estimated costs related to the management and remediation of environmentally contaminated sites. Based on management's best estimates, a liability is accrued and an expense recorded when the contamination occurs or when the department becomes aware of the contamination and is obligated, or is likely to be obligated to incur such costs. If the likelihood of the department's obligation to incur these costs is not determinable, or if an amount cannot be reasonably estimated, the costs are disclosed as contingent liabilities in the notes to the financial statements.

2. Significant accounting policies (continued)

(j) Tangible Capital Assets

All tangible capital assets and leasehold improvements having an initial cost of $10,000 or more are recorded at their acquisition cost. The department does not capitalize intangibles, works of art and historical treasures that have cultural, aesthetic or historical value, immovable assets located on Indian Reserves and museum collections.

Amortization of capital assets is done on a straight-line basis over the estimated useful life of the capital asset as follows:

Asset class	Sub-asset class	Amortization Period
Buildings	Buildings	25 years
Leasehold improvements	Leasehold improvements	Lease term, max. 40 years
Machinery and equipment	Machinery and equipment	8-12 years
	Computer equipment	3-5 years
	Computer software	3 years
	Other equipment	10-12 years
Vehicles	Motor Vehicles	4-7 years
	Other Vehicles	10 years

(k) Prepaid expenses

Prepaid expenses include prepayments of operating expenses and transfer payments. Prepaid transfer payments consist of contributions advanced to recipients as of March 31 for which it is known that the costs wil be incurred by the recipient in the subsequent fiscal year and the amount can be readily determined based on available information.

(l) Measurement uncertainty

The preparation of these financial statements in accordance with accounting policies issued by the Treasury Board of Canada which are consistent with Canadian generally accepted accounting principles for the public sector requires management to make estimates and assumptions that affect the reported amounts of assets, liabilities, revenues and expenses reported in the financial statements. At the time of preparation of these statements, management believes the estimates and assumptions to be reasonable. The most significant items where estimates are used are contingent liabilities, environmental liabilities and the useful life of tangible capital assets. Actual results could differ from those estimated. Management's estimates are reviewed periodically and, as adjustments become necessary, they are recorded in the financial statements in the year they become known.

3. Parliamentary appropriations

The Department receives most of its funding through annual Parliamentary appropriations. Items recognized in the statement of operations and the statement of financial position in one year may be funded through Parliamentary appropriations in prior, current or future years. Accordingly, the Department has different net results of operations for the year on a government funding basis than on an accrual accounting basis. The differences between net results of operations and appropriations are reconciled in the following tables.

(a) Reconciliation of net cost of operations to current year appropriations used:

(in thousands of dollars)	2006	2005
Net cost of operations	**3,002,542**	2,841,646
Adjustments for items affecting net cost of operations but not affecting appropriations:		
Add (Less):		
Services provided without charge by other government departments	**(85,575)**	(58,873)
Amortization	**(22,492)**	(21,497)
Allowances for severance pay	**(21,856)**	(6,100)
Refund/reversal of previous year's expenses	**17,224**	32,981
Revenue not available for spending	**11,234**	10,475
Justice Canada legal fees	**(10,488)**	(8,262)
Allowance for vacation and compensatory leave	**(2,736)**	(1,509)
Allowance for environmental liabilities	**1,920**	3,793
Other	**(5,671)**	428
	(118,440)	(48,564)
Adjustments for items not affecting net cost of operations but affecting appropriations:		
Add (Less):		
Acquisitions of tangible capital assets	**7,894**	23,577
Advances cleared to expenses	**(16)**	15
	7,878	23,592
Total appropriations used	**2,891,980**	2,816,674

3. Parliamentary appropriations (continued)

(b) Appropriations provided and used:

(in thousands of dollars)	2006	2005
Operating expenditures - Vote 1	**1,552,618**	1,511,233
Supplementary Vote 1a	**0**	73,942
Supplementary Vote 1b	**0**	2,581
Governor General's Special Warrants	**48,954**	0
Transfer from TB - Vote 10	**143**	0
Transfer from TB - Vote 15	**0**	14,444
	1,601,715	1,602,200
Grants and Contributions - Vote 5	**1,201,794**	1,122,844
Supplementary Vote 5a	**0**	25,329
Supplementary Vote 5b	**0**	34,433
Transfer from TB - Vote 5	**45,915**	0
	1,247,709	1,182,606
Total Voted Parliamentary Appropriations	**2,849,424**	2,784,806
Lapsed	**(66,873)**	(66,418)
Total Voted Parliamentary Appropriations Used	**2,782,551**	2,718,388
Statutory Authorities Used:		
Spending of proceeds from the disposal of surplus Crown assets	**130**	168
Minister's salary and motor car allowance	**67**	70
Contributions to employee benefit plans	**109,112**	98,060
Payments for insured health services and extended health care services	**(21)**	(79)
Refunds of previous years amounts credited to revenues	**68**	51
Collections agency fees	**5**	16
Court Awards	**68**	0
Total appropriations used	**2,891,980**	2,816,674

3. Parliamentary appropriations (continued)

(c) Reconciliation of net cash provided by Government to current year appropriations used

(in thousands of dollars)	2006	2005
Net cash provided by Government	**3,091,284**	2,625,995
Revenue not available for spending	**11,234**	10,475
Change in net position in the Consolidated Revenue Fund		
Refund/reversal of previous year's expenses	**17,224**	32,981
Justice Canada legal fees	**(10,488)**	(8,262)
Variation in accounts receivable and advance	**27,832**	(23,762)
Variation in accounts payable and accrued liabilities	**(238,830)**	179,556
Other	**(6,276)**	(309)
	(210,538)	180,204
Current year appropriations used	**2,891,980**	2,816,674

4. Accounts receivable and advances

Health Canada records receivables from three main sources. As of March 31, amounts due under each of these categories are as follows:

(in thousands of dollars)	2006	2005
Receivables from External Parties	**18,278**	16,835
Receivables from Other Government Departments	**11,861**	41,124
Employee Advances	**75**	87
Gross receivables	**30,214**	58,046
Less: Allowance for doubtful accounts on external receivables	**(2,854)**	(2,854)
Net receivables	**27,360**	55,192

5. Tangible capital assets

Capital assets (in thousands of dollars)	Balance beginning of year	Acquisitions	Disposals/ write-downs/ adjustments	Balance end of year
Land	1,181	0	0	**1,181**
Buildings	126,862	244	0	**127,106**
Leasehold improvements	19,246	31	0	**19,277**
Machinery and equipment	148,901	5,773	(361)	**154,313**
Vehicles	18,519	1,846	(79)	**20,286**
	314,709	7,894	(440)	**322,163**

Accumulated amortization (in thousands of dollars)	Balance beginning of year	Current year amortization	Disposals/ write-downs/ adjustments	Balance end of year
Buildings	71,309	5,240	0	**76,549**
Leasehold improvements	10,075	3,760	0	**13,835**
Machinery and equipment	98,144	11,672	(295)	**109,521**
Vehicles	11,643	1,820	(1,029)	**12,434**
	191,171	22,492	(1,324)	**212,339**

Net tangible capital assets (in thousands of dollars)	Balance beginning of year			Balance end of year
Land	1,181			**1,181**
Buildings	55,553			**50,557**
Leasehold improvements	9,171			**5,442**
Machinery and equipment	50,757			**44,792**
Vehicles	6,876			**7,852**
	123,538			**109,824**

6. Vacation pay and compensatory leave

(in thousands of dollars)	**2006**	2005
Allowance for vacation	**36,219**	33,459
Allowance for compensatory leave	**918**	942
Allowance for other employee benefits	**68**	68
	37,205	34,469

7. Employee benefits

(a) Pension benefits

The department's employees participate in the Public Service Pension Plan, which is sponsored and administered by the Government of Canada. Pension benefits accrue up to a maximum period of 35 years at a rate of 2 percent per year of pensionable service, times the average of the best five consecutive years of earnings. The benefits are integrated with Canada/Québec Pension Plans benefits and they are indexed to inflation.

Both the employees and the department contribute to the cost of the Plan. The current and previous year expenses, which represent approximately 2.6 times the contributions by employees, amount to:

(in thousands of dollars)	**2006**	2005
Expense for the year	**80,743**	86,437
	80,743	86,437

The department's responsibility with regard to the Plan is limited to its contributions. Actuarial surpluses or deficiencies are recognized in the financial statements of the Government of Canada, as the Plan's sponsor.

(b) Severance benefits

The department provides severance benefits to its employees based on eligibility, years of service and final salary. These severance benefits are not pre-funded. Benefits will be paid from future appropriations. Information about the severance benefits, measured as at March 31, is as follows:

(in thousands of dollars)	**2006**	2005
Accrued benefit obligation, beginning of year	**100,476**	94,376
Expense for the year	**30,517**	12,577
Benefits paid during the year	**(8,661)**	(6,477)
Accrued benefit obligation, end of year	**122,332**	100,476

8. Contingent liabilities

(a) Contaminated sites

Liabilities are accrued to record the estimated costs related to the management and remediation of contaminated sites where the department is obligated or likely to be obligated to incur such costs. The department has identified sites where such action is possible and for which a liability has been recorded.

	2006	2005
Approximate number of sites for which a liability has been recorded	**14**	14

(in thousands of dollars)		
Liability recorded for contaminated sites	**3,646**	5,566

The department's ongoing efforts to assess contaminated sites may result in additional environmental liabilities related to newly identified sites, or changes in the assessments or intended use of existing sites. These liabilities will be accrued in the year in which they become known.

(b) Claims and litigation

In the normal course of its operations, Health Canada becomes involved in various legal actions. Legal proceedings for claims totalling approximately $10,798,354,521 ($11,747,560,786 in 2005) were still pending at March 31, 2006. Some of these potential liabilities may become actual liabilities when one or more future events occur or fail to occur. To the extent that the future event is likely to occur or fail to occur, and a reasonable estimate of the loss can be made, an estimated liability is accrued and an expense recorded on the department's financial statements.

9. Related party transactions

The department is related as a result of common ownership to all Government of Canada departments, agencies, and Crown corporations. The department enters into transactions with these entities in the normal course of business and on normal trade terms. Also, during the year, the department received services which were obtained without charge from other Government departments as presented in part (a).

(a) Services provided without charge by other government departments:

During the year the department received without charge from other departments, accommodation, legal fees, worker's compensation and the employer's contribution to the health and dental insurance plans. These services without charge have been recognized in the department's Statement of Operations as follows:

(in thousands of dollars)	**2006**	2005
Accommodation	**34,481**	10,264
Employer's contribution to the health and dental insurance plans	**48,176**	44,488
Worker's compensation costs	**879**	843
Legal services	**2,039**	3,278
	85,575	58,873

The Government has structured some of its administrative activities for efficiency and cost-effectiveness purposes so that one department performs these on behalf of all without charge. The costs of these services, which include payroll and cheque issuance services provided by Public Works and Government Services Canada, are not included as an expense in the department's Statement of Operations.

(b) Payables and receivables outstanding at year-end with related parties:

(in thousands of dollars)	**2006**	2005
Accounts receivable with other government departments and agencies	**11,861**	41,124
Accounts payable to other government departments and agencies	**20,508**	16,570

10. Contractual Obligations

The nature of the Department's activity results in multi-year contracts and obligations whereby the Department will be committed to make some future payments. Significant contractual obligations that can be reasonably estimated are as follows:

(in thousands of dollars)	2006-07	2007-08	2008-09	2009-10	2010-11
Transfer payments	116,400	72,400	39,400	40,400	-
Non-Insured Health	24,000	16,000	-	-	-
	140,400	88,400	39,400	40,400	-

11. Comparative information

The control and supervision of the Population and Public Health Branch of Health Canada was transferred to the Public Health Agency of Canada (PHAC) by Order in Council pursuant to the *Public Service Rearrangement and Transfer of Duties Act*, effective 24 September 2004. The 2004-05 amounts have been amended to remove the financial transactions relating to the activities now performed by PHAC.

12. Subsequent events

On July 25, 2006, the Government reached a framework agreement on the elements of a settlement for those Canadians who contracted hepatitis C from the blood system before January 1, 1986 and after July 1, 1990. Under the terms of the agreement, the government will set aside nearly $1 billion in a special settlement fund. Health Canada has not recorded an expense or a liability for this agreement as the details of the final agreement have not yet been reached.

14 TABLE 14:

Response to Parliamentary Committees, and Audits and Evaluations 2005–2006

RESPONSE TO PARLIAMENTARY COMMITTEES	
Standing Committee on Health — *Report #6: Proposed Regulations Amending the Tobacco Reporting Regulations* (tabled March 22, 2005) In its Sixth Report (cited above), and referring to the Proposed Regulations Amending the Tobacco Reporting Regulations under the *Tobacco Act*, S.C. 1997, c. 13, sbs. 42.1 (1) ("the amending regulations"), the Standing Committee on Health recommended that "all information to be submitted to Health Canada under these regulations be made public. If need be, the Minister of Health should authorize its disclosure in the public interest in accordance with Section 20 (6) of the *Access to Information Act* (ATIA)". In its Response, the Department agreed with the spirit and intent of the Committee's recommendation, and committed to the following: • that the Government will publicly disclose all toxicity data aggregated on an industry-wide basis, so as to enable meaningful tracking and analysis of general trends in cigarette toxicity following the adoption of the ignition propensity standards; • that the Government will assess the appropriateness of publicly disclosing manufacturer or product-specific data that do not meet the tests for protection of confidentiality; • that the Government will ensure the timely consideration of requests to disclose information that may be in the public interest under the discretionary provisions of ATIA Section 20 (6). Government Response (tabled August 17, 2005): *http://cmte.parl.gc.ca/cmte/CommitteePublication.aspx?COM=8981&Lang=1&SourceId=127834*	**Standing Committee on Public Accounts** — *Report #11: Chapter Four — Management of Federal Drug Benefits Programs November 2004 — Report of the Auditor General* (tabled May 13, 2005) As per the Government of Canada's response to the Standing Committee on Public Accounts — Report #11, Health Canada and the five other departments operating public drug benefit programs have been responding individually and collectively to the Committee's recommendations. Health Canada is committed to working with the Federal Health Partnership (FHP) to explore cost-effective drug use and centrally-managed system efficiencies to assist and improve Non-Insured Health Benefits' (NIHB) clients' access to necessary health goods and services, while ensuring their safety and being accountable for public funds. Health Canada is operating a robust and effective monitoring system of prescription drug use, which alerts pharmacists, at the point-of-sale, to any issues of concern. For example, messages may alert pharmacists to the potential for adverse reactions between drugs that are being prescribed or notify them when a patient has reached their maximum allowable daily dose for a particular drug. Health Canada's NIHB Program's retrospective Drug Use Evaluation (DUE) continues to evaluate ways of improving the monitoring of prescription drug use, particularly in measuring the effectiveness of current approaches in reducing the inappropriate use of drugs. This includes working closely with stakeholders, pharmacists, physicians and health professionals on follow-up and outreach activities. Government response (tabled September 27, 2005): *http://cmte.parl.gc.ca/cmte/CommitteePublication.aspx?COM=8989&Lang=1&SourceId=129019*

14 TABLE 14:

Response to Parliamentary Committees, and Audits and Evaluations 2005–2006

(continued)

RESPONSES TO THE AUDITOR GENERAL (AG) AND THE COMMISSIONER OF THE ENVIRONMENT AND SUSTAINABLE DEVELOPMENT (CESD)	
In April 2005, the Auditor General (AG) tabled the report *Chapter 2 — National Security in Canada — The 2001 Anti-Terrorism Initiative: Air Transportation Security, Marine Security, and Emergency Preparedness*. The report recommended that Health Canada (HC) establish an appropriate legal structure for providing unlicensed drugs in an emergency. In response to public health emergencies, HC proposes to develop: • regulatory authorities to enable the Minister to authorize a block release of products; and • new regulatory authorities to authorize "emergency use" products. In September 2005, the AG tabled the report *Chapter 4 — Safety of Drinking Water: Federal Responsibilities*. Improvements were called for in the development and review of drinking water guidelines; in clearing the backlog of about 50 guidelines; in guidance to deputy heads for providing safe drinking water in areas of federal jurisdiction; and in assuring Canadians that tap water on aircraft is safe. HC is working towards the implementation of these recommendations by: streamlining the guideline development process; conducting biennial reviews to identify guidelines to be revised based on risk to public health; finalizing and providing guidance to deputy heads; and examining funding options to ensure that the airline industry is subject to routine potable water inspections.	In September 2005, the AG tabled the report *Chapter 5 — Drinking Water in First Nations Communities*. The report called for HC and Indian and Northern Affairs Canada (INAC) to: develop and implement a regulatory regime for drinking water in First Nations (FN) communities; clarify the codes and standards applicable to the design and construction of drinking water systems; ensure that appropriate drinking water tests are carried out, recorded and communicated; assess the capacity and support for FN to deliver safe drinking water; and ensure that relevant information is collected and reported to Parliament. HC will continue to work with INAC and FN for the assessment of the feasibility and/or implementation of these recommendations. In particular, HC has developed an action plan to: improve program delivery; clarify codes and standards; improve and update procedures for FN; consolidate capacity building; and modify data standards and systems for reporting.

14 TABLE 14:

Response to Parliamentary Committees, and Audits and Evaluations 2005–2006

(continued)

EXTERNAL AUDITS OR EVALUATIONS

Government-wide audits affecting Health Canada conducted by the Auditor General:

- National Security in Canada: The 2001 Anti-Terrorism Initiative — Air Transportation Security, Marine Security and Emergency Preparedness, and
- Managing Horizontal Initiatives

Reports by the Commissioner of the Environment and Sustainable Development (CESD) affecting Health Canada:

- *Chapter 4: Safety of Drinking Water: Federal Responsibilities*
- *Chapter 5: Drinking Water in First Nations Communities*
- *Chapter 6: Green Procurement*
- *Chapter 7: Sustainable Development Strategies*
- *Chapter 8: Environmental Petitions*

Audit conducted by the Public Service Human Resources Management Agency of Canada (PSHRMAC):

- Audit of Service to the Public in Both Official Languages — Three Health Canada offices in British Columbia

Audit conducted by the Office of the Commissioner of Official Languages:

- Health Canada's Official Languages Report Card: *http://www.ocol-clo.gc.ca/archives/ar_ra/2005_06/2005_06_e.htm#TOC*

INTERNAL AUDITS OR EVALUATIONS

Internal audits completed by Health Canada in 2005–2006:

- Review of the Administration of the Health Canada Contract with First Canadian Health (FCH) (No. H1021-6-9693) (Phase II)
- Follow-up of the Directed Audit of *Société Santé en français Inc.*

The executive summaries of the above two audit reports will be posted on the departmental website.

Evaluations completed by Health Canada in 2005–2006:

- Canada Health Infostructure Partnership Program (CHIPP)
- Cost Recovery in the Pest Management Regulatory Agency
- First Nations and Inuit Health Branch's Brighter Futures and Building Healthy Communities Programs
- Health Canada Innovation Fund
- Health Care Strategies and Policy Grant and Contribution Programs
- Health Transfer Policy
- Health Transition Fund
- Memoranda of Understanding between the Assistant Deputy Ministers and Regional Directors General
- Non-Insured Health Benefits (NIHB) Pilot Projects
- Primary Health Care Transition Fund
- Research Management and Dissemination Division

Treasury Board of Canada Secretariat Audit and Evaluation Database:

http://www.tbs-sct.gc.ca/rma/database/newdeptview_e.asp?id=41

14 TABLE 14:

Response to Parliamentary Committees, and Audits and Evaluations 2005–2006

(continued)

IMPLEMENTATION OF THE PROPOSED FEDERAL ACCOUNTABILITY ACT AND TREASURY BOARD'S 2006 INTERNAL AUDIT POLICY	
The proposed Federal Accountability Act (Bill C-2), which is expected to receive royal assent in autumn 2006, will, for the first time, create a legislative requirement for deputy heads to establish and adequately resource departmental audit functions. This Act will provide a legislative basis for the Audit and Accountability Bureau's (AAB) actions to implement Treasury Board's 2006 Internal Audit Policy, which took effect on April 1, 2006.	AAB has been preparing for the implementation of Treasury Board's 2006 Internal Audit Policy: • the Chief Audit Executive reports directly to the Deputy Minister's Office, effective January 2006; • AAB has been significantly restructured and is staffing to ensure it will meet the requirements of the proposed legislation and Treasury Board's 2006 Internal Audit Policy; • AAB has been very active in eight of the nine relevant Office of the Comptroller General (OCG) Internal Audit Working Groups whose efforts facilitate many initiatives, including the establishment of independent Audit Committees for all federal departments and agencies by April 1, 2009 and OCG-led practice reviews of all internal audit directorates every four years.

15 TABLE 15:
Sustainable Development

Key goals, objectives, and/or long-term targets of the SDS

Health Canada's 2004–2007 Sustainable Development Strategy is comprised of three Themes:

1) Helping to create healthy social and physical environments;
2) Integrating sustainable development into departmental decision making and management processes; and
3) Minimizing the environmental and health effects of the Departments's physical operations and activities.

Under each theme are various objectives and targets. During 2005–2006 progress was made in all three areas with some exceptional progress on Theme three.

How key goals, objectives and/or long-term targets help us achieve our strategic outcomes

Health Canada has four Strategic Outcomes:

1) A strengthened knowledge base to address health and health care priorities;
2) Access to safe and effective health products and food and information for healthy choices;
3) Reduced health and environmental risks from products and substances and safer living and working environments; and
4) Better health outcomes and reduction of health inequalities between First Nations and Inuit and other Canadians.

Targets established under Theme one directly support all four Strategic Outcomes. Targets under Theme two also support the full range of outcomes although primarily by strengthening the knowledge base and, in turn, management and decision making practices. Theme three supports the greening of HC operations government-wide.

Targets and Progress

Develop Guidelines for Canadian Drinking Water Quality. (Target 1.1.1)

Health Canada's lead in developing Guidelines for Canadian Drinking Water Quality is key to addressing health risks to Canadians from drinking water contaminants. Drinking Water Guidelines and their supporting documents are being developed for chemical and microbiological contaminants on an ongoing basis. During 2005–2006 four new guidelines were approved by the FPT Committee on Drinking Water for consultation.

Develop and/or update guidelines and standards to improve food safety and reduce food-borne illness. (Target 1.1.5)

A food safety newspaper and TV advertising campaign focussed on E-coli in ground beef and the need to cook to a sufficient internal temperature as measured with a digital food thermometer. Also during the year, HC co-developed and published Government of Canada Food Allergen pamphlets.

Improve the process of making regulatory decisions for pest control products. (Target 1.1.7)

The Pest Management Regulatory Agency continues to improve monitoring, risk assessment and mitigation under the new *Pest Control Products Act*. New regulations on the mandatory reporting of incidents (including adverse effects) are expected by the end of 2006. A national pesticide sales database will be implemented once new regulations on the mandatory reporting of sales information are made under the new PCPA; new regulations are expected by the end of 2006.

15 TABLE 15:
Sustainable Development *(continued)*

Improve and better integrate health services for First Nations and Inuit (FN/I). (Target 1.2.1)

Through the Nursing Transformation Strategy, 104 new nursing positions were added to support our efforts to ensure an adequate and stable supply of nurses to meet the needs of FN/I communities.

The Health Integration Initiative (HII), which ended in March 2006, funded eight pilot projects that focused on improving the integration of federally funded health services in FN/I communities with provincial and territorial health services. Lessons learned and analysis of the evaluations of these pilot projects is currently under way. The HII was funded through the Primary Health Care Transition Fund.

Deliver training on Sustainable Development and Strategic Environmental Assessments (SEAs). (Target 2.1.2)

HC has significantly improved the profile, training and tracking of SEAs over the past year. A detailed policy on SEAs was approved by the Department Executive Committee in late 2004. Building on this progress, 2005–2006 saw the design and delivery of SEA training for analysts and planners across the Department. In addition, senior executives have been briefed on their responsibilities under the Cabinet Directive and HC's supporting policy and guidelines.

Design and administer a Department-wide SD survey. (Target 2.1.3)

A Department-wide survey on SD was conducted in 2005–2006 to provide an environmental scan of employee knowledge and awareness of SD and to establish baseline measures for future reference.

The survey was very successful, reaching over 1,100 employees in the Health Portfolio (includes Public Health Agency of Canada). The survey helps fulfill two commitments under Theme two and provides guidance for future planning on SD training and activities.

Conduct an Environment Festival during E-week. (Target 2.1.3)

Several branches contributed to the annual E-Week zero-waste barbeque on June 8, 2005 under the theme "Linking healthy living with healthy environments." A total of 53 exhibitors raised awareness and provided valuable information to approximately 1,000 employees.

Develop a resource management guidebook for facility managers. (Target 3.1.1)

Over the past two years, a guidebook was developed to assist facility managers in managing the environmental aspects of their operations. The guide is nearing completion and will be distributed in fall 2006 during the supporting training course.

Develop a departmental Pollution Prevention Guidebook and Action Plan. (Target 3.2.1)

The completion of the Pollution Prevention Guidebook for program staff and accompanying online Pollution Prevention Training Package fulfills or partially fulfills a key Theme three SDS commitment. The Guidebook and Training Package helps employees make green choices while at work, on the road or at home and includes content specific to the Health Canada environment such as green practices for laboratories. Training on the package has now begun.

15 TABLE 15:
Sustainable Development *(continued)*

Adjustments

Health Canada considers the SDS to be a living document that evolves over time in response to emerging opportunities and to formal recommendations and audits. For example, HC made changes to Goals and Targets based on feedback from the 2004–2005 report of the Commissioner of the Environment and Sustainable Development.

The Pollution Prevention training for program staff has begun but should reach the target of 1,500 trained employees by fall 2006/spring 2007 rather than spring 2006. Training based on the guidebook for facility managers and other managers with authorities over facilities has been scheduled for fall 2006 and will ensure the completion of target 3.1.2 in 2006–2007 rather than 2005–2006.

A framework for identifying key planning and reporting activities has been developed but a more robust SD lens is being developed that will allow for a Department-wide policy review to systematically identify opportunities for integrating SD considerations into departmental policies, legislation and contracts. The timeline for this will extend into 2007.

HC continues to provide leadership by hosting the Awareness, Communication and Training (ACT) sub-committee of the Interdepartmental Network on Sustainable Development Strategies. The ACT committee is promoting the development of SD training. The Canada School of Public Service is being consulted regarding the possibility of a government-wide SD training module. Delivery may not occur until 2007 or beyond.

16 TABLE 16:
Procurement and Contracting

DEPARTMENT	
POINTS TO ADDRESS	**CONTRACT MANAGEMENT FRAMEWORK**
1. Role played by procurement and contracting in delivering programs	Procurement and contracting are essential in terms of providing goods and services to the Department by contracting for services and procuring goods, particularly in the scientific and research disciplines. Collaboration, sharing of expertise and related information, as well as providing operational support, are key to ongoing policy and program delivery.
2. Overview of how the Department manages its contracting function	Procurement and contracting are highly decentralized by branch and by region, with program managers designated with budgetary responsibilities as contracting authorities based on the Delegation of Financial Signing Authorities. Contract and procurement specialists as well as Materiel Management Policy Officers provide support services directly to program branch headquarters operations in the National Capital Region (NCR) and extend their functional liaison with the regions. Senior contract specialists have been co-located within each branch to provide improved oversight as part of the Contract and Requisition Control Committee and to promote procurement planning and the development of procurement strategies with the cooperation of program managers. Ongoing training is provided to cost centre managers and support staff alike who are involved in the contract process to ensure that informed decisions are made in compliance with regulations, policies and procedures regarding procurement and contracting within and outside of the Department's delegated authority. The quality assurance group, in conjunction with the operation of internal audit, has periodically assessed elements of contracting, including the use of acquisition cards, to ensure that the Department conforms to government policy on procurement and contracting. In 2005–2006, under its own authority, the Department awarded 20,402 contracts valued at approximately $211 million. Public Works and Government Services Canada awarded 716 contracts on behalf of Health Canada valued at approximately $79.5 million. Contracts worth $35 million were awarded in 2005 through the Procurement Strategy for Aboriginal Businesses — an increase of approximately $15 million from the previous year.
3. Progress and new initiatives enabling effective and efficient procurement practices	In order to enhance the Department's capacity to provide improved service with respect to contracting and in response to the government's Way Forward Strategy additional resources were added and new initiatives undertaken. Seven new positions were created and staff deployed to each branch headquarters within the NCR to provide consultation, advice and oversight as part of the Contract Requisition and Control Committee function, to develop procurement strategies for program managers and to liaise with all parties regarding the processing and administration of contracts. The resulting network of staff have been reassigned to provide similar support to the regions. As an enhancement to the Contract Management Framework, the Contract Requisition and Reporting System was introduced to the Department and can be described as a contract tracking, workflow and approval system. This system captures approximately 80 percent of contracting activities and continues to be expanded. It provides improved capacity to report on contract activity, to respond to Access to Information and ministerial enquiries and also incorporates a review and approval workflow for long form contracts and call-ups against standing offers. Training was completely rolled out to the regions and the NCR. The other 20 percent of contracting activities will be captured by the end of the 2006–2007 fiscal year.

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TABLE 16:

Procurement and Contracting *(continued)*

DEPARTMENT	
POINTS TO ADDRESS	**CONTRACT MANAGEMENT FRAMEWORK**
(continued)	An action plan was developed with respect to the Way Forward Strategy specific to the integration of the Government of Canada Marketplace. Staff have participated in training for commodity panel participation and are actively involved in the commodity panel for temporary help services. The use of mandatory standing offers and the standing offer index offered by PWGSC were discussed and enhancements made, followed by a bulletin to all departmental employees requesting compliance in the use of mandatory standing offers. Involvement in Common Administrative Shared Services has also been a priority and work has steadily advanced with respect to materiel management issues into 2006. The first Materiel Management Workshop was held in May 2005 with 45 attendees, mostly from the regions, to develop their understanding and working knowledge of contracting and materiel management issues. Presentations were given by managers from Materiel Management Division and Legal Services. New working tools were introduced to eliminate gaps in contract documentation formalizing certain contract activities. The Local Purchase Order for Services was created to contract for "basic" service delivery up to a maximum of $5,000 and the Memorandum of Agreement was created to include contractual clauses in agreements between Health Canada and other provincial/territorial or municipal administrations thereby replacing the Memorandum of Understanding where there is a transfer of funds.

17 TABLE 17:
Service Improvement

Pest Management Information Service

The Pest Management Information Service which operates under the auspices of the Pest Management Regulatory Agency has a service standard which states that queries will be acknowledged within 24 to 48 hours, 85 percent of the time. The acknowledgement time can range from 24 to 48 hours depending on the number of enquiries that are received by the Information Service at the same time. Because the Information Service does not provide seven days a week service, an acknowledgement on Monday or Tuesday, for a query received on the previous Friday, is acceptable.

To ensure that the Pest Management Information Service is responding to queries within the set time frame, an audit process was implemented. Another purpose of the audit is to correct system problems that hinder meeting this standard. Each month, 10 phone and 10 e-mail responses are audited to determine if all queries were responded to within the service standard limit. Results indicated that the service standard was met or exceeded 90 percent of the time.

Additionally, a Client Satisfaction Survey was conducted in March, 2006. Where possible, the results of the first two Surveys, conducted in 2002 and 2003 respectively, were compared with these results. Overall, the Information Service was able to maintain its high ratings for the service it provides. According to the survey results, clients appreciated the speed of response to their queries, found the quality of the staff to be excellent and valued the quality of the information they received.

The survey results will help to further enhance the service which will focus on improving the website to make it more informative and user-friendly and on increasing the amount of documentation available.

It's Your Health

It's Your Health (IYH) are fact sheets used to convey general health and safety information to Canadians. IYH has conducted multiple client satisfaction surveys in the past and established service standards which are published on the website. The standard was implemented for all new articles and will be put in place over time for all articles that appear on the IYH website. All IYH articles are reviewed periodically to ensure current and reliable information. An automatic reminder is sent to the IYH project manager for each article. The timing of the reminder is based on recommendations from the Health Canada (HC) or Public Health Agency of Canada (PHAC) experts or officials who contributed to the content of the original article.

Another client satisfaction survey was recently conducted and the final report, with recommendations, is pending.

Health Canada 1-800 General Enquiries Line in Pacific Region

This government information line is based on interactive telephone response technology and uses a tree structure to transfer callers to the appropriate program at HC or PHAC. It operates 24 hours daily, seven days a week and can handle up to 10 simultaneous calls.

The tree structure for this line is re-sequenced regularly so that the most common questions are addressed first (usually current hot topics such as West Nile virus or avian flu) and 90 percent of calls are addressed within the first three choices.

A client satisfaction survey was conducted in March 2005 and the findings showed that people were grateful for the service provided; praised the helpfulness of the service

17 TABLE 17:
Service Improvement *(continued)*

provider; welcomed the quick and accurate responses; and were delighted to be able to speak to someone live, rather than listening to a canned message. Complaints centered on the telephone directory which was found to be confusing, incomplete and not user-friendly.

Service standards that were subsequently established include:

- answer calls within three rings;
- reduce calls handled by branch receptionists (which are not for them) by 80 percent (2005–2006: >98 percent);
- provide information requested by caller, transfer to correct HC/PHAC program or refer to an appropriate external agency within an average of less than 1.5 minutes per client (2005–2006: 48 seconds);
- ensure that a minimum of 50 percent of calls will be handled by the ITR system without staff intervention (2005–2006: 63 percent);
- achieve the above with a complaint level not to exceed 0.2 percent or 1:500 (2005–2006: <0.001 percent).

It should be noted that less than 30 percent of the calls to this government information line are actually intended for Health Canada or the Public Health Agency of Canada. Most callers are seeking specific information about the Medical Service Plan, the BC provincial health care program. As such, there is a redirect function at the beginning of the selections on this line which immediately connects users to the province.

Given the overwhelmingly positive feedback from clients, it was determined that little can be done to further improve the high level of client satisfaction.

18 TABLE 18:
Travel Policies

Comparison to the TBS Special Travel Authorities

Travel Policy of Health Canada:
Health Canada follows and uses the TBS Special Travel Authority parameters.

Comparison to the TBS Travel Directive, Rates and Allowances

Travel Policy of Health Canada
Health Canada follows and uses the TBS Travel Directive, Rates and Allowances.

Section IV

Other Items of Interest

Advancing the Science Agenda

The Office of the Chief Scientist (OCS) was created in 2001, to strengthen Health Canada's ability to perform and use science. The OCS is a critical organization that serves the Department as a whole, as well as individual branches, programs, and scientists, in both the science and policy arenas. A key role for the OCS is to provide leadership, coherence and expertise to the Department's significant number of scientific responsibilities, activities and needs. The OCS seeks to secure a stronger role for science in improving health, by pursuing its mandate of ensuring the advancement of science in three priority areas:

1. Advocating effective use of science advice in policy making; assisting the Department in employing quality science advice in its policy and regulatory decisions;
2. Fostering science quality and integrity, encouraging due diligence and ensuring Health Canada has the science capacity it needs to meet current and emerging challenges; and
3. Raising awareness and understanding of science conducted at Health Canada; improving stakeholder and public understanding of Health Canada's science and its contribution to the health and safety of Canadians.

To enable the Department to fulfill its mandate and contribute to the Government's overarching priorities, the OCS has been facilitating the development of a plan for strengthening the management of horizontal science issues. A coherent science management plan will build on the Health Canada Framework for Science, to help ensure Health Canada's science and research addresses common priorities, including human resources, ethics, intellectual property, laboratories and other infrastructure, under a sound Management Accountability Framework.
The OCS has continued to provide secretariat support to the ministerial level Science Advisory Board (SAB). The SAB provides independent, expert advice on the science performed and used by Health Canada. In 2005–2006, 10 new members were appointed to the SAB, including a new Chair. A key theme for the SAB over the past year has been engagement; it has taken steps to ensure it is appropriately linked both within the Health Portfolio (ex-officio membership has been extended to the Public Health Agency of Canada) as well as with its counterparts at other science-based departments and agencies (such as Environment Canada and Agriculture and Agri-food Canada). Operational changes have been instituted to facilitate the provision of relevant, strategic advice on health science and research activities.

The SAB has also established an important link to research ethics within the Department by including the Chair of Health Canada's Research Ethics Board as an ex-officio member of the SAB. OCS also continues to provide secretariat support for the Research Ethics Board, which performed 53 reviews over the year.

In order to ensure the Department has access to the science and research necessary to support effective decision making, policy development and regulation, as well as to ensure its science and research activities are aligned with departmental and federal priorities, Health Canada is developing a policy for managing its current and future science and research collaborative arrangements. The policy will provide guidance and direction with respect to governance and management considerations, ensuring that science and research collaborative arrangements are focused on outcomes and better support the priorities of Canadians and the Government of Canada. A departmental working group has been formed to develop the policy, beginning with a survey of the current scope and nature of collaborative arrangements within Health Canada.

Productive and well-managed collaborative arrangements

enable our science and research activities and are a key instrument to help Health Canada and other science-based departments deliver on departmental mandates and national priorities. A working group has been formed to put forward solutions to the challenges of establishing such arrangements. The working group identified a number of issues that act as obstacles and is in the process of developing an overall strategy to streamline their formation. This includes clear roles and responsibilities, which have been identified and seeking additional financial authorities from the Federal Government.

The OECD Principles of Good Laboratory Practice (GLP) promote the development of comparable quality test data to form the basis for mutual acceptance of data for regulatory purposes among different countries. To complement the existing Canadian GLP programs for pesticides and industrial chemicals and comply with our OECD obligations, a departmental working group was established to develop policies that will create an inspection system and require the acceptance of only GLP-compliant data for pharmaceutical products, veterinary drugs and food additives.

Over the past year OCS has coordinated Health Canada involvement in numerous federal science and technology (S&T) community initiatives, including the Health Canada sponsored Partnerships Initiative, Science in Support of Mission Critical Goals, Barriers to S&T Collaboration, Identifying Emerging Priorities for S&T Integration, Opening Doors Tool Kit, Career Progression Management Framework for Federal Researchers, Learning Agenda for the S&T Community, and the initiation of development of a human resources plan for the S&T community.

The Science Forum continues to be a major event for Health Canada, bringing together at a single venue highly trained professionals from across the Department to discuss cutting-edge science that will ultimately inform and support health policies and regulations. The 2005 Forum, Science in Support of Health Policies and Regulations, spoke to the importance Canadians place on mitigating risk and maximizing health benefits. Over 500 departmental researchers and scientists, as well as senior officials from across the Department and representatives from a number of national research organizations, attended this event. More than 140 poster presentations underscored the high degree of collaboration that exists between departmental scientists and their counterparts in universities, research hospitals, provincial laboratories and other federal science departments.

To develop Health Canada's research capacity, the Postdoctoral Fellowship (PDF) program funded 12 postdoctoral applicants. The Intellectual Property and Technology Transfer Office assisted 23 scientists with intellectual property issues, divided almost equally between the Healthy Environments and Consumer Safety Branch and the Health Products and Food Branch. Of the 97 files relating to patenting inventions, licensing and other agreements, 12 were completed.

To facilitate investment into the social sciences, a proposal-writing seminar for social science and humanities researchers was organized. The aim was to assist departmental researchers in developing high quality proposals for submission to both internal Health Canada and external health research funding competitions.

Improving Performance Measurement

The objective of Health Canada's ongoing performance measurement strategy is to identify, collect and assess performance information to improve results. Health Canada is committed to creating and using a performance management system that enables us to focus our resources on those activities and health issues of highest priority to Canadians.

Following the 2003 announcement of new initiatives to strengthen comptrollership across the federal government *(http://www.tbs-sct.gc.ca/spsm-rgsp/spsm-rgsp3_e.asp)*, we revised our performance management efforts accordingly. Among the Government's new initiatives was a stronger oversight function for the Treasury Board Secretariat (TBS), including a new "enterprise-wide" expenditure management information system (EMIS), with a new Program Activity Architecture (PAA) for each department and agency at its core. The PAA links budgets and expenditures (i.e. financial information) to policy and programmatic outcomes (i.e. non-financial information).

The Government also introduced, in June 2003, the Management Accountability Framework (MAF) to further clarify its expectations of sound management practices. The MAF provides managers with a comprehensive overview of what constitutes good organizational performance. Health Canada has been proactively implementing the MAF across the Department since its introduction. Health Canada continues to improve its assessment against the MAF performance indicators. The MAF complements the PAA so that policy and programmatic performance and management are linked to resources *(http://www.tbs-sct.gc.ca/eval/tools_outils/paa-deck_e.asp)*.

This new direction has meant important changes in the design of our performance management system. The PAA exercise has been advancing in accordance with TBS requirements. In 2004–2005 Program areas developed expected results statements and performance indicators for all activities outlined in the PAA. This year, Health Canada, to the extent possible, has begun to integrate these performance indicators into this Report. We expect this information to be refined to improve its usefulness over the next few years as part of Health Canada's continuous learning and improvement approach.

Sound financial management is an integral component to understanding the performance of the Department. Health Canada re-launched its Financial Management and Control Framework with a set of 18 projects. This exercise has begun to strengthen and improve the financial practices within Health Canada. The creation of the Chief Financial Officer Branch was a key step in this process. Health Canada has also initiated a comprehensive operational planning process to link resources to planned outcomes.

A Health Approach to Sustainable Development

Health Canada's third Sustainable Development Strategy 2004–2007 outlines the Department's commitments to incorporate sustainable development principles and practices into day-to-day activities over that time period. Through this Strategy, Health Canada has committed to provide its employees with information and practical tools that will assist them to take action on sustainable development resulting in the integration of sustainable development into departmental decision making and management processes, and reduction in the environmental and health impacts of departmental physical operations and activities.

The following areas have been identified for action during the Strategy's three year period:

- helping to create healthy social and physical environments;
- integrating sustainable development into departmental decision making and management processes;
- minimizing the environmental health effects of the Department's physical operations and activities.

Within these three thematic areas, organizational commitments were classified further using objectives and targets and, as of March 31, 2006, considerable progress has been made towards completion of the 20 target commitments. Additional information can be found in Table 19. For a complete report on Health Canada's third Sustainable Development Strategy, please consult the Office of Sustainable Development *(http://hc-sc.gc.ca/ahc-asc/branch-dirgen/hecs-dgsesc/osd-bdd/index_e.html)*.

As we pursue our work of helping the people of Canada maintain and improve their health, it is important to note that Health Canada's commitment to sustainable development extends into all policy and program initiatives, well beyond the three-year lifetime of each strategy.

The Benefits of Health Canada's Regional Presence

Health Canada's six Regions, comprised of the British Columbia/Yukon, Alberta/Northwest Territories, Manitoba/Saskatchewan, Ontario/Nunavut, Quebec, and Atlantic geographic areas, continued to provide a local presence and community connection for the Department, enabling Health Canada to maximize both the reach and effectiveness of departmental programs and services in response to the unique and varied needs of the many diverse communities it serves across the country.

The pursuit of strategic partnerships, development of collaborative relationships and engagement and consultation with key stakeholders and citizens on the part of the Regions continued to ensure that the Department was informed of local issues and concerns. Consequently, departmental policy and program development and delivery were considerate and reflective of the expectations, needs and priorities of Canadians wherever they live.

Health Canada's Regions continued to advance horizontal relationships internally within the Health Portfolio. In addition, Regions served as a focal point for furthering the Department's external relationships with provinces and territories, including an extensive network of regional health authorities. In this regard, the Regions helped the Department to identify opportunities for co-operation and collaboration in the pursuit of shared objectives and in achieving demonstrable results for all Canadians.

Through the use of modest temporary funding made available through an internal reallocation, the Health Canada Innovation Fund continued to foster improvement and innovation in the ways programs and services are delivered. The Innovation Fund provided an ability in the Regions to generate additional opportunities for the Department and often advance policy, program and relationship development.

Health Canada's Regions provided continued and ongoing support for the achievement of the Strategic Outcomes and Corporate Objectives of the Department in a number of ways. To this end, Regions represented the face of the Department to Canadians through their role as front line service and information providers, by the delivery of health services and programs in First Nations and Inuit communities and through their role as both guardians and regulators.

Section V

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