Departmental Performance Report

Health Canada
2006 - 2007

For the period ending March 31, 2007

Canada

Table of contents

Section I

Overview

Minister's Message

The Departmental Performance Report (DPR) is a cornerstone of government accountability to Parliament and to Canadians. It is a public record of accomplishments and lessons learned. As Minister of Health, I am particularly pleased to share this DPR because it covers our first full year as a Government. It outlines progress that we made to fulfill our commitments to Canadians in the Speech from the Throne, the *2006-2007 Report on Plans and Priorities*, the 2006 and 2007 budgets and throughout the year. It also demonstrates sound governance and improved accountability in the delivery of our mandate.

In the 2006 Speech from the Throne, our Government specifically committed to negotiate Patient Wait Times Guarantees with the provinces as one of just five key priorities. I worked closely with my counterparts in the provincial and territorial governments and with people across Canada's health system to make these guarantees a reality.

Our government began support of four pilot projects that are building knowledge and identifying best practices related to Patient Wait Times Guarantees and the reduction and better management of wait times. By April 2007, each provincial and territorial government agreed to establish a Patient Wait Times Guarantee by 2010, in at least one of the following priority clinical areas: cancer radiation, cataract surgery, hip and knee replacement, cardiac care, diagnostic imaging and primary health care. Our additional Budget 2007 funding will help to accelerate the kinds of wait times results that Canadians want and deserve.

As Minister, I have underlined the priority that I attach to ensuring that this country is well prepared to deal with the threat of avian flu and potential emergence of pandemic influenza. I know how important it is for plans to be in place, for the necessary supplies to be ready and for international collaboration and information sharing to be established. Over the past year, I have overseen actions that mean Canada is much better able to deal effectively with these threats that could arise at any time.

Cancer remains a serious threat to Canadians and it is one that we addressed early in our mandate. This year alone, some 160,000 Canadians will be diagnosed with cancer; it will take the lives of over 70,000. Our Government heard the call of more than 700 cancer survivors and experts to pool expertise and knowledge in order to reduce the toll of cancer in our country. We answered that call in Budget 2006 with $260 million over five years for the Canadian Strategy for Cancer Control. My Department led the federal government work to create the Canadian Partnership Against Cancer, which the Prime Minister announced in November 2006. The Partnership is already guiding the flow of our Budget money in a better-coordinated approach to achieve an estimated reduction of 1.2 million cases of cancer over the next 30 years, and to prevent 423,000 cancer deaths.

Many of this Department's actions have been part of government-wide commitments over the past year. An excellent example of a shared commitment to results is the Health Canada role in our Government's Chemicals Management Plan, which the Prime Minister announced in December 2006. Under the Plan, this Department is already beginning to assess those chemicals that entered Canadian use between 1984 and 1986 for their potential threats to human health. Just as we did for more recently introduced chemicals, Health Canada sci-

entists are building an evidence base for sound scientific decisions on the future use of these chemicals. While this DPR provides details on our many steps forward to help improve the health of Canadians, I want to end this message by mentioning our launch of a revised version of *Canada's Food Guide to Healthy Eating* in February 2007. The health of Canadians is influenced by an extremely diverse range of factors. When we as individuals make choices such as a healthy diet and regular exercise, we make choices with clear and proven benefits. In a time with so many conflicting health claims and so many questions about health, it is important to be able to turn to reputable, sound sources - and Health Canada continues to consolidate its reputation as that kind of source for Canadians.

Canada's Food Guide and our many other information resources are tools that help Canadians make informed choices. They demonstrate that not only does our Government work with partners in other governments and across the health system to make that system work well, we want individuals to have the power and tools to make their own choices for better health for themselves and their families.

While we are proud of the results that we have generated in our first full year as a Government, we know there is much more work to accomplish in the years ahead.

The Honourable Tony Clement
Minister of Health
Government of Canada

Management Representation Statement

I submit for tabling in Parliament, the 2006-2007 *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 2006-2007 Estimates: Reports on Plans and Priorities and Departmental Performance Reports:*

- It adheres to the specific reporting requirements outlined in the Treasury Board Secretariat guidance;
- It is based on the Department's Strategic Outcomes and Program Activity Architecture that were approved by the Treasury Board;
- It presents consistent, comprehensive, balanced and reliable information;
- It provides a basis of accountability for the results achieved with the resources and authorities entrusted to it; and
- It reports finances based on approved numbers from the Estimates and the Public Accounts of Canada.

_____

Morris Rosenberg
Deputy Minister

Summary Information

About Health Canada

Health Canada develops, implements and enforces regulations, legislation, policies, programs, services and initiatives and works with other federal partners, the provinces and territories to maintain and improve the overall 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.*[1]

We provide policy leadership and portfolio coordination among our partners in the Government of Canada's Health Portfolio, each of which produces its own *Report on Plans and Priorities*, namely:

- Public Health Agency of Canada;[2]
- Canadian Institutes of Health Research; [3]
- Hazardous Materials Information Review Commission,[4]
- Patented Medicine Prices Review Board;[5]
- Assisted Human Reproduction Agency of Canada.[6]

Our Vision

Health Canada is committed to improve the lives of all people in Canada and to make Canada'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 and enhance the sustainability, innovation and integration of the health system;
- promote healthier lifestyles through sustained health protection and regulations;
- 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 employees play key roles in promoting, protecting and improving the health of Canadians - roles that assist other stakeholders working towards the same goals.

Health Canada operates in all regions of Canada as indicated on the accompanying map.

Health Canada at Work across the Country

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.

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 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 issues that can impact their health.

Trustees / Stewards

Health Canada, through 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 assessment of products under the *Canadian Environmental Protection Act* to 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 *Pest Control Products Act* and will continue to be consulted in other areas as part of the Department's consultations framework.

[1] For more information on legislative acts, please visit the Department of Justice website at: http://laws.justice.gc.ca/en/index.html

[2] www.phac-aspc.gc.ca/new_e.html

[3] www.cihr-irsc.gc.ca/

[4] www.hmirc-ccrmd.gc.ca/

[5] www.pmprb-cepmb.gc.ca/

[6] www.hc-sc.gc.ca/hl-vs/reprod/agenc/index_e.html

Overall Departmental Performance

Financial Resources (millions of dollars):

Planned Spending	Authorities*	Actual Spending**
3,011.1	3,090.1	2,997.5

Human Resources (FTEs):

Planned	Actual	Difference
8,711	8,686	25

* The increase from Planned Spending to Authorities is due mainly to new program initiatives and sustainability funding which is received through Supplementary Estimates.

** The difference between Authorities and Actual Spending is mainly the result of lapses in the TB Special Purpose and Frozen Allotments.

Our Operating Environment and Context

Health is a fundamental priority of the Government and Health Canada is the focal point for much of the federal health agenda. During 2006-2007, 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, agriculture and improvements to regulatory approaches.

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 improved health outcomes for First Nations and Inuit. To support greater control over their health services, Health Canada also 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 2006-2007 evolved largely as projected in the *Report on Plans and Priorities* (RPP). The Government established key health commitments such as Patient Wait Times Guarantees; action to ensure Canada's preparedness for pandemic influenza and implementation of the Canadian Strategy for Cancer Control. We recognized the resource pressures affecting many of our activities and the need to modernize some of our core work such as regulation of health products and food.

Summarizing Health Canada's Performance

Our Medium-Term Corporate Priorities and Key Areas of Focus

Health Canada continued to address four medium-term corporate priorities established in 2004 and 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.

Working with others to strengthen the efficiency and effectiveness of the publicly-funded health care system

(Including the key area of focus for 2006-2007: Develop the building blocks for establishing a Patient Wait Times Guarantee)

In its 2006 Speech from the Throne, the Government established its commitment to negotiate Patient Wait Times Guarantees as one of five key priorities. This led to discussions on research, and knowledge exchanges on wait times initiatives with governments of the provinces and territories. For example, our department began support of four pilot projects to help advance knowledge and best practices related to Patient Wait Times Guarantees and the reduction and better management of wait times. Pilot projects addressed diabetes and prenatal care for First Nations communities. An additional pilot project focussed on wait times for children in need of surgery.

By April 2007, the government of each province and territory had committed to establishing a Patient Wait Times Guarantee by 2010, in one or more of: cancer radiation, cataract surgery, hip and knee replacement, cardiac care, diagnostic imaging and primary health care. Those governments also agreed to launch at least one pilot project to test guarantees and how they can best be implemented. The Quebec National Assembly passed legislation that establishes a framework in Quebec to guarantee access to hip and knee replacement and to cataract surgery.

That work will be accelerated with the Budget 2007 commitment of $1billion from 2006-2007 expenditures to fund a Patient Wait Times Guarantee Trust. The Trust will make payments over three years to support actions by the provinces and territories. Other funds were committed in that budget for 2007-2008 and for subsequent investments in electronic health information systems and to support provincial and territorial Patient Wait Times Guarantee pilot projects.

Projects under the Primary Health Care Transition Fund came to an end as scheduled during the year and we worked with partners to make the results of those projects widely known. To help solve health human resource challenges we focused on improvements to health care workplaces to encourage professionals to stay in those settings. The Department also supported provinces and territories as they created opportunities for internationally educated health professionals to earn Canadian credentials. In November 2006 the Government signed a Memorandum of Understanding with the Province of British Columbia and the British Columbia First Nations Leadership Council. This MOU committed the parties to building a tripartite relationship for improving the health of BC First Nations, and led to the signing of the Tripartite First Nations Health Plan for British Columbia in June 2007.

Reducing the risks to the health of the people of Canada

(Including the key area of focus for 2006-2007: Advance efforts to prepare for a global pandemic outbreak)

Risks to health take many forms and Health Canada has many ongoing regulatory responsibilities that seek to reduce those risks. The Department's direct activities in fields such as the safety of health products, food, consumer products and pest management products, as well as support for the work of other levels of government in such areas as drinking water safety all contribute to the health of Canadians.

Health Canada is a participant in the government-wide effort led by the Public Health Agency of Canada (PHAC) and the Canadian Food Inspection Agency to ensure that Canada is well prepared to deal with the threat of avian flu and potential emergence of pandemic influenza. For example, we improved our regulatory system in order to respond quickly to submissions for new vaccines that may be needed and to track their results once they are in use. Provincial and territorial health care systems are responsible for meeting the needs of most Canadians in a pandemic influenza, with PHAC responsible for some cases such as quarantines involving passengers and crews of aircraft, ships and trains. Health Canada, in collaboration with PHAC, is working with First Nations, and provinces and territories to develop integrated and coordinated pandemic response plans for First Nations at the community level. We also worked closely with health officials in other countries to improve information sharing and collaborative action on avian flu and pandemic influenza.

Health Canada's contributions formed a central element of the Government's launch of the Chemicals Management Plan in December 2006. That Plan will regulate chemicals that are harmful to human health or the environment and is part of the Government's comprehensive Environmental Agenda. It will expand the rigorous assessment of chemicals for health risks to include those introduced between 1984 and 1986. This will complement the work we completed in 2006-2007 involving our categorization of the 23,000 substances already placed on the Domestic Substances List for health implications.

While not specifically identified in our RPP, in October 2006, we released the *Blueprint for Renewal: Transforming Canada's Approach to Regulating Health Products and Food* for consultation. The Blueprint articulates our vision and plan over the coming years to modernize a regulatory system for health products and food that has essentially been in place since 1953. The Blueprint targets creation of a progressive licensing framework that will evaluate and monitor the safety, quality and effectiveness of health products, such as pharmaceuticals, throughout the years they are in use in Canada. This would replace the current focus on a company's initial request to gain approval for Canadian use of a product. The Blueprint is meant to ensure that Canadian legislation, regulations and practices keep pace with advancing science and technology, existing and emerging public health challenges, consumer expectations in terms of safety, the need for transparency, faster drug approvals and international developments.

That process of modernization will be similar in many respects to the effort we completed during 2006-2007 to implement the *Pest Control Products Act.* The new Act significantly increases transparency, enables greater public participation, expedites the registration of lower risk products and includes a new process to better protect human health and the environment. Communication and stakeholder engagement ensured that Canadians, especially businesses and major users of pest control products, were properly informed about the Act, and enabled us to gain feedback on opportunities to improve our services.

Contributing to the improvement of the health of Canadians

(Including the key area of focus for 2006-2007: Implement the Canadian Strategy for Cancer Control)

Health Canada has many roles that contribute to the improvement of the health of Canadians. For example, our launch of the revised *Canada's Food Guide to Healthy Eating* in February 2007 and the number of requests for printed copies as well as visits to the online version showed the demand for this kind of resource to promote eating choices that meet nutrient needs, promote health and minimize the risk of nutrition-related chronic disease. The culturally-specific *Food Guide for First Nations, Inuit and Métis* was also produced, tailored to reflect their traditions and food choices.

In Budget 2006, the Government allocated $260 million over five years to the Canadian Strategy for Cancer Control. While we continued cancer-related work, such as sun safety information for children to reduce the risk of skin cancer, our core role was to be the federal government's liaison with the Canadian Partnership Against Cancer announced by the Prime Minister in November 2006. The Partnership will collect, classify and distribute information on preventing, diagnosing and treating cancer, so that all health care providers have access to the best cancer care practices across Canada. It has the responsibility to implement a Strategy that experts have predicted could pre-empt 1.2 million cases of cancer and prevent 423,000 cancer deaths over the next 30 years.

We played a central role in developing options which led to the creation of the Mental Health Commission of Canada that was announced in Budget 2007. The Commission will undertake knowledge exchange, anti-stigma efforts and development of a National Strategy on Mental Health and Mental Illness. Health Canada's support included research into how gender could be integrated into federal mental health policy.

By far our largest category of expenditures as a department are our programs and services for addressing the health needs of First Nations and Inuit. These include primary health care services, home and community care, public health, and community programs aimed at children and youth, mental health and addictions, chronic and communicable diseases and environmental health, as well as the Non-Insured Health Benefits program that funds supplementary health benefits for all eligible First Nations and Inuit.

With increased funding to reflect growing First Nations and Inuit populations, the Department expanded programming in some areas. For maternal and child health, we implemented home visiting in 40 communities and launched a Healthy Pregnancy campaign to provide women with information to make healthy lifestyle choices before and during pregnancy. We provided funding to expand Aboriginal Head Start On-Reserve, to provide outreach in small communities, and improved early childhood development facilities.

Our Department obtained funding to provide mental health, emotional, and cultural supports to all eligible former students of Indian Residential Schools under the new IRS Settlement Agreement. Recognizing the much greater incidence of diabetes among Aboriginal people, First Nations diabetes-related services were the focus of two of four federal Patient Wait Times Guarantee pilot projects. We also enhanced diabetes prevention activities, diagnostic and complications screening, as well as care and treatment services. Community drinking water quality monitoring activities were also expanded.

Strengthening accountability to Parliament and the public

Health Canada has continued to implement 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 well, to ensure greater accountability and transparency to Parliament and the public, the Department has developed an action plan and specifically committed to strengthening resource management and performance measurement / reporting in relation to its regulatory programs.

The Department has continued to move forward with the sustainable development (SD) initiative in all programs and activities. *Health Canada's Sustainable Development Strategy III (SDS III 2004-2007): Becoming the Change We Wish to See* is comprised of three themes: helping to create healthy social and physical environments; integrating sustainable development into departmental decision making and management processes; and minimizing the environmental and health effects of the Department's physical operations and activities.

Health Canada has successfully achieved various objectives and targets under each of the themes, including, for example, the drafting of an SD Policy Lens, which will undergo a pilot test in 2007, with the aim of improving SD considerations embedded in policies, plans and programs. We have also carried out the planning to create SDS IV, which will build on the lessons learned to date and set new directions for close alignment with government-wide SD efforts.

The 2006 Treasury Board Secretariat assessment of our Management Accountability Framework noted improvements in several areas, including IT management, citizen-focused services, effective procurement and extra-organizational contributions. It also noted the progress the Department has made in clarifying responsibilities and improving resource allocation to ensure accountability and a greater focus on priorities and results.

Our Chief Financial Officer Branch is leading a department-wide effort for improving management accountability and stewardship of resources. As part of the Financial Management Renewal Initiative led by the Office of the Comptroller General, Health Canada accelerated the development and implementation of its Financial Management and Control Framework, which, among other things, includes initiatives for enhancing budget management and assessing /ensuring readiness for audited departmental financial statements for 2008-2009.

We continued with the implementation of the Departmental Operational Planning (DOP) aimed at establishing clear linkages between priorities, planned activities, expected results, and proposed resource allocation. Enhancements to the DOP process have assisted management at all levels in focussing on priorities, identifying funding pressures, and facilitating reallocation of resources from lower to higher priorities.

As part of Treasury Board Management of Resource and Results Structure, the Department has established plans and commenced work to review and enhance baseline information for performance measurement for all areas, particularly regulatory programs. As well, the Department continues to focus on developing guidelines and tools to improve the quality and results-focus of evaluations, including the piloting of the "value for money" tool developed by Treasury Board Secretariat. The Department has also enhanced its effort for reviewing the performance measurement and evaluation strategies outlined in Treasury Board submissions and Memoranda to Cabinet.

The Department continued to integrate more rigorous management practices into its operations, including enhancement of the management of contracts, grants and contributions by ensuring that solid governance structures and administrative processes are in place. As well, the Department implemented Phase 1 of an automated Contract Requisition and Reporting System that affords more effective controls over contract administration.

Strategic Outcome 1

Strengthened Knowledge Base to Address Health and Health Care Priorities

(MILLIONS OF DOLLARS)		Planned Spending	Authorities	Actual Spending
		288.4	312.6	290.4
Program Activity	**Expected Results**	**Performance Status**		
Health Policy, Planning and Information	Goals and objectives identified for specific strategies and initiatives.	**Satisfactorily Met:** **Major commitments met included:** Developed four Patient Wait Times Guarantee (PWTG) pilot projects that focus on diabetes, prenatal care and diabetic foot ulcer care for First Nations communities and on national pediatric surgical wait times. Worked closely with provincial and territorial partners in ensuring their commitments to establish a PWTG no later than 2010 in one selected priority clinical area: cancer radiation, cataract surgery, hip and knee replacement, cardiac care, diagnostic imaging or primary health care. Completed the pre-1986 / post-1990 Hepatitis C Settlement Agreement in December 2006. Successfully developed the governance structure for the Assisted Human Reproduction Agency of Canada, including the appointment of the Chairperson, the President, and additional members of the Board of Directors. Disseminated synthesis information on chronic disease management and collaborative care from the Primary Health Care Transition Fund Program through various means, including hosting a national conference in February 2007. Supported concrete efforts, including specific projects, aimed at increasing the number of internationally educated health professionals who are able to become licensed and integrated into the Canadian health work force.
	Knowledge development and transfer of specific health policy issues.	Funded nine new learning projects in support of Inter-professional Education for Collaborative Patient-Centered Practice. Supported the creation of a network through the Rick Hansen Foundation to accelerate the translation of innovative research discoveries into practical benefits for Canadians with spinal cord injuries. Signed a formal partnership agreement with the Joint United Nations Programme on HIV/AIDS to promote joint actions aimed at strengthening global response. Signed a Canada-France agreement that outlines mutual work to be undertaken over the next four years. Supported the development of the international guidelines on Quality Assurance in Molecular Genetic Testing. **Challenge:** Despite an overall increase in the number of health professionals, including internationally educated professionals, labour shortages in the health sector continue to be a major concern. The introduction of new and emerging technologies as well as the complexity of the ethical, moral, cultural and legal issues has delayed the completion of regulation in the area of Assisted Human Reproduction.

Strategic Outcome 2

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

(MILLIONS OF DOLLARS)		Planned Spending	Authorities	Actual Spending
		262.1	278.2	262.3
Program Activity	**Expected Results**	**Performance Status**		
Health Products and Foods	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, achieved performance standard targets for reviews of new pharmaceutical and generic drug submissions. Exceeded performance targets for processing Class III and IV medical device submissions. In 2006, awarded a contract to develop a more sophisticated Adverse Reaction Reporting System that will collect and analyze adverse reaction information more effectively. In October 2006, released *Blueprint for Renewal: Transforming Canada's Approach to Regulating Health Products and Food* for consultation. The Blueprint articulates Health Canada's vision and plan over the coming years to modernize a regulatory system for health products and food that has been in place since 1953. Launched consultations to seek the views of stakeholders. Released revised guidelines on the safety assessment of novel foods to help improve the transparency of this regulatory process. Released an updated *Food Guide* in February 2007 after four years of development, and consultations with approximately 7,000 Canadians, including health and nutrition experts. Released over 100 health advisories for health professionals and consumers. **Challenges:** The challenge continues to be significant backlogs in pre-market review of submissions for natural health products, veterinary drugs and food products. We have reduced backlogs at some stages and are pursuing measures to process applications more quickly and consistently in comparison with international performance targets.		

Strategic Outcome 3 (a)

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

(MILLIONS OF DOLLARS)		Planned Spending	Authorities	Actual Spending
		289.9	305.3	294.1
Program Activity	**Expected Results**	**Performance Status**		
Healthy Environments and Consumer Safety	Improved scientific knowledge and capacity within the Canadian scientific community and international collaboration on environmental health issues.	**Satisfactorily Met:** **Major commitments met included:** Contributed to International Polar Year (2007-2009) through new research and participation in scientific peer review and ranking of $98M of human health and environmental research.		
	Availability and Canada-wide adoption of measures to control the risks to human health posed by environmental contaminants.	Fulfilled Government's Clean Air Agenda and Environmental Agenda through realignment of Federal Tobacco Control Strategy (FTCS), National Framework for Action to Reduce the Harms Associated with Alcohol and Other Drugs and Substances in Canada, Global Harmonization System of Classification and Labelling of Chemicals (GHS), Canadian Climate Change and Health Vulnerability Assessment. In response to concern of Auditor General of Canada, implemented short-term policies and developed long-term strategies and priorities to reduce health and environmental risks to Canadians. In collaboration with Environment Canada, drafted the Chemicals Management Plan (CMP), a key component of the Government's new Environmental Agenda. Successfully completed assessment of climate change impacts on human health and well-being through Canadian Climate Change and Health Vulnerability Assessment.		
	Reduced risk of death and injury from exposure to hazardous products and substances associated with solar UV radiation.	Minimized threats of skin cancer through a school-based Sun Awareness Project.		
	Reduced health and safety risks associated with tobacco consumption and the abuse of drugs, alcohol and other substances.	**Challenges:** Despite reducing health and safety risks associated of tobacco consumption through FTCS, adults aged 20-24, especially males, report the highest prevalence of any group currently smoking (29%), thus creating a ratchet effect in reaching FTCS's goal to reduce smoking prevalence to 20% from 25% in 1999.		

Strategic Outcome 3 (b)

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

(MILLIONS OF DOLLARS)	Planned Spending	Authorities	Actual Spending
	51.6	68.0	62.7

Program Activity	Expected Results	Performance Status
Pest Control Product Regulation	Access to safer pesticides.	**Satisfactorily Met:** **Major commitments met included:** Coming into force of the *Pest Control Products Act* (PCPA) - five new reduced-risk active ingredients are available for use in Canada. 71.7% of reduced-risk chemicals and 32.5% of biopesticide active ingredients registered/pending registration in the U.S. are registered/pending registration in Canada. Four new active ingredients registered through the Pest Management Regulatory Agency (PMRA)/U.S. Environmental Protection Agency (EPA) Joint Review/work share program.
	Transparency of pesticide regulation.	Introduced electronic Public Registry that gave the public access to information about new applications to register/amend pest control products, evaluation reports and conditions of registrations of newly registered or re-evaluated pesticides.
	Improved regulatory efficiencies and cost effectiveness.	Improved regulatory efficiencies and cost effectiveness by introducing electronic process and harmonization permit, integration of new science policies and methodologies by reducing paper volume, centralized information repository, Automation of Confidential Business Information (CBI) and privacy identification and segregation.
	Informed public and stakeholders.	749,566 hits by public and stakeholders on the PMRA websites for different levels of information. The Pest Management Information Service responded to 6,000 public requests. **Challenges:** There are ongoing human resource challenges with expanding scientific knowledge and industry innovations.

Strategic Outcome 4

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

(MILLIONS OF DOLLARS)		Planned Spending	Authorities	Actual Spending
		2,119.1	2,126.0	2,088.0
Program Activity	**Expected Results**	**Performance Status**		
First Nations and Inuit Health	Improve health outcomes, by ensuring the availability of, and access to, quality health services, and, supporting greater control of the health system by First Nations and Inuit.	**Satisfactorily Met:** **Major commitments met included:** Provided primary health care services in approximately 200 remote communities, and home and community care services in about 600 communities. Directly employed approximately 670 nurses to deliver health services for First Nations communities. Worked to ensure that services addressed needs of First Nations and Inuit with implementation of Aboriginal Health Transition Fund (AHTF). Negotiated an agreement with the Métis National Council to provide $10 million in bursary and scholarship funding for Métis health career students over the next four years. Launched the Nursing Portal in June 2006 at the Canadian Nurses Association Biennial Conference. Implemented the Children's Oral Health Initiative in 140 communities and provided services to 8,000 children. Constructed 14 health facilities, expanded six health facilities, and completed four major recapitalization initiatives. Spent approximately $2 million to conduct pilot Environmental Compliance Audits and Environmental Site Assessments. Prepared a mental wellness strategic action plan and implemented 60 community-based suicide prevention projects. Developed pandemic influenza plans that support First Nations communities in local preparedness. Designed communication products that will put a greater focus on preventive activities as they relate to Drinking Water Advisories. **Challenges:** Health Canada continues to work in maternal and prenatal health to improve health outcomes among First Nations and to reduce disparities between First Nations and Canada overall. Statistics for 2000 indicated that 4.7% of First Nations births are classified as low birth weight compared with 5.6% in Canada overall. The high birth weight rate for the First Nations populations is 21%, almost double the Canadian rate of approximately 13%		

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	**288.4**	**312.6**	**290.4**	
	158.1	162.9	147.7	Health Care Policy
	6.6	6.6	4.8	Intergovernmental Affairs
	16.6	19.5	12.9	Strategic Health Policy
	25.0	38.4	37.9	International Affairs
	5.4	5.7	5.4	Women's Health
	34.8	35.4	32.2	Applied Research, Dissemination and Accountability
	1.0	0.9	1.9	Nursing
	40.9	43.2	47.6	Official Language Minority Community Development
Strategic Outcome #2 Access to Safe and Effective Health Products and Food and Information for Healthy Choices				
Health Products and Food	**262.1**	**278.2**	**262.3**	
	125.8	133.6	125.9	Pre-market Regulatory Evaluation and Process Improvement
	13.1	13.9	13.1	Information, Education and Outreach on Health Products, Food and Nutrition
	104.9	111.2	104.9	Monitoring Safety and Therapeutic Effectiveness and Risk Management
	18.3	19.5	18.4	Transparency, Public Accountability and Stakeholder Relationships
Strategic Outcome #3(a) Reduced Health and Environmental Risks from Products and Substances, and Safer Living and Working Environments				
Healthy Environments and Consumer Safety	**289.9**	**305.3**	**294.1**	
	29.9	40.5	40.5	Workplace Health and Public Safety
	83.5	86.1	85.0	Safe Environments
	31.3	33.1	31.1	Product Safety
	65.7	66.4	60.8	Tobacco Control
	79.5	79.2	76.7	Drug Strategy and Controlled Substances

Note: The DPR highlights results achieved for key initiatives and PAA sub-activities outlined in the 2006-2007 Report on Plans and Priorities.

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

(millions of dollars)

Program Activity	Planned Spending	Authorities	Actual Spending	Program Sub-Activities
Strategic Outcome #3(b) Reduced Health and Environmental Risks from Products and Substances, and Safer Living and Working Environments				
Pest Control Product Regulation	**51.6**	**68.0**	**62.7**	
	25.6	33.6	27.5	New Pest Control Product Registration and Decision making
	9.8	12.8	12.1	Registered Pest Control Product Evaluation and Decision making
	7.6	10.0	11.2	Compliance
	2.6	3.3	4.1	Pesticide Risk Reduction
	6.0	8.3	7.8	Regulatory Improvement
Strategic Outcome #4 Better Health Outcomes and Reduction of Health Inequalities between First Nations and Inuit and Other Canadians				
First Nations and Inuit Health	**2,119.1**	**2,126.0**	**2,088.0**	
	292.9	326.2	290.7	First Nations and Inuit Community Health Programs
	76.5	71.9	69.6	First Nations and Inuit Health Protection
	247.0	270.5	289.0	First Nations and Inuit Primary Health Care
	966.3	1,018.7	996.4	Non-Insured Health Benefits (NIHB)
	536.4	438.7	442.3	Governance and Infrastructure Support to First Nations and Inuit Health System

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
- Knowledge development and transfer of specific health policy issues

Financial Resources (millions of dollars):

Planned Spending	Authorities	Actual Spending
288.4	312.6	290.4

Human Resources (FTEs):

Planned	Actual	Difference
627	606	21

The objective of this program activity is to provide policy advice and support to the Minister in making decisions to protect and improve the health of Canadians. Health Canada develops policies and builds and maintains linkages with provinces, territories, and other partners and stakeholders to support health care system reform. We administer the *Canada Health Act* and facilitate access to health care services for official language minority communities. We work with international organizations, and bilaterally with key countries, to advance a global health agenda. Grants and contributions accounted for approximately 68 percent of spending under this program activity, demonstrating our commitment to achieving results in collaboration with partners in the health system.

Explanation of the above financial information:

Variances between planned spending versus total authorities are mainly due to:

- funding for Federal Contaminated Sites Action Plan
- funding for the Canadian Partnership against Cancer
- contributions to the Government-Wide 2006-2007 $1 Billion Spending Restraint Exercise
- funding from Management Reserve - Litigation Management.

Actual spending is $22.2 million lower than total authorities mainly due to:

- lapse in the Health Council special purpose allotment
- contributions to the Government-Wide 2006-2007 $1 Billion Spending Restraint Exercise
- year end adjustments of Department of Justice expenditures
- other operating lapses in various programs.

In the *Report on Plans and Priorities* (RPP), we identified eight priorities under this program activity, as well as two areas addressing the role of science and horizontal linkages.

Partner in Health Reform

Canadians expect to have accessible, high quality health care services throughout their lives. To this end, the Department supported development of Patient Wait Times Guarantees (PWTGs), the Health Council of Canada and the Primary Health Care Transition Fund (PHCTF). The Department also continued to support initiatives in health human resources, home care, palliative care and access to health care for people living in official language minority communities.

One of the Government's five priorities was to negotiate PWTGs with provincial and territorial governments. All provinces and territories have now committed to establishing a PWTG by 2010 in one of the following priority clinical areas: cancer radiation, cataract surgery, hip and knee replacement, cardiac care, diagnostic imaging or primary health care. In addition, each province and territory has committed to undertaking at least one PWTG pilot project to test guarantees and inform their implementation. The Government of Quebec passed legislation to establish a framework to implement a guarantee of access to hip and knee replacement and cataract surgery.

Our Department also developed four PWTG pilot projects to help advance best practices and the reduction and better management of wait times. Two projects focus on diabetes and prenatal care in selected First Nations communities and are administered by Health Canada's First Nations and Inuit Health Branch. A third project addresses wait times for diabetic foot ulcer care for First Nations communities in Manitoba and is being administered by Saint Elizabeth Health Care. A fourth project in national paediatric surgical wait times is led by the Paediatric Surgical Chiefs of Canada and the Hospital for Sick Children in Toronto.

Health Canada also provided funding to the Canadian Institutes of Health Research to support research regarding the relationship between wait times and health and improving access to appropriate health services. In February 2007, the Minister of Health and his Saskatchewan counterpart co-hosted a Conference on Timely Access to Health Care that showcased provincial successes and innovations. Further, Health Canada released the report, *Healthy Canadians: A Federal Report on Comparable Health Indicators 2006*, which provides a snapshot of the health status of Canadians and the performance of the health care system. The report also responds to First Ministers' commitments to greater transparency and accountability in the health care system.

Following the 2004 First Ministers' agreement to provide first-dollar coverage for certain home care services, we provided policy advice within the Department and to federal partners concerning access by First Nations, Inuit and veterans to home care services at the expected levels. In March 2007, we hosted a forum with provincial and territorial stakeholders to look at opportunities for integration between home and primary health care. As well, our Department is exploring ways to work with the Canadian Home Care Association to advance home care integration models across Canada.

Health Canada continued to support the work of the Health Council of Canada, which has a mandate to monitor and report on implementation of the 2003 and 2004 Health Accords and to report annually on health status and health outcomes of Canadians.

In response to a First Ministers' 2000 commitment, the PHCTF was launched. Between 2001 and 2006, this $800 million federal investment supported the efforts of provinces, territories and stakeholders to reform the primary health care system. With the end of the PHCTF, our focus turned to applying lessons learned across Fund projects to support ongoing primary health care reform activities.

Key PHCTF dissemination activities included synthesis papers highlighting results on chronic disease management and collaborative care; a national conference in February 2007; a Best Practices Network event on responding to community needs; and fact sheets and a database on the results of each PHCTF initiative.

We supported programs and services to improve access to health care for people in official language minority communities, consistent with the *Official Languages Act.* Two contribution agreements were launched to provide primary health care services within English and French-speaking minority communities.

Health Canada hosted a national forum on Palliative and End-of-Life Care in March 2007. The purpose was to support exchange of best practices across Canada, as well as to celebrate five stakeholder groups for palliative and end-of-life care initiatives supported by Health Canada from 2002 to 2007. We also provided funding for development of a web-based research centre at the Canadian Virtual Hospice. This will ensure that the growing community of palliative care researchers have the necessary tools to provide the scientific basis for improving care.

Conference on Timely Access to Health Care
http://www.hc-sc.gc.ca/hcs-sss/qual/acces/2007conf/index_e.html

Healthy Canadians: A Federal Report on Comparable Health Indicators 2006
www.hc-sc.gc.ca/hcs-sss/pubs/system-regime/2006-fed-comp-indicat/index_e.html

Primary Health Care Transition Fund
http://www.hc-sc.gc.ca/hcs-sss/prim/phctf-fassp/index_e.html

Hepatitis C

The pre-1986/post-1990 Hepatitis C Settlement Agreement was completed in December 2006. Preparations were initiated for the compensation process, subject to a decision expected in 2007 by the courts that have been involved in this process. This should lead to the first payments beginning in 2007-2008.

Pandemic Influenza

Our Department played many roles to ensure Canada's readiness to deal with the potential emergence of pandemic influenza. These included discussions concerning innovative approaches and incentive mechanisms to stimulate research, development, and equitable global access to pandemic influenza vaccines, as well as pneumococcal vaccines. Internationally, as Chair of the Asia-Pacific Economic Cooperation (APEC) Health Task Force, Health Canada was playing a leadership role in coordinating regional response and planning for pandemic influenza and other emerging infectious diseases. We facilitated development of the APEC Action Plan on the Prevention and Response to Avian and Influenza Pandemics and followed up in 2007 with the first regional report on implementation of the plan.

Mental Health

In the RPP, we committed to work with partners to build the foundation of a national approach to mental health and mental illness. This led to the announcement of the Mental Health Commission of Canada in Budget 2007. The Commission will undertake activities in three areas: knowledge exchange, anti-stigma efforts, and a National Strategy on Mental Health and Mental Illness.

Pharmaceuticals Management

With respect to pharmaceuticals, Health Canada has a role in market approval, access, optimal prescribing and utilization, drug prices/expenditures and system cost, as well as the safety and effectiveness of drugs once on the market.

The Department's Blueprint for Renewal initiative is focused on modernizing the regulatory system for therapeutic products.

In collaboration with other departments, including Foreign Affairs and International Trade, Health Canada plays an important role in monitoring and research activities, policy development, and provision of integrated advice (reflecting health sector interests) on pharmaceuticals-related components of: international trade negotiations and treaties; transnational issues and files such as cross-border drug sales; patent policy; and cooperative research and knowledge exchange activities bilaterally and in international fora such as the Organization for Economic Cooperation and Development (OECD) and the World Health Organization (WHO).

In 2006, Health Ministers provided First Ministers with a *National Pharmaceuticals Strategy Progress Report*. The report highlighted achievements and set out next steps, with a focus on five priority areas: catastrophic drug coverage; expensive drugs for rare diseases; common national drug formulary; drug pricing and purchasing strategies; and real-world drug safety and effectiveness.

Health Canada is working to ensure that current work on the NPS complements pre-existing initiatives such as the Common Drug Review (CDR). [7]

National Pharmaceuticals Strategy: Progress Report
http://www.hc-sc.gc.ca/hcs-sss/pubs/pharma/2006-nps-snpp/index_e.html

FPT Common Drug Review
http://www.cadth.ca/index.php/en/cdr

Legislative Renewal and Regulatory Reform

Work continued to update the *Food and Drugs Act*, the *Hazardous Products Act* and the *Radiation Emitting Devices Act*. We focused on policy development for the collection, use and disclosure of health information and improved compliance and enforcement.

Health Canada improved its regulatory processes in response to the Smart Regulation Initiative and other government-wide policies. Triage and prioritization models were developed to ensure greater efficiencies while improving implementation of cost-benefit analysis, instrument choice and performance measurement.

[7] The CDR is a single process for reviewing new drugs and providing listing recommendations to participating publicly-funded federal, provincial and territorial drug benefit plans. All jurisdictions are participating except Quebec. For more information, see http://www.cadth.ca/index.php/en/cdr and http://www.hc-sc.gc.ca/hcs-sss/pharma/mgmt-gest/cdr-emuc/index_e.html. Other joint initiatives that emerged prior to the NPS and which continue to progress include the Canadian Optimal Medication Prescribing and Utilization Service (COMPUS - http://www.cadth.ca/index.php/en/compus) and the National Prescription Drug Utilization System (NPDUIS - http://www.hc-sc.gc.ca/hcs-sss/pharma/mgmt-gest/npduis-sinump/index_e.html).

Establishment of the Assisted Human Reproduction Agency of Canada and new regulations

The Assisted Human Reproduction Act (AHRA) seeks to protect and promote the health, safety, human dignity and rights of Canadians who are born of the use of reproductive technologies and to foster the application of ethical principles in relation to assisted human reproduction.

The Agency created under the Act is the Assisted Human Reproduction Agency of Canada. The Government announced the appointment of a Chairperson, President and eight additional members to its Board of Directors in December 2006. Health Canada continued research and consultations to develop the necessary regulatory framework for the AHRA. We reviewed feedback on section 8 (relating to consent) draft regulations which were subsequently published in *Canada Gazette*, Part II in June 2007 and will take effect on December 1, 2007. Health Canada continues to work on remaining regulations required by the AHRA.

Assisted Human Reproduction Agency of Canada
http://www.hc-sc.gc.ca/hl-vs/reprod/agenc/index_e.html

Health Human Resources

At the heart of any health care system are the people who deliver care – health human resources (HHR). Governments at the federal and provincial/territorial levels have recognized that it is critical to ensure the adequate supply, distribution and utilization of health human resources. In response to the 2003 and 2004 First Ministers' agreements on health, Health Canada worked to implement its responsibilities under the Pan-Canadian HHR Strategy which is being renewed for 2008-2013. The Strategy includes several initiatives: Pan-Canadian Health Human Resource Planning; Interprofessional Education for Collaborative Patient-Centred Practice; and Recruitment and Retention. In 2005, the Internationally Educated Health Professionals Initiative (IEHPI) was established to increase the supply of priority health care providers through assessment and integration of internationally educated health professionals. The IEHPI is a five-year $75 million initiative that is also part of the Pan-Canadian HHR Strategy. Multi-year contribution agreements are in place with most of the provinces and territories as well as innovative pan-Canadian projects covering seven health professions: medicine, nursing, pharmacy, occupational therapy, physiotherapy, medical laboratory technology and medical radiation technology.

We provided funding to key stakeholder-driven initiatives. For example, in response to the shortage of family physicians, the College of Family Physicians of Canada created Family Medicine Interest Groups that are using different tools to encourage more medical students to choose family medicine as a postgraduate specialty. We also supported the 2007 international conference of leaders in HHR research and policy to examine the medical work force as it concerns the evolution of health care delivery systems.

An innovative interprofessional program aimed at orienting IEHPs to the Canadian health care system was developed with representatives from provinces and territories as well as six health professions. A multi-media faculty development

As a result of its participation in the Federal Council's Ontario Information Technology Network, the Ontario Region was able to sign agreements with other federal departments to share infrastructure resources and to arrange interchange opportunities and assignments for staff. An interchange arrangement was helpful in quickly filling a vacancy in the Thunder Bay office.

program for teachers of international medical graduates was developed and will be fully implemented in 2007-2008. Similarly, a curriculum for faculty members training internationally educated nurses was created and will be piloted in 2007-2008. Supported by Health Canada, Ontario's Access Centre for IEHPs was formally launched in December 2006, and has been providing IEHPs with referral, counselling and bridging services. As of April 2007, the Centre has supported close to 400 IEHPs to integrate into the health care system.

Under Interprofessional Education for Collaborative Patient-Centred Practice, nine new learning projects were funded for $6.7 million, bringing the total to 20 projects and $20 million. The Canadian Interprofessional Health Collaborative received $775,000 to identify and share best practices in interprofessional education and collaborative practice, and to translate this knowledge so that it can be used to transform health care.

Health Human Resources Strategy
http://www.hc-sc.gc.ca/hcs-sss/hhr-rhs/strateg/index_e.html

In addition to these priorities, we addressed two areas of importance across this program activity.

Role of Science

Innovative health sciences and technologies offer potential new ways to prevent, diagnose and treat thousands of conditions affecting Canadians. These include genetic technologies, stem cell research and nanotechnologies. They also present certain challenges, such as ensuring that intellectual property and patent rights concerning genetic inventions are compatible with appropriate patient access and that Canadians receive high quality genetic services.

In consultation with many partners in Canada, our Department worked closely with the OECD to develop OECD Guidelines on Quality Assurance in Molecular Genetic Testing that are to be published in 2007. The Guidelines are an important tool to promote safe, effective and appropriate use of genetic testing in Canada. During the electronic public consultation period on the Guidelines, Canada was recognized as having the highest stakeholder participation rate of any OECD member state.

Health Canada has played a key role in the Budget 2007 commitment to invest $30 million in the Rick Hansen Foundation's Spinal Cord Injury Translational Research Network. The goal is to accelerate the translation of research discoveries into practical benefits for Canadians with spinal cord injuries while generating savings in health and social services and accelerating scientific advances towards a cure.

Health Canada conducted extensive policy research on intellectual property and patents in medical genetics and stem cells. Through workshops and symposia, we have encouraged stakeholders to adopt OECD Licensing Guidelines for Genetic Inventions. These and other creative licensing strategies will help overcome patent-related barriers to research and improve patient access to innovative biotechnology products in a cost-effective manner.

Horizontal Linkages

Research activities focused on issues such as First Nations and Inuit health sustainability, public system health care comparative analysis, health innovation and healthy communities. We continued our examination of factors influencing sustainability of the health care system including the rapidly growing pharmaceutical sector

and productivity in the health sector.

Consistent with a government-wide commitment, we addressed gender and diversity issues in areas such as mental health, cancer and clinical trials. We successfully negotiated for inclusion of health, gender and diversity considerations in the deliberations of the Working Group on Trafficking in Persons.

Health Care Policy

Financial Resources (millions of dollars):

Planned Spending	Authorities	Actual Spending
158.1	162.9	147.7

Health Canada provides policy leadership and advice on issues related to the health care system and its renewal, such as improving access to quality care, increasing the supply and improving the mix of health care professionals, and enhancing the accountability of the system to Canadians.

Policy leadership is also provided in health care delivery, particularly home care, continuing care, palliative care and primary health care, and also to issues such as the responsiveness of the health care system to aging, chronic disease management and e-health. Programs promote and facilitate effective and innovative planning, education, training, management, recruitment and retention of health human resources in Canada.

In addition to initiatives described previously under this strategic outcome, the Department provided policy leadership and coordination on other issues that are being addressed across the Health Portfolio. For example, we worked with many partners to identify how the Government of Canada could best address the needs for a coordinated approach to cancer. This supported the Government decision to create the Canadian Partnership Against Cancer (CPCC), a not-for-profit corporation. CPCC was established to implement the Canadian Strategy for Cancer Control, a five-year plan developed by more than 700 cancer survivors and experts. The CPCC has begun to take shape to serve as a clearing house for state-of-the-art information about preventing, diagnosing, and treating cancer. Its work is supported by the $260 million announced in the 2006 budget.

We also were assigned the responsibility of leading federal policy development in relation to autism spectrum disorders. This including guiding and supporting actions designed to expand understanding of autism among researchers and health professionals and to provide more information to families and others who deal with autism. Our efforts included close cooperation with partners such as the Public Health Agency of Canada and the Canadian Institutes of Health Research.

Intergovernmental

Financial Resources (millions of dollars):

Planned Spending	Authorities	Actual Spending
6.6	6.6	4.8

We continued to administer the *Canada Health Act* (CHA), which included investigations into potential cases of non-compliance and analysis of relevant emerging issues, such as patient charges for primary care in private facilities, possible extra-billing by physicians and charges for surgical services by private clinics. We continued to see the traditionally high level of provincial and territorial compliance, which we detail to Parliament and Canadians in the *Canada Health Act Annual Report*.

We provided strategic and tactical advice and support on the full range of intergovernmental health-related issues and activities, with emphasis on pandemic preparedness and Patient Wait Times Guarantees.

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

Canada Health Act Annual Report
http://www.hc-sc.gc.ca/hcs-sss/medi-assur/index_e.html

International

Financial Resources (millions of dollars):

Planned Spending	Authorities	Actual Spending
25.0	38.4	37.9

Health Canada continues to initiate, coordinate, and monitor departmental policies, strategies and activities that help promote Canadian priorities and values internationally. We collaborated with external health partners such as the WHO and the Pan American Health Organization (PAHO) on pandemic influenza preparedness, HIV/AIDS and global health security.

Health Canada coordinates the global engagement component of the Federal Initiative to Address HIV/AIDS in Canada, to ensure policy coherence of Canada's international HIV/AIDS activities. Notable achievements included a strong, coordinated and effective presence at the XVI International AIDS Conference in Toronto, August 13-18, 2006. Health Canada and the Public Health Agency of Canada signed a formal partnership agreement in August 2006 with the Joint United Nations Programme on HIV/AIDS (UNAIDS) to promote joint actions aimed at strengthening global response to the HIV and AIDS epidemic.

On August 15, 2006 in Toronto, the Health Ministers for Canada and France signed a Joint Declaration of Intent Regarding Cooperation Between the Department of Health of Canada and the Ministry of Health and Solidarity of the French Republic in the Field of Health for the Period 2006-2010. The Declaration is a framework arrangement that outlines mutual work the two countries plan to undertake in the next four years. Key areas are pandemic influenza preparedness, the strengthening of health care systems, HIV/AIDS, sexually transmitted infections, hepatitis B/C, tuberculosis and sexual and reproductive health. Other potential areas of cooperation could be on physical activity, cancer and mental health.

Assisted Human Reproduction Implementation Office

Health Canada provides policy analysis and advice towards the establishment of the Assisted Human Reproduction Agency of Canada as well as developing the regulatory framework required by the AHR Act.

Legislative Renewal

Legislative renewal activities concentrate on updating and strengthening health protection legislation to ensure that it is responsive to present and future social and technological realities.

Applied Research, Dissemination and Accountability

Financial Resources (millions of dollars):

Planned Spending	Authorities	Actual Spending
34.8	35.4	32.2

Health Canada helps to build the analytical foundation for health policy decision making, performance measurement and reporting. This includes conducting economic analysis of health policy issues, funding external policy research in priority areas, and running a policy research publications program, which includes publication of the *Health Policy Research Bulletin*. We develop, in collaboration with partners and stakeholders, federal policy on investments in Canada's health statistics system and coordinate departmental core data requirements with data providers.

Official Language Community Development

Financial Resources (millions of dollars):

Planned Spending	Authorities	Actual Spending
40.9	43.2	47.6

We provided leadership in responding to the health needs of official language minority communities by administering Health Canada's responsibilities under Section 41 of the *Official Languages Act.*

We supported programs and services to improve access to health care for people in official language minority communities, consistent with the *Official Languages Act.* Two contribution agreements were launched to provide primary health care services within English and French-speaking minority communities. A report analyzing the evolving health access concerns of Francophone minority communities was completed and presented to the Minister in February 2007 by the Consultative Committee for French-Speaking Minority Communities. Working with Statistics Canada and several other federal departments, we launched the 2006 Survey on the Vitality of Official Language Minorities to improve the Government's ability to measure their health-related challenges. The results of this Survey will be available from Statistics Canada in 2007-2008. We partnered with the Department of Canadian Heritage in launching a learning tool for development of status reports and action plans required under Part VII of the *Official Languages Act* and its accountability frameworks.

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 Results:

- Access to safe and effective health products and food and information for healthy choices

Performance Indicators	Results
Level of satisfaction of Canadians and health professionals with the information disseminated for healthy choices and informed decision making	*This indicator is being revised. No current data exists.*

Financial Resources (millions of dollars):

Planned Spending	Authorities	Actual Spending
262.1	278.2	262.3

Human Resources (FTEs):

Planned	Actual	Difference
2,592	2,563	29

Explanation of the above financial information:

Variances between planned spending versus authorities are mainly due to:
- Funding from Management Reserve - Natural Health Products
- Funding from Management Reserve - Litigation Management
- Funding for Therapeutics Access Strategy.

The actual spending is $15.9 million lower than authorities mainly due to:
- Lapse of frozen allotment for Access to Medicines Regime
- Year end adjustments of Department of Justice expenditures
- Other operating lapses in various programs.

Health Products and Food is a regulatory program. Its objective is to evaluate and monitor the safety, quality and effectiveness of the thousands of drugs, vaccines, medical devices, natural health products and other therapeutic products available to Canadians, as well as the safety and nutritional quality of their food. We also review veterinary drugs sold in Canada as well as foods derived from animals treated with these drugs. We promote the health and well-being of Canadians by developing nutritional policies and standards such as *Canada's Food Guide* and providing information to the public in newsletters such as *It's Your Health*. The Government is committed to continually modernizing its legislative and regulatory frameworks to keep pace with advancing science and technology, existing and emerging public health challenges, consumer expectations in terms of safety, the need for transparency, faster drug approvals, international developments and other factors. Since 1953, responsibilities for health products and food safety have been

primarily defined through the *Food and Drugs Act*.

Health Canada has identified challenges that must be met to ensure continued, timely access to safe and effective health products and a safe and nutritious food supply. These include but are not limited to: an outdated regulatory tool kit that is increasingly limited and inflexible in responding to today's environment; the regulatory system's incapacity to consider a product through its entire life cycle; and a regulatory system with insufficient resources for long-term efficiency and sustainability. The Office of the Auditor General came to similar conclusions when it reviewed this area for its November 2006 report.[8]

Consequently, in October 2006, we released *Blueprint for Renewal: Transforming Canada's Approach to Regulating Health Products and Food* for consultation. This policy review document builds on progress made over the last few years to improve the regulatory system's efficiency, safety and transparency. The Blueprint reflects input from Canadians and commits us to improve information for decision making. It is supported by detailed action plans, setting the stage for consultations on and implementation of specific Blueprint initiatives in 2007-2008 and 2008-2009, including a new progressive licensing framework for pharmaceuticals and biologics. We will continue to report progress on these and longer-term initiatives through the Blueprint website and in reporting frameworks such as the DPR. [9]

The Department addressed other areas that complement these directions as well as issues raised by the Auditor General. For example, we began work on a cost recovery framework and a comprehensive review of programs and resources. The cost recovery regime should be implemented in 2008-2009, updating a 10-year-old fee regime. This will support a long-term, stable and sustainable funding strategy for our regulatory programs. The assessment of all programs and activities will define the level of activities, performance and resources required to meet our regulatory and other responsibilities, based on the full cost of these activities. [10]

Under this Health Products and Food program activity, are four sub-activities as defined in our Program Activity Architecture (PAA). Achievements under each of the sub-activities are outlined below.

Pre-market Regulatory Evaluation and Process Improvement

Financial Resources (millions of dollars):

Planned Spending	Authorities	Actual Spending
125.8	133.6	125.9

8 OAG report: http://www.oag-vg.gc.ca/domino/reports.nsf/html/20061108ce.html

9 For more information on the *Blueprint for Renewal* and related specific initiatives visit: http://www.hc-sc.gc.ca/ahc-asc/branch-dirgen/hpfb-dgpsa/blueprint-plan/index_e.html.

10 http://www.hc-sc.gc.ca/dhp-mps/consultation/cri-irc/index_e.html

Expected Results	Performance Indicators	Results
Improved timeliness, transparency and predictability of the regulatory process	Percentage of overall workload in backlog and percentage of decisions issued within target for submission reviews of: • pharmaceuticals • medical devices • biologics • food additives, • packaging • novel foods and • nutritional submission processing	• 90% of new pharmaceutical and generic drug submissions decisions met within internationally comparable performance targets, compared to 13% and less than 15% respectively in 2003. • Since September 2006, 100% of decisions on biologic submissions made within time targets. • Performance targets for processing Class III and IV medical device submissions were exceeded. The target for processing Class II applications was not met (81% vs. a 90% target).

We continued to implement a long-term government commitment to improve the timeliness of the regulatory process for therapeutic products to ensure that Canadians have faster access to the safe drugs they need. This had many elements.

Improved Speed of Decision Making

Using funding received in Budget 2003 under the Therapeutics Access Strategy, a five-year, $190 million initiative, we improved our speed of decision making on new product reviews. This is demonstrated in the table above. In addition, we cleared the backlog of new biologic submissions by September 2006.

We made similar progress for medical device applications, which are assigned to classes based on their potential risk to humans. For example, bandages are Class I (low risk) devices, while pacemakers and HIV

test kits are Class IV (highest risk). [11] Our processing of Class II applications was much better than the 51 percent performance in 2004. In the area of natural health products, we are making six times as many daily decisions as we did a year ago.

We continued to reduce decision times for veterinary drugs and set service standards. We reviewed 93 percent of data packages submitted prior to October 1, 2005, exceeding our target of 90 percent. We also completed several submission reviews that were not on our target list.

The ongoing challenge continues to be significant backlogs in our pre-market review of submissions for natural health products, veterinary drugs and food products. We have reduced backlogs at some stages of our work and are pursuing measures to process these applications more quickly and consistently in comparison with international performance targets.

The Blueprint for Renewal

Under the Blueprint described earlier, a progressive licensing framework for pharmaceuticals and biologics will facilitate access to drugs while continuing to monitor safety, efficacy, and quality throughout a drug's life cycle. The project achieved its early-stage objective and benefited from outreach to patient and consumer groups, industry, academia, health care professionals and provincial representatives. We expect to formulate a more detailed framework during 2007. [12]

In 2001, Health Canada established a framework and regulations to oversee clinical trials that support applications for new drugs. At that time, we committed to assess the impact of the regulations and seek advice on improvements in three to five years. As part of the Blueprint initiative, we began a public e-consultation in June 2006. This led to a March 2007 workshop with stakeholders on specific possible improvements. [13]

In addition to work under the Blueprint, we began the review of regulations and processes related to pre-market safety assessment and authorization of foods and food products. We developed a draft *Guide for the Preparation of Submissions on Food Additives* and an options paper for a modernized regulatory framework for food additives that is expected to be released soon for external consultation.

Clinical Trials

In 2005, Health Canada received $170 million over five years to improve the safety of drugs, medical devices and other therapeutic products. As part of this initiative, we are strengthening the oversight of pharmaceutical clinical trials and investigational testing for medical devices conducted in Canada. New funding for 2006-2007 enabled us to add staff to handle significant increases in drug clinical trial applications, clinical trial

[11] Classes of medical devices:

Class	Risk	Example
Class I	Lowest risk	Reusable surgical scalpel, bandages, culture media
Class II	Low risk	Contact lenses, epidural catheters, pregnancy test kits, surgical gloves
Class III	Moderate risk	Orthopedic implants, glucose monitors, dental implants, haemodialysis systems, diagnostic ultrasound systems
Class IV	High risk	HIV test kits, pacemakers, angioplasty catheters

[12] http://www.hc-sc.gc.ca/ahc-asc/branch-dirgen/hpfb-dgpsa/blueprint-plan/index_e.html
http://www.hc-sc.gc.ca/dhp-mps/homologation-licensing/develop/plan_e.html

[13] http://www.hc-sc.gc.ca/ahc-asc/branch-dirgen/hpfb-dgpsa/blueprint-plan/index_e.html

Adverse Reaction Reports and safety reports. This has resulted in more timely responses and appropriate linkages with our pre-market review and post-market surveillance activities, although we recognize gaps that we must still address.

In addition, we increased efforts to make our internal processes as consistent and transparent as possible. As a result of posting the Clinical Trials e-manual on our website in 2006 we had fewer calls from clinical trial sponsors for information. We also discovered fewer deficiencies while screening clinical trials and investigational testing applications from clinical trial sponsors.

Regulatory Actions

We continued to develop regulatory frameworks. One seeks to minimize the potential health risks to Canadian recipients of human cells, tissues and organs through proposals for Safety of Human Cells, Tissues and Organs for Transplantation Regulations. Extensive consultations will continue in 2007-2008. We are at an earlier stage of consultations to guide a renewed regulatory framework for whole blood and blood components, typically used in transfusions, under the *Food and Drugs Act.*

Health Canada continued to lead a federal stewardship approach to manage risks and benefits of emerging biotechnologies and nanotechnologies products and services. This included work on horizontal policies, identification of barriers and implementation of strategies for supportive environments. An interdepartmental Biotechnology Regulatory ADM Steering Committee considered common biotechnology regulatory challenges among departments.

We released revised guidelines on the safety assessment of novel foods to help improve the transparency of this regulatory process. We held training sessions and a pilot workshop with academia, government and industry to further a tiered, risk-based approach.[14]

As promised in the RPP, we began to develop a new regulatory approach for radiopharmaceuticals used for diagnosis and radiation therapy. We are moving forward on two regulatory initiatives. The first will address basic clinical research involving radiopharmaceuticals or positron-emitting radiopharmaceuticals. The second will require drug identification numbers (DINs) on radiopharmaceuticals.

The Department also started work, in collaboration with Agriculture and Agri-Food Canada, on a new regulatory framework for health claims for foods, including the use of logos and symbols. This will modernize the current system and support informed consumer choice with appropriately substantiated claims.

The Community of Federal Regulators is a partnership of all federal departments and agencies with regulatory roles. In order to learn from each other and accelerate innovations consistent with the Cabinet Directive on Streamlining Regulation, 12 departments and agencies signed a Memorandum of Understanding, approved a business plan, developed a learning strategy and exchanged information and best practices.

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

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

Financial Resources (millions of dollars):

Planned Spending	Authorities	Actual Spending
13.1	13.9	13.1

Expected Results	Performance Indicators	Results
Improved adoption in making safe and healthy choices for health products, food and nutrition	Percentage of target populations using information in their decision making	

Health Canada continued to provide useful information about risks and benefits related to health products and food. For example, we conducted an educational campaign to increase consumer awareness of food safety related to meat and poultry. We completed a consultation on labeling information to reduce risks from unpasteurized juice and cider. Given concerns about health issues related to sprouted seeds and beans, we developed a policy and educational material including a page on our website [15]. A review of the risks of mercury to human health was conducted and standards and consumption advice updated on limiting exposure to mercury from certain predatory fish. We also completed a survey of benzene levels in non-alcoholic beverages and followed up with industry to ensure that levels found in beverages aimed at children were reduced through product reformulation. We released over 100 health advisories for health professionals and consumers and also developed a strategy for consumer information.

The Department provided ongoing objective information on emerging technologies and their applications. This included a list of potential nanotechnology-based products and/or delivery systems that fall under our authority. We also developed and implemented a pilot project - a high school Biotechnology Teachers' Kit to introduce students to biotechnology, to stimulate discussion on benefits and risks associated with biotechnology products and to learn how these products are regulated by Health Canada.

In February 2007, we launched the revised *Canada's Food Guide* after extensive consultations with stakeholders and the public. We disseminated 6.1 million copies and 300,000 resource guides for educators and communicators. Other resources include a web component with interactive material. From the launch of the Guide until the end of March, we recorded 6,768,674 visits to the Guide website and demand for copies has exceeded supply. [16]

We began work with the Public Health Agency of Canada (PHAC) and the World Health Organization (WHO) on an international framework to promote and support healthy eating and physical activity through schools. This framework is to be one of the tools provided by WHO to implement the global strategy on diet, physical

[15] http://www.hc-sc.gc.ca/iyh-vsv/food-aliment/sprouts-germes_e.html
http://www.hc-sc.gc.ca/fn-an/securit/facts-faits/rawmilk-laitcru_e.html
http://www.hc-sc.gc.ca/iyh-vsv/food-aliment/juice-jus_e.html
http://www.hc-sc.gc.ca/fn-an/label-etiquet/meat-viande/index_e.html
http://www.hc-sc.gc.ca/fn-an/label-etiquet/allergen/index_e.html
http://www.hc-sc.gc.ca/fn-an/label-etiquet/nutrition/index_e.html

[16] http://www.hc-sc.gc.ca/fn-an/food-guide-aliment/index_e.html

activity and health. In partnership with the U.S. Institute of Medicine, Health Canada contributed to developing and disseminating *Dietary Reference Intakes: The Essential Guide to Nutrient Requirements*, a summary report on Dietary Reference Intakes (DRIs), available in both official languages. The DRIs underpin all nutrition programs and policies in Canada and are used in risk assessment, standard-setting and policy development. A web-based Interactive Nutrition Label and Quiz helps Canadians make informed food choices and draws continued attention to nutrition labeling. [17]

Health Canada continued to distribute the *Canadian Adverse Reaction Newsletter* and publish it in the *Canadian Medical Association Journal*. There was also a 19 percent increase in MedEffect Canada e-Notice subscribers.

Monitoring safety and therapeutic effectiveness and risk management

Financial Resources (millions of dollars):

Planned Spending	Authorities	Actual Spending
104.9	111.2	104.9

Expected Results	Performance Indicators	Results
Strengthened vigilance over safety and therapeutic effectiveness for health products and food on the market	Overall rating of Health Canada's post-market safety and therapeutic effectiveness activities	*We are working on developing a new indicator*

We followed through on our RPP commitments under this sub-activity. For example, we carried out nutrition-related surveillance activities such as posting a guide to accessing and interpreting Canadian Community Health Survey data on our website, as well as printing and distributing the guide to stakeholders. [18]

The Department received $190 million and $170 million over five years through the 2003 and 2005 budgets, for the Therapeutics Access Strategy and the Therapeutic Product Safety Initiative, respectively. These funds have enabled us to enhance post-market surveillance of drugs and other therapeutic products. For example, the Therapeutics Access Strategy has facilitated the reduction in backlog reports while the Therapeutic Product Safety Initiative has increased our scientific/medical capacity to monitor and evaluate safety information and act decisively to protect Canadians.

In 2006, we awarded a contract to develop a more sophisticated Adverse Reaction Reporting System that will collect and analyze adverse reaction information more effectively. In 2007-2008, the system will focus on post-market adverse reactions to pharmaceuticals, biologics and natural health products. It will later be expanded to include pre-market Adverse Reaction Reports from clinical trials.

17 http://www.hc-sc.gc.ca/fn-an/label-etiquet/nutrition/interactive/index_e.html

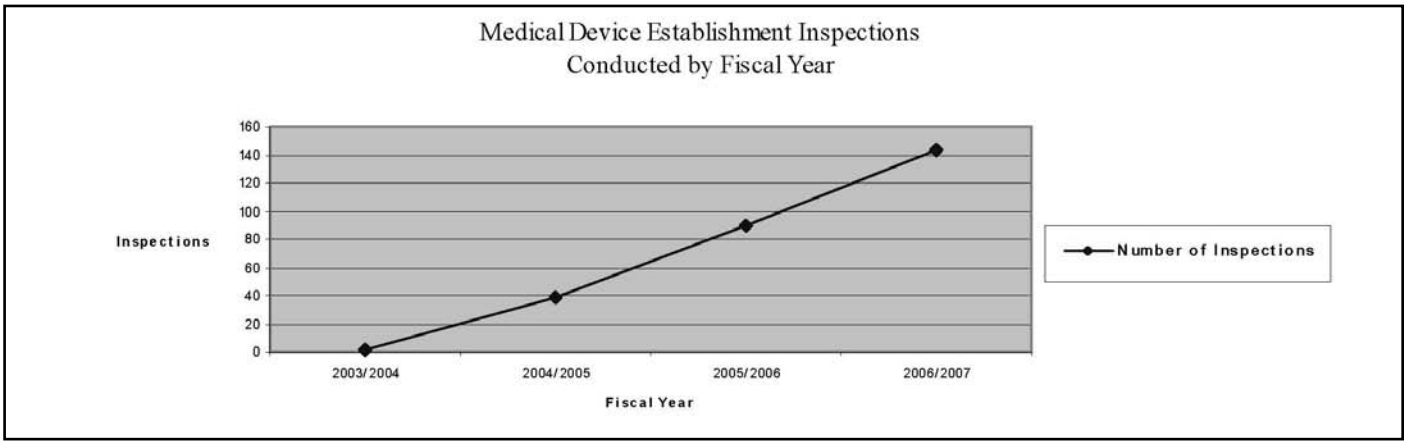
18 http://www.hc-sc.gc.ca/fn-an/surveill/nutrition/commun/cchs_guide_escc_3_e.html

We consulted on possible Environmental Assessment Regulations for substances regulated under the *Food and Drugs Act* to minimize the effects of therapeutic products on the environment, beginning with pharmaceuticals, veterinary drugs, radiopharmaceuticals, medical devices and cosmetics.

Health Canada conducted 51 clinical trial inspections, although our target was 60. This represents 1.2 percent of clinical trials, versus the targeted 1.5 percent. Our goal is to achieve the international level of 2 percent in future years, as advocated by the Standing Committee on Health in 2004. The challenge has been the availability of trained inspectors to perform Good Clinical Practices (GCP) inspections, especially given the time required to train new inspectors and competing priorities. Of the 51 clinical trials, 49 were rated compliant (96.1 percent), indicating that subjects in these trials are not exposed to undue risks and that trials are generally compliant with Canadian regulations.

Health Canada's Inspectorate Quality Management team, managed within the Quebec Region, conducted four evaluations of international mutual recognition agreements covering the Good Manufacturing Practices of drug/medicinal products with the Czech Republic and Hungary. The regulatory authorities in these two countries are now seen as equivalent relating to the mutual recognition agreements pertaining to drugs and other medicinal products.

We conducted 144 inspections of medical device establishments representing a 62 percent increase from the previous year. This fell below our target of 170 for two major reasons: more resources were required for inspection follow-up and to deal with medical device incidents that arose during the year. Nevertheless, we still made a significant improvement in the number of medical device establishments inspected, as illustrated in the figure below. [19]



In 2006, the Health Portfolio received funding over five years to improve preparedness for avian and pandemic influenza. Health Canada has used this funding to develop a guidance document that should accelerate access to available pandemic drugs.

We received 15,295 domestic Adverse Reaction Reports (compared to 15,107 in 2004-2005 and 14,868 in 2005-2006). Also received were 10,686 domestic reports of suspected adverse reactions to pharmaceuticals, biologics, natural health products and radiopharmaceuticals. An initial report and all subsequent information received as follow-up reports are combined and considered to be one case. Most domestic cases were reported by health professionals.

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

Transparency, Public Accountability and Stakeholder Relationships

Financial Resources (millions of dollars):

Planned Spending	Authorities	Actual Spending
18.3	19.5	18.4

Expected Results	Performance Indicators	Results
Improved public confidence and trust in the safety of health products, food and the regulatory system	Level of public confidence in safety of health products, food and nutrition	*We are working on developing a new indicator*
Level of public confidence in safety of health products, food and nutrition	Percentage of stakeholders who hold a positive view on HPFB's transparency and openness regarding regulation of health products and food	*We are working on developing a new indicator*

In recent years, Canadians have sought increased access to information and decision making about the processes through which food and therapeutic products are regulated. Accordingly, we developed and launched a policy on public input in the review of our regulated products. The policy sets out when Health Canada is expected to seek public input, what information will be disclosed to allow for informed participation, and how public input will be incorporated in a decision about a product. We expect this process to improve the credibility and quality of decisions.

In summer 2006, the Department held consultations on the *Blueprint for Renewal* initiatives described earlier. We posted a discussion document and electronic workbook on our Blueprint website. More than 300 stakeholders provided views on the vision and objectives. We also held regional meetings as well as consultations on Blueprint themes and initiatives such as the proposed progressive licensing framework, a policy on public input in the review of regulated products, a renewed external charging framework and a regulatory modernization strategy for food and nutrition.

There is no requirement in Canada for sponsors of clinical trials to disclose publicly the existence or results of those trials. Because disclosure of clinical trial information in a publicly available registry would increase access to that information, we convened the first meeting of an External Working Group to develop preliminary options for registration in Canada. This built on international and domestic initiatives as well as results of public consultations that we held in 2005. We developed an online workbook to get public input on policy options, later posting the results on our website. Also posted were the External Working Group's final report and recommendations on how to proceed with registration and disclosure of clinical trial information in Canada. [20]

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

In 2005 we opened our Office of Paediatric Initiatives as a focal point for an integrated approach to health and safety issues affecting children, from food and nutrition to drugs and vaccines and other therapeutic and diagnostic health products. We have invited stakeholders to identify nominees for the soon-to-be established Paediatric Expert Advisory Committee on Health Products and Food.

Strategic Outcome #3 (a)

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)

Performance Indicators	Results
Percentage of federal public employees remaining at work through and following an injury, illness or traumatic incident	84% of federal workers who had to leave work for more than 13 weeks returned to work.
Treasury Board Secretariat Statistics on leave, accommodation and injury in the workplace	Received 4,747 requests for ergonomic assessments, completed 96%; received 2,376 requests for Fitness to Work health evaluations, completed 90%.
Level of client satisfaction with occupational health and contingency planning services	Employee Assistance Program scored above 80% on surveys and interviews, including follow-up surveys that take place three months after service.
Client satisfaction surveys	97.2% of respondents are satisfied with the Employee Assistance Program
Percentage of Canadians who are aware that their health can be affected by environmental factors	Development of baseline data taking place.
Reported incidents of product-related deaths and injuries associated with: consumer products; cosmetics; workplace chemicals; new chemical substances; products of biotechnology; radiation-emitting devices; environmental noise; solar UV radiation	Development of baseline data taking place.

- Reduced health and safety risks associated with tobacco consumption and the abuse of drugs, alcohol and other substances

Performance Indicators	Results
Prevalence of drug and substance abuse in Canada. Canadian Alcohol and Drug Use Monitoring Survey	Enhanced capacity to assess prevalence of substance use and abuse is being developed.
Smoking prevalence in Canada. Reduction in smoking prevalence from 25% to 20% Canadian Tobacco Use Monitoring Survey	19% of the population, aged 15 years and older smoke.

Financial Resources (millions of dollars):

Planned Spending	Authorities	Actual Spending
289.9	305.3	294.1

Human Resources (FTEs):

Planned	Actual	Difference
1,956	1,950	6

Explanation of the above financial information:

Variances between planned spending versus total authorities are mainly due to:
- Contributions to the government-wide 2006-2007 $1 billion Spending Restraint Exercise
- Funding from Management Reserve - Public Service Health Program
- Funding from Management Reserve - Litigation Management.

Actual spending is $11.2 million lower than total authorities mainly due to:
- Year end adjustments of Department of Justice expenditures
- Other operating lapses in various programs.

Healthy Environments and Consumer Safety activities are 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*. These Acts encompass diverse elements such as drinking water quality, air quality, radiation exposure, products of biotechnology and of other new and emerging technologies (including nanotechnology), 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 the Government's public safety and antiterrorism initiatives, inspection of food and potable water for the travelling public and health contingency planning for visiting foreign dignitaries.

We seek to achieve our priorities through: enhanced compliance with regulations, standards and guidelines; increased awareness of regulated health products; action related to healthy and safe living, working and recreational environments; enhanced involvement of stakeholders; and improved scientific knowledge and capacity to support decision making. We collaborated extensively with partners and stakeholders inside and outside Canada, had an active presence in every region and used risk management processes to identify priorities for action. The Department fulfilled its responsibilities in accordance with sustainable development prin-

ciples in order to achieve economic, social, cultural and environmental objectives.

We had success in fulfilling our plans and priorities as set out in the RPP and in addressing new Government priorities that emerged such as the Clean Air Agenda and Environmental Agenda.

In response to concerns raised by the Office of the Auditor General, Health Canada has implemented policies and procedures to improve accountability and stewardship. We have developed short-term and longer-term strategies and priorities for reducing health and environmental risks to Canadians.

Our achievements and challenges in the five sub-activities under this program activity are described below.

Safe Environments Program

Financial Resources (millions of dollars):

Planned Spending	Authorities	Actual Spending
83.5	86.1	85.0

Expected Results	Performance Indicators	Results
Availability and Canada-wide adoption of measures to control the risks to human health posed by environmental contaminants	Percentage of completion of legislated obligations and other commitments	Baselines being established
Increased knowledge, understanding and involvement by Canadians in environmental health issues	Percentage of Canadians who are aware that their health can be affected by environmental factors	
Science-based decision making within Canada regarding health risks of environmental contaminants		
Improved scientific knowledge and capacity within the Canadian scientific community and international collaboration on environmental health issues to ensure that Canadians have increased confidence in environmental health information and protection mechanisms		

We continued to identify and manage health risks posed by environmental factors in living, working and recreational environments. The scope of activities included: drinking water quality, climate change, clean air programming, contaminated sites, toxicology, and regulatory activities. The Department was also involved in risk assessment and management of chemical substances, microbiological pathogens, environmental noise, environmental electromagnetic frequencies, solar ultraviolet radiation, as well as preparedness for nuclear and environmental disasters. Research related to these activities and to exposure assessment, hazard identification, mechanistic and population studies supported our science-based decision making.

We were involved in developing elements of the Government's Clean Air Agenda and Environmental Agenda. Collaboration with Environment Canada led to a comprehensive strategy to address air emissions from indoor and outdoor sources. Included is a regulatory approach to emissions of greenhouse gases and air pollutants caused by fuels and consumer and commercial products and those generated by industrial sectors such as electricity generation, upstream oil and gas, pulp and paper, and chemicals.

We carried out our responsibilities under the *Canadian Environmental Protection Act*, including completing identification and prioritization ("categorization") of the 23,000 substances on the Domestic Substances List (DSL). About 4,000 were identified as requiring further action. Of these, 1,200 were identified as low priority, 2,600 as medium priority, and 200 as high priority.

Based on these categorization results, Health Canada developed, in conjunction with Environment Canada, the Chemicals Management Plan (CMP), a key component of the Government's Environmental Agenda. The CMP will build on Canada's position as a global leader in safe management of chemical substances and products, with a focus on timely response to environmental and health threats. The CMP enables integration and coordination of the *Canadian Environmental Protection Act* (CEPA) with other federal legislative tools, such as the *Food and Drugs Act*, *Hazardous Products Act* and the *Pest Control Products Act*. In addition to increasing health and environmental research, monitoring and tracking, the CMP provides an opportunity for industry and other stakeholders to inform the decision-making process. The CMP sets timelines between now and 2020 for addressing the 4,000 substances that met categorization criteria. The CMP places the onus on industry to provide the Government with information about how they are safely managing 200 high priority chemical substances. The Government is separating those into batches of 15 to 30 substances and is publishing a batch in the *Canada Gazette* every three months. The first batch was published in February 2007.

The Alberta Region, in collaboration with the Alberta Heritage Foundation for Medical Research, the Alberta Centre for Child, Family and Community Research and key Alberta partners and stakeholders, hosted a 2006 Child Health and the Environment symposium. The subsequent work of the Alberta Child Health and Environment Advisory Group led to recommendations for leaders and champions in Alberta on needed research in this area. As well, the group offered advice to the Canadian Partnership on Child Health and the Environment's third workshop - Research Informing Policy.

The Department worked with provincial and territorial governments on drinking water quality, including finalization of four Drinking Water Quality Guidelines. In partnership with the Public Health Agency of Canada, we began development of a drinking water advisory system to help track Boil Water Advisories and their sources. We also developed a protocol for a coordinated and systematic federal approach to dealing with outbreaks of water-borne illness and contamination of drinking water.

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

Health Canada continued its involvement in developing an Air Health Indicator (AHI) for 2008 that will evaluate trends in air quality and associated health impacts over time. We also rolled out the pilot version of the Air Quality Benefits Assessment Tool (AQBAT). It was used to estimate health impacts for the Climate Change and Health Vulnerability Assessment, the benefits of gasoline blends with 10 percent ethanol, and various scenarios under potential new regulations to address air pollution. The Border Air Quality Strategy (BAQS) was completed and included an Air Quality Health Index and two regional pilot studies. One looked at impacts of air pollution on the health of children and other vulnerable populations.

Climate Change and Health
http://www.hc-sc.gc.ca/ewh-semt/climat/index_e.html

Air Health Indicator
http://www.hc-sc.gc.ca/ewh-semt/air/index_e.html

Border Air Quality Strategy
http://www.hc-sc.gc.ca/ewh-semt/air/out-ext/border_air_e.html

Departmental nuclear emergency response capabilities were used to deal with three events. Canada's networks provided the only international confirmation of the underground nuclear bomb test by North Korea. We conducted analysis of radioactively contaminated mushrooms destined for the U.S. and imported via Canada from Eastern Europe. Our laboratories were involved in assessment and monitoring of over 40 Canadians deemed to be at risk of contamination from a Polonium-210 incident in London, England. Our Department also continued support for development of the Accident Reporting and Guidance Operational System (ARGOS) and the Federal Nuclear Emergency Plan electronic mapping systems as well as work to achieve more rapid processing of emergency samples. We also undertook preliminary analysis and evaluation of the effect of radon in Canadian households to guide the expected Radon Reduction Strategy.

Departmental contributions ensured proper scope of the human health component of the Canadian International Polar Year (IPY) program (2007-2009). Outcomes will include a better understanding of the current health disparities in the North, of the impact of climate change on health, and of community resilience to change. The Department participated in the development of new methods to assess impacts of environmental change on Arctic populations and ensured that high priority health issues will be addressed during IPY.

International Polar Year
http://www.ipy-api.gc.ca/govt/index_e.html

Product Safety Program

Financial Resources (millions of dollars):

Planned Spending	Authorities	Actual Spending
31.3	33.1	31.1

Expected Results	Performance Indicators	Results
Reduced risk of death and injury from exposure to hazardous products and substances associated with: consumer products; cosmetics; workplace chemicals; new chemical substances; products of biotechnology; radiation emitting devices; environmental noise; solar UV radiation	Reported incidents of product-related deaths and injuries Level of exposure to hazardous products and substances associated with: consumer products; cosmetics; workplace chemicals; new chemical substances; products of biotechnology; radiation emitting devices; environmental noise; solar UV radiation	Working on development of baseline data through performance measurement and the Product Safety Program Capacity Assessment Project.

To reduce the number of unsafe consumer products on the market in Canada, we conducted ongoing regulatory, monitoring and compliance activities. We also provided information, education and guidance to the public and industry, such as hazard and technical information to importers and manufacturers to encourage safer product design. In addition we identified unsafe products and product-related risks through research, laboratory testing and investigation, surveillance and monitoring activities and carried out regulatory and policy development. More than 12,000 inspections comprising market surveillance in 10 consumer product areas and over 4,000 customs referrals led to removal of approximately 1,600 product lines from the market. Approximately 27 contracts involving over 2,400 consumer products were tested as part of pre-market assessment to reduce the likelihood of hazardous products available on the market.

For example, we worked on child safety issues including strangulation by the cords of window coverings such as curtains and blinds. We carried out a multimedia information campaign and drafted regulations mandating performance requirements. No incidents related to this issue were reported during the year. We continued development of regulations for children's products, such as crayons, crib toys, clothing, and strollers, under the Lead Risk Reduction Strategy (LRRS). As well, final publication of revised Glazed Ceramics and Glassware Regulations achieved harmonization between American and Canadian standards.

To minimize future threats of skin cancer among today's children, the Department continued with the Sun Awareness Project, a school-based program that educates children about sun exposure. More than 100,000 students have been taught sun safety in elementary and secondary school classrooms since 2005.

Sun Awareness Program
www.hc-sc.gc.ca/hl-vs/securit/sports/sun-sol/uv-prog/index_e.html

Health Canada collaborated with partners in Canada and internationally to implement the Globally Harmonized System of Classification and Labelling of Chemicals (GHS), which, in the Canadian context, deals with consumer chemical products and workplace chemicals.

Globally Harmonized System
www.hc-sc.gc.ca/ahc-asc/intactiv/ghs-sgh/index_e.html

The Department continued to assess the potential health risks of new chemicals such as fabric dyes and fuel additives, as well as biotechnology products. Approximately 500 new chemical notifications were received.

We completed about 850 assessment reports, significantly reducing our backlog. Risk management actions were renewed for four new perfluorinated chemical substances (commonly used as water and grease repellants for materials such as paper, textiles, carpet and leather, or in the manufacturing process for non-stick coatings on items such as pots and pans), and additional information-gathering conditions were imposed on 12 other new substances.

Chemicals Management Plan
http://www.chemicalsubstanceschimiques.gc.ca/plan/index_e.html

Weblinks: Product Safety Program

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

Lead Risk Reduction Strategy
www.hc-sc.gc.ca/cps-spc/pubs/cons/lead-plomb/index_e.html

CEPA (Canadian Environmental Protection Act)
www.hc-sc.gc.ca/iyh-vsv/environ/cepa-lcpe_e.html

Consumer Product Safety
www.hc-sc.gc.ca/cps-spc/index_e.html

Workplace Health and Public Safety

Financial Resources (millions of dollars):

Planned Spending	Authorities	Actual Spending
29.9	40.5	40.5

Expected Results	Performance Indicators	Results
Reduced risks to health and safety and improved protection against harm associated with workplace and environmental hazards and consumer products	Level of client satisfaction with occupational health and contingency planning services	• 97.2% of respondents are satisfied with the Employee Assistance Program. • 80% of clients are satisfied with health promotion by the Internationally Protected Persons Program.
	Level of reported incidents of deaths and injuries associated with: workplace chemicals; new chemical substances; radiation emitting devices; and environmental noise	• Received 330 requests for health evaluations due to hazardous exposure, completed 99%.

Expected Results	Performance Indicators	Results
	Statistics on leave, accommodation, and injury in the workplace	• Received 1,079 workplace investigation requests for biological, chemical, environmental, indoor air and hazard analysis, completed 71%. • Received 4,747 requests for ergonomic assessments, completed 96%. • Received 2,376 requests for Fitness to Work health evaluations, completed 90%.
Healthy Public Service	Percentage of federal public employees remaining at work through and following an injury, illness or traumatic incident	• 84% of federal workers who had to leave work for more than 13 weeks returned to work.
	Client satisfaction with occupational health and contingency planning services	• Employee Assistance Program scored above 80% on surveys and interviews, including follow-up surveys that take place three months after service. • 98% satisfaction rate expressed for specialized organizational services. • 40% of customers who use specialized organizational services request additional service within the same fiscal year
Improved public health for the travelling public	Percentage occurrence of incidents of gastrointestinal diseases on cruiseships with a target of less than 2% of passengers and crew	• Of 144 reports received from cruise-ships sailing in Canada, 90% reported occurrence of gastrointestinal illness to be less than 2%

The Workplace Health and Safety Program (WHPSP) provides occupational health and safety services to approximately 200,000 federal government employees, protects the health and safety of dignitaries visiting Canada, and promotes health and safety in workplaces. WHPSP also inspects and assesses cargo and passenger conveyances to protect travelling Canadians.

The Department contributed to the health and safety of federal workers by responding to:

- requests for occupational health and safety services;
- ergonomic service requests;
- Employee Assistance Program (EAP) consultations; and
- workplace investigations and consultations.

Survey respondents expressed a high level of satisfaction with the Employee Assistance Program.

To improve the health of travelling Canadians, Health Canada is collaborating with the Public Health Agency of Canada (PHAC) to prepare for and manage events that may require quarantines. Educational material on virus prevention in tourism is a joint effort between the Department and municipal health authorities. We are additionally responsible for International Health Regulations under Canada's obligations to the World Health Organization (WHO). Health Canada continued to inspect ships, aircraft and passenger trains and ancillary services, achieving the results in the table above. In collaboration with the U.S. Centers for Disease Control and the cruise industry, we are combatting the spread of norovirus among travelers through inspections and the reporting of illness in advance of arriving at Canadian ports.

The Department continued to fulfill its obligations for protecting the health and well-being of foreign dignitaries and federal public servants. We organized 114 health plans for visiting dignitaries, including the Prime Ministers of Australia, Japan and senior U.S. government officials. Work on future requirements, including the Francophonie Summit and the Olympic Games in 2010, has already been initiated.

Emergency preparedness activities involving federal, provincial and municipal authorities and agencies will improve preparedness in the event of terrorist acts of a chemical, biological, radiological or nuclear nature. We received additional funding to cover our operational deficit for these activities, stabilize the remaining fiscal year, train staff and upgrade critical technical equipment.

Workplace Health and Public Safety Program
www.hc-sc.gc.ca/ahc-asc/branch-dirgen/hecs-dgsesc/whpsp-psstsp/index_e.html

Tobacco Control Program

Financial Resources (millions of dollars):

Planned Spending	Authorities	Actual Spending
65.7	66.4	60.8

Expected Results	Performance Indicators	Results
Reduce smoking prevalence among the Canadian population	Smoking prevalence rates • measured by Canadian	19% of the population, aged 15 years and older, smoke.

Expected Results	Performance Indicators	Results
to 20%	Tobacco Use Monitoring Survey (CTUMS)	
Reduce number of cigarettes sold in Canada by 30%	Consumption rates - number of cigarettes sold in Canada • measured by industry reports	Cigarette sales declined from nearly 42 billion in 2001 to 30 billion in 2006, a decrease of close to 29%.

Health Canada continued to lead the Federal Tobacco Control Strategy (FTCS), and worked to reduce health and safety risks associated with tobacco consumption. We developed and administered programs, and partnered with provinces, territories and stakeholder groups to reach individuals with appropriate tools, information and resources. We developed, implemented and enforced regulations pursuant to the *Tobacco Act*. Our research, monitoring, surveillance and reporting activities added to our knowledge base.

Manitoba and Saskatchewan Region staff in Healthy Environments and Consumer Safety program and the First Nations and Inuit Health programs collaborated with First Nations organizations to adapt the Tobacco Control Program Retailer Tool kit to ensure it would have cultural significance. First Nations facilitators were trained and several Retailer Tool kit sessions were delivered to urban reserve retailers in Saskatchewan. As well, an Aboriginal tobacco project officer was employed in the region to facilitate regulatory education prior to the gradual introduction of enforcement activity in urban reserves. This encouraged voluntary compliance by urban First Nations retailers.

The 10-year objectives of the FTCS, which began 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.

In addition to the results in the chart above, Canadian Tobacco Use Monitoring Survey (CTUMS) data collected between February and June 2006 identified a continued downward trend in smoking among Canadians aged 15 years and older. Maintaining or improving smoking levels in the over-15 population will require sustained attention. Adults aged 20-24 are an important sub-population, since young adult males report the highest prevalence for smoking (29 percent), with 20 percent smoking daily. The 2006 survey also found the rate of retailers refusing to sell tobacco products to youth was 81.7 percent. By comparison, the rate was 47.9 percent in 1995, when this was first measured.

An evaluation of the first five years of the FTCS found that the Strategy is: making progress in meeting the five objectives: cost-effective, provides good value for money; very relevant to Canadians and stakeholders alike; and has demonstrated success in several program interventions. That evaluation predicted that the first five years of the FTCS should result in health benefits and net economic benefits, such as:

- 25,500 fewer cancer, circulatory and chronic obstructive pulmonary disease cases;
- 6,300 fewer disease-related deaths;
- 153,000 fewer disabilities-adjusted life-years lost;
- $933 million increase in tobacco taxation revenue; and
- $1.46 billion decrease in direct health costs.

The FTCS evaluation found that regulatory interventions and taxation (affecting price) were the most effective policies. It had difficulty in quantifying the impacts of grants and contributions and national mass media campaigns on changing attitudes around tobacco or smoking behaviour.

We used these evaluation results to inform our directions for the subsequent four years of the Strategy. Those directions include a Framework for Action on Tobacco Control for Youth and Young Adults in conjunction with provincial and territorial partners. We also carried out the necessary research to support preparation of regulations that would ban terms such as “light” and “mild” in relation to tobacco products.

Tobacco Control Program
www.hc-sc.gc.ca/hl-vs/tobac-tabac/index_e.html

Drug Strategy and Controlled Substances

Financial Resources (millions of dollars):

Planned Spending	Authorities	Actual Spending
79.5	79.2	76.7

Expected Results	Performance Indicators	Results
Reduced health and safety risks associated with the abuse of drugs, alcohol and other controlled substances by managing the *Controlled Drugs and Substances Act* and its Regulations, and providing national leadership for Canada's Drug Strategy	• Reduced prevalence of substance use/abuse in Canada and among target populations such as youth	• Enhanced capacity to assess prevalence of substance use and abuse is being developed through a new Canadian Alcohol and Drug Use Monitoring Survey.
	• Level of misuse/abuse of controlled substances	• Reoriented the Alcohol and Drug Treatment and Rehabilitation Program (ADTR) to enhance treatment outcomes. • Funded community-based projects promoting healthy decision making.
	• Change in the type and level of health-related, at-	• Supported national

Expected Results	Performance Indicators	Results
(continued)	risk behaviours. • Change in the nature and level of the social, health and economic costs associated with substance use and abuse in Canada.	responses to substance use/abuse to reduce overall costs. For example, established a multi-sectoral working group to develop recommendations to address the inappropriate use of alcohol which represents one-third of health, social and economic costs associated with substance use and abuse.

Health Canada reduces the harmful consequences associated with substance use/abuse through prevention, enforcement and treatment activities. By providing leadership for Canada's Drug Strategy (CDS), which is transitioning into the National Anti-Drug Strategy, we develop prevention strategies as well as monitor and report current and emerging drug trends to Canadians. We administer the *Controlled Drugs and Substances Act*, develop new or amended regulations as required, and provide analysis, scientific advice and identification services of seized controlled substances to law enforcement agencies.

According to the most recent Canadian Addictions Survey (CAS) in 2004, alcohol consumption and illegal use of drugs pose serious health threats and have an economic impact estimated at $39.8 billion or $1,267 per Canadian. Alcohol accounted for about $14.6 billion or 36.6 percent of the costs and illegal drugs accounted for approximately $8.2 billion or 20.7 percent. Risky drinking practices and the use of marijuana, cocaine/crack, LSD, Speed and heroin increased between 1994 and 2004. Prescription drug abuse involving opioids, sedatives/hypnotics and stimulants are another concern. Health Canada began to update CAS as an early step in establishing a new Canadian Alcohol and Drug Use Monitoring Survey (CADMUS). This involved work on the core questionnaire and testing of new elements concerning abuse of psychoactive pharmaceutical products.

The Interim Year 2 evaluation report on CDS was tabled and we began to address its recommendations to: streamline indicators, enhance capacity to evaluate the Drug Strategy Community Initiatives Fund (DSCIF), described below, and other programs and develop collaborative models.

The Alcohol and Drug Treatment and Rehabilitation (ADTR) Program continued to fund improved treatment for women and youth. A review of the ADTR concluded that systemic change was needed to move substance abuse treatment systems toward more evidence-informed practices. In response, we met with provincial health representatives to review the program and discuss its reorientation. Three drug treatment courts were fully implemented in Ottawa, Winnipeg, and Regina for a total of six such courts co-funded with Justice Canada. These specialized courts offer treatment as an alternative to incarceration for non-violent offenders

who are addicted to cocaine or opiates.

Our drug analysis laboratories worked with law enforcement agencies to identify and analyze approximately 105,000 samples, an increase of six percent over the previous year. Our expert advice and aid led to the dismantling of 37 clandestine labs and destruction of 118,006 seized substances.

Health Canada funded 16 new projects under DSCIF, for a total of 175 projects since its inception. The DSCIF was established under the CDS for initiatives at the national, regional, provincial/territorial and local levels to facilitate community based-solutions to substance abuse problems and promote public awareness. Our $2,912,599 in contribution funding generated almost $2 million in funding from other sources. The DSCIF will be transitioning to reflect new priorities under the National Anti-Drug Strategy, through performance measurement and evaluation work already initiated.

Weblinks: Drugs and Controlled Substances

Canada's Drug Strategy
www.hc-sc.gc.ca/ahc-asc/activit/strateg/drugs-drogues/index_e.html

Medical Use of Marihuana
www.hc-sc.gc.ca/dhp-mps/marihuana/index_e.html

Controlled Substances and Precursor Chemicals
www.hc-sc.gc.ca/dhp-mps/substancontrol/index_e.html

Health Canada's Marihuana Supply
www.hc-sc.gc.ca/dhp-mps/marihuana/supply-approvis/index_e.html

Drug Analysis Service
www.hc-sc.gc.ca/dhp-mps/substancontrol/analys-drugs-drogues/index_e.html

National Framework for Action to Reduce the Harms Associated with Alcohol and Other Drugs and Substances in Canada
www.hc-sc.gc.ca/ahc-asc/activit/strateg/drugs-drogues/nfa-can/index_e.html

Treatment and Rehabilitation
www.hc-sc.gc.ca/dhp-mps/substan/treat-trait/index_e.html

Drug Strategy Community Initiatives Fund
www.hc-sc.gc.ca/dhp-mps/substan/fond-comm-fund/index_e.html

Be Drug Wise
www.drugwise-droguesoisfute.hc-sc.gc.ca/index_e.asp

Canada's Drug Strategy Publications
www.hc-sc.gc.ca/ahc-asc/pubs/drugs-drogues/index_e.html

Overview of Alcohol and Other Drug Use in Canada
www.hc-sc.gc.ca/dhp-mps/substan/alc-can/overview-apercu/index_e.html

Strategic Outcome #3 (b)

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

Program Activity Name:
Pest Control Product Regulation

Expected Results:

- Protected health and environment
- Increased use of reduced-risk pest management practices and products
- Increased public and stakeholder confidence in pesticide regulation

Expected Results	Performance Indicators	Results
Access to safer pesticides	Number of new reduced-risk active ingredients available for use in Canada	5
	Percentage of reduced-risk chemicals and percentage of biopesticide active ingredients registered/pending registration in the U.S. that are registered/pending registration in Canada	71.7% reduced-risk chemicals and 32.5% biopesticides
	Number of new active ingredients registered through the PMRA/U.S. EPA Joint Review or work share program	4
	Number of active ingredients addressed through reevaluation	10 (244 cumulatively)
Strengthened compliance with the *Pest Control Products Act* (PCPA) and Regulations	Feedback from public and stakeholders	positive
Users informed of reduced risk practices	Number of proposed and final regulatory decisions posted on the website	38
Transparency of pesticide regulation	Implementation of reading rooms and adverse effects reporting	Implementation complete, no adverse effects requests/reports

Expected Results	Performance Indicators	Results
(continued)		received
Improved regulatory efficiencies and cost effectiveness	Efficiency gains achieved through electronic processes and harmonization permit the integration of new science policies and methodologies	Reduction of paper volume, centralized information repository supports more efficient delivery of transparency requirements, automation of Confidential Business Information (CBI) and privacy identification and segregation.
Informed public and stakeholders	Feedback from public and stakeholders	positive
	Number of web hits	749, 566
	Number of responses provided to the public through the Pest Management Information Service	6,000

Financial Resources (millions of dollars):

Planned Spending	Authorities	Actual Spending
51.6	68.0	62.7

Human Resources (FTEs):

Planned	Actual	Difference
652	574	78

A significant achievement was the coming into force of the *Pest Control Products Act* (PCPA) which strengthened the legal framework for pesticide regulation. Highlights include additional authorities to protect human health and the environment, increased transparency and greater post-market controls.

Explanation of the above financial information:

Variances between planned spending versus total authorities are mainly due to:
- Funding from Management Reserve - Pesticides Regulatory
- Funding for Collective Agreement.

The actual spending is $5.3 million lower than total authorities mainly due to:
- Additional collection of revenue well above the historical trend
- Year end adjustments of Department of Justice expenditures.

Many of the targets set in the RPP centred on supporting implementation of the new PCPA, in particular to ensure that stakeholders were well-informed about the features and requirements. Where possible, we incorporated stakeholder feedback to ensure our services would meet their needs. Consultation with our Advisory Council also guided our actions.

International regulatory cooperation was another priority. We worked with member countries of the Organization for Economic Cooperation and Development (OECD), including the United States and Mexico, to increase availability of reduced-risk pesticides for Canadian growers without compromising human health and the environment. We also consulted with and shared scientific knowledge and best practices with other departments, provincial and territorial governments and regulators in other countries.

The Department continued to recruit and retain employees through the Pest Management Regulatory Agency Science Development Program. We reviewed this program, which is aimed at biologists and chemists, and began improvements so that we will have the specialized staff we need to deliver results.

The pesticide regulation program activity encompasses five sub-activities. Achievements under each of the sub-activities are outlined below.

Regulatory Improvement

Financial Resources (millions of dollars):

Planned Spending	Authorities	Actual Spending
6.0	8.3	7.8

The PCPA which came into force in June 2006 increased the transparency of our activities, enabled greater public participation, expedited registration of lower risk products and developed a new administrative Maximum Residue Limit setting process designed to protect human health and the environment.

We have streamlined the evaluation needed to support registration of lower risk products. To increase the efficiency of our process, we conducted 38 consultations with companies before they sought formal approval of new registrations for lower risk products. We also collaborated with counterparts internationally to develop a regulatory approach for these lower risk pesticides. As well, we finalized a new formulants policy that encourages the use of less toxic ingredients. In our work on the Government's Chemicals Management Plan, we participate in risk assessment and risk management of high priority chemical substances used in pesticide products.

To support transparency requirements of the PCPA, our new electronic Public Registry gave the public access to information about new applications to register or amend pest control products, evaluation reports and conditions of registrations of newly registered or reevaluated pesticides. The PCPA incorporates into law our practice of providing the public the opportunity to comment on proposed major registration decisions.

Mandatory Sales Information Reporting Regulations as well as mandatory Incident Reporting Regulations were published. These provide information to the public about registered pesticides in the Canadian marketplace.

Enhancements to our online services included a Pesticide Products Label database that is updated in real time, and a new Incident Reporting function. Effective electronic submission tools have resulted in over 80 percent of applications being submitted electronically.

New Pest Control Product Registration and Decision Making

Financial Resources (millions of dollars):

Planned Spending	Authorities	Actual Spending
25.6	33.6	27.5

Before new pesticide products can be registered for use in Canada, Health Canada conducts extensive pre-market assessment to ensure their use poses no unacceptable risks. Using modern scientific methods and international best practices, we conducted human health, safety and environmental risk assessments, as well as value assessments.

We continued to work closely with our counterparts internationally on a joint review program. We commenced two joint reviews with other OECD member countries. The NAFTA joint review program has resulted in 21 joint reviews and seven work shares, facilitating access to 11 conventional and newer reduced-risk chemicals. The first NAFTA pesticide label was approved simultaneously by Canada and the U.S., allowing for free movement of that pesticide between the two countries. The expansion of products with NAFTA labels strengthens competitiveness of North American growers without compromising Canada's high standards for human health and the environment.

Registered Pest Control Products Evaluation and Decision Making

Financial Resources (millions of dollars):

Planned Spending	Authorities	Actual Spending
9.8	12.8	12.1

Health Canada has a responsibility to reevaluate older pesticides on the market to determine if their use is acceptable in consideration of modern information requirements and scientific assessment methods. We made 17 final reevaluation decisions, 12 proposed decisions and four interim decisions. This brought our cumulative total to 244 pesticides addressed since 2001, or 61 percent of the pesticides in the reevaluation program. At the request of stakeholders, we published a reevaluation status table for the 401 pesticide active ingredients, providing them with regular updates.

Compliance

Financial Resources (millions of dollars):

Planned Spending	Authorities	Actual Spending
7.6	10.0	11.2

Health Canada has the responsibility to promote, maintain and enforce compliance with the PCPA. We conducted 437 investigations and delivered 13 compliance programs, assessing levels of compliance in blueberry, grape and head lettuce growers; lawn care applicators; and importers of an own-use product. We worked with provincial and other federal regulators and built on our efforts to develop performance indicators for compliance.

Pesticide Risk Reduction in Agriculture

Financial Resources (millions of dollars):

Planned Spending	Authorities	Actual Spending
2.6	3.3	4.1

In partnership with Agriculture and Agri-Food Canada (AAFC), we developed and implemented commodity-based risk reduction approaches that included two new crops (blueberry and raspberry). Health Canada and AAFC also coordinated pre-submission consultation meetings with U.S. pesticide registrants who own microbial and low risk alternatives. We worked with several industrial sectors to integrate sustainable pest control into their respective strategies for issues such as the Mountain Pine Beetle in the forestry sector and the Richardson's ground squirrel population in the Prairies. As well, we promoted sustainable pest management to municipal associations and at homeowner trade shows.

Weblinks:

Pest Management Regulatory Agency (PMRA)
http://www.pmra-arla.gc.ca/

PMRA Strategic Plan 2003-2008
http://www.pmra-arla.gc.ca/english/pdf/plansandreports/pmra_strategicplan2003-2008-e.pdf

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:

The objective of the First Nations and Inuit health program activity is to improve health outcomes, by ensuring the availability of, and access to, quality health services, and supporting greater control of the health system by First Nations and Inuit.

Financial Resources (millions of dollars):

Planned Spending	Authorities	Actual Spending
2,119.1	2,126.0	2,088.0

Human Resources (FTEs):

Planned	Actual	Difference
2,884	2,993	109

Explanation of the above financial information:

Variances between planned spending versus authorities are mainly due to:
- Funding for Federal Contaminated Sites Action Plan
- Contributions to the Government-Wide 2006-2007 $1 Billion Spending Restraint Exercise
- Funding for Non-Insured Health Benefits Program
- Funding for Indian Residential Schools Program.

The actual spending is $38 million lower than authorities mainly due to:
- Delays in Indian Residential Schools Program
- First Ministers and Aboriginal Leader Meeting reprofiles
- Contributions to the Government-Wide 2006-2007 $1 Billion Spending Restraint Exercise
- Operating Budget carryforward in NIHB
- Transfers for capital projects to PACR.

Since development of the RPP, Health Canada has continued to work with First Nations and Inuit and other health partners in delivering programs and services under the four key priorities.

Continued health-related programs and services

In partnership with First Nations and Inuit, we provided primary health care services in approximately 200 remote communities, and home and community care services in about 600 communities. We directly employed 670 nurses in First Nations communities. Including nurses funded by Health Canada but employed by First Nations, the nursing work force is approximately 1,100. These nurses deliver health services through nursing stations, community health centres, and other health facilities.

Through our Regional Offices and in partnership with First Nations and Inuit, we delivered community programs that focused on children and youth, mental health and addictions, environmental health, and commu-

nicable and chronic disease prevention and management. These supplemented health services that provincial, territorial and regional health authorities provided. Through the Non-Insured Health Benefits (NIHB) Program, we provided additional benefits to eligible First Nations and Inuit regardless of their place of residence. These include coverage for drugs, dental care, vision care, medical supplies and equipment, short-term crisis intervention mental health services, and medical transportation.

The Department faces the same challenges as other health care providers such as increasing costs, demand for new health technologies, human resource shortages and an aging population. The First Nations and Inuit health system has additional challenges due to rapidly growing populations, higher than average rates of disease and injuries, and populations living in small communities, often in rural and remote areas.

Improving First Nations and Inuit health outcomes also requires action on broader determinants of health, such as economic development, education, housing and culture, so that communities can become sustainable, culturally strong and economically viable.

Expected Results	Performance Indicators	Results
Strengthened community programs	Life expectancy (at birth, on and off reserve)	While still behind the Canadian average, life expectancy for First Nations has increased. In 1980, First Nations males' life expectancy was 60.9 years, and females' was 68.0 years. By 2001, life expectancy was estimated at 70 years for males and 76 for females.
Better health protection	Infant Mortality Rates	Infant mortality rates for First Nations have exhibited a downward trend. The Department is working with stakeholders on improved methodology for tracking this data.
Improved primary health care	Birth weight	Statistics for 2000 indicate that 4.7% of First Nations births are classified as low birth weight compared with 5.6% in Canada overall. The high birth weight rate for the First Nations is 21%, almost double the Canadian rate of approximately 13%. Health Canada continues to work in maternal and prenatal health to improve outcomes.
Access to Non-Insured Health Benefits.(NIHB)	NIHB client utilization rates	NIHB utilization rates represent those clients who receive at least one pharmacy benefit paid through the Health Information and Claims Processing Services system, as a proportion of the total number of clients in the fiscal year. In 2005-2006, the national utilization rate for the pharmacy benefit was 65%. Regional rates ranged from 76% in Saskatchewan to 47% in the N.W.T. and Nunavut.

Improving quality of and access to health-related programs and services

Health Canada worked towards seamless integration of services; increasing the number of Aboriginal health professionals; supporting First Nations accreditation; improving community dental care capacity; and capital improvements and investments.

We implemented the Aboriginal Health Transition Fund (AHTF). The Fund is designed to improve access to and quality of health services for Aboriginal peoples through better adaptation of provincial and territorial health services and their integration with federal health programs. Examples of achievements include agreements for integration projects in the provinces and territories, and communication activities to build First Nations' awareness of health services. AHTF projects support joint community health planning; coordination and co-location of health services; improved health information management, including better immunization databases and patient charting; increased access to clinical knowledge; and collaborative work on suicide awareness and response. Two advisory groups have been created, with representation from all five National Aboriginal Organizations, provinces and territories, and the federal Health Portfolio.

Through the community health component of the Labrador Innu Healing Strategy, Atlantic Region staff collaborated with the Mushuau Innu First Nation in completing a functional and capital plan for a healing lodge and wellness facilities, planned to open by June 2007.

Labrador-based staff collaborated with the Sheshatshiu Innu First Nation to survey approximately 400 community members. The information gathered will be used to plan health prevention and intervention delivery in line with the community's needs. The two groups also collaborated on a training plan for addictions treatment staff to enhance skills and reduce turnover.

The Health Integration Initiative, which ended in March 2006, funded eight pilot projects. The national evaluation report, which is expected to be submitted for approval in fall 2007, found that this Initiative led to sustainable partnerships. Projects under AHTF will build on the achievements and lessons learned.

We initiated work to increase Aboriginal students' awareness of health careers; partnered with other stakeholders to improve retention of health care workers in Aboriginal communities; and increased support programs available to Aboriginal health care students. Achievements include: dissemination of career awareness materials to isolated communities using video conferencing and telehealth technologies; facilitating changes to curricula of schools of medicine and nursing; and establishment of First Nations and Inuit capacity for health human resource planning in all First Nations and Inuit provincial, territorial and land claim organizations. Funding totalling $2 million was provided to the National Aboriginal Achievement Foundation to provide bursaries and scholarships for Aboriginal health career students, and to promote health careers in First Nations and Inuit schools. An agreement negotiated with the Métis National Council will provide $10 million in bursary and scholarship funding for Métis health career students over the next four years.

Our nurses were supported with professional training and educational resource materials. Training materials include a Primary Care Clinical Practice Guidelines manual, a self-study guide, and an education program for Emergency Labour Competency. These prepare nurses to transition more readily to using an Electronic Health Record system in First Nations communities. National Nursing Security and Awareness Training sessions were also conducted and training materials developed.

The Department launched the Nursing Portal in June 2006 at the Canadian Nurses Association Biennial

Conference. This bilingual electronic gateway provides nurses access to an array of resources and services to support nursing practice. Planning continued on enabling Health Canada, as an employer of nurses working in First Nations communities, to post specific employer information, provide education courses and customize clinical resources.

First Nations Community Health Services, National Native Alcohol and Drug Abuse Program Treatment Centres, and Youth Solvent Abuse Treatment Centres have been pursuing accreditation with the Canadian Council on Health Services Accreditation for a number of years. There are 49 First Nations health organizations in the process of being accredited or already accredited. This ensures that First Nations health facilities offer service comparable to accredited provincial/territorial health services.

The Children's Oral Health Initiative was implemented in 140 First Nations communities and services were provided to 8,000 children.

To improve the working environment of clients and staff, and to enhance the quality of health care services, we constructed 14 health facilities, expanded six health facilities, and completed four major recapitalization initiatives.

Given the importance of environmental management in the Departmental Sustainable Development Strategy, we spent approximately $2 million to: conduct pilot Environmental Compliance Audits and Environmental Site Assessments; assess a waste water system to determine whether a new system is needed; upgrade a clinic crawlspace at Norway House Hospital in response to mould; conduct comprehensive microbial investigations at three health facilities to determine the extent and severity of mould contamination; monitor health facilities with previous mould issues; and perform a water well seal integrity study at four wells in Alberta as pilot projects for a larger project.

Promoting healthy living and disease prevention

Health Canada continued to focus on enhancing and strengthening maternal and child health, mental wellness, suicide prevention, prevention of chronic disease, communicable disease readiness and safe drinking water.

The Department funded 40 Maternal and Child Health programs in First Nations communities and supported other communities to provide the program in subsequent years. Activities included: hiring and training family visitors; “train the trainer” postpartum home visit training for 40 nurses and development of a screening catalogue and case management tool kit. In February 2007, Health Canada launched a Healthy Pregnancy campaign to provide women with information to make healthy lifestyle choices before and during pregnancy. Two distinct Healthy Pregnancy campaigns were developed to meet the needs of First Nations and Inuit communities.

Approximately 9,000 children participated in the Aboriginal Head Start On-Reserve (AHSOR) Program. We provided training for outreach and home visit workers in smaller communities and for asset mapping, family support and nutrition. The Department also enhanced the AHSOR capital infrastructure by spending $7.6 million to support capital projects. Seventeen Early Childhood Development single-window service delivery demonstration projects in First Nations communities tested the impact of streamlined funding, program reporting and community development.

A Mental Wellness Strategic Action Plan was developed, and the stakeholder approval process is under way. In addition, 60 community-based Aboriginal Youth Suicide Prevention projects were funded and implemened.

In November 2006, the Department received approval to provide professional counselling, emotional and cultural supports to eligible former students of Indian Residential Schools under the new Indian Residential Schools Settlement Agreement.

Through the Health Integration Initiative project in Nunavut, Health Canada's Northern Region, the Government of Nunavut and Nunavut Tunngavik Incorporated collaborated on identifying actions to better integrate federal and territorial programs and services in maternal and child health, addictions and mental health and oral health. This was the first tripartite health project to be managed and coordinated by an Inuit organization in Nunavut, enabling it to be delivered from an Inuit perspective.

Health Canada expanded the scope of health promotion and diabetes prevention services and access to them in more than 600 communities. These services included: school policies that emphasize healthy snacks; children's camps that focus on healthy lifestyles; and walking clubs to help those at risk to be more physically active. To enhance prevention and promotion for Aboriginals living off-reserve, 36 projects were funded. In addition, 48 diabetes community workers were trained to deliver programming aimed at promoting healthy behaviours.

Activities to advance a strategic and comprehensive approach to other chronic diseases in addition to diabetes were also undertaken. For example, an analysis of effective interventions to prevent chronic disease in indigenous populations was finalized and community-based models for integrated chronic disease prevention and management were developed and supported.

Pandemic influenza plans were drawn up to support First Nations communities in local preparedness and ensure better regional communicable disease emergency coordination with provinces, territories and stakeholders. A stockpile of personal protective equipment was replenished for use by front-line workers in First Nations communities in communicable disease emergencies. Health Canada provided support to the Assembly of First Nations to pilot and test a culturally-appropriate approach to pandemic planning in three First Nations communities.

By March 2007, over 40 percent of drinking water distribution systems, cisterns and community wells were routinely monitored for bacteriological contaminants as recommended in the Guidelines for Canadian Drinking Water Quality. A total of 153,604 water samples were analyzed in First Nations communities, an increase of 29 percent from last year. Health Canada is working with First Nations leadership to help communities improve their understanding of and response to Drinking Water Advisories. Six out of our seven regions now have water databases in place to monitor sample results. No instances of water-borne disease outbreaks were identified.

The British Columbia Region continues working toward accurate and timely reporting from all communities who are engaged in the Drinking Water Safety Program, while developing other communities. There are 136 community water technicians trained and supported to provide sampling programs for community water systems, in order to meet Canadian drinking water guidelines. Health Canada and the water technicians are also preparing for spring flood conditions.

Health Canada developed a school kit to raise awareness and instill an appreciation for the importance of clean, safe and reliable water among First Nations children. We also developed communication products to focus on preventive activities related to Drinking Water Advisories.

Improving accountability and performance measurement

The Department undertook initiatives to support and enhance health surveillance, information analysis, research, and data collection and analysis. An Infant Mortality Working Group was created, with participation from various levels of government, National Aboriginal Organizations and academics, to address deficits in infant mortality data for First Nations, Inuit and Métis. The Group is developing several pilot projects, to be funded by Health Canada and the Public Health Agency of Canada, that will improve data quality and coverage as well as local data capacity.

An integrated Aboriginal health surveillance strategy has been initiated to advance the Integrated Public Health Surveillance and Information plan. Pilot projects for enhanced health information management have been developed in the Alberta and Atlantic regions. These will improve surveillance systems in those regions while providing direction for other regional development in the long term.

A key challenge in reporting health information for First Nations and Inuit is to identify Aboriginal people from within administrative databases. Health Canada has funded and participated in an innovative Statistics Canada project to develop life expectancy estimates in Inuit-inhabited regions. This has led to new data on northern life expectancy. Health Canada is also supporting regional data infrastructure through the Health Data Technical Working Group, with representation from the National Aboriginal Organizations. This Group provides technical expertise on data and epidemiological matters and produces in-house statistics for the Department. Their major product is the *Statistical Profile on the Health of First Nations in Canada*.

The First Nations Regional Longitudinal Health Survey (RHS) is a "survey of First Nations developed by First Nations," and is funded by Health Canada through contribution agreements. Results of the 2002-2003 RHS, released just prior to last fiscal year, have been shared with federal and provincial governments and First Nations to support evidence-based planning and evaluation. Discussions are ongoing on the next cycle of the RHS.

Health Canada finalized a Performance Measurement Strategy Reporting Template to support First Nations recipients in data collection at the community level beginning in 2008-2009.

In the RPP, the Department identified programs and services that were the organizational base for our initiatives across all four priorities just described. The charts below set out details regarding our use of resources, expected results, performance indicators and results achieved for each program area.

First Nations and Inuit Community Health Programs

Child and Youth programs

Maternal, infant and child health; increasing children's knowledge of language and culture; and their readiness for school are the main priorities of child and youth programs. The programs are: Aboriginal Head Start On-Reserve; Canada Prenatal Nutrition; Fetal Alcohol Spectrum Disorder; and Maternal and Child Health.

Expected Results	Performance Indicators	Results
Improved continuum of programs and supports in First Nations and Inuit communities	Number and percentage of communities with programs	40 Maternal and Child Health programs have been established. Other communities have been supported to provide the program in subsequent years.
Increased participation of Aboriginal individuals, families, and communities in programs and supports	Number and type of participants in programs by program type	Approximately 9000 children participated in Aboriginal Head Start On Reserve programs.

Financial Resources (millions of dollars):

Planned Spending	Authorities	Actual Spending
108.3	110.4	97.9

Mental Health and Addictions Programs

These programs provide culturally appropriate counselling, addiction prevention and mental wellness services that are largely delivered by Aboriginal people. They include: Building Healthy Communities; Brighter Futures; National Native Alcohol and Drug Abuse Program - Residential Treatment; National Native Alcohol and Drug Abuse Program - Community-based; Youth Solvent Abuse Program; First Nations and Inuit Tobacco Control Strategy [21]; National Aboriginal Youth Suicide Prevention Strategy; Labrador Innu Comprehensive Healing Strategy; and Indian Residential Schools Resolution Health Support Program (formerly known as Indian Residential Schools - Mental Health Support Program).

Expected Results	Performance Indicators	Results
Improved continuum of programs and services in First Nations and Inuit communities	Number and percentage of communities with programs	All First Nations communities have access to National Native Alcohol and Drug Abuse Program, Youth Solvent Abuse Program and mental health programs. 60 community-based suicide prevention projects were delivered in .
Increased participation of First Nations and Inuit individuals, families and communities in programs and services	Number and type of participants in programs by program type	All former students of Residential Schools and their families are now able to access health supports via the Indian Residential Schools Resolution Health Support Program. 585 clients accessed professional mental health services.

21 As part of the federal expenditure review, $2.5 million in 2006-2007, $8.3 million in 2007-2008, and $10.8 million in ongoing funding for the First Nations and Inuit Tobacco Control Strategy was targeted for reduction. Funding for 2007-2008 will be directed at completing initiatives and working with partners to develop a new policy approach.

Financial Resources (millions of dollars):

Planned Spending	Authorities	Actual Spending
147.7	191.0	166.4

Chronic Disease and Injury Prevention Programs

Over the long term, these programs will contribute to prevention of chronic disease and injuries within First Nations and Inuit communities. They include: Aboriginal Diabetes Initiative; Nutrition and Physical Activity Promotion; and Injury Prevention.

Expected Results	Performance Indicators	Results
Improved continuum of programs and supports in First Nations and Inuit communities	Number and percentage of communities with programs	More than 600 communities have access to health promotion and diabetes prevention services. Examples include: school policies emphasizing healthy snacks, children's camps that focus on preventing diabetes through healthy lifestyles, and walking clubs to help those at risk.

Financial Resources (millions of dollars):

Planned Spending	Authorities	Actual Spending
37.0	24.6	26.4

First Nations and Inuit Health Protection and Public Health

Communicable Disease Control Programs

These programs protect First Nations and Inuit communities from communicable diseases through measures to manage, contain and control risks of outbreaks. They include: Tuberculosis; Immunization; HIV/AIDS; and Communicable Disease Emergencies.

Expected Results	Performance Indicators	Results
Improved access to communicable disease prevention and control programs for First Nations and Inuit individuals, families and communities	Number and percentage of communities with programs	All First Nations communities on-reserve are supported in communicable disease prevention and control programs. Inuit communities are supported in communicable disease prevention and control through contribution agreement funding or through National Aboriginal Organizations or transfer agreements.

Financial Resources (millions of dollars):

Planned Spending	Authorities	Actual Spending
27.6	26.2	30.6

Environmental Health and Research Programs

These programs create and maintain healthy and safe community environments through: investigation of potential environmental health-related outbreaks; raising awareness of water-borne, food-borne and vector-borne illnesses including health problems from poor indoor air quality, such as mould. They provide for pest control and build community human resource capacity to adapt to environmental conditions, to maintain safe environments and to deal safely with hazards. These programs include: First Nations Water Management Strategy; West Nile Virus; Contaminated Sites; Transportation of Dangerous Goods; Food Safety; Facilities Health Inspections; housing; and research.

Expected Results	Performance Indicators	Results
Improved environmental health risk management	Number of communities with environmental health officers	478 communities have dedicated environmental health officers.
	Number of communities equipped with water testing/sampling kits	546 communities are equipped with water testing/sampling kits.

Financial Resources (millions of dollars):

Planned Spending	Authorities	Actual Spending
48.9	46.3	39.0

First Nations and Inuit Primary Health Care

Comprehensive health care services are provided to remote First Nations and Inuit settlements to supplement primary care provided by provincial, territorial and/or regional health authorities. These include emergency and acute care. Health Canada ensures links to other health care providers and/or institutions as required by the client's condition. The continuum of care includes illness and injury prevention and health promotion such as the Home and Community Care Program and the Oral Health Strategy.

Expected Results	Performance Indicators	Results
Improved access to primary health care programs and services for First Nations and Inuit individuals, families and communities	Number and percentage of communities with programs	605 of 645 (94%) First Nations communities have access to home care services, represents 97% of eligible population. 55 (100%) Inuit communities have access to home care services, represents 100% of eligible population.
	Number of treatment centres by type, in the communities	54 Alcohol and Drug Abuse and 8 Youth Solvent Abuse treatment centres are in operation.
	Eligible client utilization rates of NIHB - Dental Benefits	In 2005-2006, the national utilization rate for the dental benefit was 37%. Regional rates ranged from 46% in Quebec to 30% in Manitoba.

Financial Resources (millions of dollars):

Planned Spending	Authorities	Actual Spending
247.0	270.5	289.0

Non-Insured Health Benefits

The NIHB program provides 765,000 registered First Nations and recognized Inuit with a limited range of medically necessary goods and services not provided through private or provincial and territorial health insurance plans. The benefits include: dental care, vision care, pharmacy benefits (prescription drugs and some over-the-counter medication), medical supplies and equipment, crisis intervention, mental health counseling, transportation to medically required health services and payment of health premiums for individuals in Alberta and British Columbia.

Financial Resources (millions of dollars):

Planned Spending	Authorities	Actual Spending
966.3	1,018.7	996.4

Governance and Infrastructure Support

Health Governance and Infrastructure Support aims to increase First Nations and Inuit control over health programs, establish an adequate First Nations and Inuit infrastructure and services and improve capacity to generate and use health information. These activities include: health planning; capacity building; integration and coordination of health services; stewardship and health research; knowledge and information management. In November 2006, the Government signed a Memorandum of Understanding with the Province of British

Columbia and the British Columbia First Nations Leadership Council. This MOU committed the parties to building a tripartite relationship for improving the health of B.C. First Nations, and led to the signing of the Tripartite First Nations Health Plan for British Columbia in June 2007.

Financial Resources (millions of dollars):

Planned Spending	Authorities	Actual Spending
536.4	438.7	442.3

Weblinks:

Non-Insured Health Benefits 2005-06 Annual Report
http://www.hc-sc.gc.ca/fnih-spni/pubs/nihb-ssna/2006_rpt/index_e.html

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

Aboriginal Head Start On-Reserve
http://www.hc-sc.gc.ca/fnih-spni/famil/develop/ahsor-papa_intro_e.html

Fetal Alcohol Spectrum Disorder
http://www.hc-sc.gc.ca/fnih-spni/famil/preg-gros/intro_e.html

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

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

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

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

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

Immunization Schedule for Infants and Children
http://www.phac-aspc.gc.ca/im/is-cv/index.html

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

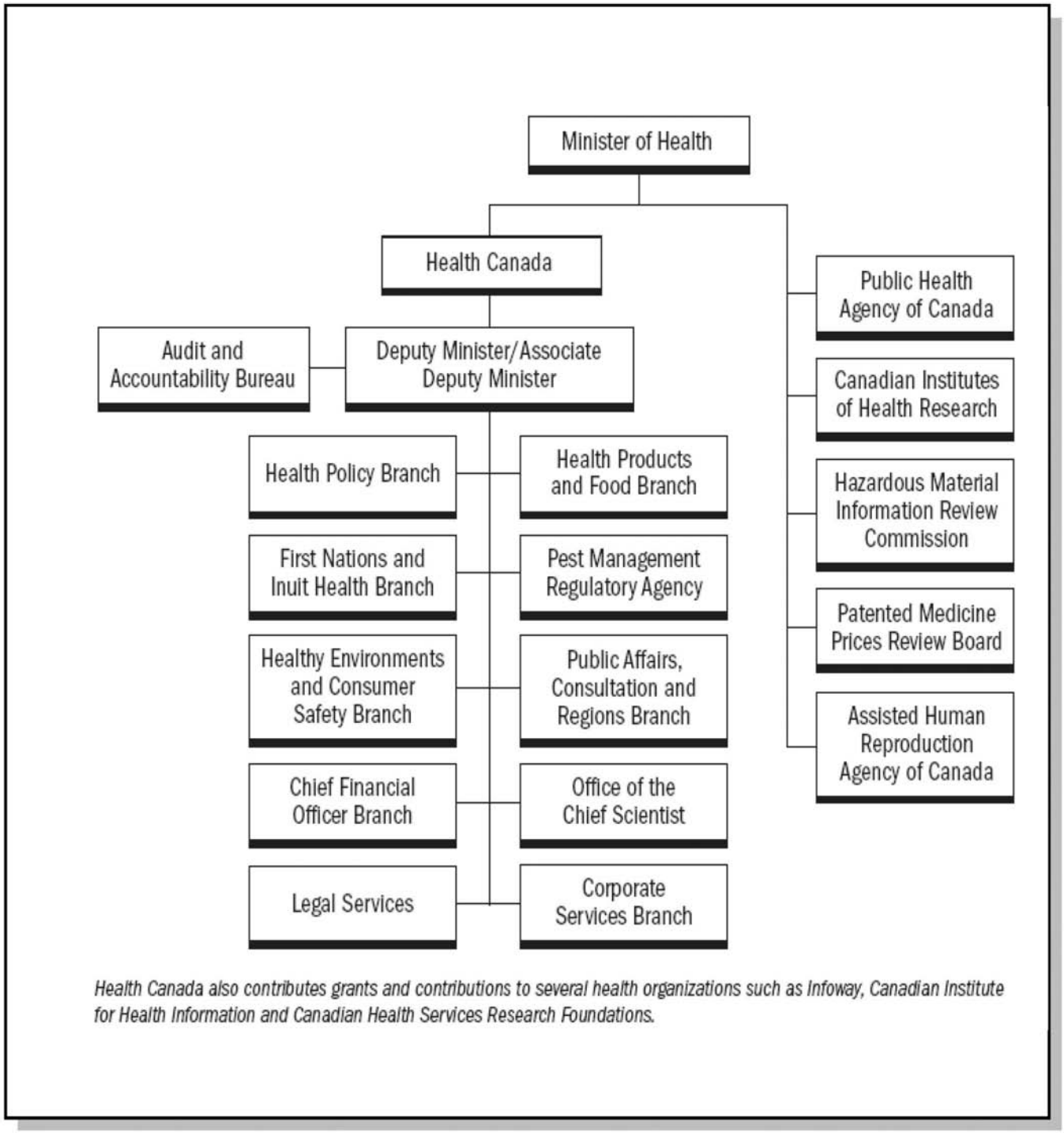
e-Health
http://www.hc-sc.gc.ca/fnih-spni/services/ehealth-esante/index_e.html

Aboriginal Health Human Resources Initiative
http://www.hc-sc.gc.ca/ahc-asc/activit/strateg/fnih-spni/ahhri-irrhs_e.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.

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 most recently completed fiscal year, as well as historical figures for Actual Spending.

The $35.7 million increase from Main Estimates to Planned Spending is due to anticipated funding for such initiatives as Avian or Pandemic Influenza Preparedness, Funding to the O-Pipon-Na-Piwin Cree Nation, Recognize a Landless Band and Registration of Newfoundland Indians and Non-Insured Health Benefits Program.

The $79.0 million increase from Planned Spending to Total Authorities is due new program initiatives and sustainability funding which is received through Supplementary Estimates.

The $92.6 million decrease 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;
- delays in the Advertising Special Purpose Allotment;
- lapse of frozen allotment which includes:
    - i) Follow-up to the Special Meeting of First Ministers and Aboriginal Leader Reprofile
    - ii) Contributions to the government-wide 2006-2007 $1 billion Spending Restraint Exercise
    - iii) Access to Medicines (Regime)
- year end adjustments of Department of Justice (DOJ) expenditures.

Table 1

Comparison of Planned to Actual Spending (Incl. FTE) *continued*

(millions of dollars)

Program Activities	2004-2005	2005-2006	2006-2007			
	Actual Spending*	Actual Spending	Main Estimates	Planned Spending (1)	Actual Authorities (2)	Actual Spending (2)
Health Policy, Planning and Information	385.9	375.1	288.6	288.4	312.6	290.4
Health Products and Foods	261.5	256.9	262.0	262.1	278.2	262.3
Healthy Environments and Consumer Safety	289.9	277.9	290.7	289.9	305.3	294.1
Pest Control Product Regulation	59.3	54.6	51.7	51.6	68.0	62.7
First Nations and Inuit Health	1,820.0	1,927.5	2,082.4	2,119.1	2,126.0	2.088.0
TOTAL	**2,816.6**	**2,892.0**	**2,975.4**	**3,011.1**	**3,090.1**	**2,997.5**
Less: Non-Respendable Revenue	-51.3	-19.8	0.0	-8.9	-8.9	-51.8
Plus: Cost of services received without charge**	58.9	85.6	0.0	84.7	84.7	91.9
Net Cost of Department	**2,824.2**	**2,957.8**	**2,975.4**	**3,086.9**	**3,165.9**	**3,076.6**
Full Time Equivalents	8,026	8,544	8,694	8,711	8,708	8,686

1) from the 2006-2007 *Report on Plans and Priorities*
2) from the 2006-2007 Public Accounts
* 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.
** 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).

Table 2

Resources by Program Activity

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

(millions of dollars)

2006 - 2007							
Program Activity	**Operating**	**Capital**	**Grants**	**Contributions and other Transfer Payments**	**Total Gross Expenditures**	**Less Respendable Revenues**	**Total Net Expenditures**
Health Policy, Planning and Information							
(Main Estimates)	95.6		57.1	135.9	288.6		288.6
(Planned Spending)	*95.4*		*57.1*	*135.9*	*288.4*		*288.4*
(Total Authorities)	125.1		53.2	134.3	312.6		312.6
(Actual Spending)	*117.6*		*43.3*	*129.5*	*290.4*		*290.4*
Health Products and Food							
(Main Estimates)	291.9	1.4	5.9	4.0	303.2	-41.2	262.0
(Planned Spending)	*292.0*	*1.4*	*5.9*	*4.0*	*303.3*	*-41.2*	*262.1*
(Total Authorities)	308.5	1.4	5.7	3.8	319.4	-41.2	278.2
(Actual Spending)	*292.5*	*1.2*	*5.5*	*3.8*	*303.0*	*-40.7*	*262.3*
Healthy Environments and Consumer Safety							
(Main Estimates)	260.4	1.0	5.1	39.6	306.1	-15.4	290.7
(Planned Spending)	*259.5*	*1.0*	*5.1*	*39.7*	*305.3*	*-15.4*	*289.9*
(Total Authorities)	275.6	1.0	5.1	39.0	320.7	-15.4	305.3
(Actual Spending)	*262.6*	*0.8*	*4.5*	*38.7*	*306.6*	*-12.5*	*294.1*

Table 2

Resources by Program Activity *continued*

(millions of dollars)

2006 - 2007							
Program Activity	**Operating**	**Capital**	**Grants**	**Contributions and other Transfer Payments**	**Total Gross Expenditures**	**Less Respendable Revenues**	**Total Net Expenditures**
Pest Control Product Regulation							
(Main Estimates)	58.7				58.7	-7.0	51.7
(Planned Spending)	*58.6*				*58.6*	*-7.0*	*51.6*
(Total Authorities)	75.0				75.0	-7.0	68.0
(Actual Spending)	*70.1*				*70.1*	*-7.4*	*62.7*
First Nations and Inuit Health							
(Main Estimates)	1,144.7	1.5	30.0	911.7	2,087.9	-5.5	2,082.4
(Planned Spending)	*1,174.6*	*1.5*	*30.0*	*918.5*	*2,124.6*	*-5.5*	*2,119.1*
(Total Authorities)	1.192.8	1.5	30.0	907.2	2,131.5	-5.5	2.162.0
(Actual Spending)	1,163.3	1.3	30.0	896.6	2,091.2	-3.2	2,088.0
TOTAL							
(Main Estimates)	1,851.3	3.9	98.1	1,091.2	3,044.5	-69.1	2,975.4
(Planned Spending)	*1,880.1*	*3.9*	*98.1*	*1,098.1*	*3,080.2*	*-69.1*	*3,011.1*
(Total Authorities)	1,977.0	3.9	94.0	1,084.3	3,159.2	-69.1	3,090.1
(Actual Spending)	*1,906.1*	*3.3*	*83.3*	*1,068.6*	*3,061.3*	*-63.8*	*2,997.5*

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

Table 3

Voted and Statutory Items

(millions of dollars)

VOTE		2006-2007			
		Main Estimates	Planned Spending (1)	Total Authorities (2)	Actual Spending (2)
	Health Canada				
1	Operating expenditures	1,674.5	1,702.9	1,805.4	1,739.6
5	Grants and contributions	1,189.3	1,196.2	1,178.3	1,151.9
(S)	Minister's car allowance and salary	0.1	0.1	0.1	0.1
(S)	Payments for insured health services & extended health care services	-	-	0.0	0.0
(S)	Spending of proceeds from the disposal of surplus Crown assets	-	-	0.5	0.1
(S)	Refunds from previous year's revenue	-	-	0.3	0.3
(S)	Collection agency fees	-	-	0.0	0.0
(S)	Court awards			0.0	0.0
(S)	Contributions to employee benefit plans	111.5	111.9	105.5	105.5
	Total Department	**2,975.4**	**3,011.1**	**3,090.1**	**2,997.5**

(1) from the 2006-2007 *Report on Plans and Priorities*
(2) from the 2006-2007 Public Accounts
(S) indicates expenditures the Department is required to make that do not require an appropriation act.

Table 4

Services Received Without Charge

(millions of dollars)

ITEM	2006-2007
Accommodation provided by Public Works and Government Services Canada	34.9
Contributions covering employer's share of employees' insurance premiums and expenditures paid by Treasury Board Secretariat	51.0
Worker's compensation coverage provided by Social Development Canada	0.7
Salary and associated expenditures of legal services provided by the Department of Justice	5.3
Total 2006-2007 Services Received without Charge	**91.9**

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 refer to funds collected for user fees or for 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 including 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.

(millions of dollars)

Respendable Revenues Program Activity/Branch	Actual Revenues 2004-2005	Actual Revenues 2005-2006	2006-2007			
			Main Estimates	Planned Revenue	Total Authorities	Actual Revenues
Health Products and Food Health Products and Food Branch	35.1	37.7	41.2	41.2	41.2	40.7
Healthy Environments and Consumer Safety Healthy Environments and Consumer Safety Branch	10.6	12.0	15.4	15.4	15.4	12.5
Pest Control Product Regulation Pest Management Regulatory Agency	6.1	5.9	7.0	7.0	7.0	7.4
First Nations and Inuit Health First Nations and Inuit Health Branch	4.0	3.4	5.5	5.5	5.5	3.2
Total Respendable Revenues	**55.8**	**58.9**	**69.1**	**69.1**	**69.1**	**63.8**

Table 5

Sources of Respendable and Non-Respendable Revenue *continued*

(millions of dollars)

Non-Respendable Revenues Main Classification and Source	Actual Revenues 2004-2005	Actual Revenues 2005-2006	2006-2007			
			Main Estimates	Planned Revenue	Total Authorities	Actual Revenues
Non-tax revenue:						
Refunds of expenditures	41.8	10.0				40.2
Sales of goods and services	2.5	2.6				3.5
Other fees and charges	6.8	7.0		8.9	8.9	7.9
Proceeds from the disposal of Crown assets	0.2	0.2				0.2
Miscellaneous non-tax revenues	0.0	0.0				0.0
Total Non-Respendable Revenue	**51.3**	**19.8**	**0.0**	**8.9**	**8.9**	**51.8**
Total Revenues	**107.1**	**78.7**	**69.1**	**78.0**	**78.0**	**115.6**

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

Table 6

Resource Requirements by Branch

Comparison of Main Estimates, 2006-2007 (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)	269.7					267.9
(Planned Spending)	269.6					296.6
(Total Authorities)	*275.2*					*275.2*
(Actual Spending)	**253.8**					**253.8**
Health Products and Food						
(Main Estimates)		204.2				204.2
(Planned Spending)		204.2				204.2
(Total Authorities)		*225.6*				*225.6*
(Actual Spending)		**212.1**				**212.1**
Healthy Environments and Consumer Safety						
(Main Estimates)			238.2			238.2
(Planned Spending)			237.5			237.5
(Total Authorities)			*243.6*			*243.6*
(Actual Spending)			**234.6**			**234.6**
Pest Management Regulatory Agency						
(Main Estimates)				40.2		40.2
(Planned Spending)				40.1		40.1
(Total Authorities)				*45.1*		*45.1*
(Actual Spending)				**40.3**		**40.3**
First Nations and Inuit Health						
(Main Estimates)					1,961.0	1,961.0
(Planned Spending)					1,997.9	1,997.9
(Total Authorities)					*1,956.2*	*1,956.2*
(Actual Spending)					**1,922.2**	**1,992.2**

Table 6

Resource Requirements by Branch *continued*

(millions of dollars)

ORGANISATION	PROGRAM ACTIVITY					
	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)	3.2	9.1	8.5	2.0	16.5	39.3
(Planned Spending)	3.2	9.2	8.6	2.0	16.7	39.7
(Total Authorities)	*5.5*	*5.7*	*7.9*	*3.4*	*17.9*	*40.4*
(Actual Spending)	**5.2**	**5.1**	**7.3**	**3.3**	**16.6**	**37.5**
Corporate Services						
(Main Estimates)	7.9	24.5	22.1	4.8	41.6	100.9
(Planned Spending)	7.9	24.3	21.9	4.8	41.3	100.2
(Total Authorities)	*17.6*	*27.7*	*30.9*	*10.7*	*64.7*	*151.6*
(Actual Spending)	**17.5**	**27.4**	**30.6**	**10.6**	**64.2**	**150.3**
Departmental Executive						
(Main Estimates)	1.9	6.1	5.5	1.1	15.3	29.9
(Planned Spending)	1.8	6.1	5.6	1.1	15.3	29.9
(Total Authorities)	*2.4*	*1.8*	*3.0*	*1.5*	*6.3*	*15.0*
(Actual Spending)	**2.3**	**1.1**	**2.4**	**1.4**	**5.5**	**12.7**
Public Affairs, Consultation and Regions						
(Main Estimates)	5.9	18.1	16.4	3.6	48.0	92.0
(Planned Spending)	5.9	18.1	16.3	3.6	47.9	91.8
(Total Authorities)	*11.9*	*17.4*	*19.9*	*7.3*	*80.9*	*137.4*
(Actual Spending)	**11.6**	**16.6**	**19.2**	**7.1**	**79.5**	**134.0**
Total						
(Main Estimates)	288.6	262.0	290.7	51.7	2,082.4	2,975.4
(Planned Spending)	288.4	262.1	289.9	51.6	2,119.1	3,011.1
(Total Authorities)	*312.6*	*278.2*	*305.3*	*68.0*	*2,126.0*	*3,090.1*
(Actual Spending)	**290.4**	**262.3**	**294.1**	**62.7**	**2,088.0**	**2,997.5**
% of Total	**9.7%**	**8.8%**	**9.8%**	**2.1%**	**69.7%**	**100.0%**

Table 7 a

User Fees Act

Health Products and Food Branch (HPFB)				2006 - 2007					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	8,039	8,020	27,599	120 calendar days to update the Drug Product Database following notification	96% within 120 calendar days	2007-08 2008-09 2009-10	8,032 18,500 18,962	36,900 37,822 38,768
Certificates of Pharmaceutical Product (Drug Export) Fees	Other (O)	Ministerial authority to enter into contract	May 2000	120	117	386	5 working days to issue certificate	95% of certificates issued within 5 working days	2007-08 2008-09 2009-10	117 157 161	157 161 165
Drug Establishment Licensing Fees	R	FAA	Dec. 1997	5,141	6,004	8,368	250 calendar days to issue / renew licence	90% of licences issued/renewed within 300 calendar days	2007-08 2008-09 2009-10	6,014 13,900 14,247	13,900 14,247 14,603
Drug Master File Fees	O	Ministerial authority to enter into contract	Jan. 1996	150	132	219	30 calendar days	100% within 30 calendar days	2007-08 2008-09 2009-10	133 378 387	378 387 397
Drug Submission Evaluation Fees	R	FAA	Aug. 1995	18,693	21,239	76,129	Review time to first decision (calendar days)	Average review time to first decision (calendar days)	2007-08 2008-09 2009-10	21,273 49,600 50,840	66,200 67,855 69,551
Pharmaceuticals							NDS: Priority NAS = 180	193			
							NDS: NOC-C NAS = 200	184			
							NDS: NOC-C Clin / C&M = 200	200			
							NDS: NAS = 300	251			
							NDS: Clin/C&M=300	252			
							NDS: Clin only = 300	188			
							NDS: Comp / C&M = 300	230			

Table 7a

User Fees Act *continued*

Health Products and Food Branch (HPFB)				2006 - 2007					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)
Pharmaceuticals *(continued)*							ANDS: C&M/Labelling = 180	165			
							ANDS: Comp/C&M = 180	165			
							SNDS: Priority Clin Only = 180	156			
							SNDS: Priority Clin / C&M = 180	131			
							SNDS: NOC-c Clin/ C&M = 200	199			
							SNDS: Clin/C&M = 300	281			
							SNDS: Clin only = 300	250			
							SNDS: Comp/C&M = 180	224			
							SNDS: C&M/ Labelling = 180	176			
							SNDS: Rx to OTC (switch) - no new indication = 180	142			
							SNDS: Labelling only = 60	39			
							SANDS: Comp / C&M = 180	180			
							SANDS: C&M / Labelling = 180	168			
							SANDS: Labelling only = 60	58			
							DINA with data = 210	190			
							DINA form only = 180	149			
							DIND with data = 210	117			
							DIND form only = 180	138			
Biological Products							NDS: Priority NAS = 180	274			
							NDS: Priority Clin/C&M = 180	378			
							NDS: NOC-C Clin / C&M = 200	185			
							NDS: NAS = 300	560			
							NDS: Clin/C&M=300	481			
							SNDS: Priority Clin Only = 180	175			

Health Products and Food Branch (HPFB)				2006 - 2007					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)
Biological Products *(continued)*							SNDS: Clin/C&M = 300	381			
							SNDS: Clin only = 300	408			
							SNDS: Comp/C&M = 180	379			
							SNDS: C&M/ Labelling = 180	188			
							DINB with data = 210	130			
							DINB form only = 180	10			
Medical Device License Application Fees	R	FAA	Aug. 1998	3,352	3,443	12,348	Time to first decision (calendar days)	Time to first decision (calendar days)	2007-08 2008-09 2009-10	3,449 7,200 7,380	9,600 9,840 10,086
							Class II = 15 (process)	13			
							Class II amendment = 15	11			
							Class III = 75	52			
							Class III amendment = 75	38			
							Class IV = 90	62			
							Class IV amendment = 90	49			
Fees for Right to Sell a Licensed Medical Device	R	FAA	Aug. 1998	1,730	1,790	9,437	20 calendar days from deadline for receipt of annual notification to update the Medical Devices Active License Listing (MDALL) database	100% updated within 20 calendar days	2007-08 2008-09 2009-10	1,793 6,300 6,457	12,700 13,017 13,342
Medical Device Establishment Licensing Fees	R	FAA	Jan . 2000	2,163	2,104	4,037	120 calendar days to issue / renew licence	90% of licences issued/renewed within 120 calendar days	2007-08 2008-09 2009-10	2,107 13,900 14,247	13,900 14,247 14,603
Veterinary Drug Evaluation Fees	R	FAA	Mar. 1996	776	769	6,859	Review time to first decision (calendar days)	Average review time to first decision (calendar days)	2007-08 2008-09 2009-10	770 789 809	6,480 6,642 6,808

Table 7a

User Fees Act *continued*

Health Products and Food Branch (HPFB)				2006 - 2007					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 *(continued)*							NDS = 300	671			
							SNDS = 240	539			
							SABNDS = 240	295			
							Admin = 90	134			
							DIN = 120	195			
							NC = 90	177			
							IND/ESC = 60	58			
							Labels = 45	28			
							Emergency Drug Release = 2	90+% within 2 days			
							NC = 90	177			
							IND/ESC = 60	58			
Subtotal (R)				39,894	43,369	144,778			2007-08 2008-09 2009-10	43,438 110,189 112,937	159,680 163,670 167,761
Subtotal (O)				270	249	605			2007-08 2008-09 2009-10	250 535 548	535 548 562
Total				**40,164**	**43,618**	**145,383**			**2007-08** **2008-09** **2009-10**	**43,688** **110,724** **113,485**	**160,215** **164,218** **168,323**

Table 7 a

User Fees Act *continued*

Health Products and Food Branch (HPFB)				2006 - 2007					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)

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
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 and Manufacturing
NOC-C: Notice of Compliance with Conditions

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

Human drugs: http://hc-sc.gc.ca/dhp-mps/prodpharma/applic-demande/guide-ld/mgmt-gest/mands_gespd_e.html
Medical devices: http://hc-sc.gc.ca/dhp-mps/md-im/applic-demande/pol/mdlapp_demhim_pol_e.html
Veterinary drugs: http://hc-sc.gc.ca/dhp-mps/vet/applic-demande/guide-ld/mors-gspr_pol_e.html

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

http://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. Costing information was developed using the Program Activity Architecture coding structure as directed through Treasury Board.

Under the Cost Recovery Initiative, HPFB is in the process of implementing a revised cost recovery framework, including revised fees and service standards; target for implementation is 2008-2009.

Table 7a

User Fees Act *continued*

Pest Management Regulatory Agency (PMRA)				2006 - 2007					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	2,637	3,825	32,246	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 = 94% Category B = 94% Category C = 86% Category D (Minor Use only) = 79% Category E = 50%	2007-08 2008-09 2009-10	8,000 8,000 8,000	58,200 54,100 56,900

Table 7 a

User Fees Act *continued*

Pest Management Regulatory Agency (PMRA)				2006 - 2007					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.	Regulatory (R)	*Financial Administration Act* (FAA)	April 1997	5,353	4674.45	37,854	All stakeholders have been consulted on the proposed service standard for invoicing clients	No objection and based on that, 100% of all fees for the right or privilege to manufacture or sell a pest control product in Canada have been invoiced by April 30th of the fiscal year	2007-08 2008-09 2009-10	8,000 8,000 8,000	58,200 54,100 56,900
				TOTAL 7,990	**TOTAL** 8,499	**TOTAL** 70,100				**Sub-Total** 2007-08 $8,000 **Sub-Total** 2008-09 $8,000 **Sub-Total** 2009-10 $8,000 **TOTAL:** 24,000	2007-08 $58,200 2008-09 $54,100 2009-10 $56,900 **TOTAL:** 169,200

Table 7 a

User Fees Act *continued*

Corporate Services Branch				2006 - 2007					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 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	$20.93	$12.1	$1,366	Response provided within 30 days following receipt of request; the response time may be extended pursuant to section 9 of the ATIA. Notice of extension to be sent within 30 days after receipt of request. *The Access to Information Act* provides fuller details: http://laws.justice.gc.ca/en/A-1/218072.html.	Of the 2,017 requests, 1,643 (81.5%) requests were completed during the 2006-2007 reporting period. The Department was able to respond within 30 days or less in 626 (38.1%) of completed cases. Response times for the remaining cases were 280 (17.0%) within 31 days to 60 days, 400 (24.3%) within 61 to 120 days, and 337 (20.5%) in 121 or more days.	2007-08 2008-09 2009-10	$13.00 $13.00 $13.00 See note 1 under Section C - Other Information	$1,400 $1,400 $1,400 See note 2 under Section C - Other Information
Sub-Total (R)					$0	$0			2007-08 2008-09	$13.00 $13.00	$1,400 $1,400
Sub-Total (O)					$12.1	$1,366			2009-10	$13.00	$1,400
Total										**$39.00**	**$4,200**

Date Last Modified: NA

1. Projection based on actual revenue received during FY 2006-07.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.
2. Estimated direct cost associated with ATI requests.

Table 7(b) 8 and 9

For detailed information on Policy on Service Standards for External Fees (Table 7b), Major Regulatory Initiatives (Table 8) and Details on Project Spending (Table 9), please visit the following website:

http://www.tbs-sct.gc.ca/rma/dpr2/06-07/index_e.asp.

Table 10a

Summary of Transfer Payments by Program Activity

This table reflects the break down of Transfer Payments (Grants and Contributions) by Program Activity. For more details refer to Table 10(b).

(millions of dollars)

Program Activities	2004-2005	2005-2006	2006-2007			
	Actual Spending	Actual Spending	Main Estimates	Planned Spending	Total Authorities	Actual Spending
Grants						
Health Policy, Planning and Information	50.7	54.6	57.1	57.1	53.2	43.3
Health Products and Foods	5.4	5.5	5.9	5.9	5.7	5.5
Healthy Environments and Consumer Safety	1.5	1.2	5.1	5.1	5.1	4.5
First Nations and Inuit Health	0.0	30.0	30.0	30.0	30.0	30.0
TOTAL GRANTS	**57.6**	**91.3**	**98.1**	**98.1**	**94.0**	**83.3**
Contributions						
Health Policy, Planning and Information	222.8	236.3	135.9	135.9	134.3	129.5
Health Products and Foods	0.4	4.1	4.0	4.0	3.8	3.8
Healthy Environments and Consumer Safety	35.8	42.3	39.6	39.7	39.0	38.7
First Nations and Inuit Health	858.9	826.8	911.7	918.5	907.2	896.6
TOTAL CONTRIBUTIONS	**1,118.0**	**1,109.5**	**1,091.2**	**1,098.1**	**1,084.3**	**1,068.6**
TOTAL TRANSFER PAYMENTS	**1,175.6**	**1,200.8**	**1,189.3**	**1,196.2**	**1,178.3**	**1,151.9**

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

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

The decrease in Health Policy, Planning and Information contributions is largely due to the reduction for the Primary Health Care Transition Fund.

Table 10b

Details on Transfer Payment Programs (TPPs)

HEALTH POLICY, PLANNING AND INFORMATION

- Grant to Health Council of Canada
- Grant to Canadian Agency for Drugs and Technologies in Health
- Grant to 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

HEALTH PRODUCTS AND FOOD

- Grant to Canadian Blood Services: Blood Safety and Effectiveness and Research and Development

HEALTHY ENVIRONMENTS AND CONSUMER SAFETY

- Alcohol and Drug Treatment and Rehabilitation Contribution Program
- Drug Strategy Community Initiatives Fund
- Contributions in support of the Federal Tobacco Control Strategy

FIRST NATIONS AND INUIT HEALTH

- Nunavut Medical Travel Fund
- Grant to Government of Yukon for the Territorial Health Access Fund and Operational Secretariat
- Contributions for First Nations and Inuit Health Benefits
- Payments to Aboriginal Health Institute/Centre for advancement of Aboriginal peoples' health
- Contributions for First Nations and Inuit Health Facilities and Capital Program
- Contributions for First Nations and Inuit Community Programs
- Payments to Indian bands, associations or groups for control and provision of health services
- Contributions for First Nations and Inuit Health Governance and Infrastructure Support
- Contributions for Bigstone Non-Insured Health Benefits Pilot Project
- Contributions for First Nations and Inuit Health Protection
- Contributions for First Nations and Inuit Primary Health Care

Supplementary information on Transfer Payment Programs can be found at:
http://www.tbs-sct.gc.ca/rma/dpr2/06-07/index_e.asp.

Table 11

Conditional Grants (Foundations)

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

Supplementary information on Conditional Grants (Foundations) can be found at:
http://www.tbs-sct.gc.ca/rma/dpr2/06-07/index_e.asp.

Table 12

Financial Statements

Statement of Management Responsibility

HEALTH CANADA

Responsibility for the integrity and objectivity of the accompanying financial statements for the year ended March 31, 2007 and all information contained in these statements rests with Health Canada's 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 Health Canada's financial transactions. Financial information submitted to the *Public Accounts of Canada* and included in Health Canada'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 Health Canada.

Management is supported by the Departmental Audit and Evaluation Committee, which provides assurance on risk management strategy and practices, management control frameworks and practices, policy and program effectiveness and improvement, and other information used for decision-making and reporting. The Committee oversees internal audit and evaluation activities and approves the department audit and evaluation plan. It also reviews the results of audits and evaluations as well as management responses and action plans developed to address related recommendations. The Committee membership is comprised of the Deputy Minister or the Associate Deputy Minister, the Assistant Deputy Ministers or their alternates, a Regional Director General, a representative from the Audit and Accountability Bureau and the Director of the Evaluation Division. A representative from the Office of the Auditor General participates as an observer.

The financial statements of Health Canada have not been audited.

Suzanne Vinet
Acting Deputy Minister
Ottawa, Canada
Date: August 9, 2007

Marcel Nouvet
Interim Chief Financial Officer
Ottawa, Canada
Date: August 9, 2007

Table 12

Financial Statements *continued*

Statement of Operations (unaudited)

HEALTH CANADA

For the year ended March 31

(in thousands of dollars)

	2007						2006
Expenses	First Nations and Inuit Health	Health Policy, Planning and Information	Health Products and Food	Healthy Environments and Consumer Safety	Pest Control Product Regulation	**Total**	**Total**
Transfer payments	909,281	594,917	9,198	42,245	-	**1,555,641**	1,191,194
Contingent Liability Expenses	(2,504)	1,023,476	-	(20)	(150)	**1,020,802**	(12)
Salaries and wages	272,447	57,700	243,436	178,198	53,405	**805,186**	783,529
Utilities, material and supplies	412,826	2,492	16,457	17,677	2,513	**451,965**	401,801
Professional and special services	294,187	42,168	40,259	47,432	6,926	**430,972**	387,867
Travel- Non-Insured Health Patient	122,676	-	-	-	-	**122,676**	112,713
Accommodation	19,347	3,735	14,964	10,756	3,421	**52,223**	50,198
Purchased repair and maintenance	14,705	2,965	9,271	9,101	2,028	**38,070**	42,570
Travel and relocation	20,654	2,816	5,235	7,602	830	**37,137**	38,748
Information	8,529	1,951	4,574	10,913	1,017	**26,984**	14,716
Communications	10,983	1,330	4,668	4,943	849	**22,773**	18,442
Amortization	7,136	3	6,967	6,754	274	**21,134**	22,492
Rentals	1,521	933	869	857	197	**4,377**	4,356
Bad debts	249	54	143	144	33	**623**	-
Other	(181)	43	189	278	19	**348**	4,216
	2,091,856	1,734,583	356,230	336,880	71,362	**4,590,911**	**3,072,830**
Revenues							
Sales of goods and services							
Services of a regulatory nature	19	-	22,324	47	3,364	**25,754**	21,364
Rights and privileges	21	-	17,123	52	4,112	**21,308**	21,206
Services of a non-regulatory nature	4,446	-	365	12,368	53	**17,232**	16,946
Lease and Use of Public Property	416	-	2	4	1	**423**	448
Revenues from fines	0	-	-	2,348	-	**2,348**	2,759
Interest	127	-	573	318	255	**1,273**	320
Other	1,809	5	3,200	1,745	1,258	**8,017**	7,245
	6,838	**5**	**43,587**	**16,882**	**9,043**	**76,355**	**70,288**
Net cost of operations	**2,085,018**	**1,734,578**	**312,643**	**319,998**	**62,319**	**4,514,556**	**3,002,542**

The accompanying notes are an integral part of the financial statements

Table 12

Financial Statements *continued*

Statement of Financial Position (unaudited)

HEALTH CANADA

As at March 31 (in thousands of dollars)	2007	2006
Assets		
Financial assets		
Accounts receivable and advances (Note 4)	**33,472**	27,360
	33,472	27,360
Non-financial assets		
Prepaid expenses	**2**	-
Tangible capital assets (Note 5)	**108,116**	109,824
	108,118	109,824
	141,590	137,184
Liabilities and Equity of Canada		
Liabilities		
Accounts payable and accrued liabilities	**395,377**	402,718
Vacation pay and compensatory leave	**39,055**	37,205
Deferred revenue	**3,683**	4,944
Employee severance benefits (Note 6)	**134,294**	122,332
Other liabilities (Note 7)	**1,461,712**	10,684
	2,034,121	577,883
Equity of Canada	**(1,892,531)**	(440,699)
	141,590	137,184

Contingent Liabilities (Note 8)
Contractual Obligations (Note 9)

The accompanying notes are an integral part of the financial statements

Table 12

Financial Statements *continued*

Statement of Equity (unaudited)

HEALTH CANADA

For the year ended March 31 (in thousands of dollars)	**2007**	2006
Equity of Canada, beginning of year	**(440,699)**	(615,016)
Net cost of operations	**(4,514,556)**	(3,002,542)
Current year appropriations used (Note 3)	**2,997,550**	2,891,980
Revenue not available for spending	**(12,597)**	(11,234)
Change in net position in the Consolidated Revenue Fund (Note 3)	**(14,173)**	210,538
Services provided without charge by other government departments (Note 10)	**91,944**	85,575
Equity of Canada, end of year	**(1,892,531)**	(440,699)

The accompanying notes are an integral part of the financial statements

Table 12

Financial Statements *continued*

Statement of Cash Flow (unaudited)

HEALTH CANADA

For the year ended March 31 (in thousands of dollars)	**2007**	2006
Operating transactions		
Net cost of operations	**4,514,556**	3,002,542
Non-cash items:		
Amortization of tangible capital assets (Note 5)	**(21,134)**	(22,492)
Gain (loss) on disposal of capital and non-capital assets	**(31)**	1,003
Services provided without charge by other government departments (Note 10)	**(91,944)**	(85,575)
Variations in Statement of Financial Position:		
Increase (decrease) in accounts receivable, advances and prepaids	**6,114**	(27,964)
Decrease (increase) in liabilities	**(1,456,238)**	215,995
Cash used by Operating Activities	**2,951,323**	3,083,509
Capital investment activities		
Acquisitions of tangible capital assets (Note 5)	**19,542**	7,894
Proceeds on disposal of tangible capital assets	**(85)**	(119)
Cash used by Investment Activities	**19,457**	7,775
Financing Activities		
Net cash provided by Government of Canada	**(2,970,780)**	(3,091,284)
Cash used by Financing Activities	**(2,970,780)**	(3,091,284)

The accompanying notes are an integral part of the financial statements

Table 12

Financial Statements *continued*

Notes to the Financial Statements (unaudited)

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.

Table 12

Financial Statements *continued*

Notes to the Financial Statements (unaudited)

HEALTH CANADA

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 as well as insect and rodent-controlling devices. Ongoing regulatory responsibilities constitute the majority of the work under this 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.*

Table 12

Financial Statements *continued*

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 12

Financial Statements *continued*

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.

Table 12

Financial Statements *continued*

Notes to the Financial Statements (unaudited)

HEALTH CANADA

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. Health Canada 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 will 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, the liability for employee severance benefits 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.

Table 12

Financial Statements *continued*

Notes to the Financial Statements (unaudited)

HEALTH CANADA

3. Parliamentary appropriations

Health Canada 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 cost of operations for the year on a government funding basis than on an accrual accounting basis. The differences between net cost 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)	2007	2006
Net cost of operations	**4,514,556**	3,002,542
Adjustments for items affecting net cost of operations but not affecting appropriations:		
Add (Less):		
Services provided without charge by other government departments	**(91,944)**	(85,575)
Amortization	**(21,134)**	(22,492)
Employee severance benefits	**(11,961)**	(21,856)
Refund/adjustment of previous year's expenditures	**40,390**	17,224
Revenue not available for spending	**12,597**	11,234
Justice Canada legal fees	**(11,785)**	(10,488)
Vacation pay and compensatory leave	**(1,918)**	(2,736)
Other increase in liabilities (see Note 7)	**(1,450,202)**	(3,751)
	(1,536,580)	(118,440)
Adjustments for items not affecting net cost of operations but affecting appropriations:		
Add (Less):		
Acquisitions of tangible capital assets	**19,542**	7,894
Net change to accountable advances	**32**	(16)
	19,574	7,878
Current year appropriations used	**2,997,550**	2,891,980

Table 12

Financial Statements *continued*

3. Parliamentary appropriations (continued)

(b) Appropriations provided and used:

(in thousands of dollars)	Appropriations Provided 2007	2006
Operating expenditures - Vote 1	**1 805 445**	1 601 715
Grants and Contributions - Vote 5	**1 178 285**	1 247 709
Statutory Amounts	**106 333**	109 688
Less:		
Appropriation available for future years	**(235)**	(238)
Lapsed appropriations	**(92,278)**	(66,894)
Current year appropriations used	**2,997,550**	2,891,980

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

(in thousands of dollars)	2007	2006
Net cash provided by Government	**2,970,780**	3,091,284
Revenue not available for spending	**12,597**	11,234
Change in net position in the Consolidated Revenue Fund		
Refund/reversal of previous year's expenses	**40,390**	17,224
Justice Canada legal fees	**(11,785)**	(10,488)
Variation in accounts receivable and advance	**(6,112)**	27,832
Variation in accounts payable and accrued liabilities	**(7,341)**	(238,830)
Other	**(979)**	(6,276)
	14,173	(210,538)
Current year appropriations used	**2,997,550**	2,891,980

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)	2007	2006
Receivables from External Parties	**21,623**	21,269
Receivables from Other Government Departments	**13,992**	8,870
Employee Advances	**106**	75
Gross receivables	**35,721**	30,214
Less: Allowance for doubtful accounts on external receivables	**(2,249)**	(2,854)
Net accounts receivable and advances	**33,472**	27,360

Table 12

Financial Statements *continued*

5. Tangible capital assets

Capital assets (in thousands of dollars)	Opening Balance	Acquisitions	Disposals/ write-downs/ adjustments	Closing Balance
Land	1,181	-	-	**1,181**
Buildings	127,106	653	-	**127,759**
Leasehold improvements	19,277	-	(4)	**19,273**
Machinery and equipment	154,313	17,008	(783)	**170,538**
Vehicles	20,286	1,881	(1,030)	**21,137**
	322,163	19,542	(1,817)	**339,888**

Accumulated amortization (in thousands of dollars)	Opening Balance	Current year amortization	Disposals/ write-downs/ adjustments	Closing Balance
Buildings	76,549	5,164	(1)	**81,712**
Leasehold improvements	13,835	3,494	-	**17,329**
Machinery and equipment	109,521	10,588	(758)	**119,351**
Vehicles	12,434	1,888	(942)	**13,380**
	212,339	21,134	(1,701)	**231,772**

Tangible capital assets net book value (in thousands of dollars)	Opening Balance	Closing Balance
Land	1,181	**1,181**
Buildings	50,557	**46,047**
Leasehold improvements	5,442	**1,944**
Machinery and equipment	44,792	**51,187**
Vehicles	7,852	**7,757**
	109,824	**108,116**

Amortization expense for the year ended March 31, 2007 is $21,134 (2006 - $22,492).

Table 12

Financial Statements *continued*

Notes to the Financial Statements (unaudited)

HEALTH CANADA

6. 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 2.2 times (2.6 in 2005-06) the contributions by employees, amount to:

(in thousands of dollars)	**2007**	2006
Expense for the year	**77,728**	80,743
	77,728	80,743

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)	**2007**	2006
Accrued benefit obligation, beginning of year	**122,332**	100,476
Expense for the year	**18,296**	30,517
Benefits paid during the year	**(6,334)**	(8,661)
Accrued benefit obligation, end of year	**134,294**	122,332

7. Other liabilities

Other liabilities include allowances and contingencies reflecting $1.023 billion for Hepatitis C litigations and two statutory grants amounting to $430 million as announced in the Budget 2007; (*Bill C-52*: $400 million to Canada Health Infoway to support the development of electronic health records and $30 million to Rick Hansen Foundation for the Spinal Cord Injury Transitional Research Network).

Table 12

Financial Statements *continued*

Notes to the Financial Statements (unaudited)

HEALTH CANADA

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. Health Canada has identified sites where such action is possible and for which a liability has been recorded.

	2007	2006
Approximate number of sites for which a liability has been recorded	**5**	14
(in thousands of dollars)		
Liability recorded for contaminated sites	**3,197**	3,646

Health Canada'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 $10,811,022,000 ($10,798,354,000 in 2006) were still pending at March 31, 2007. 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. Contractual obligations

The nature of Health Canada'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)	Transfer payments	Non-Insured Health Benefits	Total
2007-08	126,000	22,000	148,000
2008-09	97,000	31,000	128,000
2009-10	96,000	20,000	116,000
2010-11	58,000	-	58,000
2011-12 and thereafter	50,000	-	50,000
Total	427,000	73,000	500,000

Table 12

Financial Statements *continued*

Notes to the Financial Statements (unaudited)

HEALTH CANADA

10. 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)	**2007**	2006
Accommodation	**34,914**	34,481
Employer's contribution to the health and dental insurance plans	**50,980**	48,176
Worker's compensation costs	**711**	879
Legal services	**5,339**	2,039
	91,944	85,575

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 outstanding at year-end with related parties:

(in thousands of dollars)	**2007**	2006
Accounts payable to other government departments and agencies	**18,941**	20,508

11. Comparative information

Comparative figures have been reclassified to conform to the current year's presentation.

12. Subsequent events

On December 14, 2006, the Government and Class Counsel reached a settlement for those Canadians who contracted hepatitis C from the blood system before January 1, 1986 and between July 2, 1990 and September 28, 1998. Under the terms of the agreement, the Government set aside about $1 billion in a special settlement fund which is reflected in the present financial statements. On June 8, 2007, Provincial Superior Courts approved the Settlement and the settlement funds will be transferred to the appointed trustee in the upcoming fiscal year.

Table 13

Responses to Parliamentary Committees, and Audits and Evaluations

Response to Parliamentary Committee

Standing Committee on Health
Report #3 "Silicone Gel-filled Breast Implants: Areas of Concern" - tabled September 18, 2006

Committee members heard testimony on the issue of silicone gel-filled breast implants. Witnesses included officials from Health Canada and the Public Health Agency of Canada; former members of Health Canada's Expert Advisory Panel on Breast Implants, Dr. Mitchell Brown and Dr. Paula Chidwick; and Dr. Diana Zuckerman, President of the National Research Center for Women and Families in the United States.
Based on the evidence provided by these witnesses, the Committee identified key concerns regarding silicone gel-filled breast implants relating to several areas including safety assessments, special access, informed consent and post-approval surveillance. The Committee acknowledges that these recommendations may require changes to the Medical Devices Regulations and/or other supporting documents.
In its response, the Department recognizes the importance of each of the recommendations and the underlying concerns. Health Canada has considered each recommendation carefully and prepared a response to the concerns and advice contained in the Committee's report. The Government's response and actions are in line with the Committee's recommendations.

Government Response (tabled January 17, 2007):
http://cmte.parl.gc.ca/cmte/CommitteePublication.aspx?COM=10481&Lang=1&SourceId=188754

Responses to the Auditor General of Canada, including to the Commissioner of the Environment and Sustainable Development (CESD)

The Auditor General's (AG's) May 2006 Status Report included ***Chapter 5 - Management of Programs for First Nations.*** In this follow-up audit, the AG examined the progress of Health Canada and four other federal organizations in implementing 37 recommendations made between 2000 and 2003 on First Nations issues. The recommendations were included in chapters that covered housing on reserves, economic development, third-party intervention, health care, the food mail program, comprehensive land claims, and reporting requirements for First Nations. The AG also identified factors that appear to have been critical in successfully implementing the recommendations.

In its response, the Government agreed that the seven factors identified by the AG were important and that where satisfactory progress has been made on the AG's recommendations, one or more of these factors were present. In addition, the Government noted that these factors constitute an increasingly important part of its approach for the broader Aboriginal agenda. The Government noted that resolving Aboriginal issues remains an extremely difficult challenge, characterized by complex jurisdictional issues. Major reform is complex, requiring phased implementation and the establishment of strong governance and accountability measures in First Nations communities. Nevertheless, the Government will continue to take the critical factors into account when developing approaches aimed at securing a better future for Aboriginal peoples.

The AG's November 2006 Annual Report included ***Chapter 8 - Allocating Funds to Regulatory Programs - Health Canada.*** The AG examined both the process by which Health Canada decides what resources to allocate to each of its branches, as well as the information used as the basis for resource allocation. In particular, the AG examined how branches allocate resources to three regulatory programs (product safety, drug

Table 13

Responses to Parliamentary Committees, and Audits and Evaluations *(continued)*

Responses to the Auditor General of Canada, including to the Commissioner of the Environment and Sustainable Development (CESD)

products and medical devices), and assessed the impact of the Department's resource allocation process on its ability to carry out its regulatory responsibilities in these areas. The audit focused on fiscal years 2003-2004 and 2004-2005.

The AG recommended improvements in several areas, including the operational plans for each of the three Health Canada regulatory programs; various aspects of the related resource allocation process, including the establishment of user fees; and the ongoing measurement of and reporting on performance.

Health Canada is progressing in the implementation of all the AG recommendations. For example, the Department has strengthened operational planning through the launching of a combined strategic and operational planning process that includes performance measures, indicators and measurable targets, as well as decisions on resource allocations. The completion date for implementing the new process is fiscal year 2007-2008.

In addition, Health Canada recently approved a new cost recovery strategy and framework for all its user fees programs, including drugs and medical devices, in order to align with the Treasury Board Policy on Service Standards for External Fees and to develop a full costing model. Work on the cost recovery strategy and framework is expected to be completed by March 31, 2008.

Building on stakeholder consultations in 2005, Health Canada is renewing its cost-recovery regime for drugs and medical devices in accordance with the Treasury Board policy and the *User Fees Act*. Health Canada has launched consultations with stakeholders in 2006-2007 with a goal to complete the work over the next two fiscal years (2007-2008 and 2008-2009).

The AG's November 2006 Annual Report also included ***Chapter 10 - Award and Management of a Health Benefits Contract: Public Works and Government Services Canada and Health Canada.*** Health Canada is responsible for providing non-insured health benefits such as drugs and medical supplies to eligible First Nations and Inuit people. In 1997, Public Works and Government Services Canada (PWGSC) awarded a contract to First Canadian Health Management Corporation Inc. to provide claim processing services for Health Canada's Non-Insured Health Benefits (NIHB) program. The AG assessed whether PWGSC complied with the government's contracting policy when it awarded the contract and whether Health Canada exercised adequate control over public funds spent on the program.

Two of the AG's recommendations were addressed to Health Canada - one related to compliance with sections 33 and 34 of the *Financial Administration Act*, and the other related to the clarity of the Department's Delegation of Financial Signing Authorities document. As a result of additional audit work conducted between January and September 2006, the AG confirmed that Health Canada had resolved both of these issues.

External Audits or Evaluations

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

- **May 2006 Status Report:**
  - *Chapter 1 - Managing Government: Financial Information*
  - *Chapter 5 - Management of Programs for First Nations*

Table 13

Responses to Parliamentary Committees, and Audits and Evaluations *(continued)*

External Audits or Evaluations

- **November 2006 Annual Report**
  - *Chapter 8 - Allocating Funds to Regulatory Programs-Health Canada*
  - *Chapter 10 - Award and Management of a Health Benefits Contract: Public Works and Government Services Canada and Health Canada*
- **February 2007 Status Report:**
  - *Chapter 1 - Advertising and Public Opinion Research*

Government-wide audits affecting Health Canada conducted by the Commissioner of the Environment and Sustainable Development (CESD) - September 2006 Annual Report:

- *Chapter 2 - Adapting to the Impacts of Climate Change*
- *Chapter 4 - Sustainable Development Strategies*
- *Chapter 5 - Environmental Petitions*

Audits conducted by the Commissioner of Official Languages (COL):

- Audit of service to the public conducted in summer 2006 on 37 institutions, including Health Canada. The results were published in the COL's Annual Report in May 2007. The performance of 24 HC offices in relation to service to the public was examined and recorded under one of the thirteen COL criteria in the 2006-2007 annual HC report card. The annual report refers to this audit and a recommendation regarding the 37 institutions, at: http://www.ocol-clo.gc.ca/html/ar_ra_2006_07_e.php

- Audit of direct health care services delivered by four federal institutions, including Health Canada. The report that came out of this audit was published in July 2007. It contains six recommendations relating to HC and may be consulted at: http://www.ocol-clo.gc.ca/html/sante_health_2_e.php

- The Office of the Commissioner of Official Languages (OCOL) used the results of the 2005 Public Service Employee Survey to evaluate the level of satisfaction of minority personnel working in areas designated bilingual for purposes of language of work. The results are pre sented in the report card of the institutions evaluated, in Chapter 4 of the annual report, at: http://www.ocol-clo.gc.ca/html/toc_tdm_2006_07_ar_ra_e.php

Audits conducted by the Canada Public Service Agency (CPSA - formerly PSHRMAC):

- The Canada Public Service Agency presented the preliminary report on its audit of communications with the public and of service to the public in both official languages in four Health Canada offices-three in Alberta and one in Ontario. The final report has not yet been delivered.

- Audit of service to the public in both official languages: Three Health Canada service points in British Columbia were the subject of this audit done by the Agency in 2005. In 2006, a departmental action plan addressing the three recommendations was sent to the CPSA.

The audit report is available at http://www.psagency-agencefp.gc.ca/reports-rapports/ol-lo/aud-ver/aaoes-voase/aaoes-voase-hc-sc1_e.asp -_Toc124581039

Table 13

Response to Parliamentary Committees, and Audits and Evaluations *(continued)*

Internal Audits or Evaluations

Internal Audits completed by Health Canada in 2006-07

- Audit of the Handling of Controlled Drug Substances in FNIHB Health Facilities Within Two Selected Regions - Manitoba and Ontario/Nunavut
  See http://www.hc-sc.gc.ca/ahc-asc/performance/audit-verf/2006-list/SI-05-10_e.html
- Report on Health Canada's Initiatives for Government On-Line
  See http://www.hc-sc.gc.ca/ahc-asc/performance/audit-verf/2006-list/gol_ged_e.html
- Audit of Selected Administrative Areas
  See http://www.hc-sc.gc.ca/ahc-asc/performance/audit-verf/2006-list/2006-10-27_e.html
- Audit of the Implementation of Corrective Measures Ordered by the Public Service Commission of Canada
  See http://www.hc-sc.gc.ca/ahc-asc/performance/audit-verf/2006-list/2006-09-22_e.html
- Audit of the Primary Health Care Transition Fund Contributions to the Ministry of Health and Long-Term Care of the Province of Ontario
  See http://www.hc-sc.gc.ca/ahc-asc/performance/audit-verf/2006-list/2006-12-18_e.html
- Audit of the Cruise Ship Inspection Program
  See http://www.hc-sc.gc.ca/ahc-asc/performance/audit-verf/2006-list/SI-05-10_e.html
- Review of the Delegation of Financial Authorities
  See http://www.hc-sc.gc.ca/ahc-asc/performance/audit-verf/2007-list/2007-03-08c_e.html
- Audit of the Proactive Disclosure of Contracts Over $10,000
  See http://www.hc-sc.gc.ca/ahc-asc/performance/audit-verf/2007-list/2007-03-08d_e.html
- Audit of the Proactive Disclosure of Travel and Hospitality Expenses
  See http://www.hc-sc.gc.ca/ahc-asc/performance/audit-verf/2007-list/2007-03-08e_e.html
- Review of Direct Payments
  See http://www.hc-sc.gc.ca/ahc-asc/performance/audit-verf/2007-list/2007-03-08f_e.html
- Follow-up of the Review of the Administration of the Health Information and Claims Processing System Contract with First Canadian Health
  See http://www.hc-sc.gc.ca/ahc-asc/performance/audit-verf/2007-list/2007-03-08_e.html
- Review of the Development and Implementation of Results-Based Management and Accountability Frameworks at Health Canada
  See http://www.hc-sc.gc.ca/ahc-asc/performance/audit-verf/2007-list/2007-03-08_e.html
- Audits of Selected Capital Contribution Agreements for the Design, Construction and Modification of On-Reserve Health Facilities in the British Columbia/Yukon Region
  See http://www.hc-sc.gc.ca/ahc-asc/performance/audit-verf/2007-list/2007-03-08g_e.html

Table 13

Response to Parliamentary Committees, and Audits and Evaluations *(continued)*

Internal Audits or Evaluations

- Audit of the Management Processes of Medical Marihuana Program
  See http://www.hc-sc.gc.ca/ahc-asc/performance/audit-verf/2007-list/2007-03-13_e.html

Evaluations completed by Health Canada in 2006-07

- Bovine Spongiform Encephalopathy I and II Initiatives - Formative Evaluation
- Building Public Confidence in Pesticide Regulation and Improving Access to Pest Management Products Horizontal Initiative - Formative Evaluation of the Horizontal Initiative
- Canada's Drug Strategy - Interim Year-Two Risk-Based Evaluation
- Canada Prenatal Nutrition Program - First Nations and Inuit Health Branch - Evaluation Report
- Federal Tobacco Control Strategy - Summative Evaluation of the First Five Years 2001-2006
- Health Canada's Evaluation and Performance Measurement Functions, Review of Natural Health Products Research Program - Formative Evaluation
- Synthesis of Findings of 2005-2006 Health Canada Evaluations Departmental Audit and Evaluation Committee approved Evaluation Reports

Link to Treasury Board of Canada Secretariat Audit and Evaluation Database: http://www.tbs-sct.gc.ca/rma/database/newdeptview_e.asp?id=41

Implementation of the *Federal Accountability Act* and Treasury Board's 2006 Internal Audit Policy

The *Federal Accountability Act*, which was granted Royal Assent in December 2006, creates, for the first time, a legislative requirement for deputy heads to establish and adequately resource departmental audit functions. This Act provides 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 continued to prepare for the implementation of Treasury Board's 2006 Internal Audit Policy:

- implementation of the new independent Departmental Audit Committee, with external membership, is planned for 2007-08;
- expanded audit requirements of the Office of the Comptroller General (OCG)have been incorporated into the Health Canada Multi-Year Risk-Based Audit Plan;
- AAB has developed an Audit Charter, the AAB Code of Conduct, and performance and stakeholder management frameworks;
- AAB has established comprehensive audit and quality assurance processes;
- a follow-up process is in place for tracking progress on the implementation of audit recommendations;
- AAB has hired 23 additional staff including qualified audit professionals;
- a memorandum of understanding was established that sets out the framework under which AAB will conduct audits of grants and contributions programs in all Health Canada branches; and
- AAB continues to be active in the various OCG Internal Audit Working Groups;

Table 14

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 2006-2007 progress was made in all three areas.

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

Health Canada has four Strategic Outcomes as set out in the 2007-08 RPP:

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 and activities.

Targets and Progress

Health Canada has been successful in meeting most of the commitments it set out to achieve in SDS III, and has identified activities that were integrated into SDS IV to support the completion of the remainder of SDS III targets. For detailed progress information on each specific target of SDS III, see Health Canada's Sustainable Development Strategy 2004-2007: *Becoming the Change We Wish* to See Final Report on Accomplishments 2004-2007. To obtain a copy of this report please contact the Office of Sustainable Development, Health Canada, at osd@hc-sc.gc.ca or (613)954-3859.

Theme 1 Accomplishments

The objectives and targets under this theme focussed on accelerating the creation of social and physical conditions that maintain and enhance population health.

Table 14

Sustainable Development *(continued)*

Targets and Progress

Some of our key accomplishments in 2006-2007 to address these priorities included:

Health Canada successfully met its targets related to drinking water quality in Canada through development of Drinking Water Guidelines (target 1.1.1) in partnership with federal, provincial and territorial departments of health and environment, the development of a national protocol for addressing water-borne contamination and illness events, revising the Procedure Manual for Safe Drinking Water in First Nations Communities South of 60 and developing a risk assessment tool for drinking water in First Nations communities.

Health Canada worked with other federal departments to determine the vulnerability of Canadians to climate change impacts through selected case studies, methods development and literature review (target 1.1.4). A synthesis report has been developed and the final version is planned for release in November 2007.

Health Canada developed and updated science-based guidelines and standards to improve the safety of the food supply and reduce food-borne illness (target 1.1.5), The Department also began implementation of the Aboriginal Health Transition Fund to devise new ways to improve, integrate and adapt health services to better meet the needs of all Aboriginal peoples (target 1.2.2).

Significant progress was realized by the Pest Management Regulatory Agency (PMRA) in re-evaluating registered products to ensure they meet current safety standards. Proposed regulatory decisions were published for 14 pesticide active ingredients, while regulatory decisions were finalized and published for 17 pesticide active ingredients. In collaboration with Agriculture and Agri-Food Canada, PMRA constructed a website to report on risk reduction projects for priority crops (target 1.1.7).

Theme 2 Accomplishments

The objectives and targets under Theme 2 were designed to broaden Health Canada employees' knowledge of sustainable development issues and provide practical tools for integrating SD into all decision-making, programs, and policies. Work continues on integrating SD into the planning processes at the Departmental, Branch, Regional and Agency levels, to ensure that SD is not considered an “add-on” to overall operations.

Efforts in SDS III 2004-2007 focused on development and delivery of Sustainable Development (SD) training and communication tools to new and existing HC employees in order to raise awareness and improve integration of SD (targets 2.1.1 & 2.1.2). Over 200 staff were trained in Strategic Environmental Assessment (SEA) preparation and their responsibilities under the Cabinet Directive on SEAs. Health Canada completed a detailed SEA on the Government's Chemicals Management Plan.

Health Canada has drafted an SD Policy Lens, which will undergo a pilot test in 2007, with the aim of improving SD considerations embedded in policies, plans and programs.

Theme 3 Accomplishments

The objectives under this theme strengthened Health Canada's commitment to decrease adverse environmental impacts resulting from the Department's operations and to promote our social responsibility in communities with Health Canada facilities.

Table 14

Sustainable Development *(continued)*

Targets and Progress

Targets focused on greening of government operations and included providing more information to assist managers and employees when they conduct their daily activities and operations, through the production of two departmental guidebooks: *Making a Difference in Our Facilities and Our Environment: A Guide on Environmental Management Best Practices for Health Canada and Agency Facilities*; and *Making a Difference: A Departmental Guidebook on Pollution Prevention for Health Canada and Agency Employees* (targets 3.1.1 & 3.2.1). Health Canada continued to follow up, implement and report on recommendations outlined in its guidebook to improve the management of environmental impacts at its laboratories and health facilities as part of its Environmental Management System (target 3.1.3).

Best practices and initiatives on SD were implemented in the regions including practising zero-waste catering, supporting fair trade products, using photocopy and printer paper with at least 30 percent post-consumer content, and green procurement (target 3.2.3).

Adjustments

In April 2006 the federal government launched a new policy on Green Procurement. This policy encourages the selection of goods and services that are the least likely to have a negative impact on the environment during their entire 'life cycle' (production, usage and disposal). Health Canada has begun implementing this policy across the department by collecting baseline information, communicating the policy and tools available to assist employees to implement the policy and by including specific Green Procurement targets into SDS IV. The Department will continue to report progress annually toward implementing this policy.

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. Although considerable progress was made in reaching the objectives and targets in SDS III, two targets (1.1.5 and 2.1.5) were carried over to the next strategy, SDS IV, as they were not fully met within the 2004-2007 period.

SDS III had a stronger performance management framework than previous strategies. A generic example results chain was developed to outline the logic and expected outcomes for SDS III, and measure performance against indicators. However, while some targets fit well within the results chain, others did not. To address performance measurement issues in SDS IV, a concerted effort was placed on ensuring targets are “SMART”: Supportive of strategic themes and specific; Measureable; Action-oriented and achievable; Resourced (i.e. human and fiscal allocations) and relevant; Time-bound by deadlines and/or criteria. This will ensure a simple and accountable system of measuring progress. Each objective and target is associated with a clear and measurable indicator which will provide a reliable estimate and whether the target has been reached.

Table 15 and 16

For detailed information on Procurement and Contracting (Table 15) and Service Improvements (Table 16), please visit the following website:

http://www.tbs-sct.gc.ca/rma/dpr2/06-07/index_e.asp.

Table 17

Horizontal Initiatives

Name of Horizonatal Initiative	
1.	Canada's Drug Strategy
2.	Federal Tobacco Control Strategy
3.	Federal Strategy on Early Childhood Development for First Nations and Other Aboriginal Children
4.	Building Public Confidence in Pesticide Regulation and Improving Access to Pest Management Products
5.	Mental Health Support Program

Supplementary information on Horizontal Initiatives can be found at:
http://www.tbs-sct.gc.ca/rma/eppi-ibdrp/hrdb-rhbd/profil_e.asp.

Table 18

Travel Policies

Comparison to the TBS Special Travel Authorities
Health Canada follows and uses the TBS Special Travel Authority Parameters.

Comparison to the TBS Travel Directive Rates and Allowances
Health Canada follows and uses the TBS Travel Directive Rates and Allowances.

Table 19

Storage Tanks

Supplementary information on storage tanks can be found at
http://www.tbs-sct.gc.ca/rma/dpr2/06-07/index_e.asp.

Section IV

Other Items of Interest

Health Canada's Regional Structure and Operations

In January 2006, Health Canada created a new Public Affairs, Consultation and Regions Branch. The creation of the Branch afforded the Department the opportunity to better bring national and regional perspectives to policy and program development, service delivery strategies, and communication and consultation functions. It allowed the Department to clearly define and clarify roles, responsibilities and accountabilities in a manner that contributes to the overall success of the Department and allows for a greater degree of coherence and integration of all operations in the regions.

Health Canada's seven regional operations (British Columbia, Alberta, Manitoba/Saskatchewan, Ontario, Quebec, Atlantic, and Northern) represent the face of the Department to Canadians through their role as front- line service and information providers, as guardians and regulators and by the delivery of health services and programs in First Nations and Inuit communities. These roles allow Health Canada to maximize the reach and effectiveness of departmental programs and services as well as to respond to the varied needs of diverse communities that the Department serves across the country. The creation of a new single Northern Region recognized the distinct program and service delivery challenges and opportunities of people in the territories.

Regions achieved an ambitious agenda of outreach and engagement with partners and stakeholders including provincial and territorial government departments, regional health authorities, health boards, research and academic institutions, non-governmental organizations and First Nations and Inuit governing bodies. This commitment was illustrated by the negotiations that led to the signing of the First Nations Tripartite Health Plan between the British Columbia Government, Health Canada and the First Nations Leadership Council. This 10 year plan will ensure more coordinated services among the three partners and related governance development to support stronger First Nations leadership in health.

Through well-established networks, Health Canada's regions continued to ensure that the Department was informed of local issues and concerns so that policy and program development considered and reflected the expectations, needs and issues of Canadians in all parts of the country.

Health Canada Communications and Outreach to Canadians

Health Canada communications focused on providing timely, reliable, relevant and culturally appropriate health information to Canadians. More than a million Canadians visited the website monthly for information. Public opinion research was gathered to support development of programs, policies and regulations, and targeted social marketing campaigns encouraged healthy behaviours.

Supporting Health Canada's Programs and Services

The 2006-2007 *Report on Plans and Priorities* (RPP) included commitments to corporate services and management practices.

Human Resources

Health Canada has been acknowledged for its good governance and training structure around *Public Service Modernization Act* implementation, the Department continued to provide training and improve policies and tools to support the new approaches set out under the Act. Branches identify human resource priorities and strategies based on business objectives, and supported by detailed demographic and environmental scanning information.

Overall, Health Canada received ratings of 'Acceptable' on the work force and workplace elements of the 'People' components of the Management Accountability Framework (MAF) which were largely based on 2005 employee survey results.

Information Technology

As set out in the RPP, The Way Forward initiatives resulted in many changes to IT management in Health Canada. This two-year departmental initiative adopted national standards and integrated, consolidated and rationalized IT resources. Projects included consolidating and reducing the number of servers and reducing IT computing facilities from 50 to four. The majority of projects were completed, with the remainder slated for completion in 2007-2008. We also were engaged in the government-wide IT Shared Services Initiative to improve delivery of internal administrative services, increase operational efficiency and consider transaction-based services that could be delivered by a common service provider. We have already transferred responsibility for some services to Public Works and Government Services Canada (PWGSC).

Promoting Management Accountability and Operational Planning

Health Canada continued strengthening financial management, accountability and control, as well as resource allocation. Under our Financial Management and Control Framework (FMCF) project, we introduced a Budget Management Framework. We also launched the Readiness Assessment and Certification Initiative as part of the Financial Management Renewal Initiative led by the Office of the Comptroller General, which supports achievement of *Federal Accountability Act* goals. Phase 1 of the Department's automated Contract Requisition and Reporting System was implemented and is aligned with the government's priority of improving accountability.

Improvements to operational planning were a major element supporting clearer management accountability. Introduced as a pilot in June 2006, the Departmental Operational Planning (DOP) is a FMCF priority. We are moving to a standardized planning framework across the Department that will clearly demonstrate linkages between priorities, planned activities, expected results and proposed resource allocation. These plans highlight risks and include mitigation strategies needed to reflect challenges facing departmental operations

These actions were rooted in departmental analyses of areas for improvement in financial management practices and were reinforced as a result of the recommendations in Chapter 8 of the 2006 Report of the Auditor General - *Allocation of Resources to Regulatory Programs* as well as the 2006 MAF Assessment. In that assessment, Treasury Board Secretariat (TBS) recognized us fo improved management in information technology, citizen-focused services, effective procurement and extra-organizational contributions. TBS commended Health Canada for our role in supporting TBS' priority of streamlining the Government's Policy Suite.

Risk Management

Health Canada undertook exercises relating to risk management such as the annual combined update of our Corporate Risk Profile and Internal Environmental Scan, the update of the Departmental Multi-Year Risk-Based Audit Plan 2006-2007 to 2008-2009 and the testing of the Departmental Business Continuity Plan in the Event of a Pandemic Influenza Outbreak. Health Canada and the Public Health Agency of Canada's Strategic Risk Communications Framework established an in-depth training plan to provide in-depth risk communications training. Extensive risk management processes supported The Way Forward and human resource activities described elsewhere in this section.

Privacy

We processed 2,200 requests under the *Access to Information Act* and the *Privacy Act* making Health Canada one of the top three departments in terms of requests received and processed. We improved our efficiency in responding to these requests, meeting deadlines in 86 percent of cases by the end of 2006-2007, up from 78 the year before. We were on track to achieve an "ideal compliance" status of 95 by fall 2007.

We increased awareness of Access to Information and Privacy principles by providing a training program that reached 500 Health Canada and Public Health Agency of Canada employees. We also oversaw a Privacy Impact Assessment process, initiating seven Privacy Impact Assessments and three Preliminary Privacy Impact Assessments. These are part of our efforts to ensure that personal information entrusted to the Department is protected. Our newly revised Privacy Impact Assessment Tool Kit was cited by the Office of the Privacy Commissioner as an excellent guide for procedures and practices.

The Office of the Privacy Commissioner the training programs will go a long way in ensuring that the Department "becomes a leader in protecting the privacy of Canadians in the delivery of critical health services. Indeed the training program is one of the more comprehensive suites currently available within the federal government, and could very well become a benchmark for future employee privacy training."

Values and Ethics

The departmental emphasis on values and ethics included raising awareness among employees of ethical issues and engaging them in dialogue about those issues. Other efforts assisted staff in addressing specific concerns and resolving conflicts. More than 2,500 employees participated in activities to educate, promote or foster ethics and informal conflict management in the workplace. In addition, over 400 employees used Internal Ombudsman services which helped to build a positive, open and transparent working environment.

The Health Canada Sustainable Development Strategy

Sustainable development is implicit in Health Canada's plans and priorities. Health Canada's Sustainable Development Strategy III (SDS III 2004-2007): *Becoming the Change We Wish to See* is described in detail in Table 14.

We also carried out planning to create SDS IV, which will build on lessons learned as well as new directions in government-wide efforts. Sustainable development training and implementing policy and planning tools will raise awareness and improve integration of social, economic and environmental considerations in the work the Department performs.

Advancing the Science Agenda

The Office of the Chief Scientist (OCS) was created in 2001 to strengthen our ability to perform and use science. Led by the Chief Scientist, the OCS provides leadership for and promotes awareness of Health Canada's science and research and encourages and supports the science community within and outside Health Canada. This helps to ensure that the Department has the scientific information needed to make health-related decisions. The OCS undertakes activities in three key areas:

Science advice - Promoting the effective use of science in policy making: assisting the Department in employing quality science advice in its policy and regulatory decisions;

Science management - Enhancing science capacity and quality: Encouraging due diligence and ensuring Health Canada has the science capacity it needs to meet current and emerging challenges; and

Science promotion - Raising awareness and understanding of science conducted at Health Canada: Improving stakeholder and public understanding of departmental science and its contribution to the health and safety of Canadians.

Science Advice

The OCS is responsible for the provision of science advice to senior departmental officials. It continued its role as secretariat to the Science Advisory Board (SAB). The SAB provides the Minister of Health with independent, expert advice on the science performed and used by Health Canada. This advice was considered in developmentof a departmental science and technology (S&T) strategy, integrated approaches to health and the environment, pharmacosurveillance and the implications of a federal S&T Strategy on the Health Portfolio.

As a leading science-based department, Health Canada must ensure that its research is conducted in a responsible manner. Health Canada's Research Ethics Board (REB), an independent body of experts, ensures that departmental research involving humans meets the highest ethical standards. OCS also provides secretariat support to the REB, which reviewed 132 research protocols in 2006-2007. Approximately 45 percent of these protocols came from the Public Health Agency of Canada and the others were submitted by Health Canada researchers.

The OCS worked with stakeholders in the research community to establish the Canadian Research Integrity Committee (CRIC). The OCS supported the CRIC in hosting a national workshop in January 2007 to discuss research integrity and the potential for a national approach.

Science Management

Sound science management requires good sharing of information and coordination of efforts between Health Canada branches. A key mechanism is the Departmental Executive Committee's Subcommittee on Science, which the Chief Scientist chairs and has ADM-level membership from all branches.

The OCS initiated planning for the S&T Strategy, referred to above, which will be developed in 2007-2008. The Strategy will seek to strengthen management of science issues across the department and in alignment with government-wide science directions.

Fostering strategic partnerships and linkages with external partners/stakeholders is critical to accessing the science and augmenting the science capacity our Department needs to implement its mandate. The OCS worked with PHAC and Canadian Institute of Health Research (CIHR) to identify opportunities for increased collaboration and information sharing. The OCS also supported development of an integrated list of health services and policy research priorities. In addition, the OCS provided advice and guidelines for departmental researchers and scientists on collaborative arrangements with external stakeholders.

With OCS coordination, Health Canada participated in development of the new federal S&T Strategy. Other interdepartmental initiatives dealt with recruitment and development of scientific personnel. These horizontal science initiatives improve understanding within the federal community of the importance of the regulatory science that is central to Health Canada efforts to maintain and improve the health of Canadians.

The OCS coordinated Health Canada's activities with respect to the OECD Principles of Good Laboratory Practice (GLP), which promote test data of comparable quality to enable mutual acceptance of data for regulatory purposes among different countries. To complement the existing GLP programs for pesticides and industrial chemicals and comply with Canada's OECD obligations, the OCS oversaw GLP implementation approaches for health products and food additives.

In order to strengthen the Department’s research capacity, six additional postdoctoral fellowships were offered and managed by OCS. In October 2006, OCS assumed management of the NSERC Visiting Fellowship Program for the Department with 24 Fellows. These programs bring new ideas and cutting-edge science into the Department in the person of the Fellows, who gain insight into the needs and operations of Health Canada. These programs also identify potential employees.

The Intellectual Property and Technology Transfer Office assisted 25 scientists with intellectual property issues. A one-day workshop on Intellectual Property was held for departmental scientists and managers. A web-based system called “Flintbox” to market patented inventions was implemented. An award for departmental inventors was also initiated.

Science Promotion

The OCS organized the annual Health Canada Science Forum held in Ottawa in October 2006 around the theme: “Keeping our "I"s on the Future: Innovation, Integration, Information and International”. This event helped raise awareness of the excellent research performed in the department and its contribution to policy and regulatory decision making. The Forum also facilitated linkages and information sharing between Health Canada researchers and decision makers and counterparts from across Canada.

Section V

Other Information

Departmental Contact information

Northern Region
60 Queen St., Suite 1400
Ottawa, Ontario
K1A 0K9
General Inquiries: 1-866-509-1769
Non-Insured Health Benefits Inquiries:
1-888-332-9222
Fax: (613) 954-9953 or 1-800-949-2718

Atlantic Region
1505 Barrington Street, Suite 1917
Halifax, Nova Scotia
B3J 3Y6
Telephone: (902) 426-2038
Facsimile: (902) 426-3768

Manitoba and Saskatchewan Region
Suite 450 - 391 York Avenue
Postal Locator B200
Winnipeg, Manitoba
R3C 4W1
Phone: (204) 983-2508
Facsimile: (204) 983-3972

Quebec Region
Complexe Guy Favreau
East Tower, Suite 200
200 René Lévesque Blvd. West
Montreal, Quebec
H2Z 1X4
Telephone: (514) 283-5186
Facsimile: (514) 283-1364

Alberta Region
Canada Place, Suite 730
9700 Jasper Avenue
Edmonton, Alberta
T5J 4C3
Telephone: (780) 495-6815
Facsimile: (780) 495-5551

Ontario Region
180 Queen Street West,
Toronto, Ontario
M5V 3L7
Telephone: (416) 973-4389
Toll free: 1-866-999-7612
Fax: (416) 973-1423

British Columbia and Yukon Region
757 West Hastings Street, Room 235
Vancouver, British Columbia
V6C 1A1
Telephone: (604) 666-2083
Facsimile: (604) 666-2258

National Capital Region
Health Canada
0900C2 Podium Level
Brooke Claxton Building
Columbine Drive
Ottawa, Ontario
K1A 0K9
Telephone: (613) 957-2991
Facsimile: (613) 941-5366

Index