ESTIMATES

Health Canada

Performance Report

For the period ending
March 31, 2002

Canada

The Estimates Documents

Each year, the government prepares Estimates in support of its request to Parliament for authority to spend public monies. This request is formalized through the tabling of appropriation bills in Parliament.

The Estimates of the Government of Canada are structured in several parts. Beginning with an overview of total government spending in Part I, the documents become increasingly more specific. Part II outlines spending according to departments, agencies and programs and contains the proposed wording of the conditions governing spending which Parliament will be asked to approve.

The *Report on Plans and Priorities* provides additional detail on each department and its programs primarily in terms of more strategically oriented planning and results information with a focus on outcomes.

The *Departmental Performance Report* provides a focus on results-based accountability by reporting on accomplishments achieved against the performance expectations and results commitments as set out in the spring *Report on Plans and Priorities*.

The Estimates, along with the Minister of Finance's Budget, reflect the government's annual budget planning and resource allocation priorities. In combination with the subsequent reporting of financial results in the Public Accounts and of accomplishments achieved in Departmental Performance Reports, this material helps Parliament hold the government to account for the allocation and management of funds.

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Foreword

In the spring of 2000, the President of the Treasury Board tabled in Parliament the document "Results for Canadians: A Management Framework for the Government of Canada". This document sets a clear agenda for improving and modernising management practices in federal departments and agencies.

Four key management commitments form the basis for this vision of how the Government will deliver their services and benefits to Canadians in the new millennium. In this vision, departments and agencies recognise that they exist to serve Canadians and that a "citizen focus" shapes all activities, programs and services. This vision commits the Government of Canada to manage its business by the highest public service values. Responsible spending means spending wisely on the things that matter to Canadians. And finally, this vision sets a clear focus on results – the impact and effects of programs.

Departmental performance reports play a key role in the cycle of planning, monitoring, evaluating, and reporting of results through ministers to Parliament and citizens. Departments and agencies are encouraged to prepare their reports following certain principles. Based on these principles, an effective report provides a coherent and balanced picture of performance that is brief and to the point. It focuses on outcomes - benefits to Canadians and Canadian society - and describes the contribution the organisation has made toward those outcomes. It sets the department's performance in context and discusses risks and challenges faced by the organisation in delivering its commitments. The report also associates performance with earlier commitments as well as achievements realised in partnership with other governmental and non-governmental organisations. Supporting the need for responsible spending, it links resources to results. Finally, the report is credible because it substantiates the performance information with appropriate methodologies and relevant data.

In performance reports, departments and agencies strive to respond to the ongoing and evolving information needs of parliamentarians and Canadians. The input of parliamentarians and other readers can do much to improve these reports over time. The reader is encouraged to assess the performance of the organisation according to the principles outlined above, and provide comments to the department or agency that will help it in the next cycle of planning and reporting.

This report is accessible electronically from the Treasury Board of Canada Secretariat Internet site:
http://www.tbs-sct.gc.ca/rma/dpr/dpre.asp

Comments or questions can be directed to:

Results-based Management Directorate
Treasury Board of Canada Secretariat
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Ottawa, Ontario K1A OR5

OR to this Internet address: rma-mrr@tbs-sct.gc.ca

Health Canada

Departmental Performance Report

For the period ending
March 31, 2002

A. Anne McLellan
Minister of Health

READER FEEDBACK

Health Canada's 2001-2002 Departmental Performance Report

We would like to hear from Canadians who read this report. Your comments will help ensure that we provide relevant information that is easily understood. Please send your completed questionnaire or comments to the mail, e-mail address or fax number shown below.

1) Did you find the information you were looking for? ☐ yes ☐ no
If no, what information were you looking for?

2) a) What parts of the document did you find most useful?

b) the least useful?

3) Would you recommend this report to others? ☐ yes ☐ no
If no, why not?

4) Are there any other comments you would like to make regarding this report?

Send your completed questionnaire or comments:

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Thank you for your cooperation

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Annex B: Details on Transfer Payments, 2001-2002 Actual Spending.

Annex C: Health Canada's 2000 Sustainable Development Strategy: *Sustaining Our Health*.

Annex D: Response to the Public Accounts Committee - First Nations Health: Follow-Up.

Section I:

Minister's Message

I am pleased to present Health Canada's 2001-2002 Departmental Performance Report.

Health Canada promotes and protects the health of Canadians in many ways. The Department provides leadership in establishing, monitoring and enforcing national criteria in the delivery of health care under the *Canada Health Act*. Health Canada helps to prevent and reduce risks to health and the environment by ensuring the safety of health products, food, workplaces, and many consumer products and by protecting Canadians against current and emerging risks to health. Health Canada also makes valuable contributions to global health, and is committed to supporting health research and the development of health information.

By providing information and advocating healthy lifestyle choices, Health Canada helps Canadians to make informed decisions about their health and the health of their families. Working in partnership on issues such as healthy living, reduction of tobacco use, helping Canadians to identify health risk factors, as well as our focus on health priorities such as diabetes, fetal alcohol syndrome and HIV/AIDS, we are helping Canadians to lead healthier lives.

Improving the health of First Nations and Inuit and reducing health inequalities between them and other Canadians are priorities for Health Canada. Consistent with overall government commitments, we are moving on these priorities through a renewed relationship with First Nations and Inuit. Health Canada, along with First Nations and Inuit, has developed and implemented long-term strategies and activities that are encouraging community responsibility for the design, delivery and management of health programs and services. These efforts build on improvements in First Nations and Inuit health status.

In addition to the Department's ongoing responsibilities, 2001-2002 included key steps forward in important areas.

Working collaboratively with the provinces and territories, significant progress has been made in implementing the commitments of the September 2000 First Ministers Meeting and the Social Union Framework Agreement to improve reporting and measuring performance. As a result, for the first time in this country's history, in

September 2002 all jurisdictions will begin to report on indicators of health outcomes, health status and quality of services. The reports will provide consistent and comparable information to Canadians, including health policy and program decision-makers.

Working with our provincial and territorial colleagues, we developed a dispute avoidance and resolution process that will help to avoid disagreements over interpretations of the *Canada Health Act,* and resolve those that occur. The process is based on collaboration, negotiation and the advice of third-party panels, where needed, while respecting and maintaining federal authority to interpret and enforce the *Canada Health Act*.

On behalf of the Government of Canada, I introduced a proposed new *Pest Control Products Act* in Parliament. The new Act seeks to protect the health of Canadians, especially children, and the environment from risks posed by pesticides, while helping to ensure a safe and abundant food supply. It sets out a stronger and modernized process for pesticide regulation and makes the registration system more transparent.

I also introduced comprehensive legislation in Parliament to protect the health, safety and privacy of those Canadians who turn to assisted human reproduction (AHR), and their children. This legislation addresses some very complex and important issues. Canadians have made it clear that they want safe AHR procedures and the benefit of important medical discoveries, but not at any cost. This proposed Act clarifies what we, as a society, find acceptable.

As we work to renew our health care system and ensure that Canadians have access to high-quality health care, the Government of Canada is looking forward to the Final Report of the Commission on the Future of Health Care in Canada, chaired by the former Premier of Saskatchewan, Roy Romanow.

At times, events occur that demonstrate the fundamental importance of the services and programs we provide. The tragedy of September 11, 2001 was one of these. Health Canada employees from across Canada responded to the challenge, notably by providing materiel and support to local authorities to accommodate more than 10,000 stranded travellers in the Atlantic provinces. Our experience during that challenging and uncertain time has allowed us to strengthen and improve our capacity to prepare for emergencies of all kinds that may occur in the future.

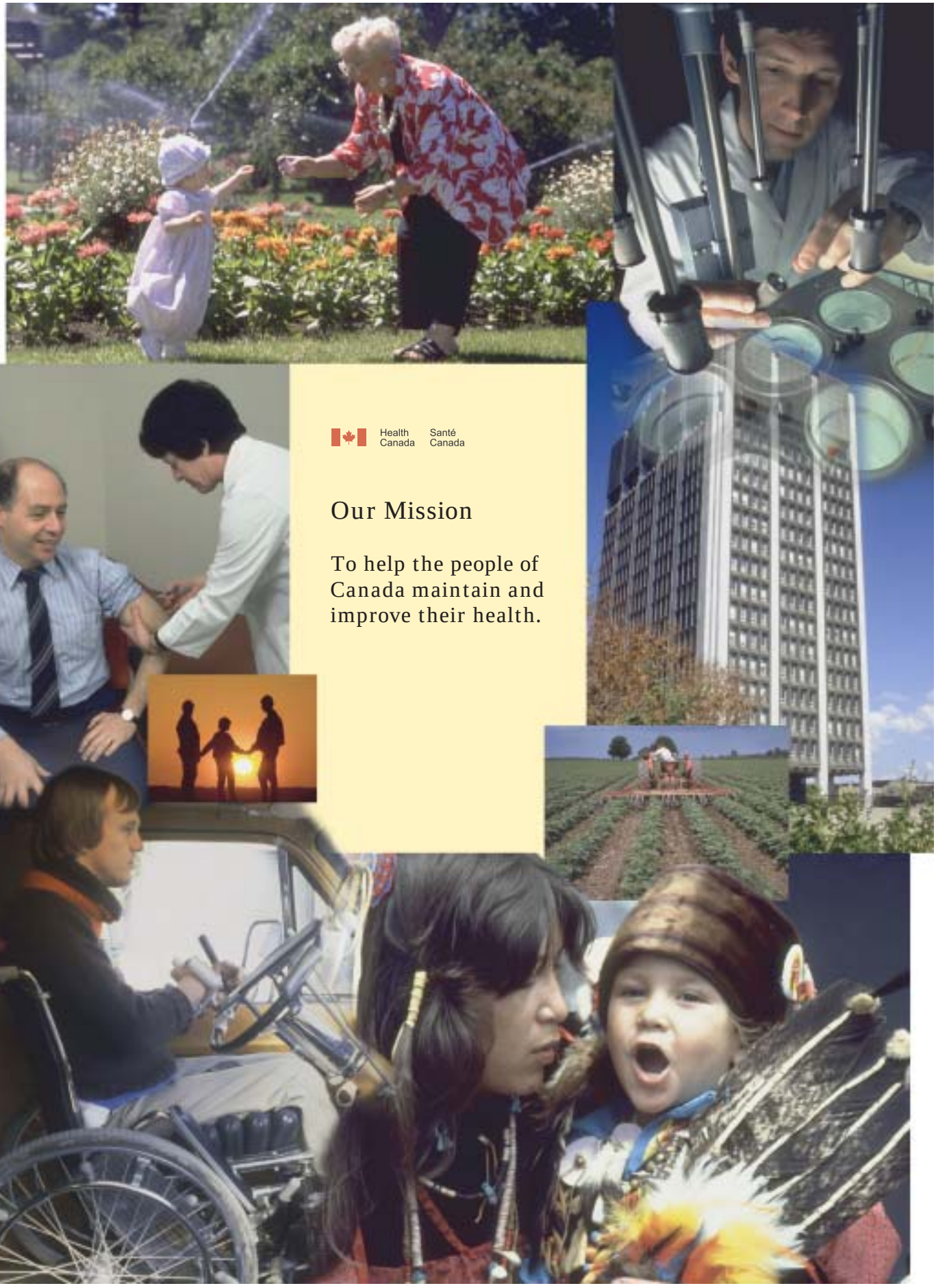
In these and many other ways, this Departmental Performance Report confirms Health Canada's commitment to maintaining and improving the health of Canadians. It demonstrates our determination to identify emerging needs and initiate responses and partnerships that help to meet them.

A. Anne McLellan

Minister of Health

Section II:

Departmental Overview



Health Canada Santé Canada

Our Mission

To help the people of Canada maintain and improve their health.

About Health Canada

Good health is a fundamental goal of all Canadians. Canada benefits socially and economically when everyone enjoys the best possible health. In order to meet that goal, the Government of Canada has given Health Canada and the Minister a broad mandate. Working with its partners, Health Canada provides Canadians with leadership in the following areas:

- Access to quality health care services for Canadians;
- Improved well-being through health promotion and illness prevention;
- Safer health products and food;
- Healthier environments and safer products for Canadians;
- Sustainable pest management and programs;
- Sustainable health services and programs for First Nations and Inuit communities so their people may attain a level of health comparable with that of other Canadians; and
- Better health outcomes through information and communications technologies and evidence-based decision making.

The Department's formal mandate is spelled out in the *Department of Health Act* while the Minister of Health is responsible for the direct administration of another 18 laws. Through policy development and the delivery of specific programs and services, Health Canada touches the lives of all Canadians.

Our Vision

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

Mission Statement

To help the people of Canada maintain and improve their health.

Objectives

Health Canada works with many partners to fulfil its mission. This objective is met in many different ways, by:

- Preventing and reducing risks to individual health and the overall environment;
- Promoting healthier lifestyles;
- Ensuring high quality health services that are efficient and accessible;
- Integrating renewal of the health care system with longer term plans in the areas of prevention, health promotion and protection;
- Reducing health inequalities in Canadian society;
- Providing health information to help Canadians make informed decision.

Health Canada seeks to ensure Canadians enjoy the best possible health outcomes. This is a challenge given the ever expanding and complex range of needs, demands and available interventions. Through a network of

regional offices and its numerous partnerships, the Department helps to maintain effective and sustainable systems for health that allow the greatest number of Canadians to enjoy good health throughout their lives. The Department strives to reduce inequalities in health status, particularly among children, youth, the elderly, and First Nations people and Inuit.

The circumstances and behaviours of Canadians vary. So, in order to successfully achieve the objectives, Health Canada strives to improve community capacity to deal with health issues while assisting Canadians in making informed choices about their health. It is through research, surveillance, and information sharing that Health Canada works to inform the development of policies by others who support health.

Along with its partners, Health Canada takes a comprehensive view of health, arrives at priorities through careful studies including science and research and evidence-based decisions, and decides how those decisions can best be put into practice. The results are effective policies, regulations and programs that help anticipate and meet future needs and challenges to the health of Canadians.

Roles

Health Canada plays many roles in order to achieve its objectives. Overall, the Department leads and partners with others in both health protection and promotion.

Leader/Partner - Health Canada is the national leader on health matters with responsibility for administering the *Canada Health Act*, the cornerstone of Medicare in Canada. The Department develops policies to help the health care system adapt to evolving realities, identifies and addresses the determinants of health, and seeks to contribute to the government's innovation agenda.

Funder - The federal government is a major contributor to health care funding through the Canada Health and Social Transfer (CHST). There are additional improvements and modernizations realized through other programs. Health Canada transfers funds to First Nations and Inuit organizations to help them provide community health services. In addition, grants and contributions to various organizations reinforce the Department's health objectives.

Guardian/Regulator - The Department protects the health of Canadians by managing product related risks and providing information to enable Canadians to make informed decisions about health products available to them. Health Canada strives to minimize health risk factors to Canadians and maximize the safety of health products and food. The regulatory system covers pesticides, toxic substances, pharmaceuticals, biologics, medical devices, cosmetics, consumer products, chemicals and natural health products. The Department delivers a range of programs and services in environmental health and protection. Other responsibilities include the areas of substance abuse, tobacco policy, workplace health and the safety of consumer products. The Department monitors and tracks diseases and takes action, where required.

Service Provider - Health Canada provides supplementary health benefits to 700,000 First Nations people and Inuit. Services available to these communities include prevention, promotion, primary care, and addiction services. In addition, the Department provides occupational health and safety services to all federal employees and in all federal facilities

Information Provider - Health Canada's high-quality science and research supports the development of new policies, regulations, services, information and management that are essential elements in maintaining Canada's world-class health care system. Through research and surveillance, the Department supplies information that Canadians can use to maintain and improve their health. It also supports research across Canada to expand the scientific and technical knowledge base. As a key national provider of health information, the Department emphasizes both positive health activities and illness prevention measures.

In Concert with Others

Health Canada works with the people of Canada through consultation and public involvement. This includes working with our partners: provinces and territories, First Nations and Inuit communities, professional associations, consumer groups, universities and research institutes, international organizations, volunteers, and other federal departments and agencies.

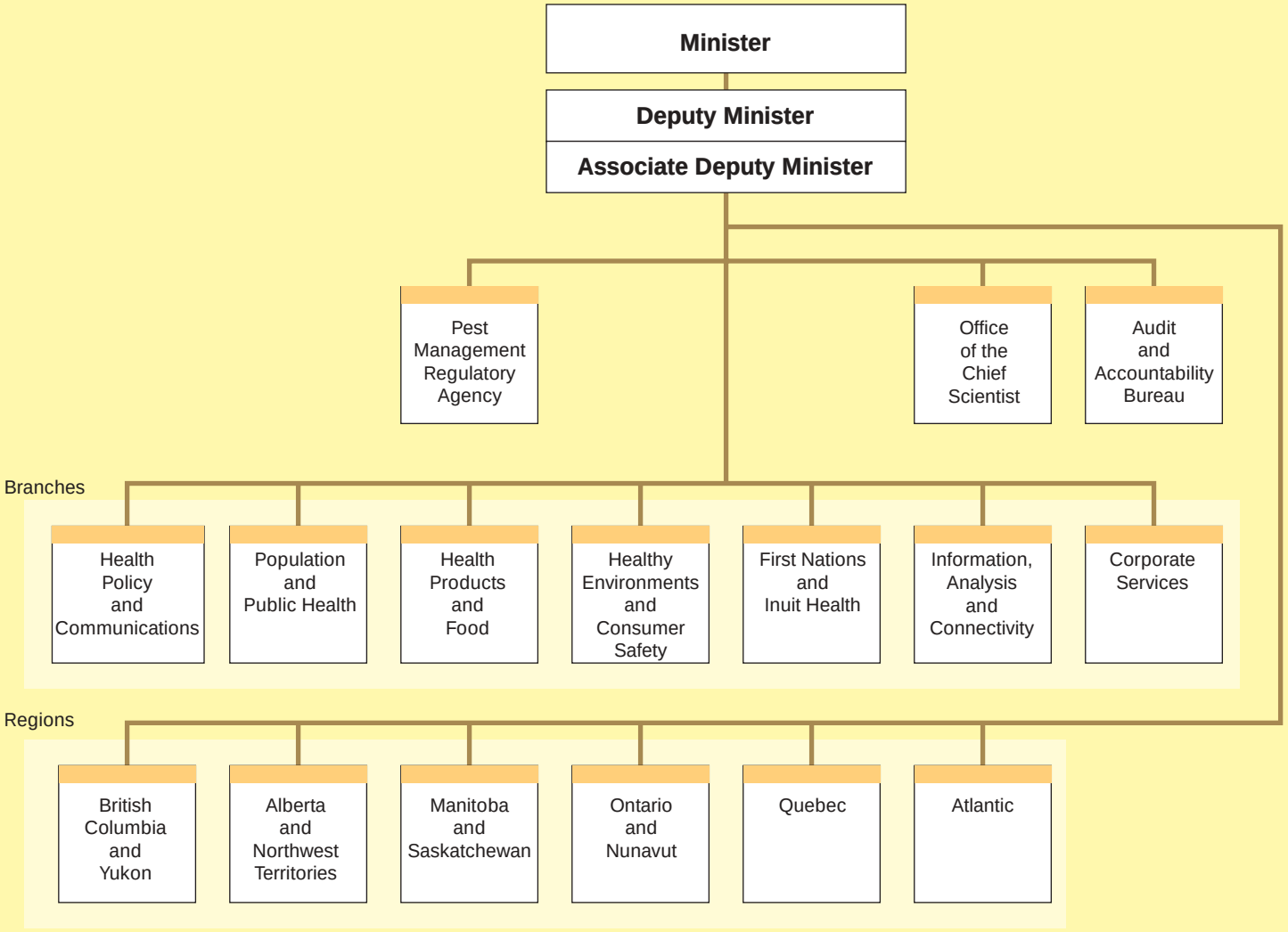
Flexibility for a Changing Environment

Health Canada is keenly aware of the forces that shape public health, with a number of factors constantly changing the environment:

- increased public preoccupation with health matters and the accompanying demands for quick access to services and information;
- shifting demographic patterns that put pressure on health care services;
- rapid scientific advances that create both health benefits and pressures;
- growing world migration, travel, and business patterns that create additional health challenges, and;
- a need for transparency in decision making and accountability.

In the face of this constant evolution, Health Canada remains flexible in its operations, its allocation of limited resources, and its response to these forces.

Health Canada Organization, 2001-2002



Strategic Outcomes at Health Canada: Accountability and Actual Spending, 2001-2002

Strategic Outcomes	Accountability (under the Deputy Minister and the Associate Deputy Minister)	2001-2002 Actual $ million Full-Time Equivalents
Access to quality health care services for Canadians	Assistant Deputy Minister (ADM), Health Policy and Communications Branch	$107.1 FTEs: 375
Improved well-being through health promotion and illness prevention	ADM, Population and Public Health Branch	$395.3 FTEs: 1,071
Safer health products and food for Canadians	ADM, Health Products and Food Branch	$128.2 FTEs: 1,472
Healthier environments and safer products for Canadians	ADM, Healthy Environments and Consumer Safety Branch	$194.5 FTEs: 1,076
Sustainable pest management and programs for Canadians	Executive Director, Pest Management Regulatory Agency	$25.0 FTEs: 332
Sustainable health services and programs for First Nations and Inuit communities so their people may attain a level of health comparable with that of other Canadians	ADM, First Nations and Inuit Health Branch	$1,339.1 FTEs: 1,555
Better health outcomes through information and communication technologies and evidence-based decision-making	ADM, Information, Analysis and Connectivity Branch	$281.3 FTEs: 690
Effective support for the delivery of Health Canada's programs	ADM, Corporate Services Branch Regional Directors General Executive Director General, Audit and Accountability Bureau Chief Scientist Executive Offices	$208.6 FTEs: 1,392
Total		**$2,679.1** **FTEs: 7,963**

Section III:

Departmental Performance by Strategic Outcome

This section of the Report highlights the Department's milestone accomplishments in achieving our Strategic Outcomes. As outcomes may take many years to be realized, where possible we have identified activities and outputs and attempted to link them to the final outcomes.

The Strategic Outcomes are based on Business/Service Line objectives and are aligned with our approved Planning, Reporting and Accountability Structure. A crosswalk between the Strategic Outcomes and the Department's Business/Service Lines can be found in Section V - Table 4 of the Financial Tables.

This year, we have incorporated as Appendix A: Measuring Health in Canada - more results relating to the Health Status of Canadians (see page 118). This Appendix provides information on the health status and health determinants of Canadians and highlights health outcomes as they relate to Health Canada.

More information on the Department and its activities can be found on our website at http://www.hc-sc.gc.ca.

Chart of Strategic Outcomes

This table of Strategic Outcomes reflects continuing efforts to articulate Health Canada's performance expectations and measurement techniques.

Strategic Outcomes*	Performance Expectations**
Access to quality health care services for Canadians	Publicly-funded hospital and physician services consistent with the principles of the *Canada Health Act (CHA)*. Initiatives and approaches that strengthen the Canadian health care system. Partnerships among federal, provincial and territorial governments, key stakeholders, Canadians and international organizations. International initiatives which support departmental priorities.
Improved well-being through health promotion and illness prevention	Public knowledge about the determinants of health and actions to take to maintain and improve health; access to tools to improve health; and enhanced community capacity to deal with individual and collective health issues. Foster collaborations that help Canadians maintain and improve their health. Preventative initiatives and practices that have enabled the reduction of illness, disability, injury and/or death. Improved surveillance capacity, emergency preparedness and response strategies.

* Strategic Outcomes are based on Business/Service Line objectives.
** Performance Expectations were identified as Sub-Key Results Commitments in the 2001-2002 RPP.

Chart of Strategic Outcomes (continued)

Strategic Outcomes*	Performance Expectations**
Safer health products and food for Canadians	Protection of Canadians against risk factors related to health products and food. Integrated management of health determinants and risks to health associated with health products and food. Canadians better informed to make decisions about their health through promotion of health behaviours and provision of information and tools.
Healthier environments and safer products for Canadians	Reduced risks to health and safety, and improved protection against harm associated with workplace and environmental hazards, consumer products (including cosmetics), radiation emitting devices, new chemical substances and products of biotechnology. Reduced health and safety risks associated with tobacco consumption and the abuse of drugs, alcohol, and other substances.
Sustainable pest management and programs for Canadians	Safe and effective pest control products. Compliance with the *Pest Control Products Act* and Regulations. Sustainable pest management practices that reduce reliance on the use of pesticides.

* Strategic Outcomes are based on Business/Service Line objectives.
** Performance Expectations were identified as Sub-Key Results Commitments in the 2001-2002 RPP.

Chart of Strategic Outcomes (continued)

Strategic Outcomes*	Performance Expectations**
Sustainable health services and programs for First Nations and Inuit communities so their people may attain a level of health comparable with that of other Canadians	Improvements in First Nations and Inuit peoples' health and a reduction in health inequalities between them and other Canadians. A First Nations and Inuit population that is informed and aware of the factors that affect health and what actions can be taken to improve health. Effective health care services available and accessible to First Nations and Inuit people that are integrated with provinces' and territories' health services. Improved management and accountability in partnership with First Nations and Inuit for health care services and the Non-Insured Health Benefits Program.
Better health outcomes through information and communication technologies and evidence-based decision-making	A well-functioning national health information infrastructure which respects privacy but shares information in support of decision-making and public accountability. Evidence-based (both data and analysis) health policy decision-making including a better understanding of the fundamental issues relating to health care. Accountability for, and effectiveness of, Health Canada's programs, policies and functions.

* Strategic Outcomes are based on Business/Service Line objectives.
** Performance Expectations were identified as Sub-Key Results Commitments in the 2001-2002 RPP.

Chart of Strategic Outcomes (continued)

Strategic Outcomes*	Performance Expectations**
Effective support for the delivery of Health Canada's programs	Continuous improvement in the provision of timely and quality corporate administrative services and in the promotion of sound management practices, including modern comptrollership. Integrated health research and continual improvements in bringing that research into decision-making.

* Strategic Outcomes are based on Business/Service Line objectives.
** Performance Expectations were identified as Sub-Key Results Commitments in the 2001-2002 RPP.

Access to Quality Health Care Services for Canadians

Health Care Policy

Health Canada's overarching vision for health care is to ensure the long-term sustainability of our system, which provides Canadians with comparable access to quality services based on their health needs, regardless of where they live or work. To help implement this vision, we have defined four key performance expectations:

- Publicly-funded hospital and physician services consistent with the principles of the *Canada Health Act (CHA)*.
- Initiatives and approaches that strengthen the Canadian health care system.

Objective

To provide a leadership role in collaboration with provinces/territories, health professionals, administrators and other key stakeholders, focussed on developing a shared vision for Canada's health system and identifying key priorities and implementation approaches to achieve needed changes that will improve the timeliness of access, and the quality and integration of health services (including primary, acute, home, community and long-term care) to better meet the health needs of Canadians wherever they live or whatever their financial circumstances.

Description

Health Care Policy supports policy development, analysis and communications related to leadership in all areas of Canada's health system, with emphasis on ensuring the viability and accessibility of Medicare; and collaborative efforts, with provinces/territories, and other stakeholders, to strengthen, modernise and sustain Canada's health system.

Actual Spending 2001-2002
(millions of dollars)

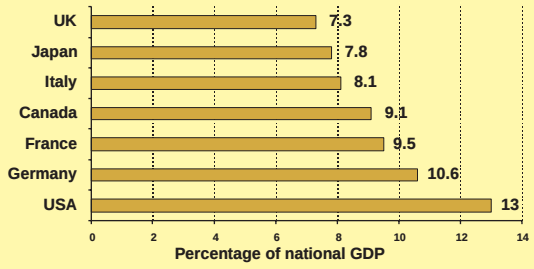
Gross	$107.1
Revenues	N/A
Net	$107.1

- Partnerships among federal, provincial and territorial governments, key stakeholders, Canadians and international organizations.
- International initiatives which support departmental priorities.

During this past year, our Department had three major priorities toward this objective:

- Modernization of our health care system.
- Uphold the *Canada Health Act* and work with the provinces and territories to ensure that all governments fulfill their commitment to the principles of Medicare.
- Improve knowledge base on health care system issues to support evidence-based decision-making.

Health Care Expenditures as Percentage of GDP, International Comparison, 2000



Source: Organization for Economic Co-Operation and Development

Modernization of our health care system

On April 4, 2001, the Prime Minister and the federal Minister of Health announced the creation of the Commission on the Future of Health Care in Canada. The Commission has been asked to recommend policies and measures to ensure, over the long-term, the sustainability of a universally accessible health care system which offers quality services to Canadians. The Commission's final report is expected in November 2002.

The work of the Commission builds on the common vision for health care that was reached in September 2000 by First Ministers when all jurisdictions agreed to work together to address key priorities to renew Canada's health care system. It is from this basis that Health Canada has engaged in much collaborative federal, provincial and territorial work during the 2001-2002 fiscal year to implement commitments made by First Ministers. Here are a few examples of progress made to date in implementing the vision.

Better Management of Pharmaceuticals

Because increasing drug costs are a shared concern, we worked with provinces and territories to improve the management of pharmaceuticals, including the development of a single, common drug review process to assess drugs for potential inclusion in government drug plans. As part of this, an interim shared drug review process was implemented in March 2002 and a National Prescription Drug Utilization Information System was developed that will provide accurate information on prescription drug use and sources of cost increases.

Improving Accountability for Health System Performance

We helped design, in collaboration with provinces and territories, a reporting framework that will provide consistent and comparable information across jurisdictions to Canadians

and decision-makers. This framework addresses health status, health outcomes and quality of services.

Addressing Health Human Resources Issues

We were active in work to address growing concerns over human resources issues facing various health professions. As a result, a three year study began to assess physician human resources issues. Similarly, we have been helping to implement the Nursing Strategy for Canada. These are both expected to help ensure that Canada has the health professionals needed for an effective health care system.

Health Canada is also playing a leadership role in encouraging key stakeholders to support easier integration of foreign trained physicians into the health care system.

Accelerating Primary Health Care Reform

The Government of Canada has committed $800 million over four years to accelerate and broaden health care reform initiatives focused on the first point-of-service for Canadians. During the year, the provincial/territorial guidelines for this Primary Health Care Transition Fund, which we administer, were completed and the provinces and territories began to submit proposals for funding.

Uphold the *Canada Health Act* and work with the provinces and territories to ensure that all governments fulfill their commitment to the principles of Medicare

Health Canada continues its efforts to ensure that all eligible residents of Canada have reasonable access to medically necessary hospital and physician services on uniform terms and conditions. We are responsible for ongoing work related to administration of the *Canada Health Act* (*CHA*), including the analysis and resolution of compliance issues with provinces and territories.

To make this process work as collaboratively as possible, the federal Minister of Health gained the agreement of the provinces and territories (with the exception of Quebec) on a new *CHA* dispute avoidance and resolution process. This will help address issues related to differences in interpretation of the Act.

Increased use of private payment options for high-technology diagnostic services such as Magnetic Resonance Imaging (MRI) and Computed Tomography (CT) are creating accessibility and availability concerns. Ongoing collaboration with the provinces and territories on this priority issue has helped strengthen the ability of jurisdictions to deliver these services in a fiscally and socially responsible manner, and in a manner that is consistent with Canadians' values and expectations of appropriate and timely

access to publicly-funded health care services.

Improve knowledge base on health care system issues to support evidence-based decision-making

Health Canada participates in various analytical initiatives and projects to track, understand and provide evidence-based policy advice on current and emerging issues that relate to health care. Our Department also continues to generate and disseminate evidence on new approaches to health care delivery. Here are a few examples of how Health Canada supports evidence-based decision-making in health care policy:

- For a health professional, promoting self-care is an effective way of helping patients participate in decisions about their own and their communities' health. To support health professionals in their efforts to promote self-care, Health Canada has funded and worked in collaboration with national health organizations to implement the program *Supporting Self-Care: A Shared Initiative*. The collaborative report of this initiative was published by the Canadian Nurses Association in the spring of 2002. We also developed a network for the purpose of facilitating information sharing, support and connections among health professionals and interested users. The components of this network include an electronic directory, a discussion mailing list, a quarterly newsletter and a website.
- Health Canada undertook various studies in collaboration with nursing associations, provinces and territories to better understand the challenges facing the nursing profession and the related impacts on the quality of services received by patients. A compelling body of evidence is suggesting that more nurses, and more satisfied nurses, are associated with healthier and more satisfied patients.
- From 1997 to 2001, our Department's $150 million Health Transition Fund (HTF) supported projects across Canada to test and evaluate innovative ways to deliver health care services. A total of 138 projects have been successfully completed and several have paved the way to effective improvements in service delivery. Syntheses of the projects were prepared across 10 themes. The HTF's national dissemination strategy included support to individual projects to disseminate results to target audiences and five regional workshops in the spring of 2001. For more information, consult: http://www.hc-sc.gc.ca/htf-fass/english/.
- As part of its ongoing departmental business activities, Health Canada facilitated increased capacity of women's organizations and local, provincial and national stakeholders in support of the holistic and disease-specific approach to women's health. Through the Women's Health Contribution Program, our Department supported a National Think Tank on Gender and Unpaid Caregiving, informing gender im-

plications of home and community care. In addition, several projects were undertaken through the Centers of Excellence for Women's Health and the Canadian Women's Health Network, including research and consultation resulting in new regional guidelines for mental health service intake of women who are victims of domestic abuse and the establishment of a new Aboriginal Women's Health Network.

- In November 2001, Health Canada hosted a major Organization for Economic Cooperation and Development (OECD) conference, which was attended by 450 participants from 30 countries. The conference offered participants the chance to learn about best practices in health system performance measurement and to share experiences about how citizens, providers, governments and managers can best use performance measures to improve health systems within the OECD.

Improved Well-Being Through Health Promotion and Illness Prevention

Population and Public Health

Healthy, active, engaged citizens build strong, vibrant communities. The Government of Canada recognizes the importance of helping Canadians maintain and improve their health through the many health promotion and illness prevention activities accomplished under Health Canada's leadership.

Objective

Promote health, and prevent and control injury and disease.

Description

Population and Public Health includes responsibility for policies, programs and research relating to disease surveillance, prevention and control, health promotion, and community action.

Actual Spending 2001-2002
(millions of dollars)

Gross	$395.4
Revenues	$(0.1)
Net	$395.3

The Department seeks to understand what makes people healthy or sick and, based on this knowledge, develops interventions that improve the health status of individuals, particular groups and the population as a whole. Through our research and our interventions, we know that five factors influence health: genetic, biophysical, socio-economic and behavioural, in addition to the quality and accessibility of the health care system.

The Department achieves its health promotion and protection objectives through leadership and partnerships in health promotion, protection and illness prevention and control, by creating and disseminating knowledge based on sound science, research and surveillance data and by funding community health projects. Through our work with provinces and territories, we also translate our public health knowledge into practices and actions aimed at safeguarding the health of Canadians.

To achieve its objectives, the Department defined four key performance expectations for 2001-2002:

- Public knowledge about the determinants of health and actions to take to maintain and improve health; access to tools to improve their health; and enhanced community capacity to deal with individual and collective health issues.
- Foster collaborations that help Canadians maintain and improve their health.
- Preventative initiatives and practices that have enabled a reduction of illness, disability, injury and/or death.
- Improved health surveillance, emergency preparedness and response strategies.

The health policies of the federal government recognize that an overall health strategy builds on both a quality and accessible health care system and interventions that address the factors that help determine the health of Canadians. During this past year, our Department had four major priorities toward this objective:

- Protect Canadians against the health implications of disasters.
- Promote healthy living.
- Prevent illness.
- Protect the health of Canadians through surveillance and laboratory research.

Protect Canadians against the health implications of disasters

Protecting Canadians from the health hazards of natural and man-made disasters is a key responsibility of the Department. This capacity was tested to its fullest on September 11, 2001 when we immediately mobilized to provide public health assistance, most notably, to more than 47,000 people whose flights to the United States were diverted to Canada and to other stranded passengers. And in the weeks following the discovery, in the United States, of letters contaminated with anthrax, Health Canada collected and analyzed hundreds of suspicious packages.

In the months since, contingency plans have been renewed and will continue to be revitalized to adapt to rapid changes in the public health security environment.

As part of the overall government response to the new security situation, $7.94 million was allocated to the National Emergency Stockpile System to expand Canada's existing pharmaceuticals stockpile to treat victims of infectious disease outbreaks, chemical attacks and exposure to chemical agents. This complements the stockpile of supplies available to treat trauma-related injuries.

We also accelerated staffing, budgetary and business planning activities within our Centre for Emergency Response and Preparedness to ensure that the necessary resources would be in place to operate effectively in this new environment. Consistent with these investments, we introduced a mobile first-response laboratory which can be quickly deployed in the field. Because it is a Level 4 laboratory, it has the capacity and security to deal with possible cases involving the world's most dangerous chemical and biologic agents.

Promote healthy living

Encouraging Healthier Children

Early childhood development is critical to the health of our communities. For example, through investments of $59.5 million in the Community Action Program for Children (CAPC) and $30.8 million in the Canada Prenatal Nutrition Program (CPNP), mothers', children and families' well-being are enhanced through the transfer of good parenting skills, early childhood intervention and community programs.

Evaluations of the benefits of CAPC and CPNP programs demonstrate that these programs are successful in reaching people living in disadvantaged conditions. Regional CAPC evaluation findings indicate that parents involved in caregiver and child-focused programs report improvements in their children's social behaviour. Data collected from CPNP participants between 1996 and 2001 reveals a low birth weight rate of 6.9 percent. While higher than the national rate of 5.9 percent, it is lower than rates for similar at-risk populations (8.7 to 20 percent). Breast-feeding initiation rates among CPNP participants were 78.5 percent, exceeding the national rate of 76.7 percent.

In partnership with the provinces and territories, the Department is developing a shared reporting framework for Early Childhood Development expenditures and activities, and identifying common child health and well-being indicators, such as immunization and healthy birth weight as a gauge of physical health. Starting in September 2002, the information generated by these tools will help inform program and policy decisions across all levels of governments.

Fetal Alcohol Syndrome/Fetal Alcohol Effects

(FAS/FAE) is 100% preventable. Significant health and social services costs are saved every time a FAS birth is prevented through the work of community-based programming funded by Health Canada. Through regional initiatives, we are supplementing CAPC and CPNP projects to incorporate FAS/FAE components. For example, through telehealth distance learning technology, 180 front line community-based workers in Manitoba and Saskatchewan were provided with skill development training to assist in early detection and appropriate intervention with pregnant women who may be at risk. For more information on FAS/FAE, please consult: http://www.hc-sc.gc.ca/hppb/childhood-youth/cyfh/fas/.

Further guidance for policies and programs regarding children is being developed by the five Centres of Excellence for Children's Well-Being. Through a five year, $20 million commitment from the Government of Canada, the Centres are creating and disseminating knowledge concerning child welfare, communities, early childhood development, special needs, and youth engagement issues.

We have learned from our experiences with campaigns promoting healthy living practices. For example, we encourage women of childbearing age to take folic acid supplementation to prevent spina bifida and other

neural tube defects in their children. Because of the low impact of previous campaigns that targeted health professionals, we shifted to directing the information at women of childbearing age. In this manner, women take an active role in speaking to their health professionals about folic acid supplementation. For more information on this campaign, consult: http://www.hc-sc.gc.ca/english/folicacid/index.html.

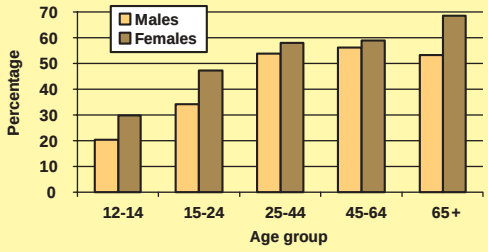
Promote Healthy Aging

A November 2001 workshop on Healthy Aging provided experts and stakeholder groups with an opportunity to highlight strategic directions for Health Canada regarding key issues contributing to healthy aging. Four issues papers were developed: (1) physical activity and elders; (2) tobacco use and smoking cessation among seniors; (3) nutrition and healthy aging; (4) prevention of unintentional injuries among seniors. We are reviewing these four documents to help determine future federal action regarding the health of seniors. For more information on seniors' health issues, consult: http://www.hc-sc.gc.ca/english/for_you/seniors.html.

More Integrated Approaches to Healthy Living

Between 1981 and 1996, the prevalence of overweight doubled and obesity tripled for both boys and girls. Research has shown that more than half of Canadian children are not active enough for optimal growth and development. In 2000-2001, an average of 40 percent of females and 33 percent of males aged 12-24 indicated they lead inactive lifestyles.

Physical Inactivity, by Age and Sex, Canada, 2000/01



Source: Canadian Community Health Survey, 2000/01

In light of the proven health benefits, and consistent with our long-standing support for increased physical activity, we published the first ever national guidelines for young people – *Canada's Physical Activity Guide for Children and Youth* (http://www.hc-sc.gc.ca/hppb/paguide/youth.html) and a guide encouraging workplaces to support physical activity–*Active Living at Work* (http://www.hc-sc.gc.ca/hppb/fitness/work/).

As physical inactivity and unhealthy weights are risk factors for many health-related ailments, we continue to integrate physical activity into our broader health strategies. For example, 85 percent of the 96 Canadian Diabetes Strategy community-based projects funded to date promote physical activity because this can reduce the incidence of diabetes.

Strengthening the Health of our Communities

The January 2001 Speech from the Throne highlighted the importance of community-based health promotion and disease prevention measures. This builds on our ongoing role in the regions to mobilize partnerships with other levels of government, stakeholders and citizens towards common objectives. For example, the Department continues to work with its partners to help people living with hepatitis C and breast cancer, to further our knowledge on mental health and to disseminate information on family violence.

The two-year **Mobilizing a Population Health Approach** evaluation which analyzed a case study in each of Health Canada's six regions has provided valuable new knowledge on how the Department can lead and partner in diverse ways according to situational requirements when it works with other sectors and organizations around various determinants of health. For more information, consult:

http://www.hc-sc.gc.ca/hppb/phdd/case_studies/index.html.

To meet commitments outlined in the 1999 and 2001 Speeches from the Throne, the Government of Canada launched the Voluntary Sector Initiative (VSI) to strengthen the voluntary sector's capacity to meet the challenges of the future and its ability to serve Canadians and enhance its relationship with the federal government.

As a key department in VSI, we are investing $6.1 million for projects enhancing the voluntary health sector's capacity to contribute to Health Canada's policy development in Aboriginal health, seniors and housing, mental health, chronic disease prevention and multiculturalism.

Rural and Remote Health

Through an $11 million grants and contributions program, the Department is addressing the health concerns of Canadians living in rural, remote and northern areas of the country. The program was designed to promote the integration and accessibility of health services in rural and remote areas and to explore ways to address health work force issues. The program was developed in close collaboration with the provinces and territories. An evaluation of this program is scheduled to be completed in 2002.

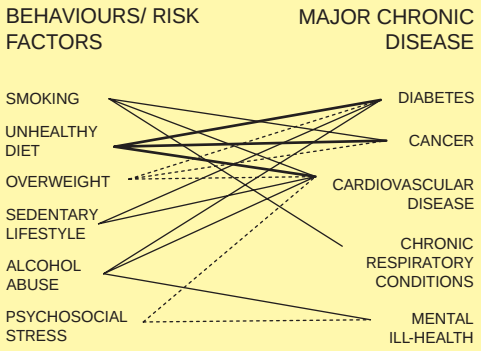
Prevent illness

Building Innovative Responses to Chronic Diseases

More than half of Canadians live with chronic disease which puts strain on individuals, families, and the health care system.

The Department is increasingly recognizing and promoting the advantages of better integration of prevention and promotion efforts to address risk factors that are common to many chronic diseases (tobacco, unhealthy eating and physical inactivity). Integration will capitalize on existing investments in disease-specific approaches and move us towards the

Commonality of Risk Factors and Chronic Diseases



critical mass of preventative effort required to improve health outcomes.

Avenues for disease interventions are also being discovered through our surveillance activities, which can identify disease patterns and provide new insights into risk factors. For example, our research has demonstrated that physical activity helps to protect against cognitive impairment and dementia. The Alzheimer's Society of Canada has incorporated this knowledge in its information/dissemination strategies.

Canadian Diabetes Strategy (CDS)

Early results of the process evaluation of the prevention and promotion projects under the CDS demonstrate the elements of successful community-based programming such as evidence-based approaches and community participation. Further evaluations to measure the impact of these projects will follow. For more information, please consult: http://www.hc-sc.gc.ca/hppb/ahi/diabetes/english/index.html.

The 15-year Canadian Heart Health Initiative is a population health approach to implementing a policy on heart health at the national, provincial and community levels. The recent process evaluation of the Initiative is supporting the implementation of heart health programming across the country. Other evaluative work has identified clear directions for future policy and research to further enhance heart health promotion such as the need to pool and share best practices for cardiovascular disease prevention.

Tracking and Responding to Infectious Disease Threats

In collaboration with international organizations, provinces and territories, we have an important role in tracking the progression of infectious diseases across Canada and internationally, as these represent significant health risks if they cannot be quickly identified and addressed.

We have coordinated Canada's pandemic influenza contingency planning efforts. Our new agreement with the provinces and territories ensures the security of supply of a pandemic influenza vaccine and will lead to an improved capacity to respond to the next pandemic.

With the growing threats of emerging diseases, the health surveillance system ensures that information rapidly reaches people who protect the health of Canadians. We paid particular attention to West Nile virus (WNv), which was first identified in Canada in 2001 in birds in southern Ontario. While most people infected with WNv show no or only mild flu-like symptoms, people with weaker immune

systems are at greater risk as they can develop severe illnesses (meningitis or encephalitis). In collaboration with other federal and provincial partners and stakeholders we led the development of a WNv plan. The result is that confirmed cases of WNv in birds trigger local level public health actions to protect the population from infection.

The Canadian Strategy on HIV/AIDS (CSHA) provides $10 million per year in funding to community groups and national non-government organizations and $4.75 million to fund community-based care, treatment and support programs. In 2001-2002, Health Canada focused on improving the management, planning, accountability and communications aspects of this work. For example, the CSHA Annual Report was expanded to include stakeholder perspectives and thereby provide a more comprehensive picture of HIV/AIDS in Canada and the response of both governmental and non-governmental actors to the epidemic.

Protect the health of Canadians through surveillance and laboratory research

Health surveillance can be defined as the tracking and forecasting of any health event or health determinant through the continuous collection of health data. The integration, analysis and interpretation of this data are then collated into surveillance products, which can be disseminated to those who need them.

The establishment of strong, sustainable national surveillance networks depends on the full participation of data collectors. Through its leadership in health surveillance, the Department is working with provincial and territorial partners to ensure that surveillance networks are compatible across the country. The Department recognizes the need for full provincial and territorial participation if the surveillance networks it manages are to provide health professionals, scientists and policy officers the data they need to safeguard Canadians' health.

The **Geographic Information System (GIS)** demonstrates the benefits of health surveillance through the conversion of population health data gathered by surveillance activities into graphic representations (maps, charts, graphs). Public health officials can use this type of information in their work to improve population health and reduce the risk of disease outbreaks or negative environmental impact.

Laboratory research carried out by the Department is also contributing to building the evidence base that guides policy and program development. Research is ongoing into infectious diseases transmitted through blood, food and water and the resistance of these infections to antibiotics. For example, Health Canada's research to track the development of drug-resistant HIV strains has improved our understanding of the persistence of drug-resistant mutations in individuals infected with HIV. This information will be useful in the development of more effective treatments.

Important research is also being conducted into the transference of disease-causing agents from animals to humans, through the food chain or the environment. Through this type of research, the Department can identify risks and propose corrective measures (e.g. new regulations, guidelines) to prevent such incidents.

As a partner in the **Oldman River Basin Water Quality Initiative** the Department has been looking at the risks to health associated with human/animal interface and water consumption in an area of high cattle density (namely the prevalence of *E. coli* O157:H7 and *Salmonella* in water).

Population and Public Health Branch

http://www.hc-sc.gc.ca/pphb-dgspsp/new_e.html

Safer Health Products and Food for Canadians

Health Products and Food

The safety and efficacy of health products and food is of considerable interest to Canadians, and is seen as a critical component in accomplishing the government-wide objective of a healthier population. Health Canada's contribution to achieving this objective is through its responsibility for the regulations, policies, standards and programs relating to the safety of health products and food.

The three key performance expectations involved in this work are:

Objective

The safety of food, and the safety and efficacy of drugs, natural health products, medical devices, biologics and related biotechnology products in the Canadian marketplace and health system, through the development and implementation of policies, legislation and regulatory frameworks, the promotion of good nutrition and the informed use of drugs, medical devices, food and natural health products.

Actual Spending 2001-2002
(millions of dollars)

Gross	$163.7
Revenues	$(35.5)
Net	$128.2

Description

Health Products and Food is responsible for the policies, standards and programs relating to:

- the safety and nutritional quality of food, the safety and efficacy of drugs, medical devices, natural health products, biologics and related biotechnology products in the Canadian marketplace and health system;
- the promotion of good nutrition and the informed use of pharmaceuticals, medical devices, biologics, food and natural health products.

- Protection of Canadians against risk factors related to health products and food.
- Integrated management of health determinants and risks to health associated with health products and food.
- Canadians better informed to make decisions about their health through promotion of health behaviours and provision of information and tools.

Highlights of significant accomplishments:

Canadians have high expectations with respect to their ability to access safe and effective health products and food. In order to continue to effectively carry out our mandate to deliver on that expectation, Health Canada has placed a major emphasis on continuously improving the knowledge base and processes we use to make health products and foods safer and to promote health.

For example, we have established a focus on post-approval and assessment of marketed health products to enhance our ability to monitor risks and benefits of products once they are on the market. As well, we have obtained the International Standards Organization (ISO) accreditation for our Inspectorate Laboratory Program, which provides chemical, physical and microbiological analytical support to inspection, investigation and surveillance activities of the Inspectorate. The ISO accreditation is a recognition of the Laboratory's high standard and quality of work and services to Canadians.

Risk factors related to health products and food

To minimize risk factors, existing processes have been improved and new processes have been put in place. In the accomplishments below, we have acknowledged, where appropriate, partnerships with our stakeholders, other government departments, international organizations, the United States, European Union and Canadian public.

Working to Provide Timely Access to High Quality Health Products

Canada is recognized internationally as providing consistently high quality health products including drugs and medical devices to its citizens and we continue to seek out new and improved ways of meeting these high standards. We have, therefore, placed considerable emphasis on improvements to both our submission review and decision-making processes.

As a result, during the past year, the Department processed over 7,600 submissions to assess the safety of biological and pharmaceutical products, an increase of 18.5 percent over the past two years.

The effectiveness of our national compliance and enforcement program has been strengthened by employing the consistent and disciplined approach embodied in Health Canada's Decision-Making Framework, risk management principles and by employing the best science available.

Significant progress has been made in carrying out an inspection function for clinical trials to comply with new regulations. As a result we processed about 20 percent more clinical trials

(from 800 in 1999 to 950 in 2001). The trials included sponsors, researchers, patient groups, associations and others.

Resources have been invested to develop and implement surveillance mechanisms to gather much-needed data and to track antibiotic resistance and antibiotic use in order to control the spread of resistant bacteria from animals to humans.

Surveillance, policy and science disciplines were brought together to develop the most appropriate strategic action to control and mitigate the threat to health of the growth and proliferation of undesirable microorganisms and of antibiotic resistance in humans.

We made progress on backlogs: an 80 percent reduction in the backlog for short-term submissions in the Clinical Evaluation Division; elimination of the backlog on corporate name changes on New Drug Submissions (NDS); a 40 percent reduction in the manufacturing review backlog of NDSs; and a 70 percent reduction on Experimental Studies Certificates.

Negotiations were conducted pertaining to the implementation of Mutual Recognition Agreements between Canada and Switzerland for Drug Good Manufacturing Practices. We are finalizing confidence building exercises with the European Union and Australia. The Mutual Recognition Agreement approach is an effective way to ensure the participation of Health Canada in enhancing international regulatory cooperation and maintaining high standards of product safety and quality, while facilitating the reduction of the regulatory burden for industries.

Improve integrated management of risks and benefits to health

Developing New Safety Regulations

New regulations, which included a definition of Good Clinical Practices, went into effect to improve the approach to clinical trials. Our efforts to build science capacity in this area have been significant, with an increase in the number of staff from 130 to 180. We have also reduced the time for decisions on acceptance for clinical trials from the 60 day default to 30 days, thereby improving timely access to clinical trials for experimental drugs.

Development has begun on regulations for natural health products that are distinct from, but consistent with, the Food and Drug Regulations to provide Canadians with increased access to safe and effective natural health products, with enhanced information on their use, while respecting freedom of choice and philosophical and cultural diversity.

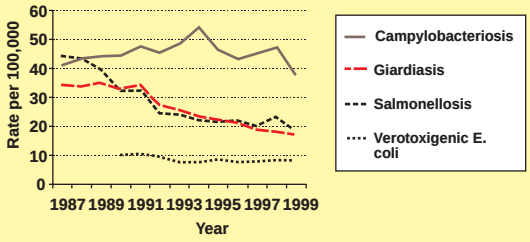
Work began on the development of regulatory amendments for nutrition labelling of prepackaged foods to ensure the nutrition content and health claims are accurate. This will facilitate the ability of Canadians to select healthy diets and thus reduce the risk of illness and premature death due to diet-related chronic diseases.

Reducing Risks related to Foods

A number of activities were undertaken to effectively reduce levels of food-borne illnesses in Canada. As the

chart below shows, we have had continued success and the incidence of food-borne illness is decreasing over the years.

Incidence of Food-Borne Illness, Canada, 1987-1999



Source: Population and Public Health Branch, Health Canada

Increasing consumer awareness of microbial hazards

To reduce food-borne illnesses, (the majority of about 30,000 cases reported in Canada yearly are due to the microbial contamination of raw foods of animal origin), we have distributed: 250,000 refrigerator magnets with food safety messages to retail outlets selling ground beef across Canada; about 5 million newspaper supplements carrying Health Canada's food safety messages to homes advising on the need to cook hamburgers to an internal temperature of 71^0 Celsius.

We have initiated an ongoing evaluation of industry submissions to apply food irradiation to certain foods (mangoes, shrimp, poultry, and ground beef) to ensure that proposed irradiation processes for food are effective and safe. Currently, the only foods permitted to be irradiated and sold in Canada are: wheat, flour, whole wheat flour, potatoes, onions, whole and ground spices and dehydrated seasoning preparations.

A strategy to reduce the risk of contamination of unpasteurized juice and cider by harmful microorganisms such as *E.coli* 0157:H7 and *Salmonella* was developed and implemented. Working in partnership with the Canadian Food Inspection Agency (CFIA), we have launched an ongoing education campaign by distributing pamphlets to Canadian daycares and seniors centres, elementary schools and school boards. Health Canada continues to work with CFIA to collect data in readiness for the performance evaluation of the policy.

An action plan was developed to further refine the approach to safety assessment of foods derived from biotechnology to address Canadians' concern over the safety of genetically modified foods. At the same time, we are working closely with the Canadian General Standards Board to develop standards for industry to voluntarily label foods derived from biotechnology. This is expected to provide Canadians more information on which foods have been genetically modified (GM) or have GM ingredients in them.

Building an Excellent Science Capacity

Our science capacity has been increased enabling us do a better job as demonstrated in the following examples.

- Strategies to understand the scientific and industrial trends in health

related biotechnologies were developed, as well as new expertise in evaluating and regulating new biotechnology products such as therapeutics, recombinant vaccines, microbial pesticides, human and animal pathogen diagnostics, and safety of genetically modified foods.

- We began to manage three streams of federal funds allocated to the Genomics Research and Development Fund ($10 million for 1999-2002); Biotechnology Regulatory Fund ($46.5 million for 2000-2003); and the Canadian Biotechnology Strategy Fund ($1.6 million for 1999-2002). These programs have resulted in the enhanced scientific knowledge required for the Department's regulatory mandate and have allowed us to increase the transparency of our regulatory activities and the international harmonization of our standards for human foods and animal feeds.
- Surveillance of marketed health products was improved and staff was increased from 33 to 55, with a particular focus on building capacity for scientific evaluator positions.

Enable Canadians to make healthy choices and informed decisions about their health

Many aspects of our communications have been enhanced to enable Canadians to make healthy choices and informed decisions about their health.

Promoting the Nutritional Health and Well-being of Canadians

We supported nutrition and healthy eating in Canada through a combination of initiatives.

- A Network on Healthy Eating was established to enhance collaboration and alignment of efforts; key messages were developed to support the nutrition labelling education initiative.
- An Expert Working Group was established to advise Health Canada on the development of updated Healthy Weight Guidelines to be used by health professionals to monitor health risks associated with weight in populations and provide Canadians with a screening tool to relate their weight to their health status.

Enhancing Communications with Canadians and Increased Public Participation in our Decision-Making Process

Information was provided on compliance and enforcement, and, on an ongoing basis, warnings, safety alerts, news releases, product recalls, and other notices from industry were

Improved Adverse Drug Reaction Reporting

We have introduced new health professional and consumer toll-free telephone and fax numbers to report adverse drug reactions (ADRs). Calls are automatically routed to the appropriate regional ADR centre.

issued as a service to health professionals, consumers, and other interested parties. In addition, we created a new web posting "Advisories for Health Professionals or Consumers".

A series of public information and consultation sessions on food irradiation was conducted in several Canadian centres to provide consumers with appropriate information and educational materials to make informed choices.

Canadians and our stakeholders, about 260 groups in seven cities across Canada, were consulted to obtain their input on: i) future priority areas for the food safety and nutrition needs of Canadians ii) the proposed regulatory amendments on nutrition labelling of prepackaged foods.

Health Canada's Science and Technology Highlights: *Investing in Excellence, 1996-2001, a Report on Federal Science and Technology* was published to provide Canadians with information on the role of science and technology in Canada's Innovation Strategy and economic growth.

Challenges to our 2001 performance

Challenges to our performance over the last three years have revolved around recruitment, building infrastructure to support program objectives, building knowledge and expertise, developing information products, and knowledge management.

As a science-based organization, we continually need to increase our scientific expertise and knowledge base. For example, we need scientific evaluators in order to meet our mandate and to ensure we provide effective and efficient services in our programs. To address this challenge we initiated staff training and a development program to enhance quality management objectives. This has increased the expertise and knowledge base required to provide essential quality services to Canadians.

We continue to experience new challenges such as the need to keep up with the rapid pace of new technology and the continued exponential increases in science and technology developments. For example, a 500 fold increase is expected in the number of new health and biotechnology products on the market in the next 10 years.

Next steps

We anticipate the completion by December 2002 of work on national standards in the area of biologics and genetic therapies, specifically, new standards-based regulatory frameworks for cells, tissues, and organs, including reproductive tissues.

Regulations on nutrition labelling are expected to be published in the fall of 2002.

It is also anticipated that the regulations on natural health products will go to *Canada Gazette*, Part II by the end of December 2002 and come into force shortly after.

By the end of 2002-2003, Health Canada intends to have information on its website that details the many steps and factors considered in the biotechnology products approval process.

Health Products and Food Branch

http://www.hc-sc.gc.ca/hpfb-dgpsa

Healthier Environments and Safer Products for Canadians

Healthy Environments and Consumer Safety

The Government of Canada and Health Canada recognize the importance of promoting healthy behaviours, developing and applying harm reduction and prevention methods, and

Objective

Promote healthy living, working and recreational environments, and ensure the safety and efficacy of producer and consumer products in the Canadian marketplace.

Description

- promotes healthy and safe living, working and recreational environments;
- assesses and reduces health risks posed by environmental factors;
- regulates the safety of commercial and consumer chemicals and products, and promotes their safe use;
- regulates tobacco and controlled substances and promotes initiatives that reduce or prevent the harm associated with these substances and alcohol;
- provides expert advice and drug analysis services to law enforcement agencies across the country;
- establishes workplace health and safety policies and provides services to protect the health of the public sector, the travelling public and dignitaries visiting Canada;
- is responsible for public health measures designed to prevent the entry and spread of communicable diseases in Canada;
- is responsible for coordinating the implementation and monitoring of Health Canada's Sustainable Development Strategy.

Actual Spending 2001-2002
(millions of dollars)

Gross	$201.9
Revenues	$(7.4)
Net	$194.5

enforcing health protection legislation and regulations. To achieve this objective, two key performance expectations were identified:

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

The planned results from the *2001-2002 Report on Plans and Priorities* are expressed in the following high-level priorities:

- Enhancing health, safety, and well-being through evidence-based research.
- Improving health through collaboration and coordination activities.
- Supporting informed decision-making through awareness activities.

Highlights

The key results arising from five distinct programmes (Drug Strategy and Controlled Substances, Product Safety, Safe Environments, Tobacco Control, and Workplace Health and Public Safety) established to address the objective are described below. Important contributions were made towards the improvement of the health, safety and well-being of Canadians through risk reduction activities in response to legislated mandates and identified needs.

Enhance health, safety and well-being through evidence-based research

Sharing Best Practices

Best practice studies on smoking prevention and cessation targeting youth, pregnant and post-partum women (http://www.gosmokefree.ca) were conducted, and national training sessions for enforcement personnel to improve the application of legislation and regulations were undertaken to reduce health risks associated with smoking. Through joint efforts with our partners across the country, a smoking prevalence of 22 percent among those aged 15 years and over was achieved, down two percent from the previous year. (Source: Canadian Tobacco Use Monitoring Survey, Statistics Canada).

Health Canada also developed and circulated best practices concerning the prevention of substance abuse through the identification of innovations and provision of evidence-based research to more than 54,000 front line health and social services providers in response to needs identified by the provinces and territories. These practices contribute to the prevention of substance abuse among young people (http://www.hc-sc.gc.ca/hppb/cds-sca/cds/pdf/substanceyoungpeople.pdf) and concurrent mental health and substance use disorders (http://www.hc-sc.gc.ca/hppb/cds-sca/cds/pdf/concurrentbestpractice.pdf). The report entitled *Reducing the Harm Associated with Injection Drug Use in Canada* (http://www.hc-sc.gc.ca/hppb/cds-sca/cds/pdf/injectiondrug_e.pdf) indicated the seriousness of injection drug use as a public

health and social problem in Canada. Feedback received from related workshops on these issues has been very positive, indicating the importance of the best practices in these communities.

Red Book III -

"A healthy population is the foundation of a smart country."

Reducing Radiation and Environmental Risks

In addition to regulatory audits of inspection programs (e.g. X-ray equipment at airports), radiation safety courses, and the development of Safety Codes (e.g. for small radiological facilities), we targeted our resources towards inspections of ultrasound therapy devices from manufacturers and evaluated over 30 new radiation emitting devices for compliance with the *Radiation Emitting Devices Act* because of the potential hazards associated with these devices. We developed guidelines on machinery noise measurement to educate Canadians on the prevention of hearing loss and published updated *Guidelines for the Safe Use of Diagnostic Ultrasound Devices*.

Health Canada's participation in a global network to detect radiation releases worldwide provided data to enable accurate health assessments and risk reduction for the protection of Canadians. Additionally, we offered a quality assurance program to over 200 Canadian employers concerning radiation reduction in hospitals and other workplaces. As well, the collection of more than 600,000 new records from Canadian workers enabled monitoring and risk assessments of the effects of radiation on human health. Risk assessments to determine the relationship between radiation (including noise) and cardiovascular diseases produced a better understanding of public health issues and the preventative measures required to minimize these risks.

In response to increasing demands, Health Canada processed 155 project notifications from other federal departments and undertook environmental assessments for 20 of its own projects pursuant to the *Canadian Environmental Assessment Act* (*CEAA*). Advice was provided to mitigate health concerns and potential adverse health effects of physical, chemical, biological, and radiological agents, prior to implementation of these development projects (such as nuclear waste management, hydro-electric, and mining).

In fulfilment of the commitment made in the 2001 Speech from the Throne, Health Canada devoted more resources towards increasing its knowledge of the effects of toxic and environmental substances on human health. We collaborated with the private sector and academia to complete 99 research projects to enhance the understanding of risks posed by these substances. Some pollutants, metals in the environment, chemicals, and urban air quality can alter or disrupt hormonal or endocrine systems (e.g. birth defects, thyroid cancer) . Exposure to airborne pollutants has been linked to a variety of respiratory and cardiac health effects. As such, this research will enhance our ability to better understand risks posed by toxins and to manage toxic substances.

Improve health through collaboration and coordination activities

Access and Availability

Health Canada issued 3,977 import/export permits to allow legitimate trade in controlled drugs and substances for medical and scientific purposes. This is a 38 percent increase from the previous year due to additions to the list of controlled drugs in September 2000. Shipments are validated by the Canada Customs and Revenue Agency for compliance with the *Controlled Drugs and Substances Act.*

Health Canada issued 1,392 exemptions to the *Controlled Drugs and Substances Act* to enable access to controlled drugs. This allows researchers to advance scientific knowledge, and physicians to prescribe controlled drugs (such as methadone and medical marijuana). Health Canada also provided access to medical marijuana to 255 seriously ill patients for the alleviation of certain conditions.

Enhancing Health, Safety, and Health Security

In partnership with the provinces, territories and municipal governments, Health Canada revised recreational and drinking water guidelines, published research results concerning water disinfectants and methods of dealing with parasites, and reviewed health impacts arising from chlorination disinfection by-products. At the request of the governments of Ontario and Saskatchewan, Health Canada assisted in the Walkerton and North Battleford epidemiological investigations. Subsequently, all jurisdictions in Canada have examined their drinking water regulations, guidelines and policies. Activities of this nature enable actions to be taken to decrease the prevalence of contaminants and by-products, thereby reducing the incidence of illness.

Guidelines and voluntary compliance programs for the inspection of food, water and sanitation services aboard various modes of transportation (e.g. airplanes, trains, and cruise ships) are the product of partnership activities with industry, the United States, and the World Health Organization. The resulting health outcomes include reduced passenger illness, higher sanitation practices, and increased food and water safety for more than 80 million travellers annually.

Health Canada collaborated with health care professionals and industry to implement healthy workplaces by assessing needs, and introducing policies and strategies to enhance productivity and competitiveness and minimize associated health care costs by reducing work-related diseases, accidents, disabilities, and absenteeism.

Health Canada completed 85,750 analyses of seized drugs for prosecution. This represents an eight percent increase over the previous year due to increased enforcement activity. In addition, we dismantled 40 clandestine

laboratories which produce illicit drugs (such as ecstasy) and pose significant hazards to public health and safety and to the environment. An audit confirmed that we are providing an objective, high-quality service to the criminal justice system. Two factors are expected to contribute to increased workload: (1) aftermath of September 11 (2) Precursor (i.e. chemicals used to manufacture illicit drugs) Control Regulations. These regulations concern the manufacture and movement of illicit drugs (e.g. ecstasy and GHB/ date rape drug) that pose public health, environmental and security hazards to Canadians.

Health Canada invested $14M in the Alcohol and Drug Treatment and Rehabilitation (ADTR) Program to improve access to treatment and rehabilitation services among women and youth.

Through joint projects with the International Atomic Energy Agency, Health Canada provided expertise to 37 other countries which improved radiation protection for their workers. Following the events of September 11, we received $2 million in funding to further enhance the security and preparedness for radio-nuclear emergencies.

Support informed decision-making through awareness activities

Informing Public Decision-making

Because of the recognized need to address smoking cessation, Health Canada engaged youth in the development of anti-smoking advertisements, television productions, and educational environmental tobacco smoke (ETS) resource kits. The distribution of these kits encouraged the implementation of smoke-free policies in schools and communities. Along with three major media campaigns, these initiatives contributed to improved health of Canadians by educating and informing, and providing enabling tools to reduce health care burdens.

Health Canada, in partnership with Environment Canada, participated in the Sun Savvy Club which educated children about safe sun behaviour. For more information, please consult: http://www.hc-sc.gc.ca/ehp/ehd/catalogue/rpb_pubs/00ehd241.htm.

New Consumer Chemicals and Containers Regulations were introduced to improve the labelling and packaging requirements for consumer chemicals. They will assist in reducing the number of deaths, injuries and associated health care costs due to unintentional exposures involving hazardous consumer chemical products.

Lab evaluation methodologies for flame projection and flashback of

consumer products packaged in aerosol containers have also been updated to (1) ensure analytical support for enforcement of the new regulations, and (2) inform consumers of the safe handling of these products. The result of these efforts is a reduced number of hazardous products on the market, thereby protecting the health and safety of Canadians.

Healthy Environments and Consumer Safety Branch

http://www.hc-sc.gc.ca/hecs-sesc/hecs/dscs.htm

http://www.hc-sc.gc.ca/psp

http://www.hc-sc.gc.ca/hecs-sesc/hecs/sep/index.htm

http://www.hc-sc.gc.ca/hecs-sesc/tobacco

http://www.hc-sc.gc.ca/hecs-sesc/whpsp

Flame projection and flashback testing of aerosol containers

Sustainable Pest Management and Programs for Canadians

Pest Management Regulation

The Pest Management Regulatory Agency (PMRA) was established in 1995 to improve the regulation of pesticides in Canada. The mandate of the PMRA is to protect human health and the environment by minimizing the risks associated with pesticides, while enabling access to pest management tools and sustainable pest management strategies. To meet our mandate we established three strategic objectives for the period 1998 - 2003:

- Protect health, safety and the environment from the risks of pesticides through the use of sound, progressive science, including innovative approaches to sustainable pest management.

Objective

To protect human health and the environment by minimizing the risks associated with pest control products.

Description

- New product evaluation including regulatory decisions within specified performance standards on applications for the registration of new pest control products.
- Registered product evaluation where registered products are re-evaluated against current standards;
- Compliance enforcement under the *Pest Control Products Act (PCPA)* and Regulations through investigations and inspections;
- Development and implementation of sustainable pest management policies and programs to integrate sustainable pest management in registration decisions.

Actual Spending 2001-2002
(millions of dollars)

Gross	$31.9
Revenues	$(6.9)
Net	$25.0

- Meet the needs of Canadians for an open, transparent and participatory process and for timely access to new, safer pest control products.
- Effectively manage human and financial resources.

Since then, we have implemented a range of strategies, activities, regulations and guidelines to help us reach these goals. PMRA has established a joint review program with the United States Environmental Protection Agency (EPA) to speed up access to reduced-risk products, and established a number of integrated pest management strategies to complement sustainable pest management. We also solicit public input on major regulatory decisions and invite stakeholder and provincial and territorial participation in regulatory development to help us achieve transparency in the pest management regulatory process.

PMRA has three key performance expectations:

- Safe and effective pest control products.
- Compliance with the *Pest Control Products Act* and Regulations.
- Sustainable pest management practices that reduce reliance on the use of pesticides.

Safe and effective pest control products

Re-evaluating Older Pesticides

Re-evaluation is the review of pesticide active ingredients and their end-use products on the basis of updated data and information to determine whether, and under what conditions, their continued registration is acceptable. At the time of their registration, these pesticides were considered acceptable, but the scientific knowledge that forms the underpinning of these assessments is continually evolving and new methodologies and tools are being integrated into regulatory risk assessments. The re-evaluation of older pesticides can also take into consideration the full extent of the use patterns of the active ingredients, the diversity of their end-use products, and their market penetration.

PMRA implemented a re-evaluation program in 2000. Our re-evaluation of organophosphate pesticides (OP's) resulted in the discontinuation of four more OP's; to date PMRA has re-evaluated seven OP's. OP products are mainly insecticides and cover a broad variety of uses, such as greenhouse food and non-food crops, livestock, seed treatments, oilseed and fibre crops, stored food and feed, and terrestrial feed and food crops. We also began to re-evaluate lawn and turf insecticides and herbicides in response to increased public interest, to ensure they meet health and environmental safety standards. We facilitated the development of an agreement with the Canadian manufacturers of chromated copper arsenate (CCA) to discontinue the use of arsenic-containing preservatives on wood for consumer use by December 31, 2003. CCA treated wood is commonly used in decking, fencing and play structures in a residential setting. This agreement was reached by giving priority review to replacement wood-treatment products for CCA. A decision on the

industrial use of CCA treated wood is still pending.

The re-evaluation of food use products helps maintain our stringent health based safety standards for pesticide residues in food, by establishing or reassessing maximum residue limits. It also ensures the continued protection of health and environmental safety from risks of pesticides registered for use in Canada by eliminating the exposure to pesticides that no longer meet our safety standards. For more information, please consult:

http://www.hc-sc.gc.ca/pmra-arla/english/pdf/dir/dir2001-03-e.pdf.

Formulants

Formulants are any substance or group of substances other than the active ingredient that is intentionally added to a pest control product to improve its physical characteristics (e.g. spray ability, solubility, spreadability and stability). These formulants, much like the active ingredient in a pesticide, can pose toxicological concerns with respect to the environment and health. List 1 formulants have been identified as being of significant concern with respect to their potential adverse effects on health and the environment. These are to be phased out of pesticide products by December 31, 2002.

As a result of our actions, all registrants with List 1 formulants in their products have been contacted and most registrants have communicated intent to remove List 1 formulants. To date, approximately 33 percent of the products have been discontinued.

Therefore, pest control products in Canada now pose less risk to human health and the environment. For more information, please consult:

http://www.hc-sc.gc.ca/pmra-arla/english/pdf/pro/pro2000-04-e.pdf.

A New Pest Control Products Act

We supported the parliamentary process for Bill C-53, the proposed new *Pest Control Products Act,* which was introduced in the House of Commons on March 21, 2002. The *Pest Control Products Act* (*PCPA*) is the primary federal legislation to control the import, manufacture, sale and use of all pesticides in Canada.

The new Act would safeguard Canadians, especially children, and help ensure a safe and abundant food supply. New pesticide legislation would strengthen Canada's rigorous safeguards against the risks to people and the environment from the use of pesticides. Canadians would have access to more information and new opportunities for input into major pesticide registration decisions. A modernized, strengthened and clarified law on pesticide regulation would provide the solid legislative foundation needed to reduce risks posed by pesticides and facilitate the availability of newer, safer products and the removal of older products that might pose greater risks. For more information, please consult:

http://www.hc-sc.gc.ca/pmra-arla/english/legis/pcpa-e.html.

Improving product labelling

We prepared amendments to the Pest Control Products Regulations to require mandatory bilingual labelling

on all pest control products. This will ensure that all users of pesticides in Canada have access to complete label information in both official languages, to strengthen the protection of health, safety and the environment. The requirements for bilingual labelling will be phased in over a five year period beginning January 1, 2003.

We introduced a directive on a label improvement program aimed at reducing the potential for misuse of pesticides used on companion animals

> "We met our performance standard for review of pesticide application more than 85 percent of the time. This means quicker access to new pesticides for Canadians."

and at safeguarding animal and human health. The initiative addresses pesticides that are applied dermally to companion animals (products administered via other routes such as by mouth or to the eye are regulated as veterinary drugs). Labels will now provide more details, including the type of animal the product is intended for, reapplication frequency, rate and method of application, and minimum age of animals. For more information, please consult:

http://www.hc-sc.gc.ca/pmra-arla/english/pdf/dir/dir2002-01-e.pdf.

Increased efficiencies

We continued our work to reduce regulatory duplication. For example, the regulation of disinfectants is now consolidated under the *Food and Drugs Act*, while use of pesticides in a swimming pool or spa or use as a preservative or slimicide will still be covered under the *PCPA*. We also helped reduce the regulatory burden on registrants by listing the *PCPA* and its regulations in a schedule under the new *Canadian Environmental Protection Act (CEPA)*. This exempts registrants from having to have their new products officially notified and assessed for risks to human and environmental health under *CEPA*, as well as under *PCPA*.

The reduction in duplication will help reduce the cost to industry of registering a product and to Canadian taxpayers by assuring similar risk assessments of products do not need to be done by two separate departments.

New risk assessment/risk management techniques

We adopted three new risk assessment/risk management policies and guidelines as part of our commitment within NAFTA to harmonize dietary risk assessment procedures for determination of the safety of pesticide residues in domestic and imported treated foods.

Such policies play an increasingly important role in the evaluation and assessment of risks posed by pesticides, and improve the regulator's ability to make decisions that fully protect public health and sensitive subpopulations. PMRA's goal is to make exposure and risk assessments as accurate and realistic as possible, so that the entire population, including infants and children, is fully protected.

Compliance with the *Pest Control Products Act* and Regulations

Administrative Monetary Penalties

This fiscal year marked the first full year of use of Administrative Monetary Penalties (AMPs) as a compliance tool. AMPs provide an enforcement option that can be imposed when an individual or company has contravened the *PCPA*, rather than pursuing prosecution under the Act itself and can be imposed instead of or in addition to other sanctions available under the *PCPA* and Regulations.

AMPs allow us to be more strategic and proactive in our enforcement approach. Since the PMRA has full authority to decide when to issue a monetary penalty, PMRA officials can act on non-compliance situations more efficiently. Where non-compliance is identified, action can be taken immediately. AMPs provide the PMRA with a broader array of options to determine an appropriate enforcement response when non-compliance occurs. The experience of other agencies administering similar penalties shows that this approach is very effective in increasing compliance.

In our first full year using AMPs, Notices of Violations were issued for four AMPs cases and 20 other AMPs case files were commenced during the fiscal year. These will be completed during 2002-2003. We also successfully completed six prosecutions for violations that included the illegal use of a pesticide on raspberries and the sale of an unregistered control product. Criminal prosecution is pursued in cases where a company or an individual has acted wilfully or with negligence and the violation poses a significant health and safety or environmental risk or constitutes significant fraud. From 1995 to 2001, the Agency has conducted 32 successful prosecutions, thereby reducing risks to Canadians from improper/unlawful use of pesticides.

Sustainable pest management practices that reduce reliance on the use of pesticides

Healthy Lawns

We continued implementation of the **Action Plan for Urban Use Pesticides** including the **Healthy Lawns Strategy** (http://www.healthylawns.net). This strategy has the objective of reducing Canadians' reliance on pesticides for lawn care by developing educational material for homeowners, improving pesticide product labelling, assessing types of pesticide products available to homeowners, revising classification of pesticide products and increasing the knowledge of landscape service providers as well as **re-evaluation** of the most commonly available insecticides and herbicides to ensure that they meet current day standards.

National Pesticide Sales Database

PMRA completed the pesticide database framework and electronic data entry system for registrants. Work is in progress to improve

technical aspects of the data collection. As well, work continued on the development of regulations to require mandatory reporting of sales data. The pesticide sales database will be used to track the amounts and types of pesticides sold in Canada. This information can then help estimate risks to health and the environment and may also be used to help set priorities for re-evaluation or to determine the extent of use of reduced-risk pesticides.

Reduced-Risk Pesticides

The PMRA and the U.S. EPA, in co-operation with Mexico's CICOPLAFEST, established a joint review process for pest control products that contain conventional chemical pesticides (1996) and a joint review process for pest control products in which the active ingredient is a microbial or an arthropod semiochemical (1997). These reviews increase the efficiency of the registration process, facilitate simultaneous registration in participating countries and increase access to new pest management tools. Results of these programs give Canadian growers access to new and better technologies at the same time as their U.S. counterparts, and the access to new lower risk technology helps reduce the risk to Canadians from pesticides.

This year the NAFTA Joint Review Program registered one reduced-risk pesticide, and started review on three other reduced-risk chemical pesticides and two microbial pesticides. To date, 23 registrations have been granted under the Joint Review / Workshare programs. This includes 10 traditional chemicals, nine reduced-risk chemicals, two microbials and two pheromones (active ingredients and end-use products). Currently, there are 31 submissions undergoing joint review or workshare reviews, of which 11 are traditional chemicals, 13 are reduced-risk products, six are microbials and one is a pilot minor use product. For more information, please consult:

http://www.hc-sc.gc.ca/pmra-arla/english/pdf/dir/dir2002-02-e.pdf.

Sustainable Health Services and Programs for First Nations and Inuit Communities so Their People May Attain a Level of Health Comparable with that of Other Canadians

First Nations and Inuit Health

We have implemented a range of long-term strategies and activities that are expanding First Nations and Inuit community responsibility for the design, delivery, priority-setting and management of health programs and services. Our actions are helping to build on gains in First Nations and Inuit health status. For example, infant mortality has dropped by half

Objective

Sustainable health services and programs for First Nations and Inuit communities and people that address health inequalities and disease threats so that they may attain a level of health comparable with that of other Canadians, within a context of First Nations and Inuit autonomy and control and in collaboration with the provinces and territories.

Description

First Nations and Inuit Health carries out its mandate through:

- provision of community-based health promotion and prevention programs on-reserve and in Inuit communities;
- provision of Non-Insured Health Benefits to First Nations and Inuit people regardless of location of residence in Canada;
- provision of primary care and emergency services on-reserve in remote and isolated areas where no provincial services are readily available.

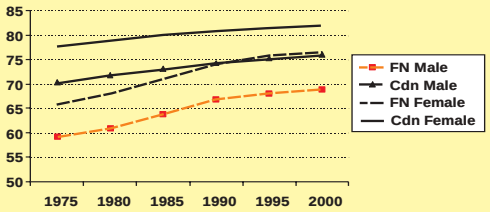
Health Canada also supports the transition to increased control and management of these health services, based on a renewed relationship with First Nations and the Inuit and a refocused federal role. Health Canada participates in government policy development on Aboriginal issues.

Actual Spending 2001-2002
(millions of dollars)

Gross	$1,346.0
Revenues	$(6.9)
Net	$1,339.1

and life expectancy has risen by 10 years since 1979.

Life Expectancy at Birth by Sex,
Registered First Nations and General Population,
Canada, 1975-2000



First Nations are classified as Registered Indians both on and off-reserve.
Year 2000 life expectancy is an estimate.
Source: Population Projections of Registered Indians, 1998-2008, DIAND, 1999

At the same time, we face the pressures that affect other health care providers such as nursing shortages, rapidly rising drug costs and expensive new technology. These are in addition to the specific challenges posed by factors that particularly affect our management of First Nations and Inuit health services, such as the remoteness and isolation of many communities we serve, the lower health status of First Nations people and Inuit and the implications of a projected on-reserve population increase that was 2.9 percent just in 2001-2002 alone. We have had to address the reality of a growing seniors population in these communities that is 40 percent higher than among Canadians in general. We are also challenged by the aging and maintenance of our 691 hospitals, addiction treatment centres, nursing stations and other facilities.

Health Canada recognizes as a priority improving the health of First Nations and Inuit people and reducing health inequalities between them and other Canadians. Consistent with overall government commitments, we are moving on this priority through a renewed relationship with First Nations and Inuit and a refocused federal role. Building on existing funding, the 2000 Budget announced additional allocations for First Nations and Inuit Health in the amount of $50 million for 2001-2002. This new investment will assist in the sustainability of our community health programs and address the cost pressures in the Non-Insured Health Benefits (NIHB) Program. To help achieve our goals, we have defined four key performance expectations for 2001-2002:

- Improvements in First Nations and Inuit peoples' health and a reduction in health inequalities between them and other Canadians.
- A First Nations and Inuit population that is informed and aware of the factors that affect health and what actions can be taken to improve health.
- Effective health care services available and accessible to First Nations and Inuit that are integrated with provinces' and territories' health services.
- Improved management and accountability in partnership with First Nations and Inuit for health care services and the NIHB Program.

Improvements in First Nations and Inuit peoples' health and a reduction in health inequalities between them and other Canadians

We worked with approximately 630 First Nations and Inuit communities to provide a range of primary public health and community care services. These services focus on communicable disease prevention, diabetes prevention and health promotion, environmental health and water safety, addiction services and extended health benefits. We funded some 800 nursing positions and 700 community health workers to deliver our programs. These programs and services focused on decreasing the gaps in health care between First Nations and Inuit communities and the general population.

Almost 6,500 First Nations children living on reserves benefited from 314 Aboriginal Head Start projects that feature early intervention strategies to help their development.

During the year, we paid particular attention to the following key health challenges.

Launching Action Plans on HIV/AIDS

Because of the impact of HIV/AIDS on First Nations and Inuit communities, we supported the development of HIV/AIDS regional action plans to increase awareness through education and prevention initiatives. They also focus on treatment, care and support in partnership with First Nations and Inuit. At the national level, we supported a national implementation plan by the Assembly of First Nations and the development of a comprehensive National Aboriginal Strategy for HIV/AIDS which is being coordinated by the Canadian Aboriginal AIDS Network through a national working group.

Reducing the Impact of Diabetes

One of the major chronic diseases affecting First Nations and Inuit communities is diabetes, which is three to five times higher than the rate in the general population. In response, we had previously worked with Aboriginal peoples to create the Aboriginal Diabetes Initiative. It increases prevention and treatment and enhances access to culturally appropriate diabetes programs for Aboriginal peoples. During 2001-2002, the Initiative was at work in 580 First Nations and Inuit communities, resulting in increased awareness of diabetes, strengthened community based participation in programs, and better access to prevention, health promotion, care and treatment services. Additionally, 39 Metis programs have been funded to create culturally appropriate primary prevention and health promotion for Metis and urban Aboriginal peoples.

To access more information on this program, please consult: http://www.hc-sc.gc.ca/fnihb/cp/adi/index.htm.

Addressing Environmental Health Challenges

We responded to the health threats facing some First Nations and Inuit communities due to local environmental hazards. As a key priority was to enhance drinking water monitoring, we provided bacteriological water and chemical test kits to communities. We also trained local Environmental Health Officers in ensuring appropriate air quality in housing and provided refresher courses on the safe transportation of dangerous goods. These measures helped to decrease adverse health effects caused by unsafe water, waste disposal and environmental contaminants; increased the number of facilities on-reserve that meet health and safety standards; and ensured the proper disposal of hazardous goods.

Promoting Mental Health

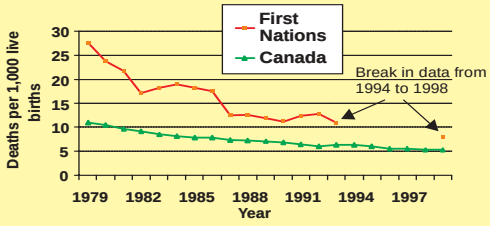
We completed a National Mental Health Framework in consultation with front line community mental health workers and created an advisory group on suicide prevention. A report with recommendations on Aboriginal mental health will be provided to the National Chief of the Assembly of First Nations in the upcoming year to begin the process of developing strategies to combat mental health issues within First Nations communities.

A First Nations and Inuit population that is informed and aware of the factors that affect health and actions that can improve their health

Meeting the Needs of Children, Youth and Families

An increased awareness of health issues improves the development and good health of First Nations and Inuit children and their families. An informed community is able to make decisions about programs and services that will result in better health. To ensure a better quality of life for First Nations and Inuit families, we implemented programs that focus on early interventions in a child's life and developed awareness campaigns to highlight the conditions that threaten the health of families. The Department's administration of programs and initiatives that focus on improvement of health status for First Nations and Inuit children and families has produced a steady decrease in infant mortality rates over the past 20 years.

Infant Mortality Rates, First Nations and Canada, 1979 - 1999



Source: Statistics Canada; Health Canada, First Nations and Inuit Branch (formerly Medical Services Branch),
Trends in First Nations Mortality 1979 -1993

- Rates include all births under 500 grams
- Data were unavailable for the First Nations population for the years 1994-1998.
- Current data may not be directly comparable to previous years due to different data collection methods.

Sharing Best Aboriginal Head Start Practices

The Aboriginal Head Start On-Reserve (AHSOR) program is designed to prepare young First Nations children for their school years by providing for their emotional, social, health, nutritional and psychological needs. The program encourages the development of locally controlled projects covering the program components in First Nations communities that strive to instill a sense of pride and desire to learn, strengthen parenting skills, foster emotional and social development, increase self-confidence and improve family relationships.

In December 2001, we sponsored the annual training workshop for AHS coordinators enabling them to share their experience and knowledge and then to pass on what they had learned to other community members. The conference and Final Report produced helped to build skills and strengthen the capacity of community-based Aboriginal Head Start coordinators.

To access more information on this program, please consult: http://www.hc-sc.gc.ca/fnihb/cp/fnhsor/index.htm.

Updating the Canada Prenatal Nutrition Program(CPNP)

The First Nations and Inuit component of CPNP is designed to improve the nutrition of pregnant women who face conditions of risk that threaten their health and the development of their babies. We have extended the reach and depth of programming to First Nations and Inuit women and infants. Approximately 90 percent of eligible women participate in the program and more than one third enter the program in the first trimester of pregnancy. Preliminary evidence demonstrates a positive impact of CPNP on some key indicators of maternal and child health. Breast-feeding duration rates, in particular, appear to be extended with participation in CPNP. As well, more than 500 front line health workers participated in regionally based training events that support our commitment to build capacity in program design, delivery and evaluation.

Meeting the Fetal Alcohol Syndrome/Fetal Alcohol Effects(FAS/E) Challenge

The 2001 Speech from the Throne committed the government to cooperative efforts to reduce the number of newborns affected by fetal alcohol syndrome. To enhance FAS/E prevention knowledge, we supported the development and initial distribution of awareness materials to First Nations and Inuit communities. These were complemented by efforts to build local capacity to deal with FAS/E issues and training workshops on awareness, prevention and parenting skills were delivered in several regions. We also developed a FAS/E evaluation framework.

Effective health care services available and accessible to First Nations and Inuit that are integrated with provinces' and territories' health services

We have worked with First Nations and Inuit partners to define shared health priorities in a renewed health care system. The provision of effective and accessible health care services to First Nations and Inuit communities requires long-range strategies to address sustainability of health services and programs. Integral to this are improvements in evidence-based decision-making by, for example, enhancing the First Nations and Inuit Health Information System (FNIHIS).

Combatting Alcohol and Drug Abuse

Alcohol and drug abuse are serious concerns for First Nations and Inuit communities. We worked with communities to provide treatment, prevention and intervention through the National Native Alcohol and Drug Abuse Program (NNADAP).

Capacity at the community level has increased and First Nations and Inuit people now manage 96 percent of the NNADAP resources through contribution agreements and through eight regional addiction partnership groups working with the National Native Addictions Partnership Foundation (NNAPF).

During 2001-2002, 48 NNADAP Treatment Centres offered 695 inpatient treatment beds. In addition, the nine Solvent Addiction Treatment Centres, housing 120 beds, provided treatment to approximately 321 clients. Also, there are over 550 community-based programs served by approximately 734 field workers. The ongoing inpatient treatment and community programs are designed to increase quality of life of those seeking treatment and enhance treatment availability.

Another priority during the year was to improve the quality of care and 20 centres have received full accreditation for treatment standards under NNADAP. To improve access to addictions information, we designed a new addictions information system and selected sites have begun pilot testing of the new system.

To access more information on NNADAP, please consult: http://www.hc-sc.gc.ca/fnihb/cp/nnadap/index.htm.

Expanding Home and Community Care

We are committed to assisting First Nations and Inuit people living with chronic and acute illness to maintain optimum health, well-being and independence in their home and community. The program ensures that a universal set of essential services in home and community care is in place to assist clients. In collaboration with First Nations and Inuit, the First Nations and Inuit Home and Community Care (FNIHCC) Program was developed and rolled out. As of 2001-2002, 96 percent of First Nations and Inuit communities have the resources available to prepare for service delivery and there has been a growth of 51

percent in communities which now have access to FNIHCC services. To ensure program effectiveness, we developed a results-based management and accountability framework for the program, a service delivery handbook, as well as accountability tools.

To access more information on this program, please consult: http://www.hc-sc.gc.ca/fnihb/phcph/fnihccp/index.htm.

Enhancing the First Nations and Inuit Health Information System (FNIHIS)

Improved health information and technology are essential to gathering and managing the data needed to understand First Nations and Inuit health issues and to ensure system effectiveness. This is critical for effective service delivery, better management and to predict health care needs. Accordingly, we have expanded the FNIHIS. By the end of 2001-2002, we implemented the system in approximately 65 percent of communities. In April 1999, 190 sites served 275 communities and in March 2002, 360 sites served 437 communities.

A major FNIHIS priority is integration with provincial public health information systems. For example, we have piloted data exchange projects with British Columbia's Centre for Disease Control. We also began projects aimed at coordinating information on home and community care and diabetes. These are expected to improve patient care by identifying potential conflicts in treatment therapies.

Expanding Telehealth Access

Because many First Nations and Inuit communities are in remote areas, telehealth services promise to be a valuable way to link these communities with specialized health experts, improving access to services and reducing transportation costs. To explore this, we implemented and completed telehealth research projects in La Romaine, QC, Berens River, MB, Southend, SK, Fort Chipewyan, AB and Anahim Lake, BC. We also implemented telehealth services in 41 Alberta First Nations communities with the Alberta government, Telus and Blue Quills First Nations College. Residents are now linked to mental health and diabetes education, tele-electrocardiogram and tele-rehabilitation services.

For more information on telehealth, please consult:

http://www.hc-sc.gc.ca/fnihb/phcph/telehealth/index.htm.

Surveillance Indicators

We improved our ability to report on and analyze First Nations and Inuit health and to develop comparisons to the general Canadian population by expanding health surveillance indicators. As part of this, we obtained information on communicable diseases and routine immunization data for First Nations and Inuit from all provinces and territories. This information enabled us to review new vaccines, plan disease interventions and investigate relationships between environmental factors and the spread of infectious diseases. We also broadened the set of surveillance indicators

to include chronic conditions, for example, cancer, diabetes and injury.

Non-Insured Health Benefits

The NIHB Program complements community-based programs and services and provides a range of medically necessary goods and services to Status Indians and recognized Inuit and Innu that supplement benefits provided through other private or provincial/ territorial programs. The program largely contributes to the achievement of an overall health care coverage for First Nations and Inuit. Benefits include drugs, dental care, vision care, medical supplies and equipment, short-term mental health services, and transportation to access medical services and medical premiums in selected provinces. These benefits are provided by health professionals, consistent with the best practices of health services delivery and evidence-based standards of care.

Building Partnerships

We established a joint committee with the Assembly of First Nations and the Inuit Tapiriit Kanatami (ITK) for a partnership on renewal. The goal of this partnership is to develop a renewed First Nations and Inuit health system by examining issues of integration, accountability, sustainability, and capacity building and to develop a framework to support that relationship. The committee is exploring ways of improving health outcomes and access to quality health services for First Nations and Inuit through control of their own health programs.

We also developed and implemented the Territorial Wellness Strategy in partnership with territorial governments and First Nations and Inuit groups. This strategy will improve dialogue, understanding and co-operation between federal, territorial and community levels, as well as improving synergy, efficiency and cost-effectiveness, reducing the administrative burden and improving policy decisions.

Improved management and accountability for health care services and the Non-Insured Health Benefits (NIHB)

Ensuring Sustainable and Accountable Programming

Focus was placed on improving accountability in order to enhance program design and delivery while keeping First Nations, Inuit and other Canadians well informed of the efficiency and effectiveness of programs and public funds spending. Health Canada works in partnership with First Nations and Inuit towards sustainable and accountable programming. A special focus is the transfer of knowledge and increased capacity on management and control issues.

Improving Management Accountability for Community Health Programs

To improve accountability and strengthen management practices, we have streamlined 16 contribution agreements into seven new standardized contribution agreements. The agreements clarify and define roles and responsibilities of all parties involved. New clauses were added or amended to

improve risk management and to respond to recommendations made by the Auditor General. They also allow the Department and First Nations and Inuit communities to better reflect accountability to the public for the prudent use of public funds. We have published a comprehensive *Guide for the Standard Agreements*, and a new Intervention Policy Framework was introduced. Our own internal accountability was strengthened with a new routing process, and the implementation of a contribution agreement monitoring system.

Response to the Public Accounts Committee

The Public Accounts Committee (PAC) followed-up the 2000 Report by the Auditor General. Its December 2001 recommendations require Health Canada to implement and report on improvements to our accountability and management activities.

Several important milestones were reached in 2001-2002 as we worked to implement corrective measures. For instance, new program accountability frameworks were introduced, comprehensive standard agreements were developed and implemented and a single contracts and contributions management system was implemented to enhance reporting, monitoring and auditing.

The follow-up actions taken in response to the PAC recommendations and a copy of the Government Response to the PAC Report can be found in the electronic Annex D at: http://www.hc-sc.gc.ca/english/care/estimates/index.htm. We also developed a summary report of our follow-up actions that is included as Appendix B.

Effective Management of Non-Insured Health Benefits (NIHB)

During the year we addressed specific service needs and built on previous work to improve management of NIHB to enhance the quality of services to First Nations and Inuit and better address cost pressures. To better manage the cost of transportation, we have renegotiated fees with taxi companies and ambulance providers servicing First Nations and Inuit communities in some regions; implemented NIHB medical transportation schedules for new standard contribution agreements with First Nations and Inuit communities; developed the medical transportation audit framework which will allow for greater ability to detect billing irregularities and recover overpayments; and developed an electronic web-based medical transportation reporting system to be implemented in July 2002.

We have made significant progress in cost management through the implementation of a number of efficiency measures. These measures were very successful and the rate of growth in program expenditures declined over the past 10 years from 22.9 percent in 1990-1991 to 5.7 percent in 2000-2001. Despite the cost management strategies adopted, projections indicate that continued increases are likely in program expenditures. For instance, the drug benefit expenditures alone grew by 25 percent between 1995-1996 and 1999-2000. Although this compares favourably to the six provincial benefits plans that experienced over a 50 percent increase in drug costs during the same period, spiralling drug costs represent a significant burden to overall NIHB Program sustainability.

We also enhanced the management of medical supplies and equipment by implementing a framework to provide guidelines for approving benefits; establishing provider qualification requirements to best meet the needs of clients, by ensuring proper assessment of providers to dispense medical supplies and equipment; and setting up an initiative to reuse medical equipment. This generated a total cost savings in medical supplies and equipment for 2001-2002 of 19.8 percent.

Improved services in the NIHB Drug Exception Centre have ensured that First Nations and Inuit clients have equal access to prescription drugs and that a fair and consistent approach to approvals is provided at all times. Constant streamlining of procedures and systems within the Centre has resulted in improved customer service and timely handling of approvals.

A particular focus was placed on improved dental health services. We implemented changes to the dental component of the Health Information and Claims Processing System which meant that both the dental and pharmacy components were delivered by the same sub-contractor. Using one uniform system has streamlined the processing of all claims. It also increased system response time for claims processors, toll-free inquiry, and dental submission predetermination in the regions. The enhancement of the ad hoc reporting system tool has improved reporting turnaround times.

Adding Capacity through Comprehensive Community Health Plans

Internal and external capacity was identified as key to achieving successful accountability. We have already engaged discussions with First Nations, Inuit and with other federal government departments on capacity building. And to support our clients, we have developed internal capacity plans focusing on planning, monitoring and reporting.

Health Canada has taken a lead role in establishing an Interdepartmental Committee on Capacity Building. This committee provides a forum for government departments to share information and best practices on capacity building initiatives, and to identify possible linkages and commonalities within their respective responsibilities.

To respond to particular community health needs, comprehensive Community Health Plans are being developed and tested in four First Nations communities: Kitselas Band Council in Pacific Region; Bigstone Cree First Nation in Alberta; Little Grand Rapids First Nation in Manitoba Region and Eagle Village First Nation (Kipawa) in Quebec. Training, templates and guidelines were provided to the communities to assist with the development of their health plans. These Community Health Plans will improve First Nations and Inuit capacity to prioritize their health needs and resources, improve the management and integration of programs and services; and streamline financial and human resources while improving data collection and reporting. We developed a First Nations and Inuit Program

Compendium which allows communities to have the information needed to select the appropriate programs for their Community Health Plans. It details all programs that are available to First Nations and Inuit communities. The Compendium forms the basis by which First Nations and Inuit will select the programs that will best serve their communities, and informs them of reporting requirements for each program.

Integrating Sustainable Development Principles

We have established a permanent function under the First Nations and Inuit Health Business Line in order to integrate sustainable development and environmental management principles into our programs and activities. We have developed an environmental management system that is used for training and for tracking the activities that we have undertaken to minimize negative impacts on the environment, such as non-hazardous waste and water audits of our hospitals.

Evaluation of our Programs

We completed evaluations of the pilot projects supporting transfer of the NIHB. These evaluations provide evidence-based guidance for development of further pilot projects. During 2001-2002 we received final reports on all 10 projects tested including an integrated overview report. Three of the pilots continued and the others have reverted to contribution agreements. To address issues around economies of scale and sustainability, all pilots that continued will have to take on all benefits and all members/clients by October 2002.

Health Canada has also developed a three-part performance measurement strategy for community-based programs. Annual program updates will provide short-term outcome information generated through a core set of program indicators (i.e. client information, program function, capacity/education and financial management). Intermediate national program evaluations will provide a more comprehensive and risk-based program assessment. Health surveillance activities will monitor health change over the long-term. We will test this performance strategy through the Community Health Plan demonstration sites.

First Nations and Inuit Health Branch

http://www.hc-sc.gc.ca/fnihb/index.htm

Better Health Outcomes through Information and Communication Technologies and Evidence-Based Decision-Making

Information and Knowledge Management

Improved health service delivery and better informed decision-making each contribute to better health outcomes for Canadians.

A total of 49 percent of departmental spending in this area funds the operations of essential departmental information and knowledge management and information technology systems. This includes mission critical computer operations, telecommunica-

Objective

A health system that delivers better health outcomes through more effective use of information technologies; more and better health research; and the effective use of a base of timely, accessible and reliable health information and analysis for evidence-based decision-making and better public accountability.

Description

Information and Knowledge Management is responsible for improving the evidence base (both information and analysis) for decision-making and public accountability; updating the long-range strategic framework and policies that establish, direct and redirect the involvement of the federal government in health research policy; developing the creative use of modern information and communications technologies (including the Information Highway) in the health sector; and, in cooperation with the provinces and territories, the private sector and international partners, providing advice, expertise and assistance with respect to information management and information technology, planning and operations.

Actual Spending 2001-2002
(millions of dollars)

Gross	$281.3
Revenues	N/A
Net	$281.3

tions, software application development, and information management systems and services that support national health programs and services for Canadians as well as support the more than 8,000 departmental employees across the country. The remaining 51 percent supports the achievement of better health outcomes through innovations and implementation of information and communication technologies and through evidence-based decision-making.

To help reach our objective, we have defined three performance expectations:

- A well-functioning national health information infrastructure which respects privacy and shares information in support of decision-making and public accountability.
- Evidence-based health policy decision-making including a better understanding of the issues relating to health care.
- Accountability for, and effectiveness of, Health Canada's programs, policies and functions.

Working with the provinces and territories, our health sector clients and other partners, we have implemented a range of strategies and activities over time to help reach these objectives. For 2001-2002, Health Canada had four major priorities to meet these objectives:

- Make significant progress on key priorities for a pan-Canadian Health Infostructure.
- Demonstrate the potential for measurable improvements in the quality, accessibility and efficiency of health systems and services, through the use of information and communications technology.
- Increase data and analysis on the health of Canadians and the performance of the health care system.
- Increase the capacity of Health Canada to monitor, report on and improve the performance of its major programs.

Significant progress on key priorities for a pan-Canadian Health Infostructure

An ambitious, long-term undertaking, the development of a health infostructure in Canada will help our health care system meet the challenges of the 21st century.

The term "health infostructure" refers to modern information and communications technologies, such as electronic health records. The infostructure will allow the general public, patients and caregivers, as well as health professionals to obtain and provide information and data faster, thus facilitating more informed and timely decisions about one's health, medical interventions, or health services.

One of the challenges of implementing a national health information infostructure is identifying and addressing the gaps in research concerning information and communications technologies and health. Due to other priorities within the Department, funding of 15 projects planned for 2001-2002 to address various gaps was delayed but is now under way.

An effective national health information infostructure also requires working with our partners to develop national strategies to enhance the use of information, and information and communications technologies, in the health sector. Collaborative efforts with our partners can reduce duplication and unnecessary expense and ensure different systems can communicate with each other. Examples of such collaboration are highlighted below.

More Focused Work with an Updated Tactical Plan

A Tactical Plan to assist all health jurisdictions make planning and funding decisions for establishing a national health infostructure was updated in 2001 in collaboration with provincial and territorial jurisdictions. The Plan has led to more focused activity across jurisdictions. For example, a consortium of western provinces and territories is working on the recommendations of the Plan dealing with the "building blocks" of a pan-Canadian health infostructure; those elements are inter-operable, on-line client and provider registries, and pharmacy and laboratory systems. The Atlantic provinces are also engaged in similar activities intended to allow both interoperability and integration of electronic health services. These initiatives are expected to lead to improved access to health care services and consequently, to improved health status.

Implementing Health Canada Pan-Canadian Health Infostructure Initiatives

Our Department has three core initiatives: the Canadian Health Network, the National Health Surveillance Infostructure and the First Nations and Inuit Health Information System.

The Canadian Health Network (CHN) is an Internet-based health information service built collaboratively by government and non-government organizations across Canada. It offers Canadians an on-line gateway to credible, relevant, up-to-date information in four key areas: health promotion, disease prevention, self-care, and performance of the health care system. Through collaboration with major health organizations across the country, we expanded and promoted the CHN. In March 2002, a study found that the CHN is the third most visited health or medical-related website by Canadians. As a result, Canadians have better access to timely, credible and comprehensive information on health promotion and disease prevention. Sixty-six percent of respondents to the first CHN on-line survey indicated satisfaction with the information provided. For further information, please consult:

http://www.canadian-health-network.ca/.

The **National Health Surveillance Infostructure** initiative continues to provide information important to health professionals and decision-makers in making public health decisions. The initiative is guided by a partnership of people representing the health surveillance interests of local, provincial, territorial and national governments, non-government organizations, First Nations, and universities.

As a result of activities undertaken or completed in 2001-2002, 95 public

health practitioners such as medical officers of health, epidemiologists, researchers and planners are able to produce detailed maps of disease incidence and trends, tailored specifically to their needs. For example, Health Canada researchers discovered a link between health events in southern Ontario and a census of agriculture data by overlaying *E. coli* health event data with census boundaries. The system was also used to monitor the impact of the Walkerton outbreak and the West Nile virus on the health of Canadians.

The **First Nations and Inuit Health Information System** provides accurate and timely data to First Nations and Inuit for case management, health planning and evaluation. It provides First Nations and Inuit communities with access to health information not previously available through provincial, territorial or federal databases.

Approximately 65 percent of First Nations communities are now being served by the system, an increase of 24 percent from 1999 when 275 communities were served. These include the 41 Alberta First Nations communities which have access to mental health and tele-electrocardiogram telehealth services. For more information, please see page 64.

Protection of Personal Health Information

Canadians care deeply about the privacy of their health care information. As a result of the work on the *Personal Information Protection and Electronic Documents Act*, agreement was reached with national health associations, provinces, territories and other federal departments to support the Canadian Standards Association model code as a basis for protecting personal health information. This agreement sets the foundation for ensuring that major health providers support the same privacy principles and standards for handling the personal health information of all Canadians and ensures that work on a Canadian health infostructure, including the implementation of electronic health records and telehealth solutions, can effectively continue.

Demonstration of the potential for measurable improvements in the quality, accessibility and efficiency of health systems and services, through the use of information and communications technology

Just as Canadians expect that their personal health information will be protected, surveys also show that they want simplified access to health information and services. We have addressed this in many ways.

Canada Health Infostructure Partnerships Program (CHIPP)

During the year, Health Canada funded innovative projects under the Canada Health Infostructure Partnerships Program, an $80 million program that tests and applies new technologies to improve health service delivery, especially to people in remote areas.

For example, the Central BC and Yukon Telehealth project launched the Picture Archiving Communications System (PACS) at the Royal Inland Hospital in Kamloops, British Columbia, and satellite equipment was placed at two other hospitals in British Columbia and the Yukon. The PACS enables doctors in these regions to instantly access patient X-rays and other images related to a patient's chart thereby increasing the speed of diagnosis and treatment. Once the infrastructure is fully in place, the network will serve as a model for the delivery of other telemedicine applications.

As well, the Government of Nunavut started the expansion of a pioneering telehealth network, called the Ikajuruti Inungnik Ungasiktumi (IIU) Network, in order to link more communities to more services and more clinical expertise within and outside the northern territory. The CHIPP funds enable the IIU Network to improve access to health care for the people of Nunavut including social services, public health, education and administration.

Of the 29 CHIPP projects with anticipated completion of implementation by March 31, 2003, a few were delayed and will not be completed until 2003-2004.

Simplified Access to Health Information and Services

We partnered with other federal departments to develop the **Canada Health Portal** (CHP) as part of the larger Government of Canada On-Line initiative. The CHP is an Internet site providing Canadians with single-window access to trusted and credible health information from many sources, including Health Canada and the Canadian Health Network. The portal now links the public to current health-related information from across the federal government and agencies as well as to provincial and territorial departments of health. This initial effort is expected to serve as a base from which we can expand partnerships and integrate more content in order to achieve the most user-friendly site possible.

Increased data and analysis on the health of Canadians and the performance of the health care system

As the discussion in the Health Care Policy section of this report notes, our partners look to Health Canada for information that can be applied for better evidence-based health policy decision-making.

To respond to this need, we published three issues of a new *Health Policy Research Bulletin* and five *Policy Research Working Papers*. In addition to serving policy makers in Health Canada, the publications were distributed to policy makers and analysts in other government departments, non-government organizations, academic institutions, interested citizens and international organizations. The *Bulletin* received excellent reviews, with 5,000 additional copies of an issue on genetic testing reprinted in response to demand. The Policy Research Publications Program brings information to both health professionals and Canadians, enabling them to

learn about the policy research that underpins the decisions taken by Health Canada. The publications help to educate the public about complex issues and promote the concept of building health policy on a credible evidence base. In the coming year we will survey users to determine the extent to which the research and analysis made available through the Policy Research Publications Program is influencing program and policy decision-making.

Increased capacity of Health Canada to monitor, report on and improve the performance of its major programs

A key element in achieving better health outcomes is knowing with some certainty what works well and what could work better. Progress to date in enhancing such information is noted below.

Improving Departmental Performance Reporting and Helping Meet Accountability and Reporting Commitments

As noted under the Health Care Policy section of this report, we worked with our provincial and territorial counterparts to fulfill the commitments in the First Ministers' September 2000 Communiqué on Health to develop a framework for comparable reporting. All jurisdictions will begin this reporting in September 2002, using a framework that includes indicators of health outcomes, health status and quality of services. The reports will provide consistent and comparable information to Canadians and decision-makers. We began to reflect this type of information in the quantitative Annex to our Departmental Performance Report in 2000-2001. For further information, please consult:

http://www.hc-sc.gc.ca/english/pdf/estimates/HCDPR%202001-Final-EN.pdf.

Improving Performance Measurement

We concluded a three year pilot Performance Measurement Development Project that developed and implemented accountability frameworks in key departmental areas to improve performance management and measurement. For example, a First Nations and Inuit Health Program Compendium was developed which details all First Nations and Inuit Health Branch programs that are

available to those communities. It enables First Nations and Inuit communities to select the programs that best serve their communities, and informs them of reporting requirements for each program.

In addition, more than 150 departmental employees participated in performance measurement training.

As well, we worked with stakeholders as we developed performance measurement frameworks for more than 20 of our programs. These covered activities such as our Hepatitis C Prevention, Support and Research Program and First Nations and Inuit Home and Community Care. The frameworks clarify performance expectations and are expected to lead to improved program outcomes once the necessary data collection and analysis process begins. They will form a base as we examine new or updated performance frameworks for other programs.

Information, Analysis and Connectivity Branch

http://www.hc-sc.gc.ca/iacb-dgiac/english/iacb/branchindex.html

Effective Support for the Delivery of Health Canada's Programs

Departmental Management and Administration

Our Department achieves many of its objectives due to core services that support the activities and operations of all branches. We also have an extensive regional structure that is increasingly called on to deliver Health Canada's programs and ensure the best possible collaboration with our partners in provincial and territorial governments and other organizations. To help achieve our goals, we have set out these commitments:

- Continuous improvement in the provision of timely and quality corporate administrative services and in the promotion of sound management practices, including modern comptrollership.
- Integrated health research and continual improvements in bringing that research into decision-making.

During 2001-2002, in addition to our ongoing responsibilities we achieved important progress in improved management through a number of major initiatives.

Objective

To provide effective support for the delivery of Health Canada's programs and for sound management practices across the Department.

Description

Responsible for providing administrative services to the Department.

Actual Spending 2001-2002
(millions of dollars)

Gross	$209.0
Revenues	$(0.4)
Net	$208.6

Modernizing Management Practices

As part of the government-wide modern comptrollership initiative, we developed and acted on a strategy document to implement modern management practices in Health Canada. Health Canada's vision of modern

comptrollership is an organization, which focuses at every level on the effective management of resources for the achievement of results in a manner consistent with clearly defined and commonly accepted values and ethics.

Our new Centre for Workplace Ethics worked with more than 700 employees and managers to raise awareness of values and ethics issues in our workplaces, as well as how to operationalize these core values into day to day business

A Departmental Workplace Health Initiative was established and an Office of Workplace Health created to make Health Canada a workplace that values and actively promotes employees' health and well-being and supports their ability to fulfill Health Canada's mission.

A key departmental initiative being championed is making Health Canada a "True Learning Organization". The Learning and Development Policy is under revision and a Continuing Education Council has been created as part of our investment in learning and development opportunities for our employees.

We introduced new control frameworks that strengthen accountability in the areas of grants and contributions, contracting and financial management. We support this work with training and tools for managers.

We improved our ability to ensure effective management of resources through new standard agreements for our grant and contribution programs. The new agreements reflect Treasury Board policy, respond to recommendations made by the Auditor General and streamline processes in response to requests from funding recipients.

Recruitment at Health Canada

Recruitment of skilled young people was a major human resource focus, which saw us marketing and promoting the Department through career and job fairs, on-campus recruitment at universities and student employment programs. This enabled us to attract qualified candidates for jobs. We also worked with the Department of Canadian Heritage on a guide of suggestions that managers are now using to identify and select diverse candidates, develop talent and create an inclusive workplace. For further information regarding the staffing environment pertaining to regulatory and surveillance programs refer to Appendix C.

Health Canada continues to place emphasis on, and make good progress in, its creation of a diversified work force.

Development of French and English Language Minority Communities

Part VII of the *Official Languages Act* mandates us to support the development of French and English language minority communities, which we did through support to the work of Consultative Committees that are addressing the health-related priorities of both groups. Agreement has been reached on implementing a networking initiative that will provide a foundation from which to develop

better access to health services for such minority communities. In addition to our involvement in interdepartmental responses through the Interdepartmental Partnership with the Official Language Communities initiative, we provided direct funding for specific initiatives of importance to official language minority communities such as the "Santé en français" national forum held in Moncton and the "Building on our Strengths" initiative in Quebec.

Office Expansion in the National Capital Region

In order to address the Department's rapid growth and subsequent shortage of departmental office space within the National Capital Region, we accommodated over 900 new employees, through our Departmental Accommodation Plan.

Enhancements in Security Post September 11

A number of security elements have been implemented to protect employees, information and other valuable assets following the events of September 11, such as, enhanced access controls and emergency response capability, a national security review and threat and risk assessments at major facilities.

Role of the Chief Scientist

The Department's Office of the Chief Scientist has played an important role in strengthening our departmental links to the science community and fostering more research that improves the quality of our decisions and programming. During the year, it strengthened its research relationship with the Canadian Institutes of Health Research (CIHR). This improved the Department's capacity to guide and draw on the health research we require for evidence-based decisions. We also took part in joint research initiatives in areas such as bioterrorism, children's health and the environment, and gender and health.

Regional Accomplishments

Our regional operations continued to be the focal point for the delivery of many of the programs and services that are described throughout this Report. For example, our Regional Offices continued to network with their provincial and territorial government counterparts in the development of provincial primary health care initiatives; the expansion of multi-jurisdictional funding, e.g. Primary Health Care Transition Fund; action on northern health issues through collaboration with territorial governments; and improvements in the delivery of our program and services to communities and First Nations and Inuit people.

Regions also worked together on common issues. For example, the regions responsible for program delivery in Nunavut, the Northwest Territories and the Yukon worked with those territorial governments and the Northern Secretariat to develop the Territorial Wellness Initiative. This

initiative is a response to territorial requests for a focal point within Health Canada to provide easier and more equitable access to programs and funding for people living in the North. A key step towards this provision of single-window services to territorial residents was taken through the transfer of the Population and Public Health Branch and First Nations and Inuit Health Branch programs in the three territories to the Northern Secretariat. Health Canada manages its program delivery in the territories by working collaboratively with the territorial governments, First Nations and Inuit organizations, and other voluntary sector organizations.

Regional offices for Alberta/Northwest Territories and Manitoba/Saskatchewan worked with Environment Canada and over 80 other federal government managers and scientists at the Winnipeg Prairie Water Quality Workshop to craft an interdepartmental resolution. The resolution recommended that a regional water framework be developed as a basis for a cohesive federal strategy to address prairie water quality issues.

Each region has identified some specific accomplishments for 2001-2002. Regions also contribute actively to all departmental program outcomes.

Atlantic Region

Health Canada launched a formal partnership with the four Atlantic provincial health departments to share information, determine joint priorities and develop a common approach to wellness in Atlantic Canada.

Chronic health risk assessments were completed for residents living near the contaminated Sydney Tar Ponds site. This new information helped to determine future options for the local residents based on actual levels of risk.

Québec Region

The success of Aboriginal Head Start pilot projects in Kuujjuak and Inukjuak demonstrated the value of the program for young Inuit children. As a result, we collaborated with le Ministère de la famille et de l'enfance du Québec, le Secrétariat des affaires autochtones du Québec, les Fonds de la Convention de la Baie-James, Human Resources Development Canada and local groups to establish similar projects in 14 Inuit villages in the Nunavik.

The Ambassador Program was launched to enable Québec Region employees to learn about our full range of health programs and services so they can draw on that information to provide higher quality service.

Ontario/Nunavut Region

Recognizing the value of enabling project sponsors to learn from each other, the Ontario and Nunavut Region designed a webboard to connect sponsors of Health Canada-funded children's projects. During 2001-2002, we worked with the Ontario government to expand the webboard to include provincial children's programs, which created an interactive learning environment for all major agencies in Ontario that offer children's services.

Ontario and Nunavut Region participated on the Ontario Hospital Association's Task Force on Supply

Chain Management along with representatives from hospitals, suppliers, group purchasing organizations, government agencies and industry consultants. In its report, *Improving Supply Chain Management for Better Health Care* released in November 2001, the Task Force reported its finding that Ontario hospitals could achieve significant savings (approximately $320 million annually) and improve patient safety through a more efficient supply chain.

The Ontario and Nunavut Regional Office, in collaboration with Environment Canada, formed a secretariat to follow the Walkerton Inquiry. This group monitored proceedings and analyzed findings in order to identify any scientific or technical issues for consideration in the development of federal policy and programs.

Manitoba/Saskatchewan Region

In Manitoba and Saskatchewan, we helped to launch Federal-Provincial Senior Officials Committees on Early Childhood Development. These are encouraging better communication and collaboration on children's health policy and program development, implementation and evaluation.

A regional public health capacity pilot project was completed that identified ways to increase interdepartmental and stakeholder collaboration and coordination on water-borne diseases, tobacco use, Aboriginal public health issues, regional research priorities and regional public health needs assessments.

A model report on grants and contributions and official languages minority communities was completed and distributed in order to assist clients in applying for assistance under our programs.

Alberta/Northwest Territories Region

The Alberta/Northwest Territories Region took steps to strengthen the effective use of their resources through a pilot project involving a service level agreement between its regional branches and their finance unit. Through better definition of accountabilities and responsibilities, efficiencies are being realized and the public will receive more streamlined and effective regional program delivery.

Preparations for the protection of public health and safety for the June 2002 G8 Summit in Kananaskis involved intensive work on the part of Alberta/Northwest Territories Region in collaboration with a diverse group of external and internal stakeholders. Key among the external stakeholders were Alberta Health and Wellness, Calgary and Headwaters Regional Health Authorities, the towns of Cochrane and Canmore, the Stoney First Nation and the Kananaskis Improvement District. Internal stakeholders were the Summit Management Office (Foreign Affairs and International Trade), the Solicitor General's Department, and Treasury Board, as well as Health Canada Corporate and Legal Services, and Cabinet Affairs and International Programs within the Healthy Environments and Consumer Safety Branch.

British Columbia/Yukon Region

Our Regional Office sought feedback on health issues of local concern through five health round tables held in local communities.

We also partnered with Simon Fraser University to deliver two policy forums: New Reproductive Technologies and Alternative Medicine. These allowed us to gain stakeholder feedback and provide Health Canada positions to participants.

We explored new approaches to prenatal services with the Mount Currie Indian Band. The use of prenatal coupons exchangeable for food at Band and local area grocery stores, and access to prenatal classes, community kitchens and baby clinics, has been effective in the promotion of healthy birth weights, encouraging early access to prenatal care, increasing breast-feeding rates and duration, and promoting nutrition education among pregnant women.

Through the Vancouver Agreement, an initiative involving three levels of government, we are contributing to the efforts of multiple sectors to address drug-related problems in Vancouver's Downtown Eastside. The opening of the Health Contact Centre in January 2002, in combination with enforcement efforts, has visibly decreased the open drug scene and provided treatment options that were formerly unavailable. Efforts to include diverse communities in the implementation of Vancouver Agreement initiatives are helping to build community acceptance of innovative solutions to long-standing and complex problems.

Section IV:

Reporting on Government Themes and Management Issues

Modernizing Comptrollership

Health Canada achieved significant milestones over the past year in relation to implementing modern management practices.

A modern comptrollership capacity self-assessment was completed.

An internal governance structure was established with the creation of a Departmental Executive Sub-Committee on Operations to oversee the modern comptrollership initiative and provide a champion for support and leadership in all activities related to the initiative.

A strategy document entitled, *A Modern Management Strategy - Implementing Modern Comptrollership in Health Canada,* which included an action plan, was developed and distributed to internal and external stakeholders. The Strategy presents Health Canada's vision of a modern comptrollership organization, describes the elements of modern comptrollership being addressed through initiatives under way within the Department, and provides opportunities and actions for improvement, including planned activities to maintain the momentum.

In conducting the capacity assessment and developing the Modern Management Strategy, awareness of the concepts of modern comptrollership was increased and inculcated into the departmental culture.

In particular, a number of management practices were implemented which further enhanced the Department's management framework, such as:

- creation of a Centre for Workplace Ethics responsible for the conduct of a dialogue on values and ethics. This initiative defined, described and communicated to over 700 employees and managers a number of core departmental values of importance to employees of Health Canada;

- development of accountability frameworks in the areas of grants and contributions and contracting, including action plans for improving the Department's practices and procedures and training for all managers;
- creation of a financial management control framework which documents essential requirements and control objectives, and produces practical and maintainable tools for managers and functional specialists to better understand their roles and responsibilities in relation to controls;
- successful piloting of a new course for managers entitled "Managing for Results" aimed at increasing managers' awareness and knowledge through the provision of a comprehensive orientation on the administrative processes of management within Health Canada.

Health Canada has recognized the need to improve the management of its procurement and contracting activities by implementing more effective control practices and managing risk to acceptable levels of exposure. These improvements are part of the Department's overall approach to enhancing its management practices.

Procurement and Contracting

1. Role played by procurement and contracting in delivering programs.	Procurement and contracting play an integral role in the support of program delivery in this Department. The aim of procurement and contracting is to provide materiel and services in conjunction with program activities aimed at achieving departmental goals and objectives.
2. Overview of the contracting management processes and strategy within the Department.	As part of overall efforts to strengthen its management practices and processes, Health Canada launched a management review of its contracting function. As a result, consistent with modern comptrollership, Health Canada has prepared a Contract Management Framework and Action Plan for implementation of the recommended improvement opportunities. The Action Plan deals with four major themes: responsibility, accountability, oversight and monitoring, and audit. Health Canada senior management is committed to rigorous contract management practices across the Department.
3. Progress and new initiatives enabling effective and efficient procurement practices.	See 2 above.
4. Internet links and/or website addresses.	Health Canada does not have an Internet/Intranet site on procurement and contracting. Health Canada does, however, have a departmental policy centre database on Materiel Management in Lotus Notes.

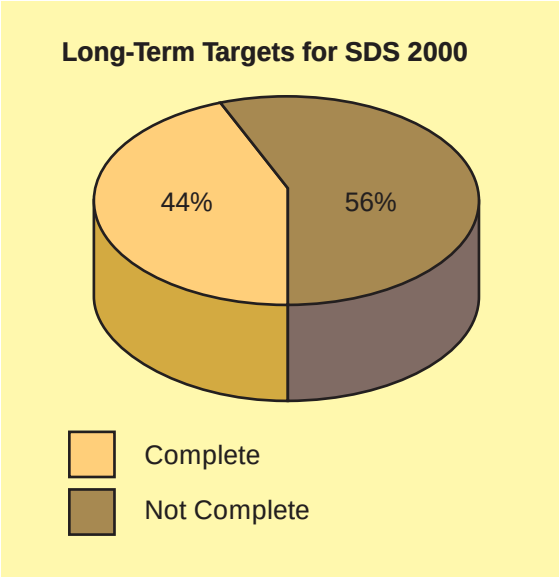
Materiel Management

1. Has there been an assessment and/or inventory of resources?	A complete inventory was taken of all capital assets in the fall of 2000. This inventory listing is maintained on an ongoing basis.
2. What is the basis of the assessment and the Department's level of confidence in the outcomes?	All assets that have a value in excess of $1,000 or that are considered to be of an attractive nature valued at less than $1,000 were inventoried. This inventory was verified in each program area.
3. Have the life-cycle costs for mission critical assets been identified?	Yes, as part of the Long-Term Capital Plan (LTCP).
4. Has a plan been developed for life-cycle, mission critical assets?	A Long-Term Capital Plan was submitted and noted by the Treasury Board on February 12, 2002. A Part II update is being developed for submission with the Annual Reference Level Update (fall 2002).
5. What progress has been made to identify these assets and their operational cost?	All such assets have been inventoried and their operational cost identified.
6. Have any serious concerns or problem areas been identified?	The LTCP has identified gaps in O&M and capital funding for the maintenance and upkeep of assets.
7. Have risk management assessments been made on mission critical assets and if so, has the financial impact on operational capabilities been determined?	Construction projects undergo a review by the Labour Canada, Fire Commissioner's Office, during the architectural plan preparation as well as a final inspection prior to move-in to ensure all newly constructed or renovated facilities comply with appropriate building codes and regulations. Additionally, building condition reports are periodically undertaken on facilities to identify any potentially hazardous situations or health and safety concerns. Annual inspections of facilities are also completed by regional maintenance staff and a repair and replacement budget prepared to address any outstanding issues requiring attention. The financial impact identified is a shortfall in O&M and capital funding for the maintenance and sustainability of assets.

Sustainable Development

Health Canada's final report on its first sustainable development strategy, *Sustaining Our Health (1997),* was completed this past year. The Department originally reported in the 2000-2001 Departmental Performance Report, that approximately 75 percent of the strategy targets were completed. In fact, the final target completion is 81 percent, and a full analysis of lapsed targets has taken place resulting in a corrective action plan to ensure that all outstanding targets are addressed.

Health Canada's Sustainable Development Strategy 2000 (SDS 2000) has been under way for a full year.



This second departmental sustainable development strategy builds on the lessons learned from the implementation and evaluation of the first, and provides an outcome oriented action plan for the three years of the Strategy (April 2001 - March 2004). In SDS 2000, the Department has focused its sustainable development commitments on three priority areas, or themes:

- Helping to create healthy social and physical environments.
- Integrating sustainable development into departmental decision-making and management processes.
- Minimizing the environmental health effects of the Department's physical operations and activities.

Within these three theme areas, the specific commitments of SDS 2000 are organized into Objectives and Targets. Objectives are the overall directions arising under each sustainable development theme, while Targets are the detailed performance requirements that the Department has set out to achieve. Long-Term Targets have been further organized into specific Short-Term Targets that are outcome oriented, measurable, time limited and directly related to the eight federal themes for sustainable development.

For the SDS 1997 Final Report and an Annual Report for SDS 2000, please consult: http://www.hc-sc.gc.ca/susdevdur.

It is clear that many of Health Canada's programs and activities are supportive of an integrative approach to environmental, economic, and social/cultural issues, as is the underlying principle of sustainable development. The departmental SDS provides an opportunity to focus beyond these programs, and establish specific sustainable development objectives where significant and concrete advances can be made.

Business Line Sustainable Development highlights for 2001-2002 include:

Health Promotion and Protection Business Line

Long-Term Target (LTT): Incorporated the principles of sustainable development and population health into public education and awareness campaigns.

- Launched three public awareness campaigns that promote healthy lifestyles.
- Disseminated information about best practices in five areas to health care and other professionals working in the field of family violence prevention.

LTT: Supported projects, research and initiatives to improve community capacity to take action on health and healthy environments.

- Enhanced the health of communities and their capacity to take action on health and healthy environments in all six Health Canada regions.

LTT: Provided information to Canadians so that they can make more informed decisions about their exposure to products and environmental hazards.

- Provided callers to the Pest Management Regulatory Agency's (PMRA) information services with information on non-pesticidal ways to control home and garden pests, as well as on pesticides.

LTT: Reduce risks from selected products and environmental hazards by improving risk assessment and risk management processes.

- Announced the discontinuation of four of the 27 organophosphate pesticides in use in Canada (in consultation with industry stakeholders and the U.S. Environmental Protection Agency). For more information, please consult: http://www.hc-sc.gc.ca/pmra-arla/english/pubs/pubs-e.html.

First Nations and Inuit Health Business Line

Long-Term Target (LTT): Reduced the health inequities between Canada's First Nations and Inuit and the general population for selected health problems.

- Developed action plans for targeted priority notifiable diseases, such as tuberculosis, and an integrated communicable disease control program at the national, regional and community levels in partnership with First Nations.

LTT: Strengthened the Non-Insured Health Benefits Program (NIHB) that provides for medically necessary health-related goods and services for First Nations and Inuit that are not provided through other private or provincial/territorial health insurance plans.

- Implemented a pharmacy, medical supplies and medical equipment and dental provider audit plan.

- Established a mechanism to identify and address policy and financial risks to the NIHB.

LTT: Increased home and community care capacity in First Nations and Inuit communities.

- Implemented the development phase of the First Nations and Inuit Home and Community Care Program. The goal is to make it accessible to a minimum of 75 percent of First Nations living on-reserve and Inuit by the end of 2002-2003, with specific focus on services to the chronically ill, disabled and on post-hospital care.

LTT: Controlled risks to health and the environment through environmentally-responsible land and facilities management.

- In total, nine out of 37 of the assessed First Nations and Inuit Health Branch's fuel contaminated sites have undergone complete remediation and work is under way to decontaminate another 17 sites.

Departmental Management and Administration Business Line

Health Canada has incorporated the targets outlined in the Sustainable Development in Government Operations (SDGO) document into the 2000 Sustainable Development Strategy. Progress on the SDGO targets is highlighted in our Annual Report.

Long-Term Targets (LTT): Implemented a Department-wide Environmental Management System, consistent with ISO 14001.

- Implemented a process for ongoing annual reporting on the status of the Departmental Environmental Management System (EMS).
- Inaugurated Building Performance Reviews at all Health Canada laboratories on an annual basis.

LTT: Increased water conservation and efficient wastewater management.

- Conducted water audits to investigate water saving initiatives at Health Canada laboratories.

Service Improvement Initiative

Results for Canadians commits the Government of Canada to a "citizen focus" and "citizen-centered service delivery". In May 2000, the Treasury Board approved the Service Improvement Initiative (SII), which contributes to achieving this commitment by identifying citizen expectations and priorities for service improvement, and implementing a program towards progressively improving client satisfaction with key services.

Because the Citizens First 2000 national survey indicated that Health Canada's information services were a priority, five key information services became the initial focus for departmental service improvement efforts:

- *It's Your Health* publications - A client survey of distributors and users of *It's Your Health* publications identified opportunities to improve distribution, including pro-

motion of the on-line version and updating database lists.

- Pest management 1-800 information system - A client satisfaction survey was designed for implementation in June 2002.
- Canadian Health Network (CHN) - A pilot website survey found that 29 percent of users who replied were very satisfied with the CHN site, with the majority of respondents being females (63 percent), from Ontario and Quebec (25 and 20 percent respectively).
- Non-Insured Health Benefits Drug Exception Centre - A random sample survey of 1000 pharmacists who need to request approval of certain drugs for Status Indian and Inuit clients was completed in June 2002, using toll-free fax technology. The Drug Exception Centre responded to comments received from the pharmacists and adjustments were made.
- Health Canada's general enquiries 1-800 lines - A six-month regional pilot project to improve services through the General Enquiries Centre in Toronto is set to begin in September 2002.

A sixth project, a 24/7 Emergency Call Management System, was added later to assess implementation of a special 1-800 number to provide better coordination of, and access to, timely health information for the professional community in the case of a health emergency/crisis.

Government On-Line

Health Canada made significant progress on three Government On-Line (GOL) projects with funding from Treasury Board in the amount of $6.9 million:

- Canada Health Portal (CHP): Health Canada partnered with several other federal departments to develop the CHP: http://www.chp-pcs.gc.ca, as part of the larger Government of Canada On-Line initiative. The CHP is an Internet site providing Canadians with single-window access to trusted and credible health information from multiple sources such as the Canadian Health Network. The portal links the public to current health-related information from across the federal government as well as to the homepages of the provincial and territorial departments of health. The focus will now be on expanding the partnership base and integrating more content into an increasingly user-friendly site.
- Provincial-Federal First Nations and Inuit Telehealth Project: Initial phases of this project involved the development and rollout of the technical infrastructure for 41 First Nations communities, enabling them to access health care through telehealth programs. The Telehealth Project also allows for increased access to health care information through a web-based health document repository. For further information, please refer to page 64.

- First Nations and Inuit Primary Care Electronic Health Record Project: This project accelerated the development of the First Nations and Inuit Health Information System (FNIHIS) from a case management tool used by public health nurses in First Nations and Inuit communities to an integrated, primary care Electronic Health Record (EHR) used by all community health providers and linked to provincial/territorial EHRs. Experience was gained in cross-jurisdictional GOL initiatives with First Nations and Inuit. For further information, please refer to page 64.

As a result of efforts made this fiscal year, Canadians will also benefit when the National Dosimetry Services goes on-line with the measurement, analysis and reporting of radiation exposure results, improving service delivery for its 95,000 clients.

Work is also under way at Health Canada to develop procedures for the creation, publication and management of web information and services, in accordance with the Treasury Board requirement for departments to meet Common Look and Feel (CLF) and other standards for their websites by December 2002. At the same time, Health Canada is taking steps to ensure that its website continues to be a reliable and trustworthy source of health information for Canadians. These activities support the role of Health Canada as a provider of information to Canadians as well as the Government On-Line goal of making information and services accessible on-line.

> "Yahoo Health" and the Health Canada site are the most commonly visited websites, followed by the Canadian Health Network.
>
> EKOS Research Associates

Health System Performance Reporting

The Department continued its work with provincial and territorial government counterparts to realize the commitments in the Social Union Framework Agreement (SUFA) to improved performance measuring and reporting and in the First Ministers' September 2000 Communiqué on Health to develop a framework for comparable reporting. As a result, in September 2002 all jurisdictions will begin to report on indicators of health outcomes, health status and quality of services. The reports will provide consistent and comparable information to Canadians, including health policy and program decision-makers.

We began to reflect this approach in the quantitative Annex that we included in the electronic version of the Departmental Performance Report for 2000-2001 and in Appendix A of this Report. This information indicates a broad level of outcomes that cannot normally be ascribed to the actions of one Department or jurisdiction.

Health Canada has also been working with Treasury Board and a number of federal departments to

promote the principles embedded in the Social Union Framework Agreement in program delivery. For further details, please consult the SUFA Accountability Templates at:

http://www.tbs-sct.gc.ca/rma/account/sufa_e.asp.

Alternative Service Delivery - Foundations

In general, while departments continue to play an important role in service delivery, a growing need for flexibility, interdependence and innovation has produced an increasing diversity of organizational forms and service delivery arrangements to provide more responsive service to Canadians. With respect to improving the delivery of health programs and services, two foundations have been created to meet specific needs.

Improving Canada's health statistics system

In support of better decision-making and public accountability, the Government of Canada has been making a major financial contribution to improving Canada's health statistics system. In the December 2001 Budget, the Government committed a further $95 million for the Health Information Roadmap project. This will help the **Canadian Institute for Health Information (CIHI)** and Statistics Canada carry on with activities begun with the $95 million Roadmap funding (over four years) of the 1999 Budget. This funding has enabled new reports on the health of Canadians and the health of our health care system and new data sources, especially a major new survey of population health in 133 different regions that was designed and mounted in the last three years, with first results published in May 2002. Roadmap data is being used in the reports on health system performance that federal/provincial/territorial governments will publish this September and in the analysis of the Commissi on on the Future of Health Care in Canada. Roadmap funding is in addition to ongoing funding of $2.2 million provided by Health Canada to CIHI to support core CIHI programs and activities.

Accelerating the development of electronic health record solutions in the health sector

As a result of the First Ministers' Agreement on Health of September 2000, the federal government provided an initial investment of $500 million in March 2001 for the creation of an independent not-for-profit corporation mandated to accelerate the development and adoption of modern health systems of information and communications technology. **Canada Health Infoway Inc. (Infoway)** is that corporation. The corporation's membership consists of the Deputy Ministers of Health from the federal, provincial and territorial governments (to date, the Quebec Deputy Minister has chosen not to participate). Infoway's immediate priority is to foster and

accelerate the development of inter-operable electronic health record solutions on a pan-Canadian basis in a cost-effective manner to support improved quality of care. Infoway is expected to publish its annual report and business plan this year. For further information, please consult: http://www.canadahealthinfoway.ca/.

Section V:

Financial Performance

Financial Performance Overview

The following financial summary tables are presented to provide an overview of Health Canada's 2001-2002 resource utilization along with prior years' comparative information. Again this year, Health Canada has strived to utilize resources in the most effective and efficient way possible, in an effort to ensure Canadians receive value for resources expended.

Overall in 2001-2002, Health Canada did not have significant lapses. A surplus of $56.5 million or two percent of the authorities in operating and grants and contributions resources did occur. This was primarily attributable to delays encountered during the year in specific activities some of which will be completed in 2002-2003, a frozen allotment, and other small operating lapses.

Financial Summary Tables

Financial Table 1: Summary of Voted Appropriations Authorities for 2001-2002

This table reflects the break down of Health Canada's resources by Voted Appropriations. Health Canada at present has two votes: Vote 1 for Operating Expenditures and Vote 5 for Grants and Contributions.

Actual spending for Vote 1 is $38.7 million lower than authorities, mainly resulting from delays in some activities which will be carried out in 2002-2003, a frozen allotment, and other small operating lapses. The total authorities for Vote 1 are $153.7 million higher than the planned spending mainly due to newly approved resources of several initiatives such as Federal Tobacco Control, Public Security and Anti-Terrorism and Program Integrity initiatives.

Actual spending for Vote 5 is $17.8 million lower than authorities, mainly caused by delays in receiving proposals for Primary Health Care Transition Fund (PHCTF). The total authorities for Vote 5 are $71.2 million lower than the planned spending mainly resulting from a change to the funding profile related to PHCTF and the reprofiling of resources to future years related to Hepatitis C - Health Care Services, Lookback/Traceback and the Canada Health Infostructure Partnerships Program (CHIPP).

Financial Requirements by Authority (millions of dollars)

Vote		2001-2002		
		Planned Spending[1]	Total Authorities[2]	Actual Spending[2]
	Health Canada			
1	Operating expenditures	1,355.3	1,509.0	**1,470.3**
5	Grants and Contributions	1,211.4	1,140.2	**1,122.4**
(S)	Minister of Health - Salary and motor car allowance	-	0.1	**0.1**
(S)	Contributions to employee benefit plans	79.5	82.4	**82.4**
(S)	Spending of proceeds from the disposal of surplus Crown assets	-	0.8	**0.5**
(S)	Refunds of amounts credited to revenues in previous years	-	3.7	**3.7**
(S)	Payments for insured health services and extended health care services	-	(0.3)	**(0.3)**
	Total Department	**2,646.2**	**2,735.9**	**2,679.1**

Total Authorities are Main Estimates plus Supplementary Estimates plus other authorities.
1) from the 2001-2002 Report on Plans and Priorities
2) from the 2001-2002 Public Accounts

Financial Table 2: Comparison of Total Planned Spending to Actual Spending

This table reflects how resources are used within Health Canada by appropriation and by business line. Explanations of variances by business line can be found in Table 9: Details of Financial Information by Business Lines and Service Lines.

Further details for non-respendable revenues can be found in Table 5: Revenue. Cost of services provided by other departments includes accommodation, workers' compensation coverage, legal services, and employee insurance plans.

Departmental Planned versus Actual Spending 2001-2002 by Business Line (millions of dollars)

Business Lines	Full-Time Equivalents	Operating	Capital	Grants & Contributions	Total Gross Expenditures	Less: Respendable Revenues	Total Net Expenditures
Health Care Policy							
(Planned spending)	353	90.5		204.7	295.2		295.2
(Total authorities)	*341*	*82.5*		*46.6*	*129.1*		*129.1*
(Actual spending)	**375**	**76.5**		**30.6**	**107.1**		**107.1**
Health Promotion and Protection							
(Planned spending)	4,169	474.3		309.0	783.3	(39.7)	743.6
(Total authorities)	*4,128*	*549.6*	*1.2*	*260.0*	*810.8*	*(52.9)*	*757.9*
(Actual spending)	**3,951**	**533.5**	**1.2**	**258.2**	**792.9**	**(49.9)**	**743.0**
First Nations and Inuit Health							
(Planned spending)	1,414	705.1		627.6	1,332.7	(9.1)	1,323.6
(Total authorities)	*1,443*	*711.2*		*637.0*	*1,348.2*	*(9.1)*	*1,339.1*
(Actual spending)	**1,555**	**709.0**		**637.0**	**1,346.0**	**(6.9)**	**1,339.1**
Information & Knowledge Management							
(Planned spending)	635	119.3		52.8	172.1		172.1
(Total authorities)	*669*	*143.7*		*144.2*	*287.9*		*287.9*
(Actual spending)	**690**	**137.1**		**144.2**	**281.3**		**281.3**
Departmental Management & Administration							
(Planned spending)	747	91.2	3.9	17.3	112.4	(0.7)	111.7
(Total authorities)	*1,165*	*154.7*	*15.8*	*52.1*	*222.6*	*(0.7)*	*221.9*
(Actual spending)	**1,392**	**141.1**	**15.8**	**52.1**	**209.0**	**(0.4)**	**208.6**
Total							
(Planned spending)	7,318	1,480.4	3.9	1,211.4	2,695.7	(49.5)	2,646.2
(Total authorities)	*7,746*	*1,641.7*	*17.0*	*1,139.9*	*2,798.6*	*(62.7)*	*2,735.9*
(Actual spending)	**7,963**	**1,597.2**	**17.0**	**1,122.1**	**2,736.3**	**(57.2)**	**2,679.1**
Other Revenues and Expenditures							
Non-Respendable Revenues							
(Planned spending)							(7.8)
(Total authorities)							*(7.8)*
(Actual spending)							**(32.5)**
Cost of services provided by other departments							
(Planned spending)							58.6
(Total authorities)							*58.6*
(Actual spending)							**70.3**
Net Cost of the Program							
(Planned spending)							2,697.0
(Total authorities)							*2,786.7*
(Actual spending)							**2,716.9**

Financial Table 3: Historical Comparison of Total Planned Spending to Actual Spending

This table shows the trend of expenditures over time by business line. Large variances are mainly the result of new initiatives announced in recent Budget speeches, reprofiling of resources, or sunsetting of initiatives.

Some funding announcements were for one year only, as was the case in Information & Knowledge Management in 2001-2002 (e.g. Canadian Institute for Health Information).

Departmental Planned versus Actual Spending by Business Line (millions of dollars)

Business Lines	1999-2000	2000-2001	2001-2002		
	Actual Spending	Actual Spending	Planned Spending	Total Authorities	Actual Spending
Health Care Policy	128.4	112.6	295.2	129.1	107.1
Health Promotion and Protection	1,401.4[1]	634.4	743.6	757.9	743.0
First Nations and Inuit Health	1,128.1	1,266.5	1,323.6	1,339.1	1,339.1
Information & Knowledge Management	88.7	126.7	172.1	287.9	281.3
Departmental Management & Administration	148.7	180.3	111.7	221.9	208.6
Total	**2,895.3**	**2,320.5**	**2,646.2**	**2,735.9**	**2,679.1**

Total Authorities are Main Estimates plus Supplementary Estimates plus other authorities.

1) 1999-2000 Actual Spending for Health Promotion and Protection includes $855.3 million for a one-time court-ordered payment.

Financial Table 4: Crosswalk between Strategic Outcomes and Business Lines

Total Planned Spending and Actual Spending 2001-2002 (millions of dollars)

Strategic Outcomes		Business Lines: Health Care Policy	Health Promotion & Protection	First Nations & Inuit Health	Information & Knowledge Management	Departmental Management & Administration	Business Lines: Total ($)	% of Total	FTEs
Access to quality health care services for Canadians	(Planned spending)	295.2					295.2	11.2%	353
	(Actual spending)	**107.1**					**107.1**	**4.0%**	**375**
Improved well-being through health promotion and illness prevention	(Planned spending)		438.6				438.6	16.6%	1,150
	(Actual spending)		**395.3**				**395.3**	**14.7%**	**1,071**
Safer health products and food for Canadians	(Planned spending)		144.3				144.3	5.4%	**1,684**
	(Actual spending)		**128.2**				**128.2**	**4.8%**	**1,472**
Healthier environments and safer products for Canadians	(Planned spending)		139.3				139.3	5.3%	**1,051**
	(Actual spending)		**194.5**				**194.5**	**7.3%**	**1,076**
Sustainable pest management and programs for Canadians	(Planned spending)		21.4				21.4	0.8%	**284**
	(Actual spending)		**25.0**				**25.0**	**0.9%**	**332**
Sustainable health services and programs for First Nations and Inuit communities so their people may attain a level of health comparable with that of other Canadians	(Planned spending)			1,323.6			1,323.6	50.0%	1,414
	(Actual spending)			**1,339.1**			**1,339.1**	**50.0%**	**1,555**
Better health outcomes through information and communication technologies and evidence-based decision-making	(Planned spending)				172.1		172.1	6.5%	635
	(Actual spending)				**281.3**		**281.3**	**10.5%**	**690**
Effective support for the delivery of Health Canada's programs	(Planned spending)					111.7	111.7	4.2%	747
	(Actual spending)					**208.6**	**208.6**	**7.8%**	**1,392**
Strategic Outcomes	(Planned spending)	295.2	743.6	1,323.6	172.1	111.7	2,646.2		
	(Actual spending)	**107.1**	**743.0**	**1,339.1**	**281.3**	**208.6**	**2,679.1**		
% of Total	(Planned spending)	11.2%	28.1%	50.0%	6.5%	4.2%		100.0%	
	(Actual spending)	**4.0%**	**27.7%**	**50.0%**	**10.5%**	**7.8%**		**100.0%**	
Full-Time Equivalents (FTEs)	(Planned spending)	353	4,169	1,414	635	747			7,318
	(Actual spending)	**375**	**3,951**	**1,555**	**690**	**1,392**			**7,963**

Note: Due to rounding, figures may not add up to totals shown.

Financial Table 5: Revenue

Reflected in this table is the collection of respendable revenues by business line/service line and of non-respendable revenues by classification and source. Non-respendable revenues are shown by source in order to reflect the information in a useful format.

A variety of respendable revenues are collected which include Medical Devices, Radiation Dosimetry, Drug Submission Evaluation, Veterinary Drugs, Pest Management Regulation and Product Safety.

Revenues (millions of dollars)

	1999-2000 Actual Revenues	2000-2001 Actual Revenues	2001-2002 Planned Revenues	2001-2002 Total Authorities[1]	2001-2002 Actual Revenues
Respendable Revenues[2]					
Business Lines/Service Lines					
Health Promotion and Protection					
Population and Public Health	0.1	0.0	0.0	0.0	0.1
Health Products and Food	39.8	34.5	36.0	36.0	35.5
Healthy Environments and Consumer Safety	6.6	6.9	3.5	9.9	7.4
Pest Management Regulation	7.3	7.0	0.2	7.0	6.9
First Nations and Inuit Health					
First Nations and Inuit Health	6.8	7.2	9.1	9.1	6.9
Departmental Management and Administration					
Corporate Services	0.4	0.3	0.7	0.7	0.4
Total Respendable Revenues[2]	**61.0**	**55.9**	**49.5**	**62.7**	**57.2**
Non-Respendable Revenues					
Main Classification and Source					
Tax revenues:					
Goods and services tax	0.3	0.2	-	-	-
Non-tax revenues:					
Food and drug analysis fees	-	-	0.2	0.2	-
Refunds of expenditures	5.2	11.6	-	-	14.5
Service fees	1.9	1.7	2.8	2.8	1.8
Pharmacy and dietary revenues	-	-	3.6	3.6	
Proceeds from the disposal of surplus Crown assets	0.6	0.8	-	-	0.6
Miscellaneous non-tax revenues	6.6	8.5	1.2	1.2	15.6
Total Non-Respendable Revenues	**14.6**	**22.8**	**7.8**	**7.8**	**32.5**
Total Revenues	**75.6**	**78.7**	**57.3**	**70.5**	**89.7**

1) Total Authorities are Main Estimates plus Supplementary Estimates plus other authorities.
2) Respendable Revenues: These revenues were formerly called "Revenues Credited to the Vote" and are available for spending by the Department.

Financial Table 6: Statutory Payments

Health Canada's only statutory payment in recent years was for a one-time court-ordered payment of $855.3 million providing compensation to individuals infected with Hepatitis C through the blood supply between January 1, 1986 and July 1, 1990.

Statutory Payments by Business Line (millions of dollars)

Business Line	1999-2000 Actual Spending	2000-2001 Actual Spending	2001-2002 Planned Spending	2001-2002 Total Authorities[1]	2001-2002 Actual Spending
Health Promotion and Protection	855.3	0.0	0.0	0.0	**0.0**
Total Statutory Payments	**855.3**	**0.0**	**0.0**	**0.0**	**0.0**

1) Total Authorities are Main Estimates plus Supplementary Estimates plus other authorities.

Financial Table 7: Transfer Payments

This table reflects the break down of Transfer Payments (Grants, Contributions, and Other Transfer Payments) by Business Line. Large variances are mainly the result of new initiatives announced in recent Budget speeches (e.g. Canada Prenatal Nutrition Program, Canadian Diabetes Strategy, Sustaining the Health Protection Capacity, Federal Tobacco Control Strategy, Primary Health Care Transition Fund) and the reprofiling of resources (e.g. Hepatitis C Health Care Services and Lookback/Traceback). Some funding announcements were for one year only, as was the case in Information & Knowledge Management in 2001-2002 (e.g. Canadian Institute for Health Information).

Transfer Payments by Business Line (millions of dollars)

Business Lines	1999-2000 Actual Spending	2000-2001 Actual Spending	2001-2002 Planned Spending	2001-2002 Total Authorities[1]	2001-2002 Actual Spending
Grants					
Health Care Policy	11.9	11.9	0.9	1.1	**1.1**
Health Promotion and Protection	54.9	23.7	28.4	23.3	**23.3**
Information and Knowledge Management	0.0	0.0	0.0	95.0	**95.0**
Total Grants	**66.8**	**35.6**	**29.3**	**119.4**	**119.4**
Contributions					
Health Care Policy	49.3	43.0	203.8	45.5	**29.5**
Health Promotion and Protection	157.8	172.6	209.6	180.9	**179.1**
First Nations and Inuit Health	545.9	589.1	627.6	637.0	**637.0**
Information and Knowledge Management	12.5	20.8	52.8	49.2	**49.2**
Departmental Management and Administration	32.2	41.0	17.3	52.1	**52.1**
Total Contributions	**797.7**	**866.5**	**1,111.1**	**964.7**	**946.9**
Other Transfer Payments					
Health Promotion and Protection	0.0	29.6	71.0	55.8	**55.8**
Total Other Transfer Payments	**0.0**	**29.6**	**71.0**	**55.8**	**55.8**
Total Transfer Payments	**864.5**	**931.7**	**1,211.4**	**1,139.9**	**1,122.1**

1) Total Authorities are Main Estimates plus Supplementary Estimates plus other authorities.

Financial Table 8: Resource Requirements by Organization and Business Lines

Comparison of 2001-2002 (RPP) planned spending and total authorities to actual spending by organization and business line.
Explanations of variances by business line can be found in Table 9: Details of Financial Information by Business Lines and Service Lines (millions of dollars)

Organization	Business Lines					Total
	Health Care Policy	Health Promotion and Protection	First Nations and Inuit Health	Information and Knowledge Management	Departmental Management and Administration	
Health Policy and Communications						
(Planned spending)	295.2					295.2
(Total authorities)	*129.1*					*129.1*
(Actual Spending)	**107.1**					**107.1**
Population and Public Health						
(Planned spending)		438.6				438.6
(Total authorities)		*395.4*				*395.4*
(Actual Spending)		**395.3**				**395.3**
Health Products and Food						
(Planned spending)		144.3				144.3
(Total authorities)		*138.4*				*138.4*
(Actual Spending)		**128.2**				**128.2**
Healthy Environments and Consumer Safety						
(Planned spending)		139.3				139.3
(Total authorities)		*199.1*				*199.1*
(Actual Spending)		**194.5**				**194.5**
Pest Management Regulatory Agency						
(Planned spending)		21.4				21.4
(Total authorities)		*25.0*				*25.0*
(Actual Spending)		**25.0**				**25.0**
First Nations and Inuit Health						
(Planned spending)			1,323.6			1,323.6
(Total authorities)			*1,339.1*			*1,339.1*
(Actual Spending)			**1,339.1**			**1,339.1**
Information, Analysis and Connectivity						
(Planned spending)				172.1		172.1
(Total authorities)				*287.9*		*287.9*
(Actual Spending)				**281.3**		**281.3**
Corporate Services						
(Planned spending)					90.8	90.8
(Total authorities)					*103.7*	*103.7*
(Actual Spending)					**101.6**	**101.6**
Departmental Executive						
(Planned spending)					20.9	20.9
(Total authorities)					*118.2*	*118.2*
(Actual Spending)					**107.0**	**107.0**
Total						
(Planned spending)	295.2	743.6	1,323.6	172.1	111.7	2,646.2
(Total authorities)	*129.1*	*757.9*	*1,339.1*	*287.9*	*221.9*	*2,735.9*
(Actual Spending)	**107.1**	**743.0**	**1,339.1**	**281.3**	**208.6**	**2,679.1**
% of Total	**4.0%**	**27.7%**	**50.0%**	**10.5%**	**7.8%**	**100.0%**

Numbers in italics denote Total Authorities for 2001-2002 (Main and Supplementary Estimates and other authorities).

Financial Table 9: Details of Financial Information by Business Lines and Service Lines

Business Line 1: Health Care Policy (millions of dollars)

	Planned Spending 2001-2002	Total Authorities 2001-2002	Actual Spending 2001-2002
Gross expenditures	295.2	129.1	107.1
Revenues	N/A	N/A	N/A
Net expenditures	295.2	129.1	107.1*

* This represents 4.0 percent of the Department's actual spending.

Decrease between planned spending versus authorities is mainly due to a change in the funding profile of the Primary Health Care Transition Fund (PHCTF).

Variance between authorities and actual spending is also mainly caused by delays in receiving proposals for the PHCTF.

Business Line 2: Health Promotion and Protection (millions of dollars)

	Planned Spending 2001-2002	Total Authorities 2001-2002	Actual Spending 2001-2002
Gross expenditures	783.3	810.8	792.9
Revenues	(39.7)	(52.9)	(49.9)
Net expenditures	743.6	757.9	743.0*

* This represents 27.7 percent of the Department's actual spending.

Refer to Service Lines for explanations of variances.

Financial Table 9: Details of Financial Information by Business Lines and Service Lines (continued)

Service Line 1: Population and Public Health (millions of dollars)

	Planned Spending 2001-2002	Total Authorities 2001-2002	Actual Spending 2001-2002
Gross expenditures	438.6	395.4	395.4
Revenues	0.0	0.0	(0.1)
Net expenditures	438.6	395.4	395.3*

* This represents 53.1 percent of the Health Promotion and Protection actual spending.

Variances between planned spending versus total authorities and actual spending are mainly due to reprofiling of resources to future years of Hepatitis C - Health Care Services and Lookback/Traceback initiatives.

Service Line 2: Health Products and Food (millions of dollars)

	Planned Spending 2001-2002	Total Authorities 2001-2002	Actual Spending 2001-2002
Gross expenditures	180.3	174.4	163.7
Revenues	(36.0)	(36.0)	(35.5)
Net expenditures	144.3	138.4	128.2*

* This represents 17.3 percent of the Health Promotion and Protection actual spending.

The actual spending is $10.2 million lower than total authorities. This is the result of delays in various activities throughout this service line as well as some reduced program requirements. Revenues collected in excess of forecast also contributed to the lapse.

Resources will be carried forward to 2002-2003 when delayed activities will be carried out.

Financial Table 9: Details of Financial Information by Business Lines and Service Lines (continued)

Service Line 3: Healthy Environments and Consumer Safety (millions of dollars)

	Planned Spending 2001-2002	Total Authorities 2001-2002	Actual Spending 2001-2002
Gross expenditures	142.8	209.0	201.9
Revenues	(3.5)	(9.9)	(7.4)
Net expenditures	139.3	199.1	194.5*

* This represents 26.2 percent of the Health Promotion and Protection actual spending.

Variances between planned spending and total authorities are due to the approval of the Workplace Health and Public Safety Program (WHPSP) vote netting authority, and funding for the Federal Tobacco Control Strategy and the *Canadian Environmental Protection Act (CEPA)* and Public Security and Anti-Terrorism (PSAT).

Variances between total authorities and actual spending for revenues are mainly due to less revenues than anticipated collected by the Workplace Health and Public Safety Program.

The actual spending is $4.6 million lower than total authorities mainly resulting from delays in some activities related to the areas of Tobacco Control, Drug Strategy and Controlled Substances, and Environmental Assessment.

Resources will be carried forward to 2002-2003 when delayed activities will be carried out.

Service Line 4: Pest Management Regulation (millions of dollars)

	Planned Spending 2001-2002	Total Authorities 2001-2002	Actual Spending 2001-2002
Gross expenditures	21.6	32.0	31.9
Revenues	(0.2)	(7.0)	(6.9)
Net expenditures	21.4	25.0	25.0*

* This represents 3.4 percent of the Health Promotion and Protection actual spending.

Variances between planned spending and total authorities are mainly due to the approval of Pest Management Regulatory Agency vote netting authority.

Financial Table 9: Details of Financial Information by Business Lines and Service Lines (continued)

Business Line 3: First Nations and Inuit Health (millions of dollars)

	Planned Spending 2001-2002	Total Authorities 2001-2002	Actual Spending 2001-2002
Gross expenditures	1,332.7	1,348.2	1,346.0
Revenues	(9.1)	(9.1)	(6.9)
Net expenditures	1,323.6	1,339.1	1,339.1*

* This represents 50.0 percent of the Department's actual spending.

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

- funding for First Nations' construction and restoration of on-reserve facilities being shown in the Departmental Management and Administration business line;
- newly approved funding (i.e. not in planned spending) to maintain the sustainability of the Program.

Business Line 4: Information and Knowledge Management (millions of dollars)

	Planned Spending 2001-2002	Total Authorities 2001-2002	Actual Spending 2001-2002
Gross expenditures	172.1	287.9	281.3
Revenues	N/A	N/A	N/A
Net expenditures	172.1	287.9	281.3*

* This represents 10.5 percent of the Department's actual spending.

The variance between planned spending and authorities is mainly due to:

- the approval of a one-time grant of $95 million to the Canadian Institute for Health Information (CIHI);
- Program Integrity funding for IM/IT Implementation;
- the reprofiling to future years of the Canada Health Infostructure Partnerships Program (CHIPP)

The actual spending is $6.6 million lower than total authorities mainly resulting from delays in the implementation of a new platform for the Canadian Health Network.

Resources will be carried forward to 2002-2003 when delayed activities will be carried out.

Financial Table 9: Details of Financial Information by Business Lines and Service Lines (continued)

Business Line 5: Departmental Management and Administration (millions of dollars)

	Planned Spending 2001-2002	Total Authorities 2001-2002	Actual Spending 2001-2002
Gross expenditures	112.4	222.6	209.0
Revenues	(0.7)	(0.7)	(0.4)
Net expenditures	111.7	221.9	208.6*

* This represents 7.8 percent of the Department's actual spending.

Variances between planned spending versus total authorities and actual spending are mainly due to newly approved resources for several initiatives such as Capital Rust-Out, as well as funding related to the support for First Nations' construction/restoration of on-reserve facilities and other functions that were realigned to this business line during the year.

The actual spending is $13.3 million lower than total authorities mainly resulting from the setting aside of funds to cover the increased costs of the employee benefit plan and other departmentally-supported costs.

Financial Table 10: Contingent Liabilities

There are a number of individual and class action suits against the Government involving allegations of negligence related to its role in the regulation of medical devices, blood and drug products. Because of the complexity of the claims and the early stage of the litigation in these cases, any estimation of contingent liability at this point would be highly speculative and could not be said to be a reasoned evaluation.

Section VI:

Other Information

Departmental Contacts

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Vancouver, British Columbia
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Telephone: (604) 666-2083
Facsimile: (604) 666-2258

Headquarters

Telephone: (613) 957-2991

Facsimile: (613) 941-5366

Website: http://www.hc-sc.gc.ca

or write to:

Health Canada
0900C2 Podium Level,
Brooke Claxton Building
Ottawa, Ontario, CANADA
K1A 0K9

References

Selected Health Canada Publications

Best Practices: Concurrent Mental Health and Substance Use Disorders

Best Practices: Fetal Alcohol Syndrome/Fetal Alcohol Effects and the Effects of Other Substance Use During Pregnancy

Best Practices: Treatment and Rehabilitation for Women with Substance Use Problems

Best Practices: Treatment and Rehabilitation for Youth with Substance Use Problems

Bringing Up Baby

Canada's Physical Activity Guide for Healthy Active Living for Older Adults

Child Health Record

Healthy Development of Children and Youth: The Role of the Determinants of Health

It Helps to Talk: How to Get the Most from a Visit to your Doctor. Patient's Guide

It Helps to Talk: The 5-minute Guide to better Communication. Doctor's Guide

Nutrition for Healthy Term Infants

Perspectives on Complementary and Alternative Health Care

Profile - Substance Abuse Treatment and Rehabilitation in Canada

Second Report on the Health of Canadians: Toward a Healthy Future

Trends in the Health of Canadian Youth

Why All Women Who Could Become Pregnant Should be Taking Folic Acid

Documents can be ordered from:

Publications

Health Canada

Ottawa, Ontario

K1A 0K9

Telephone: (613) 954-5995

Facsimile: (613) 941-5366

Telecommunication Device for the Deaf: 1-800-267-1245

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Appendix A:

Measuring Health in Canada - more results relating to the Health Status of Canadians

Measuring Health in Canada provides information on the health status and health determinants of Canadians, with a particular emphasis on the health of the First Nations. International comparisons have been made on these topics whenever available. Where possible, a standard subset of nations was used for these comparisons; however, data restrictions limit this for some indicators.

Measuring Health in Canada is organized around the three major topics for health system performance reporting identified in the First Ministers' Communiqué on Health of September 2000. These are: 1) health status; 2) health outcomes; and 3) quality of service. At that time, First Ministers reaffirmed their commitment in the 1999 Social Union Framework Agreement to report regularly to constituents. Governments agreed to provide comprehensive and regular public reporting on health programs and services they deliver, on health system performance, and on progress on key priorities. Jurisdictions released their reports in September 2002. The *Federal Report on Comparable Health Indicators* may be found at:

http://www.hc-sc.gc.ca/iacb-dgiac/arad-draa/english/accountability/indicators.html

In *Measuring Health in Canada*, we have, wherever possible, used indicators and definitions agreed to in the First Ministers' process. However, the charts that have been included in this Appendix place more emphasis on areas specific to Health Canada's programs and activities and present a slightly different look at the underlying data by profiling health trends, and highlighting health outcomes as they relate to Health Canada.

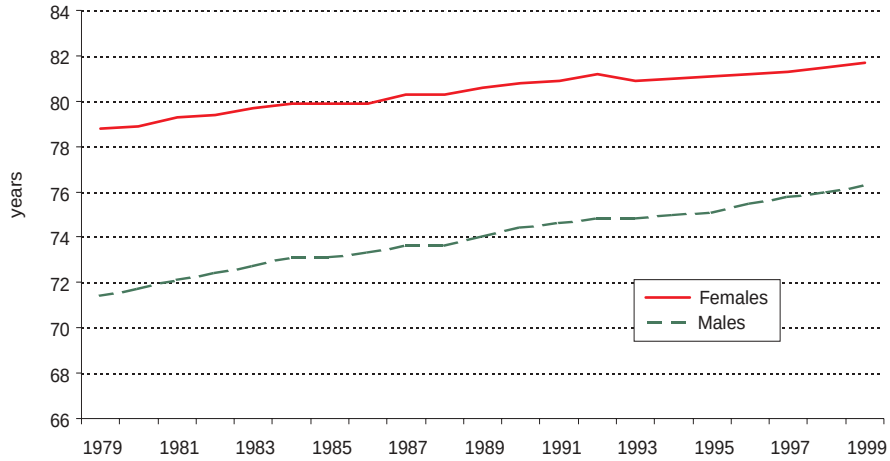
Measuring Health in Canada provides information on:

1. Health Status

2. Health Outcomes

3. Quality of Service

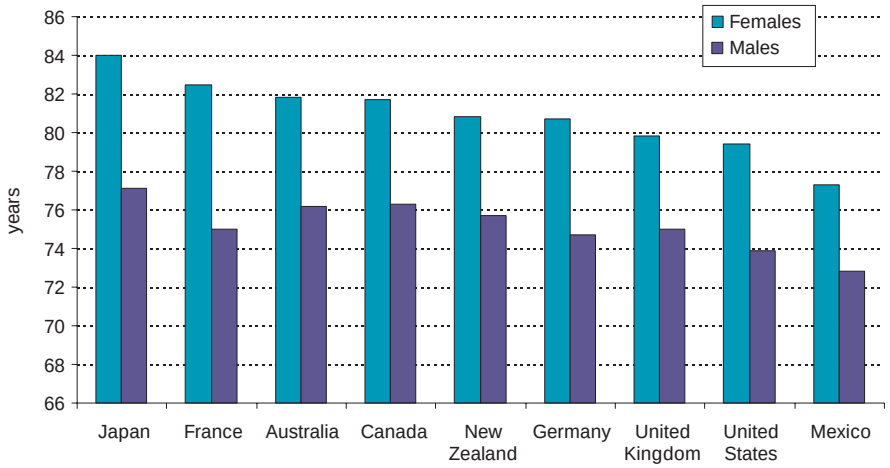
Life Expectancy at Birth by Sex, Canada, 1979-1999



Source: Statistics Canada, Canadian Vital Statistics, Birth and Death Databases, and Demography Division (population estimates)

Life expectancy at birth has increased steadily over the 20th century, even in recent decades. In 1999, life expectancy was 81.7 for women and 76.3 for men. While women in general live longer than men, the gap between the sexes has decreased from 6.3 in 1990 to 5.4 in 1999.

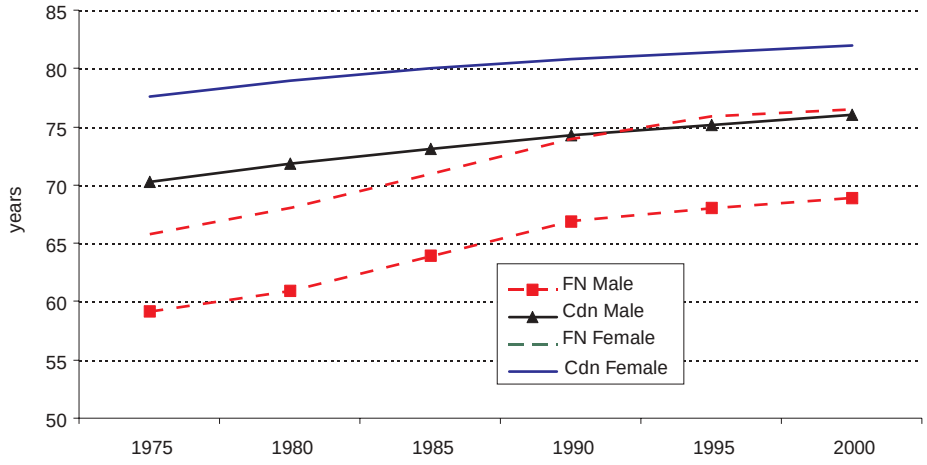
Life Expectancy at Birth by Sex, International Comparisons, 1999



Source: OECD Health Data 2002

Life expectancy of Canadians is higher than in most countries. Life expectancy across the countries listed ranges, for both men and women, from a low in Mexico (males 72.8 and females 77.3) to a high in Japan (males 77.1 and females 84.0).

Life Expectancy at Birth by Sex, Registered First Nations and General Population, 1975 – 2000

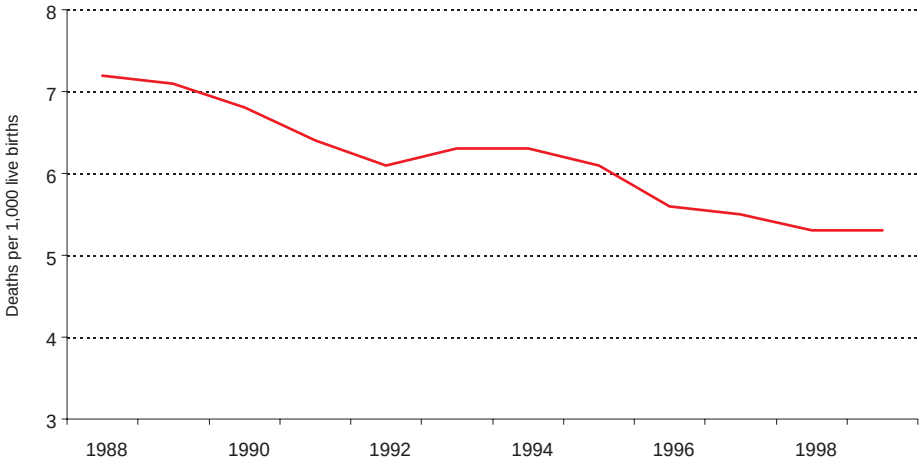


Source: Population Projections of Registered Indians, 1998-2008, Department of Indian Affairs and Northern Development, 1999

Life expectancy for Registered Indian males and females has been increasing steadily since 1975, at a pace such that the gap with the general population continues to steadily decrease.

Note: First Nations are classified as Registered Indians both on and off-reserve. Year 2000 life expectancy is an estimate.

Infant Mortality Rates, Canada, 1988 – 1999

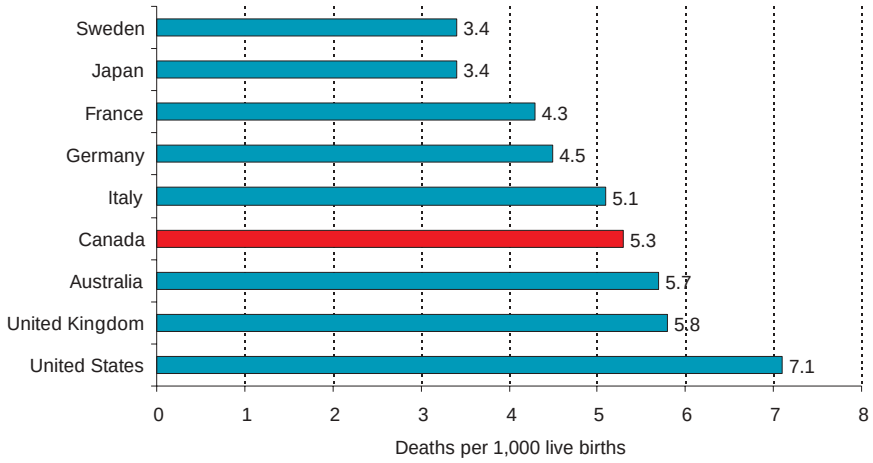


Source: Statistics Canada, Birth and Death Databases

Canada's infant mortality rate has decreased steadily, with gains even since the late 1980s.

Note: Infant Mortality Rate is defined as number of infants who die in the first year of life (i.e. from time of birth to first birthday), expressed as a rate per 1,000 live births.

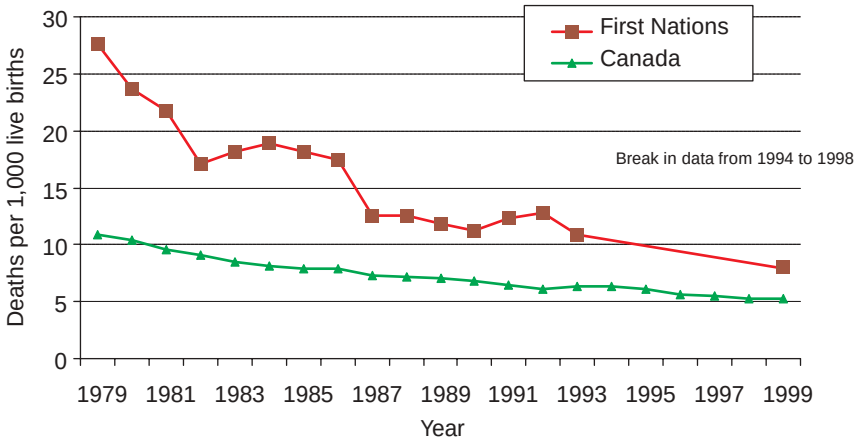
Infant Mortality Rates, International Comparisons, 1999



Source: OECD Health Data 2002

Canada has one of the best infant mortality rates in the world, at 5.3 deaths per 1,000 live births. Japan and Sweden had the lowest infant mortality rate in 1999 at 3.4 per 1,000 live births.

Infant Mortality Rates, First Nations and Canada, 1979 – 1999

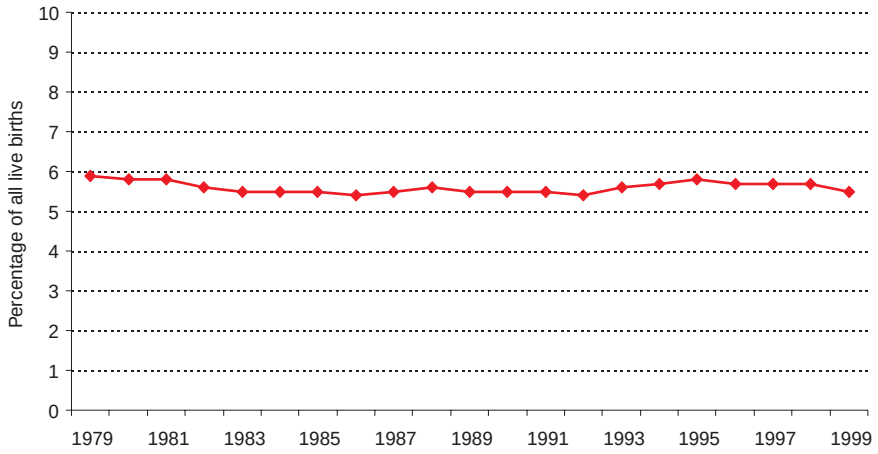


Source: Statistics Canada; Health Canada, First Nations and Inuit Branch (formerly Medical Services Branch), Trends in First Nations Mortality 1979 -1993

The First Nations infant mortality rate has been declining steadily since the mid 1980s. Historically, infant mortality in First Nations has been higher than in the general population, but the gap is narrowing.

Notes: Rates include all births under 500 grams. Data were unavailable for the First Nations population for the years 1994-1998. Current data may not be directly comparable to previous years due to different data collection methods.

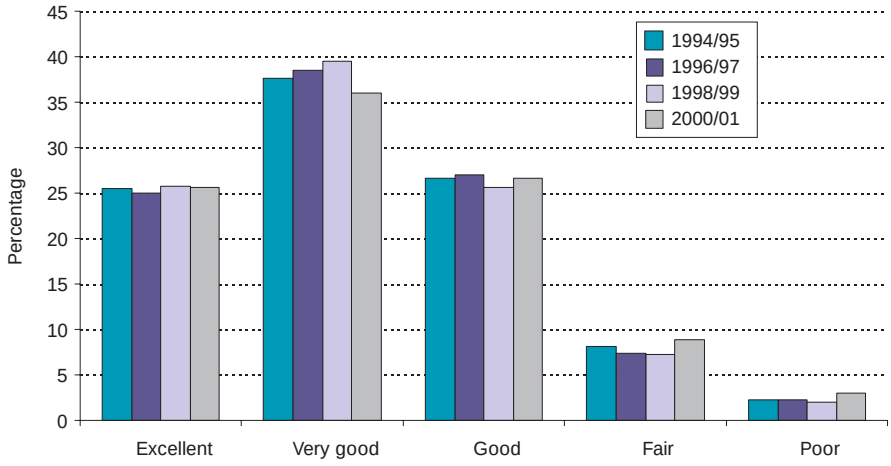
Prevalence of Low Birth Weight, Canada, 1979 – 1999



Source: Statistics Canada, Canadian Vital Statistics, Birth Database

Infants born with low birth weight are more likely to experience complications. The rate for low birth weight (i.e. less than 2,500 grams) in Canada has been relatively stable for the past two decades, and is down significantly from the 1960s.

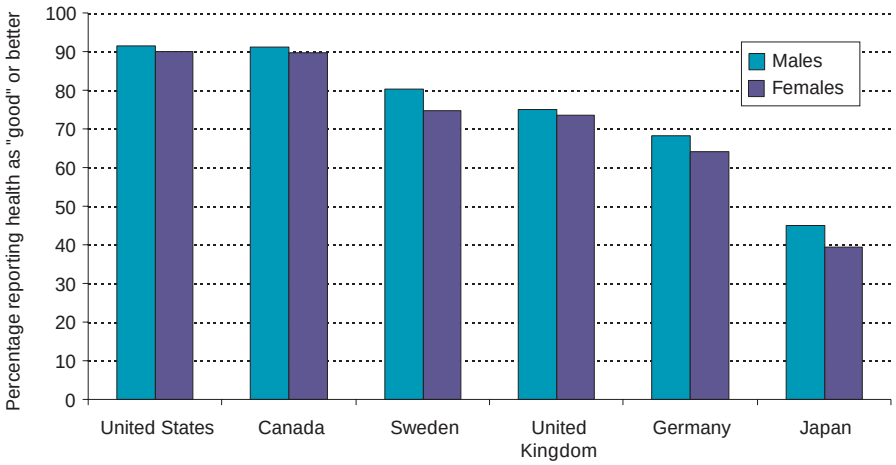
Self-Reported Health Status, Canada, 1994/95 – 2000/01



Source: National Population Health Survey 1994/95 – 1998/99,
Canadian Community Health Survey 2000/01

In 2000/01, approximately 88% of Canadians rated their health as good, very good or excellent. However, the number of Canadians who reported their health as fair or poor increased slightly between 1994/95 and 2000/01.

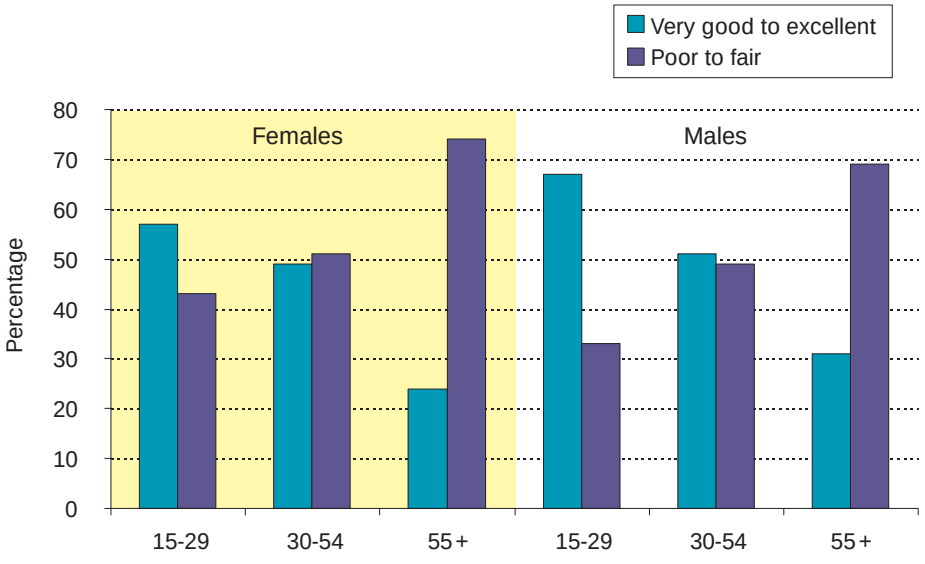
Self-Reported Health Status, International Comparisons, 1998



Source: OECD Health Data 2002

Self-reported health status of Canadians is virtually the same as that of Americans. The two countries have significantly higher rates of good health than other industrialized countries.

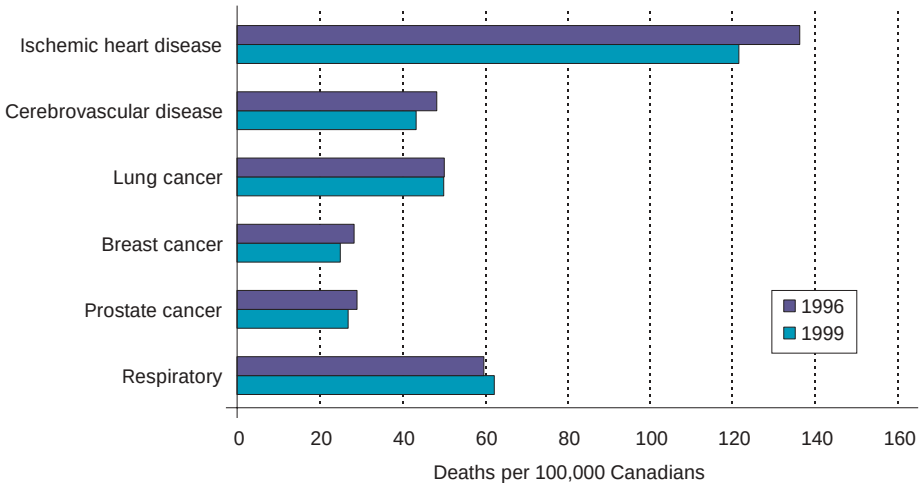
Self-Reported Health Status, First Nations, by Age and Sex, 1999



Source: First Nations and Inuit Regional Health Survey, National Report 1999

In younger age groups, more First Nations men than women report very good to excellent health status. In the age group 15-29, only 57% of women report their health status as very good to excellent.

Age-Standardized Mortality for Chronic Conditions, Canada, 1996, 1999

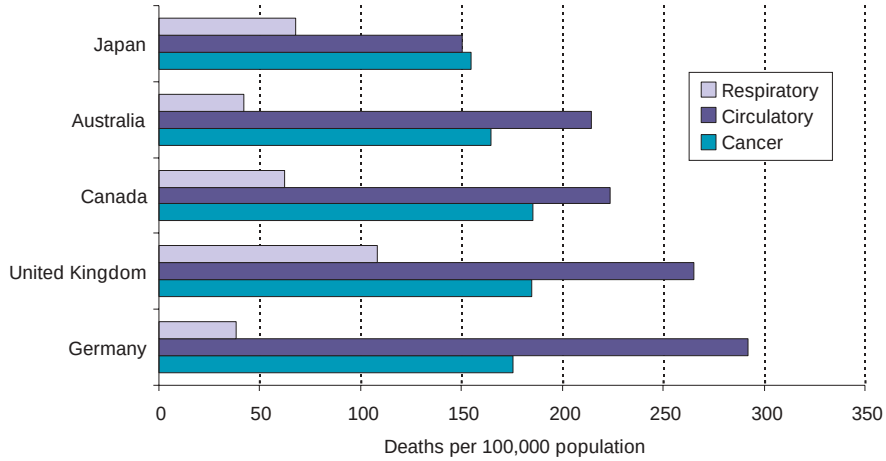


Source: Statistics Canada Health Indicators 2002 (1996 data), Statistics Canada Deaths Shelf Tables, 1999 (1999 data)

Heart disease continues to be the leading cause of death in the Canadian population, with 121.7 deaths per 100,000 Canadians in 1999. Among the causes listed, respiratory disease is the next most common cause (62.3 deaths per 100,000 in 1999), while lung cancer has overtaken stroke as the third leading cause (50.0 deaths per 100,000 in 1999).

Note: Prostate cancer figures are for males only; breast cancer figures are for females only.

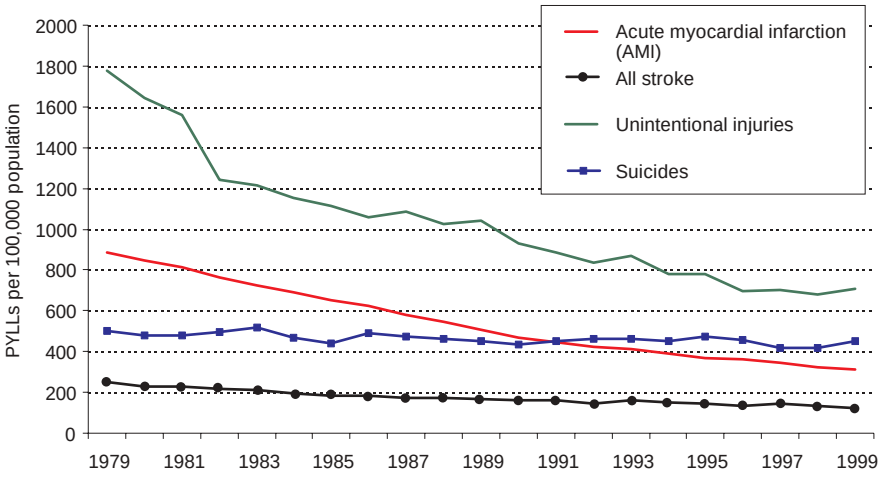
Age-Standardized Mortality for Selected Causes, International Comparisons, 1999



Source: OECD Health Data 2002

Age-standardized mortality rates in Canada for cancer and respiratory and circulatory diseases are comparable to other OECD countries.

Potential Years of Life Lost, Selected Causes of Death, Canada, 1979 – 1999

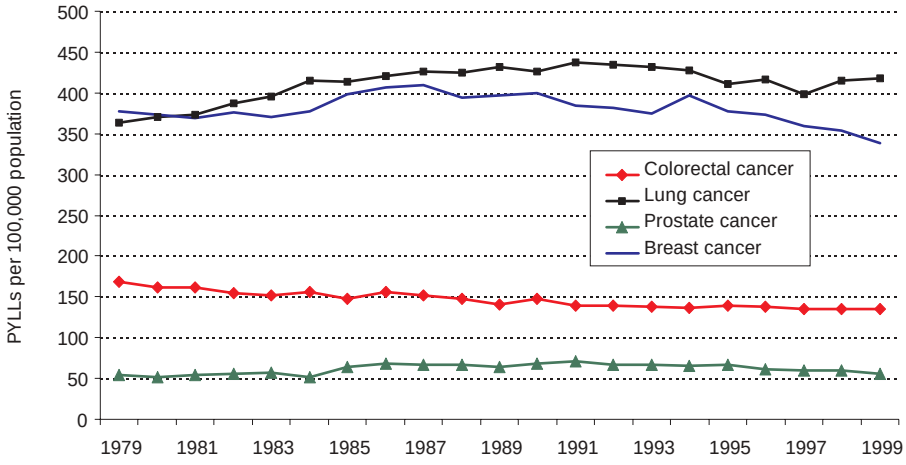


Source: Statistics Canada Health Indicators 2002

Potential years of life lost to acute myocardial infarction (heart attack) have decreased steadily in the past two decades. PYLLs due to unintentional injury have also decreased significantly.

Note: Potential years of life lost (PYLL) is the number of years of life "lost" when a person dies "prematurely" from any cause before age 75.

Potential Years of Life Lost, Selected Cancers, Canada, 1979 – 1999

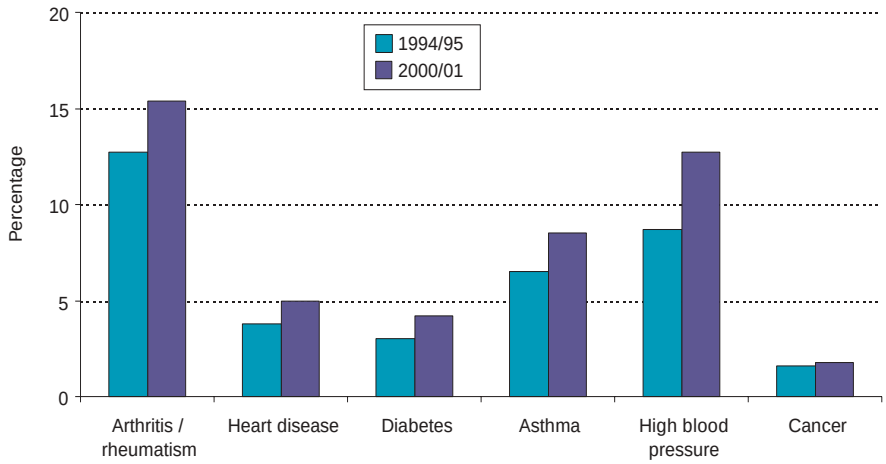


Source: Statistics Canada Health Indicators 2002

Lung cancer costs Canadians more potential years of life than any other form of cancer. Potential years of life lost to breast cancer have dropped since 1994.

Note: Prostate cancer figures are for males only; breast cancer figures are for females only.

Self-Assessed Prevalence of Chronic Conditions, Canada, 1994/95 – 2000/01

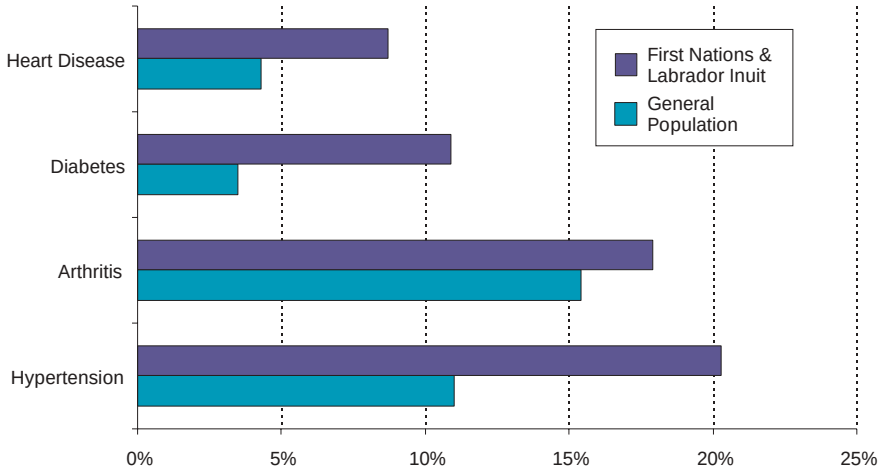


Source: National Population Health Survey 1994/95, Canadian Community Health Survey 2000/01

The number of Canadians who have had a chronic condition diagnosed by a health professional has increased for all major chronic conditions since 1994/95. This may be reflective of an aging population.

Note: Question asked whether respondent had a condition which had lasted or would last for 6 months, diagnosed by a health professional.

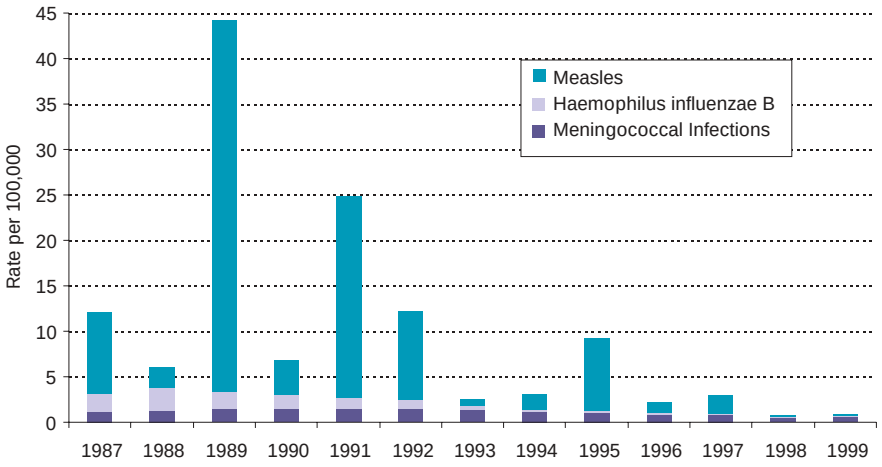
Prevalence of Chronic Conditions, First Nations/Labrador Inuit and General Population, Canada, 1998/99



Source: National Population Health Survey (1998/99), Statistics Canada.
First Nations and Inuit Regional Health Survey (1999), Assembly of First Nations

Heart disease, diabetes, arthritis and hypertension are all more prevalent among the First Nations and Labrador Inuit people than in the general population.

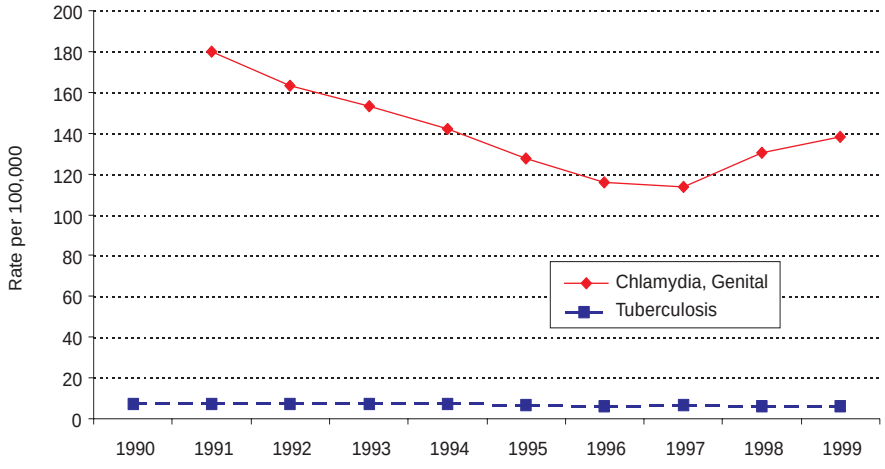
Incidence of Selected Vaccine-Preventable Diseases, Canada, 1987 – 1999



Source: Population and Public Health Branch, Health Canada

Vaccine-preventable diseases are, by definition, diseases whose burden can be reduced by effective uses of health system resources. Incidence rates for vaccine-preventable diseases have diminished since 1987.

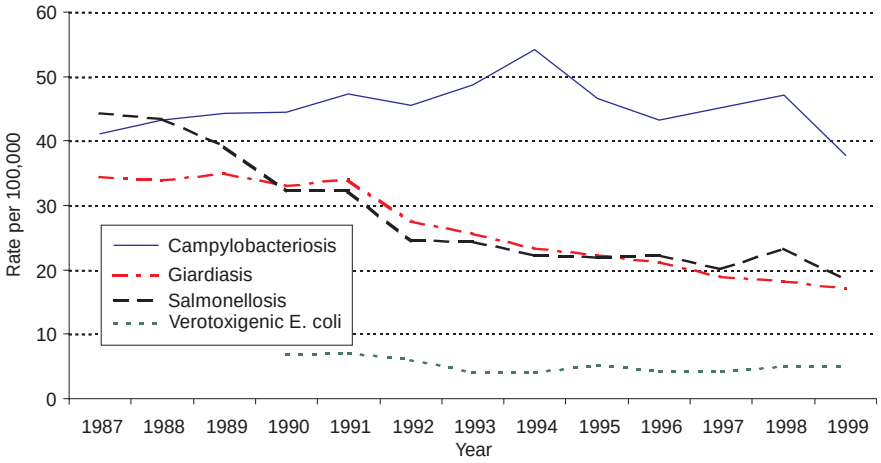
Incidence of Selected Notifiable Diseases, Canada, 1990-1999



Source: Population and Public Health Branch, Health Canada

The incidence rate for chlamydia, a sexually transmitted disease, has decreased 23.3% since 1991; however, there is an increase from its low in 1997. Incidence of tuberculosis remained consistently low for the entire decade.

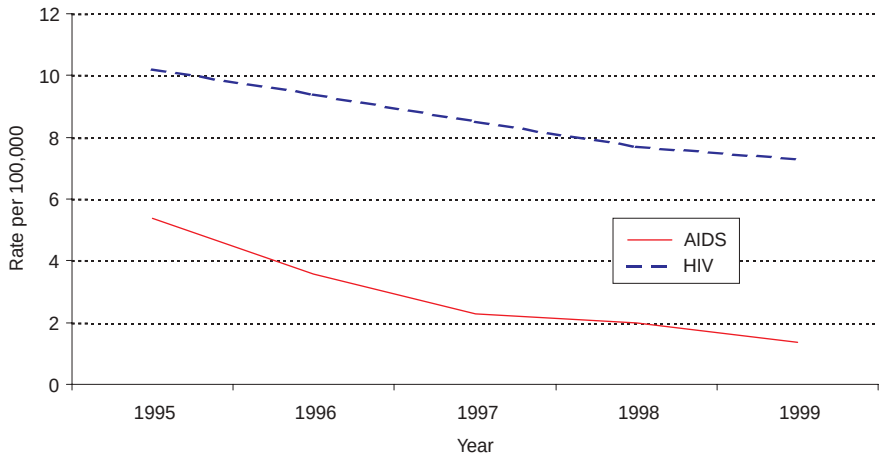
Incidence of Food-Borne Illness, Canada, 1987 – 1999



Source: Population and Public Health Branch, Health Canada

Reported incidence of food- and water-borne illnesses shown here has diminished since 1987. Incidence of salmonellosis has shown the greatest decline in that period (58.4%).

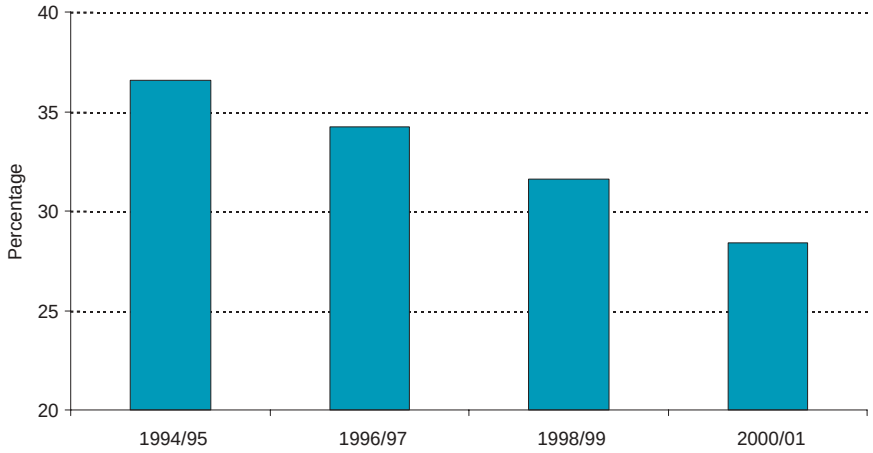
Incidence of HIV and AIDS per 100,000, Canada, 1995 – 1999



Source: Population and Public Health Branch, Health Canada

The incidence of both HIV and AIDS has declined significantly since 1991. New reported cases of AIDS have decreased from 5.38 cases per 100,000 Canadians in 1995 to 1.36 per 100,000 in 1999, a decrease of 74.7%. New incidences of HIV have declined from 10.2 to 7.3 cases per 100,000 Canadians in that same period, for a decrease of 28.4%.

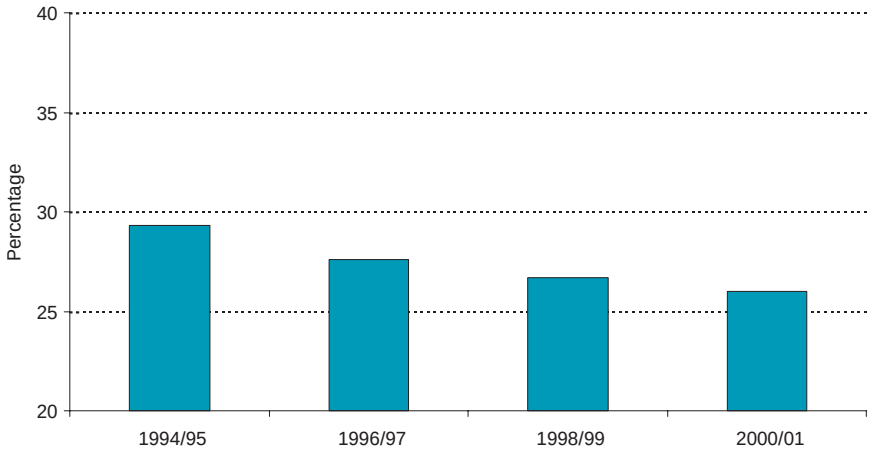
Exposure to Cigarette Smoke in the Home, Canada, 1994/95 – 2000/01



Source: National Population Health Survey 1994/95 – 1998/99, Canadian Community Health Survey 2000/01

The percentage of Canadians who reported being in the same household as a smoker has decreased steadily since 1994/95.

Current Smoker Rate, Age 12+, Canada, 1994/95 – 2000/01

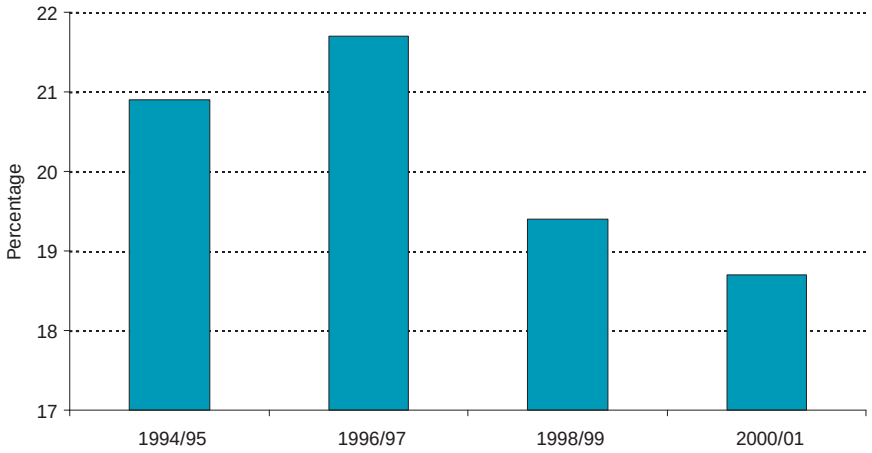


Source: National Population Health Survey 1994/95 – 1998/99, Canadian Community Health Survey 2000/01

Canada's smoking rate has decreased in the last decade, from 29.3% in 1994/95 to 26.0% in 2000/01.

Note: Current smoker is defined as someone who is either a daily smoker or an occasional smoker.

Current Smoker Rate, Age 12-19, Canada, 1994/95 - 2000/01

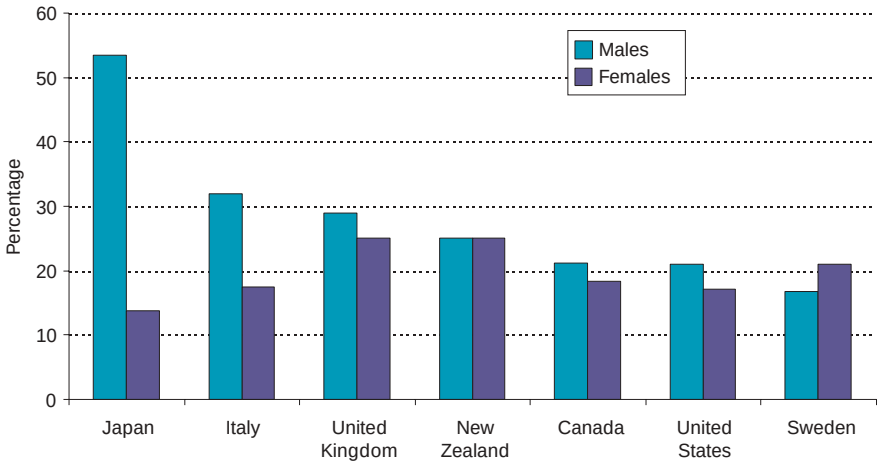


Source: National Population Health Survey 1994/95 – 1998/99, Canadian Community Health Survey 2000/01

Similarly, prevalence of smoking among young Canadians has declined. The smoking rate among Canadians aged 12-19 has decreased 13.8% since 1996/97.

Note: Current smoker is defined as someone who is either a daily smoker or an occasional smoker.

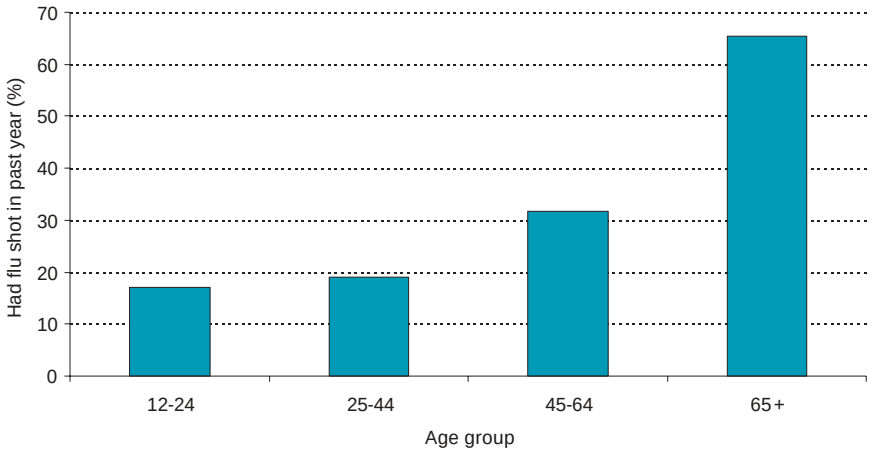
Prevalence of Daily Smoking, Age 15+, International Comparisons, 2000



Source: OECD Health Data 2002

Canada's smoking rates for both sexes are similar to those of the OECD countries shown.

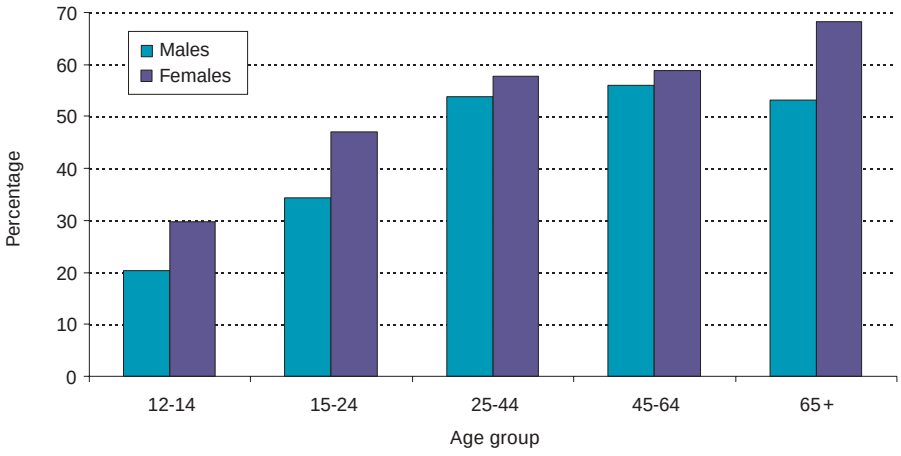
Influenza Inoculation in Past Year, by Age, Canada, 2000/01



Source: Canadian Community Health Survey 2000/01

The likelihood of Canadians having been inoculated against influenza in the past year increases with age, to a high of 65.5% for Canadians aged 65 or over.

Physical Inactivity, by Age and Sex, Canada, 2000/01

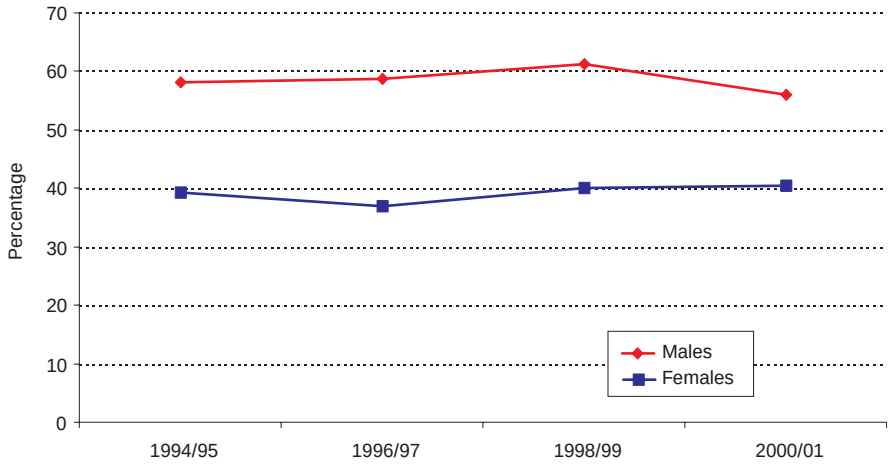


Source: Canadian Community Health Survey 2000/01

Physical inactivity is one of the prime risk factors for many chronic conditions, including heart disease, stroke and diabetes.

Canadians tend to be less active as they grow older. Males tend to be more active than females across all age groups.

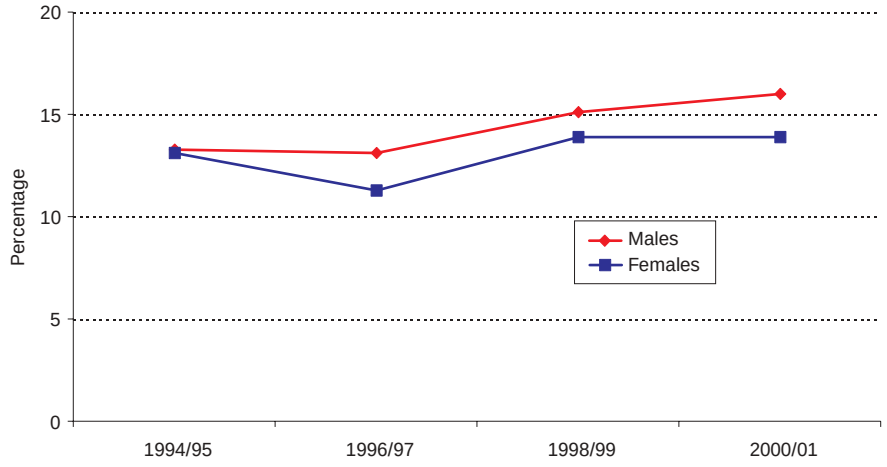
Overweight/Obesity Prevalence, by Sex, Canada, 1994/95 – 2000/01



Source: National Population Health Survey 1994/95 – 1998/99, Canadian Community Health Survey 2000/01

Prevalence of overweight/obesity has remained relatively stable since 1994/95, for both males and females.

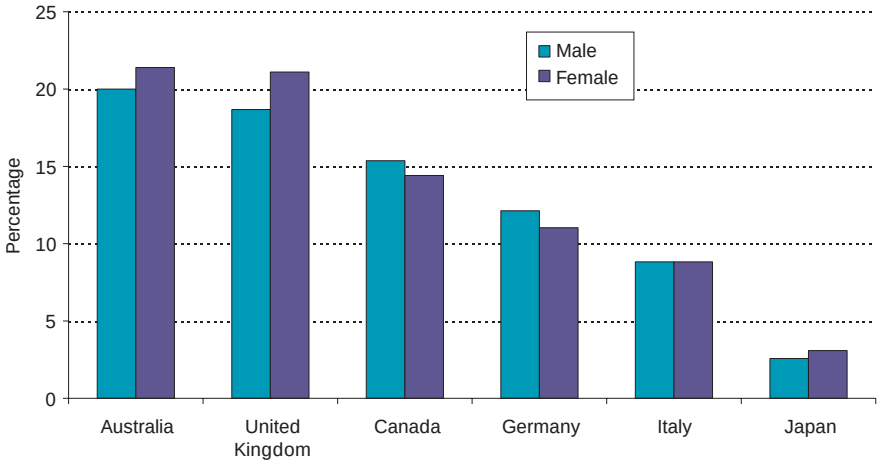
Obesity Prevalence, by Sex, Canada, 1994/95 – 2000/01



Source: National Population Health Survey 1994/95 – 1998/99, Canadian Community Health Survey 2000/01

Prevalence of obesity (body mass index greater than 30) has increased for both sexes since 1994/95.

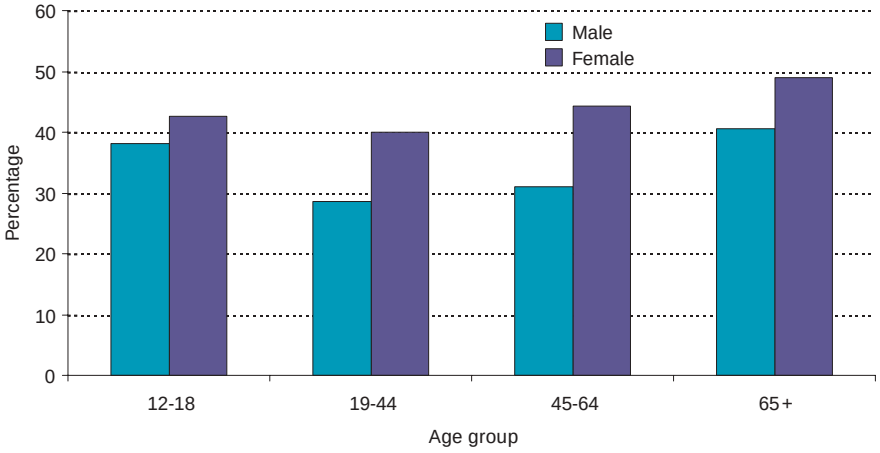
Obesity by Sex, International Comparisons, 1999



Source: OECD Health Data 2002 (Canadian data obtained from 1998/99 National Population Health Survey, American data obtained from National Center for Chronic Disease Prevention and Health Promotion)

Rates of obesity in Canada in 1999 (15.4% for males, 14.4% for females) were in the middle of other OECD countries, for both males and females.

Daily Fruit and Vegetable Consumption of Five or More Servings, by Age and Sex, Canada, 2000/01



Source: Canadian Community Health Survey, 2000/01

According to the Canada Food Guide, the recommended amount of fruit and vegetable consumption is 5-10 servings per day. Only 37.4% of Canadians consume at least five servings of fruit and vegetables each day. Women are more likely to consume fruits and vegetables than men, regardless of age.

Appendix B:

Executive Summary: Response to the Public Accounts Committee - First Nations Health: Follow-Up

Response to the Public Accounts Committee Tenth Report on the Auditor General's Report, October 2000 (Health Canada – First Nations follow-up)

Introduction

The Public Accounts Committee (PAC) as a follow-up to the 2000 Auditor General's report, tabled recommendations in December 2001 requiring Health Canada to implement and report on improvements to its accountability and management activities. Health Canada agrees with the Standing Committee and the Auditor General (OAG) that health programs for First Nations and Inuit must be well managed and accountable. This document highlights some of the progress made by the Department since the release of the PAC/OAG report. Our progress on actions taken towards Auditor General and Public Accounts Committee recommendations is fully reported in the electronic Annex D of the Departmental Performance Report 2001-2002. The continuing need for additional reporting will be reviewed with the Auditor General after three years of reporting. A copy of the Government Response to the PAC Report is also part of the comprehensive electronic Annex D of the Departmental Performance Report (http://www.hc-sc.gc.ca/english/care/estimates/index.htm).

Health Canada has chosen to respond to the 26 recommendations by grouping information under five themes:

- Reporting to Parliament on progress
- Community Health Programs (CHP) accountability
- Supporting capacity development
- Measuring performances, outcomes achievement, and managing information
- Non-Insured Health Benefits (NIHB) control and prevention measures

Several important milestones were reached in 2001-2002 as Health Canada worked to implement a strong

accountable management regime. New program accountability frameworks were introduced, comprehensive standard agreements were developed and implemented, a single contracts and contributions management system was implemented to enhance reporting, monitoring and auditing and an Intervention Policy was introduced to guide our actions in communities which have been unable or unwilling to address problem areas.

Recommendations and follow-up actions

Reporting to Parliament on progress. The major recommendation under this theme is that Health Canada inform Parliament of the progress it is making in implementing the recommendations contained in chapter 13 of the 1997 Report and chapter 15 of the 2000 Report of the Auditor General of Canada and in the Committee's 5th Report (36th Parliament, 1st Session). This information must make specific reference to progress in implementing each recommendation and be provided annually in Health Canada's Performance Reports, beginning with the Report for the period ending March 31, 2002.

Key actions taken

To respond to this Recommendation as well as Recommendations 5, 9, 11, 16, 19, 23 and 24, we will be reporting with a web-based link to Departmental Performance Reports. Paper copies will be available upon request. The ongoing need for this special reporting requirement will be reassessed with the Auditor General in three years, after her next audit on First Nations and Inuit health programs. An initial PAC reporting Annex was prepared for the Departmental Performance Report 2001-2002 and full reporting will begin in 2002-2003.

Community Health Programs (CHP) accountability. Greater focus is being placed by the Department on providing accountable and sustainable programs and services for First Nations and Inuit. We are implementing measures to better manage internally and externally to deliver the best possible service to First Nations and Inuit communities.

Key actions taken

To address the recommendations regarding accountability and respond to the need for a nationwide standardized system for monitoring contribution agreements, First Nations and Inuit Health Branch (FNIHB) developed and implemented the Monitoring Contract and Contribution System (MCCS). This is one of the ways we will address the need for risk-based monitoring in our accountability documents. We will also conduct an MCCS Quality Assurance Review during the course of 2002-2003.

FNIHB is developing a comprehensive reporting handbook for Community Health Programs with Program Reporting Guidelines.

- A draft of the Financial Reporting Guidelines for the handbook was developed and reviewed by a working group.
- A quality assurance review of the reporting process is being planned and will be done once results of the OAG First Nations Reporting Study is undertaken.

An Intervention Policy was developed to address problem situations that may arise under health funding arrangements. A handbook to assist in implementing the policy was approved and distributed.

- A communication plan was developed.
- A review of the Intervention Policy will take place in three years.

Supporting capacity development. Health Canada shares the Public Accounts Committee's belief that capacity development is a priority. The Government recognizes that a participatory approach contributes to community capacity development. The Transfer Policy (1988) and the Integrated Community-Based Health Services Approach (1999) allow Health Canada to engage First Nations and Inuit in arrangements that permit various levels of control ranging from general and integrated contribution agreements to transfer contribution agreements.

Actions taken

We have developed Health Plan Demonstration Sites that will improve our capacity to manage health programs and services; improve capacity to identify community health needs and resources; improve management coordination; integrated health programs and services; improve financial and human resources allocation processes; and enhance programs and services management information and reporting.

FNIHB is looking at adapting some of the tools developed or being developed for the Health Plan Demonstration Projects for First Nations and Inuit communities interested in pursuing transfer activities. As of June 30, 2002, there are seven demonstration sites for the health planning process across Canada. These are: Pacific Region - Kitselas Band Council; Alberta Region - Bigstone Cree First Nation and Blood Tribe; Saskatchewan Region - Gordon First Nation; Manitoba Region - Little Grand Rapids First Nation; Quebec Region - Eagle Village First Nation (Kipawa); and Yukon Region - Liard First Nation.

In addition, to improve internal capacity, FNIHB is holding two regional training sessions - in August and fall 2002. We will provide refreshers for existing staff and training for new staff on the authorities, accountability requirements, policies, guidelines and procedures for all new and renewal transfer agreements.

Measuring performances, outcomes achievement, and managing information. Health Canada is committed to effective management of its programs by making important decisions with relevant data. Collecting good performance information is a priority of the Department.

Key actions taken

FNIHB is planning to work with Statistics Canada and the National Aboriginal Health Organization (NAHO) to support the First Nations Regional Longitudinal Survey to provide health information about on-reserve populations.

- Three questionnaires for the survey have been finalized and translated into French.
- The sampling plan, training materials, and field manuals are complete.

- NAHO and FNIHB are developing a License to Use Data Agreement which will be finalized in September 2002.

First Nations and Inuit Health Branch will report on the data collected to demonstrate the health outcomes achieved by Community Health Programs and the Non-Insured Health Benefits Program in the Annex to the Departmental Performance Report beginning with the 2003-2004 Report.

FNIHB is currently developing its multi-year evaluation plan in the context of its contribution programs authority renewal initiative. In accordance with the Transfer Payment Policy, all terms and conditions of contributions programs must be renewed by March 31, 2005. The authority renewal submission must be supported by program evaluation information and a Result-Based Management Accountability Framework must be defined for each of the programs. The evaluation strategy will be finalized in the fall of 2002. Program evaluations for the Canada Prenatal Nutrition Program, Aboriginal Head Start for First Nations On-Reserve, and the Canadian Strategy on HIV/AIDS for First Nations On-Reserve will be undertaken by March 31, 2003 and evaluation results will be available by 2004.

Non-Insured Health Benefits (NIHB) control and prevention measures The Public Accounts Committee recommended that Health Canada enhance the quality of management of services provided to First Nations and Inuit. The Department is committed to progress and has taken steps to improve the management of NIHB.

Key actions taken

The PAC recommended that Health Canada immediately upgrade the Point-of-Sale system for pharmacies under the NIHB Program so that the system provides the dates, quantities, and drugs prescribed of at least a client's last three prescriptions and information on doctors visited. The Point-of-Sale system or Pharmacy Electronic Communication Standard (PECS) Version 3 is the current industry standard. Currently over 99 percent of providers on the NIHB Program are utilizing this system.

- A technical advisory group representing the Canadian Pharmacists Association and a broad spectrum of users including FNIHB has been tasked with developing enhancements to Version 3.
- Once implemented, the enhanced standard will streamline claims administration, facilitate efficient coordination of benefits, improve access to patient medication history (including Drug Utilization Review data) and provide interactive communication with other health professionals.

FNIHB will continue to ensure that the analysis of pharmacists' overrides of warnings is done, and will conduct audits on providers and continue generating quarterly reports on the number of Drug Utilization Review (DUR) claims submitted, accepted and rejected. These actions will be reported in the annual Departmental Performance Report beginning with 2002-2003.

The PAC/OAG also recommended that Health Canada develop a policy to guide its response in cases where it is unable to obtain the consent of

recipients of Non-Insured Health Benefits to share information on their use of pharmaceuticals with health care professionals and that the Department make that policy known prior to the implementation of a client consent arrangement under the NIHB Program. In July 2002, the NIHB Program conducted the national rollout of the consent initiative and developed a communication package outlining the consent initiative. The campaign outlined the purpose of consent, the options for giving consent and how the information will be used, collected and disclosed. If the recipient does not sign the general consent form, covering all benefit areas in conjunction with the consent campaign, the recipient must complete an NIHB Program reimbursement form in order for benefits to be provided.

Summary

The Department is committed to reporting on actions taken on the Public Accounts Committee and Auditor General recommendations. We will implement greater measures to improve on our management of First Nations and Inuit programs and services. We will report on progress made in the annual Departmental Performance Report.

Appendix C:

Executive Summary: Response to the Public Accounts Committee - Human Resources

Response to the Public Accounts Committee Tenth Report on the Auditor General's Report, October 2000 (Health Canada - Vacancies in regulatory and surveillance programs)

Introduction

The Public Accounts Committee (PAC) as a follow-up to the 2000 Auditor General's report, tabled recommendations requiring Health Canada to fill outstanding vacancies in its regulatory and surveillance programs for related biologics and to report progress on these initiatives.

Recommendation 26.41 states that "Health Canada should take measures to ensure authorized positions are staffed." This recommendation is in the context of funding received to strengthen the regulatory side of Health Canada's Blood Safety Program and is tied to recommendations by the Public Accounts Committee in their Seventeenth Report, as follows.

Recommendation 11

That Health Canada undertake all the necessary measures to fill outstanding vacancies in its regulatory and surveillance programs for related biologics and report the progress of these initiatives in its annual Performance Report to Parliament for the period ending March 31, 2003.

Recommendation 12

That Health Canada include in its annual Performance Report a section containing the number of technical and scientific vacancies in its regulatory and surveillance programs at each year end with the length of time each position has been vacant.

Actions and current status

Several organizational changes have taken place over the past two years in an effort to strengthen both the regulation and surveillance of biological products within the Health

Products and Food Branch (HPFB). These include the creation of the Biologics and Genetic Therapies Directorate (BGTD), the Marketed Health Products Directorate (MHPD) and the Inspectorate.

Management recently approved a special Human Resources Initiative to accelerate recruitment. The project will focus internally on the retention of the highly qualified staff needed to deliver the program and externally on attracting and recruiting highly specialized staff to fill the numerous vacancies in a timely fashion.

During 2001-2002, BGTD has grown from 130 to 180 filled positions. Specific focus continues to be paid to staffing to address attrition and internal movement, as well as gaps in expertise.

In MHPD, priorities for staffing will concentrate on Medical Officers and management staff in the short-term. Staff within the Biologics Division of MHPD has grown from approximately 12 to 23. Staffing over the past year has become more efficient through hiring from Scientific Job Fairs. Operational planning for the current year combined with three year strategic planning will be conducted in the near future now that stable funding has been secured.

The HPFB Inspectorate's 17 positions assigned to biologics have been staffed and the planned projects implemented.