Health Canada

Departmental Performance Report

For the period ending
March 31, 2005

The Honourable Ujjal Dosanjh
Minister of Health

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Section I

Overview

Minister's Message

Every day we are reminded that health issues are a top priority for Canadians. To meet the many challenges and responsibilities associated with this priority, it is essential that this Department and Government continually invest in effective health policies and programs that improve the lives of all Canadians.

At the heart of our responsibilities is our role in promoting and protecting the health of Canadians. This Departmental Performance Report illustrates how we listened to concerns, responded, and worked with many partners to deliver results in a number of specific areas.

I am proud of our many accomplishments in 2004–2005. Among the most notable achievements was the 10-Year Plan to Strengthen Health Care which First Ministers agreed upon in September 2004. That Plan, supported by federal funding of $41 billion to the provinces and territories, is already generating the results that Canadians expect, including progress on initiatives to reduce wait times and to increase the numbers of doctors, nurses and other health professionals, as well as enhancements in other key areas such as primary health care and pharmaceuticals management.

In September 2004, the First Ministers also reached an agreement with Aboriginal leaders to develop a Blueprint to improve the health of Aboriginal peoples. This cooperative approach and federal investment of $700 million over five years demonstrate a commitment to work with all jurisdictions and Aboriginal communities to improve life chances and close the gap in health status between Aboriginal peoples and other Canadians. Working in conjunction with these communities, Health Canada continued to target the health promotion and disease prevention needs of First Nations and Inuit through a broad range of services and community programs. The Department also improved health facilities in a number of First Nations communities and funded the creation of nursing positions to better meet health needs. Initiatives such as these continue to be key components to the overall goal of improved access to health services for First Nations and Inuit.

In 2004–2005, significant progress was made in regulatory efficiency, effectiveness, and responsiveness by improving drug submission review times and facilitating access to new medicines. We responded to Canadians' concerns and strengthened public trust and stakeholder relationships by seeking public input concerning certain drugs, such as COX-2 inhibitors, and by committing to establish a permanent Safety Board to advise us on an ongoing basis.

In terms of nutrition, the revision of *Canada's Food Guide to Healthy Eating* will ensure that the Department continues to provide information on a pattern of eating

that promotes health and minimizes the risk of nutrition-related chronic disease. The Guide was the most visited page on our Web site, a clear signal that our efforts to encourage Canadians to take control of their health are working.

In 2004–2005, following the Severe Acute Respiratory Syndrome (SARS) crisis, Health Canada oversaw the transition of our Population and Public Health Branch into the new Public Health Agency of Canada. This development ensures strong direction with the support of legislative authority in the protection and promotion of public health and the prevention of injury.

We also continued our positive work on decreasing tobacco use by developing and implementing a national coordinated approach to tobacco cessation, and Canada was one of the first countries to ratify the Framework Convention on Tobacco Control, the first international health treaty adopted by the World Health Assembly.

Health Canada also made substantial progress in our ongoing pursuit of improvements in environmental health. The Department developed a National Air Quality Index that is now ready to be piloted, worked to reduce risks to child health from lead content in children's jewellery, and strengthened regulations on cosmetic ingredient labelling. And thanks to our efforts in 2004–2005, Canadians now have better access to safer pesticides that are regulated by a more effective and transparent process.

Our Department recognizes that all sectors of Canadian society are subject to the harms that can result from problematic use of alcohol, other drugs and substances. Therefore, we committed to spearheading the development of a National Framework for Action to reduce the harms associated with alcohol and drugs and substances. All sectors, including provincial, territorial and municipal governments and agencies, non-governmental organizations, and many others are coming together to develop and implement this Framework.

One of the most important missions for this Department, and for the Government of Canada, has been the ongoing strengthening of our accountability, openness and transparency. Canadians need to have confidence that their governments are not just investing in health, but investing effectively. Indicators of the health of Canadians have been established as measurement tools to monitor, evaluate and improve health services. Overall, we continue to ensure good management and value for money invested.

During 2004–2005, Health Canada and the Government of Canada continued to work to maintain and improve the health of Canadians—to deliver results that make a difference in their lives. The scientific activities undertaken at Health Canada, and by our partners across the national health research system, have played an important role in the accomplishments outlined in this Report and in contributing to improved health for Canadians. We are proud to have honoured the commitment to renew and revitalize the health care system. Moreover, our accomplishments over the past year attest that we are taking the right steps to ensure that Canadians will remain among the healthiest people in the world.

While this Departmental Performance Report is focused on Health Canada's performance, we recognize that "health is everybody's business." As such, our achievements are also the result of collaboration with provincial and territorial governments, First Nations and Inuit communities, and our many stakeholders: non-governmental organizations, health care providers, the medical industry, and other sectors and organizations—and of the effort and passion of Health Canada's own employees.

Ujjal Dosanjh
Minister of Health

Management Representation Statement

I submit for tabling in Parliament, the 2004–2005 Departmental Performance Report (DPR) for Health Canada.

This document has been prepared based on the reporting principles contained in the Treasury Board of Canada Secretariat's Guide for the preparation of 2004–2005 Departmental Performance Reports. It adheres to the specific reporting requirements:

- uses an approved Business Lines structure;
- presents consistent, comprehensive, balanced and accurate information;
- provides a basis of accountability for the results pursued or achieved with the resources and authorities entrusted to it; and
- reports finances based on approved numbers from the Estimates and the Public Accounts of Canada.

Morris Rosenberg
Deputy Minister

Summary Information

About Health Canada

The Canadian health system is one of our most cherished institutions, and is an embodiment of our national character and our values as a people. As such, there is no more important challenge or responsibility for this Government, and for the country as a whole, than meeting the health needs and expectations of its people.

The fact that health is a paramount priority is recognized by Parliament and the Government of Canada, and accordingly, Health Canada is mandated to address the health agenda in this country.

The *Department of Health Act* formally establishes the Department's mandate, while the Minister of Health is also responsible for the direct administration of another 18 laws, which to mention a few, include the *Canada Health Act*, the *Food and Drugs Act*, the *Pest Control Products Act*, the *Tobacco Control Act*, the *Hazardous Products Act*, and the *Controlled Drugs and Substances Act*. In addition to these legislated responsibilities, the Department has significant science and research, policy development, and program and service delivery roles that benefit Canadians.

Our Vision

As the federal department responsible for helping the people of Canada maintain and improve their health, 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

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

- prevent and reduce risks to individual health and the overall environment;
- promote healthier lifestyles;
- ensure high quality health services that are efficient and accessible;
- integrate renewal of the health care system with longer term plans in the areas of prevention, health promotion and protection;

- reduce health inequalities in Canadian society; and
- provide health information to help Canadians make informed decisions.

Achieving Results in a Complex Health Environment

As our Report on Plans and Priorities for 2004–2005 described in detail, Health Canada operates in a complex environment.[1] We generate knowledge through the research, analysis and evaluations that we conduct, partner in and support. We also draw on the knowledge that is being generated around the world to help us and others make informed, effective choices. The five core roles we play that achieve results, drawing on our strengths as a science-based department include the following:

Leader/Partner—through the administration of the *Canada Health Act*, which embodies the key values and principles of Medicare. By its role as champion, Health Canada provides leadership, by example, for other federal departments in the implementing a Gender-Based Analysis policy as a reflection of the federal government's commitment to reducing health inequalities for all people living in Canada.

Funder—through policy support for the federal government's Canada Health Transfer. Health Canada also transfers funds to First Nations and Inuit organizations to help them deliver community health services and provides grants and contributions to various organizations which reinforce the Department's health objectives.

Guardian/Regulator—through a stewardship role that involves both protecting Canadians and facilitating the provision of products vital to health and well-being. Our Department regulates and approves the use of thousands of products, including pesticides, toxic substances, pharmaceuticals, biologics, medical devices, natural health products, consumer goods and foods. We deliver a range of programs and services in environmental health and protection, and have responsibilities in the areas of substance abuse, tobacco policy, workplace health and the safe use of consumer products.

Service Provider—through the provision of supplementary health benefits to approximately 765,000 eligible First Nations and Inuit people to cover pharmaceuticals, dental services, vision services, medical transportation, medical supplies and equipment and provincial health premiums. We provide health programs and services to First Nations and Inuit communities, including prevention, promotion, and primary care, as well as addiction services.

Information Provider—through performing high-quality science and research, we support policy development, regulate increasingly sophisticated products and provide the services, information and management essential to affordable and world-class health care for Canadians. Through research and surveillance, we provide information that Canadians can use to maintain and improve their health.

Canadians increasingly recognize that their health and quality of life are determined by environmental, social and economic factors. Health Canada is committed to helping create and maintain healthy social and physical environments and to promote a vigorous economy for all Canadians. This is achieved by integrating sustainable development into departmental decision-making, management processes and physical operations.

Health Canada analyzes the health issues facing Canada and specific groups of Canadians by applying gender and diversity lenses, and identifies the most appropriate opportunities to achieve results or to support other partners in doing so. In choosing the most appropriate roles to action, we recognize that the health status of Canadians is the result of many factors and determinants. Many of these are beyond the scope or mandate of Health Canada or any government, with others representing areas where this Department can make a difference.

To get results, we work with partners in all levels of government, throughout the health system, among specific groups such as First Nations and Inuit, across Canadian society and internationally to achieve shared commitments and results. In many cases, these partners

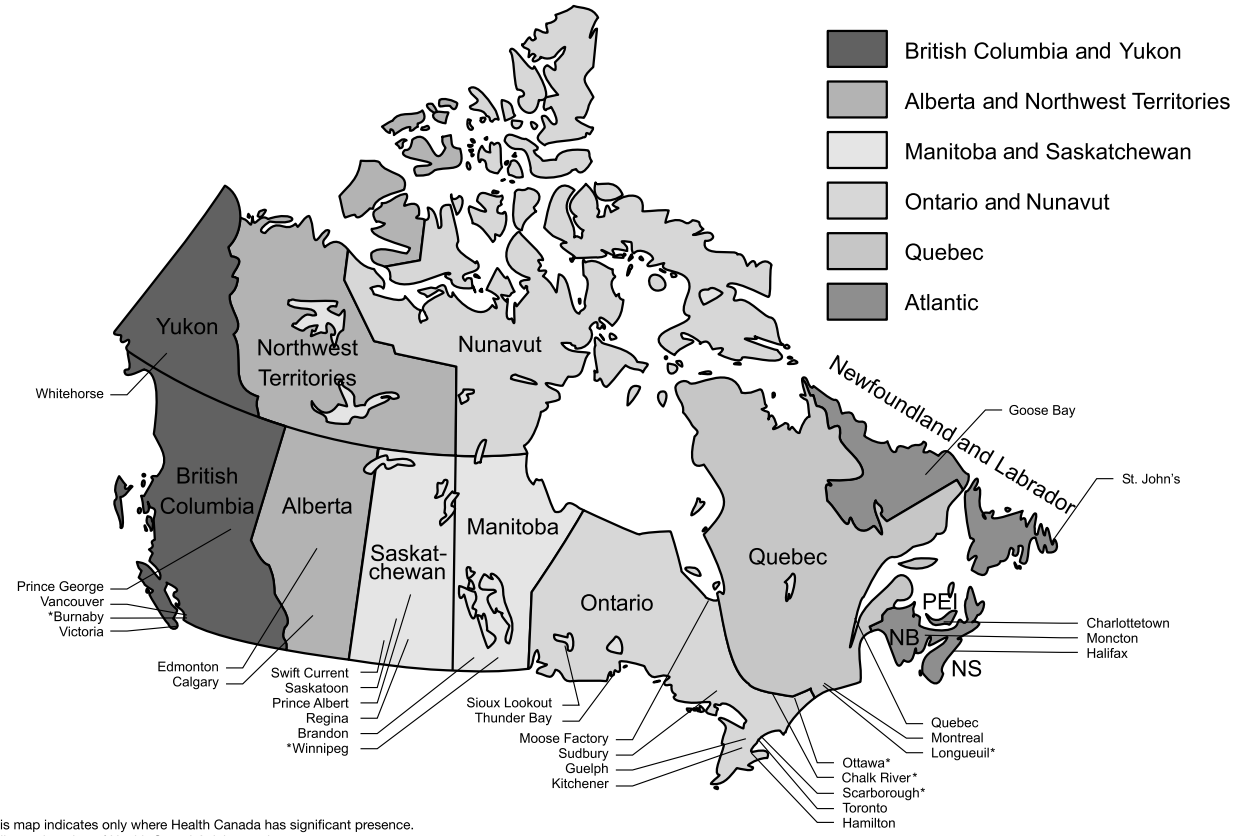
[1] http://www.tbs-sct.gc.ca/est-pre/20042005/HLTH-SANT/HLTH-SANTr45_e.asp

include other agencies within the Government of Canada Health Portfolio, each of which has its own Performance Report:

- Canadian Institutes of Health Research;
- Hazardous Materials Information Review Commission;
- Patented Medicine Prices Review Board; and
- new Public Health Agency of Canada, which was created in September 2004.

As the accompanying map shows, our Department achieves results through efforts and partnerships across a range of departmental branches, each of which has specific mandates. Roughly 35 percent of Health Canada employees work outside of the National Capital Region. They deliver health services and programs in First Nations and Inuit communities, manage links with provincial and territorial governments, conduct laboratory investigations, work with local health organizations, serve as a front-line service and information provider for Canadians and much more. This strong regional presence enables us to maximize the reach and effectiveness of departmental programs and resources, by matching national directions to local conditions and opportunities.

Health Canada at Work Across the Country



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

Contributing to Canada's Performance

The President of the Treasury Board Secretariat (TBS) issues an annual report to Parliament, *Canada's Performance*. As part of implementing a more strategic approach to policy-setting, program operations and resource allocation across the Government of Canada, this report analyzes the current situation and progress towards major outcomes that the Government seeks and Canadians expect. This information is drawn from linkages to the strategic outcomes that individual departments and agencies have identified in their DPRs.

Our Department specifically contributes to the achievement of three outcomes identified in *Canada's Performance*: Healthy Canadians with Access to Quality Health Care; Improved Health of Aboriginal People; and Inclusive Society that Promotes Linguistic Duality and Diversity.

Improving Performance Measurement

Health Canada is committed to creating and using a performance management system that enables us to focus our resources to maximize the health benefits for Canadians. Given the importance that Canadians attach to effective and meaningful government actions in support of health, our performance measurement system is an important element of Government-wide initiatives such as Results for Canadians: A Management Framework for the Government of Canada.[2]

Following the 2003 TBS announcement of new government initiatives to strengthen comptrollership across the federal government (http://www.tbs-sct.gc.ca/spsm-rgsp/spsm-rgsp3_e.asp), we revised our performance management efforts accordingly. Among the new initiatives was a stronger oversight function for the TBS, including a new "enterprise-wide" expenditure management information system (EMIS) with, at its core, a new Program Activity Architecture (PAA) for each department and agency. Each PAA is expected to support the Management Accountability Framework (MAF) for the department or agency by linking programs to results and financial and non-financial information (http://www.tbs-sct.gc.ca/eval/tools_outils/paa-deck_e.asp).

During 2004–2005, we began to seek data pertaining to the performance indicators for each departmental strategic outcome. We saw these performance indicators as the best way to focus attention on and help monitor important outcomes. To the extent possible, we have begun to integrate these indicators into this Report. Over the next few years, we expect the information to be refined to improve on its usefulness as part of Health Canada's continuous learning and improvement approach.

This new direction has meant important changes in our design of Health Canada's performance management framework. While our approach was initially oriented to managing based on department-level outcomes, the PAA initiative has both "bottom-up" and "top-down" elements.

The PAA exercise has been advancing in accordance with TBS requirements. We are continuing to develop appropriate indicators to define and measure our results for future years. We expect to report on the PAA approach starting in 2005–2006.

Reliability of Performance Data

Many data sources were used in the preparation of this Report. Charts in Section II were produced using databases and population health surveys from Statistics Canada and internal data sources.

Statistics Canada — Population Surveys

Population surveys are frequently used by Health Canada in measuring the health of Canadians. Health Canada either funds or subscribes to many population health surveys conducted by Statistics Canada. Surveys which were used for indicators contained within this Report include the Canadian Alcohol and Other Drugs Survey, Canadian Community Health Survey, and Canadian Tobacco Use Monitoring Survey, among others.

Population health surveys are used to estimate certain key performance indicators. All data which have come from a population health survey conducted by Statistics Canada and are used in this Report have variability which falls within Statistics Canada guidelines for reporting of data.

[2] http://www.tbs-sct.gc.ca/res_can/rc_e.asp

A Statistical Profile on the Health of First Nations in Canada

Data on the First Nations and Inuit population come from the above noted report, published by Health Canada in 2003. This report presents a description of the health status and conditions of First Nations people on reserves in Canada. Limitations on the data used in preparing the report are described in greater detail at: http://www.hc-sc.gc.ca/fnih-spni/pubs/gen/2003_stat_profil/index_e.html

Internal Data Sources

Data from several internal sources were used in preparing this Report, including various evaluations and Branch databases. Reliability is constrained by issues such as differences in definitions and gaps in some data.

Overall Departmental Performance

Key Departmental Priorities and Performance

For 2004–2005 and beyond, Health Canada established four medium-term corporate priorities that continue to reflect the Department's vision, mission, mandate and jurisdiction. They contribute to the achievement of Government-wide priorities as set out in recent Speeches from the Throne and through First Ministers' Agreements. In addition, they demonstrate the Government's commitment to action on the health issues affecting Canadians and to achieving results effectively. They also illustrate the Government's commitment to demonstrating accountability for public resources.

These priorities were designed to focus key issues, important health challenges and the Government of Canada's agenda into departmental action. They combine to help achieve the Government-wide outcomes that are set out in *Canada's Performance*: Healthy Canadians with Access to Quality Health Care; Improved Health of Aboriginal People; and Inclusive Society that Promotes Linguistic Duality and Diversity.

These priorities, which are reflected across all departmental strategic outcomes, and were described in detail in the Report on Plans and Priorities (RPP) for 2004–2005, were:

- to improve the quality of life of Canadians;
- to reduce risks to the health of Canadians;
- to maintain confidence in a publicly-funded health care system; and
- to improve accountability to Canadians.

In this Report, we have continued to align our priorities and reporting with our traditional strategic outcomes and business lines, as will be the case until we finalize our new Program Activity Architecture (PAA).

During the year, our operating environment was largely as we anticipated in our RPP. Canadians continued to place a great deal of importance and attention on the health system. All governments responded to this responsibility, with strong leadership by the Government of Canada, through actions such as the 10-Year Plan to Strengthen Health Care and commitments to improve First Nations and Inuit health. The Department acted on the Government of Canada's decision to create the new Public Health Agency of Canada, and worked to establish the initial authorities for the new Agency during its transition from the former Population and Public Health Branch of Health Canada.

These actions added to other strategies already under way by the Department, such as: improving how federal departments and agencies carry out their regulatory responsibilities; ensuring a strong role for science in Health Canada decision-making; and broadly committing to increase and clarify accountability both in departmental

operations and in the definition and reporting of our results.

Health Canada has contributed to another Government-wide initiative and commitment through the Agenda for Gender Equality, which ensures that policies, programs and services reflect the specific needs and interests of women. The Department has moved forward on its Gender-Based Analysis implementation strategy, through training, and tool and resource development, and has increased its capacity to develop targeted policies and programs on emerging health issues, such as Aboriginal women's health and home care.

To Improve the Quality of Life of Canadians

While Canadians are among the healthiest people in the world by most indicators, the mandate to maintain and improve their quality of life has focused Health Canada's ongoing and expanded actions to protect and promote health and to address specific challenges. During 2004–2005, we strengthened our continuing efforts to support improved health outcomes among First Nations and Inuit people. The Department was able to draw on the enhanced resources for First Nations and Inuit health programs provided through Budget 2003. These are described in detail under the strategic outcome: Healthier First Nations and Inuit through Collaborative Delivery of Health Promotion, Disease Prevention and Health Care Services. They included additional funding for the Non-Insured Health Benefits program; capital reinvestment to improve health facilities; an immunization strategy for First Nations children on-reserve; a comprehensive Nursing Strategy; and pilot programs to improve the integration of services with those of the provinces and territories. We also began to move forward on the commitments in the February 2004 Speech from the Throne by expanding our actions in support of early childhood services and safer drinking water in First Nations and Inuit communities. During 2004–2005, capacity building continued in First Nations communities to monitor their drinking water quality and to detect potential problems was facilitated through the Community-Based Water Monitor program. A total of 492 community sites had trained community-based water monitors in 2004–2005.

Another major element of our work during 2004–2005 was our modernization of the regulatory regime designed to minimize risks and generate benefits to Canadians from foods, pharmaceuticals, and natural health, consumer and pest management products. For example, we continued to implement our Therapeutics Access Strategy, through which we improved the timeliness, transparency and predictability of our reviews of therapeutic products seeking access to the Canadian market, as well as strengthening Health Canada's oversight of the safety of products on the market and the transparency and openness of the regulatory process. Part of our approach included increased work with regulators in other countries. We also expanded our surveillance of products already on the market and made significant amendments in areas such as cosmetics and tobacco labelling. Both were contributions to the Government-wide commitment to smart regulation. Further, we continued to follow through on our Minister's commitment to enhance the openness and transparency of departmental decision-making, and to encourage engagement by the public, particularly with respect to the regulatory regime for drugs and other therapeutic products. These activities are described in detail under the strategic outcomes: Safe Health Products and Food for Canadians and Healthier Environments and Safer Products for Canadians.

A similar contribution was made by our preparations for the expected coming into force of the new *Pest Control Products Act*. We issued three proposed regulations for public comment as part of these preparations. We also worked with other countries to harmonize regulatory processes and continued to review older pest control products against current risk assessment methods and scientific data as part of a larger effort to minimize risks to Canadians and the environment. These activities are described in detail under the strategic outcome: Sustainable Pest Management Products and Programs for Canadians.

To Reduce the Risks to the Health of Canadians

This corporate priority included some aspects of the responsibilities noted under the previous priority. However, it was largely oriented to Health Canada's public health mandate and activities. Through a combination of health promotion and protection activities, the Department made progress on this priority.

Canadians, health professionals and educators are becoming more knowledgeable and sophisticated about managing health and are seeking more information to make decisions and healthy choices. This includes information such as *Canada's Food Guide to Healthy Eating* that promotes a pattern of eating that meets nutritional needs and minimizes the risk of nutrition-related chronic disease such as Type II diabetes. Obesity, which has gained prevalence in Canada over the past 25 years, is an important factor that puts people at a greater risk for developing such diseases. Thus, in 2004–2005, in addition to providing such valuable information, the Department also established a multi-stakeholder task force to investigate and make recommendations to significantly reduce trans fats in the diet of Canadians. We also committed to implementing Nutrition Labelling Regulations which require that trans fats be listed on the labels of most pre-packaged foods by December 12, 2005.

The Department also continued to identify and assess health and safety risks of health products and alerted the public to any associated problems. It enhanced its surveillance capacity for drugs and other therapeutic products in real world use, and increased awareness of adverse reaction reporting and risk communication through newsletters and advisories. We also conducted compliance and enforcement activities to ensure that health products meet high domestic and international standards for safety, quality and efficacy.

During 2004–2005, one of our major roles was to manage the transition of some activities to the new Public Health Agency of Canada to meet the commitment made in the February 2004 Speech from the Throne. In the wake of the outbreak of Severe Acute Respiratory Syndrome (SARS) in early 2004 and other public health concerns, a number of studies took place to examine how Canada could best address public health priorities and threats. Those analyses recognized that public health is about more than the prevention and control of infectious diseases but is also about broader risks to health, such as potential bioterrorism threats, chronic diseases and other preventable threats to health.[3]

In general, the reports highlighted the need for improved leadership, legislative authorities, roles and responsibilities as well as capacity and coordination within and between jurisdictions, including internationally, in public health. They identified gaps in resources, whether those included the skilled people needed to deal with public health issues or the laboratory and emergency capacity for quick action.

To follow through on the Government's commitment, Health Canada established a transition process to help us advise the Government on options for structuring the new Agency. It enabled the Department to identify and manage the many actions necessary to create the Agency and ensure an effective relationship with the Department on key policy and program issues. While this transition is expected to continue into 2005–2006, we made the quick progress necessary for the Government to announce on September 24, 2004, the creation of the Public Health Agency of Canada (http://www.phac-aspc.gc.ca/new_e.html). As part of the Agency's creation, the staff of the former Population and Public Health Branch, as well as assets and responsibilities for specific programs, including grants and contributions, were transferred to the new Agency. The Agency is reporting to Parliament on its activities throughout 2004–2005 through its own Departmental Performance Report.

To Maintain Confidence in a Publicly-funded Health Care System

Health Canada has been the focal point for collaboration with provincial and territorial governments to ensure that Canadians have timely access to quality health care on the basis of need, not ability to pay. During 2004–2005, we continued to follow through on previous commitments,

[3] See the reports of: the National Advisory Committee on SARS and Public Health (the Naylor Committee) (http://www.hc-sc.gc.ca/english/protection/warnings/sars/learning.html); the Government of Ontario's Campbell Commission (http://www.sarscommission.ca/report/Interim_Report.pdf); the Walker Panel (http://www.health.gov.on.ca/english/public/pub/ministry_reports/walker_panel_2003/introduction.pdf); and the Standing Senate Committee on Social Affairs, Science and Technology (http://www.parl.gc.ca/37/2/parlbus/commbus/senate/com-e/soci-e/rep-e/repfinnov03-e.htm).

particularly those in the 2003 First Ministers' Accord on Health Care Renewal. Those actions included continued support for the Primary Health Care Transition Fund, to support front-line health care innovations, particularly by the provinces and territories. It also included support for assessment of new health technologies, actions to address health human resources priorities and new comparable indicators enabling Canadians to better assess the performance of the health care system. Work on these indicators is described under the strategic outcome: Improved Evidence-Base and Increased Use of Information and Communications Technologies to Support Health Decision-Making.

Our work under this priority was expanded by the February 2004 Speech from the Throne's attention to wait times and the Government of Canada's commitment to work with other jurisdictions on the issue. The substantial cooperation with our provincial and territorial counterparts led to proposals that the First Ministers discussed at their meeting in September 2004. The result was the 10-Year Plan to Strengthen Health Care, an action plan to guide federal, provincial and territorial governments on health care renewal initiatives in wait times, health human resources, home care, primary health care, pharmaceuticals and other key areas. The 10-Year Plan was supported by federal investments of $41 billion over 10 years to provinces and territories, as well as Budget 2005 commitments of $200 million over five years to support health human resources and improve wait times and health performance reporting.

After agreement on the 10-Year Plan was achieved, the Department worked closely with our provincial and territorial counterparts to move forward on implementing the plan. Details on the commitments and actions in 2004–2005 on health care renewal are set out under the strategic outcome: Access to Quality Health Services for Canadians.

For example, the Department examined wait times issues in Canada and internationally to help identify potential best practices and areas for action in reaching the March 31, 2007 target for meaningful reductions in wait times in priority areas such as cancer, heart, diagnostic imaging, joint replacements, and sight restoration.

The Department helped lead the process that led to agreement on a Pan-Canadian Health Human Resources Planning Framework that is beginning to help all jurisdictions to achieve a more stable, effective health work force, including one that responds to the needs of Aboriginal communities and official language minority communities.

The First Ministers directed their Health Ministers to establish a Ministerial Task Force to develop and implement the National Pharmaceuticals Strategy and report on progress by June 30, 2006. To support this work, the Department has collaborated with our provincial and territorial partners on a series of measures that identify best practices in drug prescribing and use; harmonize how governments incorporate generic drugs into their drug benefit programs and review non-patented drug pricing in Canada; and that will strengthen real world safety and effectiveness of drugs.

In many other areas such as home and continuing care and palliative and end-of-life care, the Department carried out the policy and knowledge development work that is providing a base for the provinces, territories and other partners to draw on for health care renewal.

To Improve Accountability to Canadians

The Government of Canada has made improved accountability to Canadians a priority for all its departments and agencies and a consistent element of agreements such as the 10-Year Plan. This commitment took many forms in our Department during 2004–2005, with many of the actions described in detail under the strategic outcome: Effective Support for the Delivery of Health Canada's Programs.

Building on progress in implementing its vision of a modern organization, as established in the Modern Management Strategy developed under the Modern Comptrollership Initiative, the Department has continued to integrate the principles of modern comptrollership into management processes and systems.

In support of the Department's efforts to promote sound management practices, the Management Accountability Framework (MAF), introduced by TBS, is utilized as a guide to assess management practices and identify further areas of improvement. The Department firmly supports and nurtures a modern management

culture by encouraging management excellence within its operating environment.

This included a range of actions to improve accountability and strengthen stewardship throughout Health Canada. Many of these actions addressed human resources and workplace needs, including emphasizing and communicating the Department's commitment to high ethical standards. We reinforced our internal audit and special investigations functions, as well as introducing a new Financial Management and Control Framework. This was matched by a new Contract Management Control Framework and Action Plan to improve the way we manage our contracts. This is complemented by our Departmental Grants and Contributions Management Framework which was launched in 2002 and as well the recent launch in 2004 of the Grants and Contributions Portal/Web site, to improve the management of our grants and contributions programs.

To help strengthen accountability at all levels, we are defining appropriate performance measures and are building the new PAA. In many cases, these initiatives are being complemented by our commitments to report to Canadians using comparable indicators and through ensuring that accountability measures are a central component of our agreements with organizations that receive grants and contributions.

Summary of Performance in Relation to Departmental Strategic Outcomes, Priorities and Commitments

DEPARTMENTAL SPENDING		
Total Financial Resources (millions of dollars)		
Planned[1]	**Authorities**	**Actual**
$3,307.5	$2,883.3	$2,816.6
Total Human Resources (full-time equivalents)		
Planned[1]	**Actual**	**Difference**
9,133	8,026	1,107

[1] *The Planned figures include the Public Health Agency of Canada (PHAC) as it was not formed until September 24, 2004. Comparative Authorities and Actuals can be found in PHAC's 2004–2005 Departmental Performance Report (http://publiservice.tbs-sct.gc.ca/rma/dpr1/04-05/index_e.asp).*

As shown by the following tables, the Department acted upon the four corporate priorities in support of progress towards the achievement of the seven strategic outcomes.

1. Access to Quality Health Services for Canadians;
2. Healthier First Nations and Inuit Through Collaborative Delivery of Health Promotion, Disease Prevention and Health Care Services;
3. Safe Health Products and Food for Canadians;
4. Healthier Environments and Safer Products for Canadians;
5. Sustainable Pest Management Products and Programs for Canadians;
6. Improved Evidence-Base and Increased Use of Information and Communications Technologies to Support Health Decision-Making; and
7. Effective Support for the Delivery of Health Canada's Programs.

1 STRATEGIC OUTCOME:

Access to Quality Health Services for Canadians

TOTAL PLANNED SPENDING[1] ($M): 378.4		TOTAL ACTUAL SPENDING[1] ($M): 356.4
2004–2005 Priorities/Commitments	**Type**	**Results Achieved[2]**
Work in partnership with provinces and territories to improve access to quality health care services for all Canadians and to ensure the system's future sustainability	Ongoing	Supported the Government and First Ministers in developing the 10-Year Plan to Strengthen Health Care and implementing actions such as first steps to reducing wait times. Continued to address implementation of previous First Ministers' health care commitments (e.g. access to home and community care, pharmaceutical issues, health human resources and use of new technologies).
Meeting ongoing obligations of the *Canada Health Act* (CHA)	Ongoing	Continued work with provinces and territories to resolve *Canada Health Act* issues through consultation, collaboration and cooperation. The CHA Dispute Avoidance and Resolution process was formalized in the 10-Year Plan to Strengthen Health Care. Compliance issues are reported each year in the *Canada Health Act* Annual Report.
Design 21st century national policy approaches to emerging issues, particularly genetics (e.g. socio-demographic and ethical implications)	New	Health Canada has been working both domestically and internationally on policy approaches to a wide range of emerging issues, most notably human genetics, research involving human biological materials and nanotechnology. These areas have great potential to deliver new ways to prevent, diagnose, and treat health disorders, but also present policy, ethical and regulatory challenges that must be addressed so that health system sustainability, patient safety and public confidence are maintained.
Activities related to regulatory reform and legislative issues	Ongoing	Worked toward the modernization of health protection and safety regulatory systems and legislative initiatives. Continued collaboration with Industry Canada to build modern intellectual property frameworks.
International collaboration	Ongoing	Continued to develop and maintain bilateral and multilateral relationships with key international organizations and countries. Continued to ensure that our Department's international policies and programs are consistent and coherent with Government-wide policies as well as Canada's foreign policy positions.

[1] *Resource amounts have been provided at the Strategic Outcome level and not the Priorities/Commitments level since a mechanism doesn't exist to provide the Actual Spending at the Priority level.*

[2] *In order to report on the Strategic Outcomes and accurately reflect Health Canada's results under Priorities/Commitments for 2004–2005, the heading of the column has been modified to read: Results Achieved as opposed to Expected Results and Current Status.*

2 STRATEGIC OUTCOME:

Healthier First Nations and Inuit (FNI) Through Collaborative Delivery of Health Promotion, Disease Prevention and Health Care Services

TOTAL PLANNED SPENDING[1] ($M): 1,701.9		TOTAL ACTUAL SPENDING[1] ($M): 1,684.6
2004–2005 Priorities/Commitments	**Type**	**Results Achieved[2]**
Enhance health promotion and prevention programs	Ongoing	Supported the delivery of programs aimed at FNI infants and children, and to assist pregnant women, caregivers, families and communities in raising healthy children. Programs targeted maternal, infant and child health; increasing children's knowledge of language and culture; and increasing children's readiness for school.
Improve the quality, accessibility and effectiveness of health care services	Ongoing	Strategies increased the number of certified health professionals, enhanced health facilities to improve FNI access to health programs and services, supported acquiring accreditation for treatment centres and ensured FNI had access to Home and Community Care services.
Collaborate and cooperate with FNI communities, provinces and territories and service providers to modernize and adapt the health service system for FNI	Ongoing	Work continued to implement initiatives funded through the Aboriginal component of the Primary Health Care Transition Fund, such as midwife training programs, health and social services projects and telehealth, and to improve the coordination and integration of federal Aboriginal Early Childhood Development (ECD) programs.
Strengthen information and knowledge management to improve delivery of health care services and programs	Ongoing	Introduced the new Home and Community Care and Diabetes Information Systems and piloted the National Native Addictions Information Management System (NNAIMS).
Improve the management practices of Health Canada and FNI communities by implementing effective evaluation and accountability mechanisms	Ongoing	Developed new contract management tools, updated the FNI funding agreements templates, further streamlined and reduced duplication of FNI reporting requirements and strengthened management and administrative capacity in FNI contribution agreement recipients.

[1] *Resource amounts have been provided at the Strategic Outcome level and not the Priorities/Commitments level since a mechanism doesn't exist to provide the Actual Spending at the Priority level.*

[2] *In order to report on the Strategic Outcomes and accurately reflect Health Canada's results under Priorities/Commitments for 2004–2005, the heading of the column has been modified to read: Results Achieved as opposed to Expected Results and Current Status.*

3 STRATEGIC OUTCOME:

Safe Health Products and Food for Canadians

TOTAL PLANNED SPENDING[1] ($M): 183.4		TOTAL ACTUAL SPENDING[1] ($M): 184.0
2004–2005 Priorities/Commitments	**Type**	**Results Achieved[2]**
Transforming our efficiency, effectiveness and responsiveness as a regulator	Ongoing	Improved timeliness, transparency and predictability of the regulatory and health product submission processes as demonstrated by our performance on commitments, for example, the reduction in the backlog of reviews of new pharmaceutical drug submissions by 89 percent from April 2003 to March 2005.
Providing authoritative information for healthy choices and informed decisions by Canadians	Ongoing	Improved awareness and informed decisions concerning health products, food and nutrition by Canadians, such as healthy eating supported through *Canada's Food Guide to Healthy Eating* and visits to the Food Guide Web page, Health Canada's most visited page.
Increasing responsiveness to public health issues and greater vigilance of safety and therapeutic effectiveness in real world use	Ongoing	Strengthened monitoring of safety and therapeutic effectiveness and risk management for health products and food in real world use, through enhanced surveillance capacity, including a focus on adverse drug reaction reporting for children, and strengthened Canada's safeguards against Bovine Spongiform Encephalopathy (BSE).
Improving transparency, openness and accountability to strengthen public trust and stakeholder relationships	Ongoing	Enhanced public involvement in health products, food and nutrition policy and program development and implementation, such as improved public involvement activities and improved public understanding of and input into decision-making processes.

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4 STRATEGIC OUTCOME:

Healthier Environments and Safer Products for Canadians

TOTAL PLANNED SPENDING[1] ($M): 235.4		TOTAL ACTUAL SPENDING[1] ($M): 211.7
2004–2005 Priorities/Commitments	**Type**	**Results Achieved[2]**
Reduce risks to health and safety, and improve protection against harm associated with workplace and environmental hazards, consumer products (including cosmetics), radiation-emitting devices, new chemical substances and products of biotechnology	Ongoing	Completed regulatory initiatives to reduce risks to health from lead exposure and lack of cosmetic ingredient labelling. A National Air Quality Index was completed. On target to meet our objectives under the *Canadian Environmental Protection Act* by 2006; the implementation of Globally Harmonized System for Labelling and Classifying Chemicals; and the Canadian Climate Change and Health Vulnerability Assessment 2007. Continue to provide inspections/assessments for the health protection of travellers, workers, and the public, as well as the National Dosimetry Services.
Reduce health and safety risks associated with tobacco consumption and the abuse of drugs, alcohol and other controlled substances	Ongoing	Efforts were focused on the continued development and implementation of a national coordinated approach to tobacco cessation and the implementation of a renewed Alcohol and Drug Treatment and Rehabilitation Program. We have ratified the Framework Convention on Tobacco Control (FCTC), initiated the development of a National Framework for Action on Substance Use and Abuse, established an overall governance structure for Canada's Drug Strategy, and provided funding for innovative community-based projects through our Drug Strategy Community Initiatives Fund. Cigarette Ignition Propensity Regulations, aimed at reducing the number of deaths and harm due to cigarette-lit fires, are under development and will be completed in 2005.

[1] *Resource amounts have been provided at the Strategic Outcome level and not the Priorities/Commitments level since a mechanism doesn't exist to provide the Actual Spending at the Priority level.*

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5 STRATEGIC OUTCOME:

Sustainable Pest Management Products and Programs for Canadians

TOTAL PLANNED SPENDING[1] ($M): 38.3		TOTAL ACTUAL SPENDING[1] ($M): 41.4
2004–2005 Priorities/Commitments	**Type**	**Results Achieved[2]**
Ensure safe and effective pest control products	Ongoing	Continued to facilitate access to safer pesticides. Expanded information to public and stakeholders. Transparency of pesticide regulation increased. Improved regulatory efficiencies and cost effectiveness.
Ensure compliance with *Pest Control Products Act*	Ongoing	Strengthened compliance with the *Pest Control Products Act* and Regulations.
Ensure sustainable pest management practices that reduce reliance on the use of pesticides	Ongoing	Users informed of reduced-risk practices.

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6 STRATEGIC OUTCOME:

Improved Evidence-Base and Increased Use of Information and Communications Technologies to Support Health Decision-Making

TOTAL PLANNED SPENDING[1] ($M): 98.7		TOTAL ACTUAL SPENDING[1] ($M): 107.3
2004–2005 Priorities/Commitments	**Type**	**Results Achieved[2]**
Accelerate the use of information and communication technologies in the health sector	Ongoing	Continued to work with partners on key policy issues related to the use of e-technology in the health sector.
Develop a pan-Canadian framework to protect the privacy and confidentiality of personal health information	Ongoing	The Pan-Canadian Health Information Privacy and Confidentiality Framework was completed and endorsed by the F/P/T Conference of Deputy Ministers of Health (with Quebec and Saskatchewan abstaining).
Increase access to health evidence/ information and its use in support of decision-making and accountability	Ongoing	The *Federal Report on Comparable Health Indicators* was released, program evaluation continued to be strengthened, and ongoing efforts to increase access to health evidence/information in support of decision-making and accountability continued.
Implement a Departmental Information Management/Information Technology (IM/IT) Strategy	Ongoing	Made best use of limited funding by developing clear priority-setting processes, including a final draft departmental IM/IT Strategy to guide spending and technology choices, particularly for information management and telecommunications.

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7 STRATEGIC OUTCOME:

Effective Support for the Delivery of Health Canada's Programs

TOTAL PLANNED SPENDING[1] ($M): 198.6		TOTAL ACTUAL SPENDING[1] ($M): 231.2
2004–2005 Priorities/Commitments	**Type**	**Results Achieved[2]**
Improving accountability to Canadians through continuous improvement of management practices and rigorous stewardship of resources	Ongoing	Improvements to management practices, strengthened stewardship and accountability. Shift to a culture where managers focus on improving transparency and openness, and strengthening stewardship and accountability.
Effective regional delivery of Health Canada programs tailored to meet local conditions	Ongoing	Regional operations used partnerships and collaborative relationships, as well as the engagement of key stakeholders and citizens, to address local and regional priorities.
Improve the Department's capacity to perform, harness, translate and use sound science to support evidence-based decision-making, thereby optimizing health outcomes and minimizing health risks for Canadians	Ongoing	Analyzed science strengths, gaps and opportunities to promote effective use of science in policy and regulatory decisions. The Post-Doctoral Fellowship Program is enhancing departmental science capacity and quality. Partnerships with other departments and the Canadian Institutes of Health Research on many initiatives raised awareness and understanding of science conducted at Health Canada.
Implement Health Canada's component of the Federal Government's Official Languages Action Plan for increasing access to services by Official Language Minority Communities	Ongoing	To date, 27 official language minority community networks in place; 140 French language graduates of college and university health programs. Implemented a new internal policy to support Official Language Minority Communities.

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Section II

Analysis of Performance by Strategic Outcome

Strategic Outcome:
Access to Quality Health Services for Canadians

Relevant Outcome in "Canada's Performance":
Healthy Canadians with Access to Quality Health Care

Objective

To provide a leadership role in collaboration with provinces/territories, health professionals, administrators and other key stakeholders, focused 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.

Financial Information

2004–2005 (MILLIONS OF DOLLARS)			
	Planned Spending	Total Authorities	Actual Spending
Gross expenditures	378.4	363.3	356.4
Revenues	0	0	0
Net expenditures	378.4	363.3	356.4*
FTEs	465	470	473

* *This represents 12.7 percent of the Department's actual spending (excluding the Public Health Agency of Canada).*

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

- additional funding related to initiatives set out in the 2003 First Ministers' Accord on Health Care Renewal
- additional funding for the Assisted Human Reproduction Agency of Canada (AHR) not required this fiscal year to be in sync with the creation of the agency
- re-profile of some planned funding of the Primary Health Care Transition Fund (PHCTF) to future years to meet program needs
- transfer portion of funding for PHCTF to the Strategic Outcome "Improved Evidence-Base and Increased Use of Information and Communications Technologies to Support Health Decision-Making" Management
- internal funding provided to First Nations and Inuit Health Branch towards the Named Contribution to the Province of Ontario for the construction of the Meno Ya Win Health Centre

The actual spending is $6.9 million lower than total authorities mainly due to:

- lower than expected requirements in contributions related to PHCTF and Health Human Resources (HHR)
- year end adjustments and lower than expected expenditures in various programs

Intermediate outcomes

- Improved health policy coherence
- Ongoing implementation
- Enhanced health policy research capacity (ongoing)
- Consensus developed among well-informed stakeholders and governments

Immediate outcomes

- Identification of goals and objectives
- Knowledge development and transfer for specific health policy issues
- Collaboration with and engagement of stakeholders and governments

Priorities

- Work in partnership with the provinces and territories to improve access to quality health care services for all Canadians and to ensure the system's future sustainability
- Meet ongoing obligations of the *Canada Health Act*
- Design 21st century national policy approaches to emerging issues, particularly genetics (e.g. socio-demographic and ethical implications)
- Activities related to regulatory reform and legislative issues
- International collaboration

Program, resources and results linkages

Program	Actual Expenditures[1] ($M)	Result Linkage
Health Care Policy	291.4	Goals and objectives identified for specific strategies and initiatives. Collaboration with and engagement of governments and stakeholders. Knowledge development and transfer for specific health policy issues.
Intergovernmental Affairs	5.2	Collaboration with and engagement of governments and stakeholders. Knowledge development and transfer for specific health policy issues.
Strategic Health Policy	8.0	Goals and objectives identified for specific strategies and initiatives. Collaboration with and engagement of governments and stakeholders. Knowledge development and transfer for specific health policy issues.
International Affairs	19.8	Collaboration with and engagement of governments and stakeholders.
Women's Health	4.5	Knowledge development and transfer for specific health policy issues.
Communications, Marketing & Consultation	27.5	Activities generally consist of ongoing support services rather than defined programs.

[1] *The title has been changed from Resources to Actual Expenditures for clarification.*

Executive Summary

Health Canada plays an active role in the renewal of Canada's health care system. We are responsible for Government of Canada initiatives and investments that promote structural change in the health care system and enhance access to quality health care services for all Canadians. We carry out this role through our activities that help to fulfill: Government of Canada commitments under the September 2004 First Ministers' Agreement on the 10-Year Plan to Strengthen Health Care and previous First Ministers' agreements; our responsibility to ensure that the principles of the *Canada Health Act* are respected; our efforts to support the development of health system practices; and policies, regulations and legislation that meet current needs and reflect leading-edge knowledge.

During 2004–2005, we continued to meet our ongoing responsibilities under this strategic outcome as well as achieving progress on the new activities that we had projected in the Report on Plans and Priorities (RPP) for the year. A major focus was the preparatory work that led to the September First Ministers' Meeting and the 10-Year Plan. After the Plan was finalized, we worked closely with our colleagues in provincial and territorial governments and with health stakeholders to begin action on the commitments, particularly as a number of them have specific target dates for results.

In addition, we continued our ongoing efforts to improve the knowledge base necessary for developing effective policies, through our own policy research on emerging issues such as human genetics, nanotechnology and biotechnology issues. We also contributed to international initiatives on issues such as HIV/AIDS, tobacco control and health security related to a potential influenza pandemic.

PRIORITY 1: ONGOING

Work in partnership with the provinces and territories to improve access to quality health care services for all Canadians and to ensure the system's future sustainability

Under this priority, our Department continued to support the implementation of commitments to health care system innovation and reform made at recent First Ministers' Meetings. We also carried out much of the work that clarified options for the First Ministers in preparation for their meeting in September 2004, which led to the 10-Year Plan. Following that meeting, we worked on issues and commitments arising from the 10-Year Plan with the provinces and territories. In many cases, these modified and expanded the commitments that we originally made in the RPP for 2004–2005.

RPP Commitments 2004–2005	Report on Results
Support the process leading to the 10-Year Plan	Although not anticipated in the RPP, a major action for 2004–2005 was the support that we provided to the Government of Canada in preparation for the First Ministers' Meeting in September 2004 and then to follow-up with actions to implement the First Ministers' commitments. The 10-Year Plan is an action plan to guide federal, provincial and territorial governments on health care renewal initiatives in areas such as wait times, health human resources, home care, primary health care, and pharmaceuticals. The Plan is supported by federal investments of $41 billion over 10 years to provinces and territories, which will promote predictable and growing funding to strengthen the health care system. These funding commitments were implemented through Bill C-39 which received Royal Assent in March 2005. Budget 2005 committed a total of $200 million over five years to support health human resources and improve wait times and health performance reporting to implement the 10-Year Plan.
Health Care Access/Wait Times	The 10-Year Plan outlines specific commitments to achieve meaningful reductions in wait times starting in the five priority areas (cancer, cardiac, diagnostic imaging, joint replacement and sight restoration), and to develop evidence-based benchmarks and comparable indicators. For Canadians, this will mean improved access to quality care, starting in the five priority areas. To improve access to quality care, Health Canada: • established operating principles for the $4.25 billion five-year Wait Times Reduction Transfer; • continued multi-partner collaboration with the Western Canada Waiting List Project; • supported the dissemination of national and international best practices in wait times management; • developed knowledge of acute care trends and approaches to hospital efficiency; • facilitated knowledge of access issues for populations under federal jurisdiction; • examined the issue of wait times in emergency departments; • facilitated consultations with and consensus building among various key players of the health care system on wait times commitments; and • received $15 million over four years from Budget 2005 for national wait time initiatives.

RPP Commitments 2004–2005	Report on Results
Manage progress under the Primary Health Care Transition Fund (PHCTF)	The $800 million five-year PHCTF, established in the 2000 First Ministers' Agreement, continued to support the transitional costs associated with making fundamental changes to primary health care. The PHCTF is supporting over 60 initiatives, with the majority of funding directed to provincial and territorial governments to support their primary health care renewal plans. Virtually all remaining funds were committed in 2004–2005. In 2004–2005, significant progress was made on three national strategies focusing on the promotion of multi-disciplinary teamwork, the development of an evaluation framework and increasing public awareness of primary health care. All three strategies will continue until 2006–2007. In May 2004, more than 1,000 people took part in a successful conference on primary health care bringing together experts from Canada and abroad to share best practices and discuss policy directions for primary health care renewal. It set the stage for continued improvements to the delivery of primary health care.
Implement commitments made through the 2003 First Ministers' Accord (as expanded on through the 10-Year Plan) on Home Care	The 10-Year Plan outlines specific short-term acute home care services that will be available to all Canadians, based on assessed need and at first-dollar coverage, by 2006. This will mean better access to home care services after leaving the hospital, to end-of-life care, and for some patients with mental health problems. All jurisdictions, including the federal government, are working towards meeting the 2006 target for implementing the home care commitments specified in the 10-Year Plan. Health Canada's activities on home and continuing care included policy and knowledge development and adoption that support the advancement of home and continuing care across Canada with a focus on innovative models and programs, particularly in the areas of mental health, case management, family/informal caregivers, long-term facility-based care and supportive housing; promoting the appropriate use of health human resources; and promoting the use of technology (tele-home care and therapies) in developing new models and programs.
Address pharmaceuticals issues of relevance to health care reform (as expanded on through the 10-Year Plan)	Health Canada has continued to collaborate with its provincial and territorial partners on pharmaceuticals management initiatives. The Canadian Optimal Medication Prescribing and Utilization Service (COMPUS) was established with Health Canada funding from the Therapeutics Access Strategy (TAS) in March 2004 following federal, provincial and territorial approval of the initiative and agreement on initial priorities. COMPUS will be the Canadian centre for information and education on best practices in drug prescribing and utilization. Federal, provincial and territorial (F/P/T) health ministers established the F/P/T Ministerial Task Force in October 2004 to develop and implement the National Pharmaceuticals Strategy (NPS), which builds on and complements TAS and other federal and FPT initiatives aimed at improving Canadians' access to safe, effective and affordable drugs. Since then, Health Canada has continued its collaborative work with provincial and territorial health ministries to develop and implement the action elements of the NPS as well as related, pre-existing initiatives such as COMPUS and the Common Drug Review (CDR).

RPP Commitments 2004–2005	Report on Results
	Our Department continued joint work with other jurisdictions towards harmonizing the treatment and listing of generic drugs in order to improve the access of public drug benefit programs across Canada to less expensive generic equivalents for brand name, patented drugs. We made progress on our analysis of non-patented drug pricing in Canada, and on the assessment of options for moderating or controlling pricing. This work, originally launched prior to the 10-Year Plan, continues as part of the F/P/T collaborative work under the NPS. We and our partner jurisdictions continued to use the CDR process for new prescription drugs. The CDR is a single process for reviewing new drugs and providing benefit listing recommendations to participating publicly-funded federal, provincial and territorial drug benefit plans in Canada (except Quebec). The CDR promises to increase harmonization of listing decisions and reduce duplication of effort. The Department funded 11 projects under the Best Practices Contribution Program, which offers financial support to initiatives that evaluate best practices related to optimal prescribing and utilization of drug therapy, and encourages the uptake of such best practices across jurisdictions.
Address health technologies issues (as expanded on through the 10-Year Plan)	In October 2004, Health Ministers approved the Canadian Health Technology Strategy. This Strategy represents a collaboration to promote the management, diffusion and use of health care technologies. More specifically, Health Canada was responsible for promoting and ensuring accountability and transparency for arm's-length organizations and project partners such as the Canadian Coordinating Office for Health Technology Assessment (CCOHTA). This involved focusing work on health care technology uptake and utilization, with a particular emphasis on medical and diagnostic equipment. This means increasing knowledge in health care technology uptake and utilization through domestic and international research and providing a leadership role in the promotion of collaboration among stakeholders in the health care system. The $500 million in 2004–2005 for medical equipment was provided to provinces and territories for diagnostic and medical equipment and related specialized staff training to improve access to publicly-funded diagnostic and treatment services in a timely manner.
Support action on palliative end-of-life care issues	In addition to leadership in support of the Canadian Strategy on Palliative and End-of-Life Care and work with many stakeholder organizations and provincial and territorial governments, we supported the advancement of best practices in palliative and end-of-life care, as well as accreditation standards and interprofessional education.
Support action on Health Human Resources (HHR) planning (as expanded on through the 10-Year Plan)	We were actively involved in the development of a Pan-Canadian Health Human Resources Planning Framework in 2004–2005. The Framework, which has been approved by almost all jurisdictions, makes the case for a pan-Canadian collaborative approach to planning, describes the challenges, identifies priorities for collaborative action and sets out tangible actions that jurisdictions can take together to achieve a more stable, effective health work force. Our role included infrastructure support for HHR planning, enhanced HHR data collection and standardization, and forecasting modelling. In partnership with Human Resources and Skills Development Canada, our Department continued to engage in occupational and sector studies with specific health professions in order to better understand the human resource requirements for these professions.

PRIORITY 2: ONGOING

Meeting ongoing obligations of the *Canada Health Act*

The *Canada Health Act* (CHA) is Canada's federal health insurance legislation. The Act defines the national principles that govern the health care system (public administration, comprehensiveness, universality, portability and accessibility). Its aim is to ensure that all eligible residents of Canada have reasonable access to medically necessary hospital and physician services on a prepaid basis, without direct charges at the point of service. In 2004–2005, Health Canada continued to ensure compliance with the Act and improve reporting to Parliament and Canadians. *The Canada Health Act Annual Report* can be found at: http://www.hc-sc.gc.ca/hcs-sss/medi-assur/index_e.html

Health Canada's approach to CHA administration emphasizes transparency, consultation and dialogue with provincial and territorial health care authorities. The application of financial penalties is considered only as a last resort when all options to resolve an issue collaboratively have been exhausted. Pursuant to the commitment made by all premiers (except Quebec's) under the Social Union Framework Agreement of 1999, federal, provincial and territorial governments (except Quebec) agreed, in April 2002, to a *Canada Health Act* Dispute Avoidance and Resolution Process. On September 16, 2004, all First Ministers, except for Quebec, formalized that process as part of their 10-Year Plan to Strengthen Health Care.

RPP Commitments 2004–2005	Report on Results
Ensure compliance with the conditions and extra-billing and user-charge provisions of the *Canada Health Act*	Our work with provinces and territories has indicated a high level of compliance with the legislation. We increased our monitoring of health care delivery, developed better information tracking and analysis and tools, and investigated and reported on potential non-compliance and emerging health issues.
Improve reporting to Parliament and Canadians on insured health care services provided by the provinces and territories	We worked with provinces and territories to improve the information collected and reported in the *Canada Health Act Annual Report* by streamlining the process, increasing collaboration and communication with the provinces and territories, and by increasing the scope and detail of information provided in the report.
	The *Canada Health Act Annual Report 2003–2004* was tabled in the House of Commons on February 18, 2005, and in the Senate on February 22, 2005.

PRIORITY 3: NEW

Design 21st century national policy approaches to emerging issues, particularly genetics (e.g. socio-demographic and ethical implications)

Health Canada has been working both domestically and internationally on policy approaches to a wide range of emerging issues, most notably human genetics, research involving human biological materials and nanotechnology. These areas have great potential to deliver new ways to prevent, diagnose, and treat health disorders, but also present policy, ethical and regulatory challenges that must be addressed so that health system sustainability, patient safety and public confidence are maintained.

RPP Commitments 2004–2005	Report on Results
Develop an overall strategy for addressing emerging technologies	We led the Government of Canada's negotiations on UNESCO's proposed Declaration on Universal Norms on Bioethics, an overarching principles-based text to help states develop and implement policies and legislation related to ethical issues raised by advances in technology.
The strategy will include specific approaches to genetics and nanotechnology	We worked through the Organization for Economic Cooperation and Development (OECD) on three key initiatives: (1) finalizing a report on the current status of quality assurance in molecular genetic testing laboratories, which will lead to the development of quality assurance guidelines by 2006 to improve the quality of genetic testing; (2) provided input to work on biotechnology and health innovation addressing how genetics technology can be used effectively for good health and better quality of life; and (3) drafting OECD Best Practice Guidelines for licensing genetic innovations to improve licensing practices so that more patients can benefit from new genetic diagnostics and therapeutics. At the national level, we worked with the Canadian Biotechnology Advisory Council (CBAC) in its study of the health system impacts of patents on human genetic materials, which will culminate in a report with recommendations in fall 2005. Our research and policy development activities on broader human genetics policy issues included collaboration with other departments and the Canadian Biotechnology Secretariat on a government conference on pharmacogenomics. We also held a symposium on genetics and diversity to advance understanding of the interrelationships between genetics research, health care applications and policy, and factors such as sex and gender, disability, race and ethnicity. Our nanotechnology work involved support of, and participation in, interdepartmental nanotechnology efforts led by the Office of the National Science Advisor. We also conducted research on the ethical, legal and social implications of nanotechnology.
Other initiatives	We have been examining approaches to the collection, use and storage of human biological materials (HBM) in research, that would serve to maximize health gains and safeguard individual privacy and informed consent. In 2004, our Department began working to develop a consolidated single guidance instrument for Health Canada researchers on good research practices for HBM. As part of this, we have worked to assess the scope of Health Canada's storage of HBMs and to identify issue areas, determine the nature of the guidance instrument, identify gaps in existing policies and guidelines and identify priority areas to move forward to ensure improved protection for Canadians whose HBM is held by Health Canada.

PRIORITY 4: ONGOING

Activities related to regulatory reform and legislative issues

Health Canada has undertaken work toward the modernization of our regulatory systems and legislative initiatives to maximize the protection of Canadians' health and safety.

Health Canada's Report on Plans and Priorities for 2004–2005 highlighted other regulatory frameworks under which work would be completed. We continue to collaborate with Industry Canada to build modern intellectual property frameworks.

RPP Commitments 2004–2005	Report on Results
Moving forward with a Smart Regulation strategy to accelerate reforms in key areas	Health Canada has been an active participant in the Government of Canada's work to develop a Smart Regulation implementation strategy based upon strengthening regulatory management, improving coordination and cooperation, and measuring performance. Eight Health Canada initiatives were included in the Government of Canada's first *Smart Regulation Report on Actions and Plans*, released in March 2005. These initiatives include efforts to improve efficiency and effectiveness, along with transparency and public input (e.g. Therapeutics Access Strategy for drugs), innovative risk-based approaches (e.g. standards-based regulation for cells, tissues and organs for transplantation), and multi-stakeholder involvement (e.g. Task Force to Reduce Trans Fats in Canadian Food). Another initiative was a Health Canada-Privy Council Office-International Trade Canada MOU signed in February 2005 to streamline the regulatory process for submissions in two high-volume areas (establishment of pesticide Maximum Residue Limits (MRLs) in food, and amendments to Schedule F of the Food and Drug Regulations governing prescription status), while preserving rigorous scientific review and maintaining existing consultation with stakeholders and trading partners. This MOU will mean that growers will have quicker access to new and safer pesticides, and consumers will have quicker access to new prescription medicines and faster reimbursement from private insurers.
Modernization of our regulatory systems and legislative initiatives	Health Canada has undertaken work toward the modernization of our regulatory systems and legislative initiatives to maximize the protection of Canadians' health and safety. Health Canada completed national consultations on the Health Protection Legislation Renewal (HPLR) proposal, and more than 300 written submissions, containing more than 1,600 specific comments, were analyzed. Meetings were organized to address specific issues, including a meeting of federal/provincial/territorial officials. In spring 2004, the Department separated the chapter on communicable disease from the original HPLR proposal, and moved forward with a new Quarantine Bill. This was done in light of analysis following the SARS outbreak, which identified the need to modernize existing quarantine legislation. The Bill received Royal Assent in May 2005. In fall 2004, the Department introduced new legislation to amend the *Food and Drugs Act* concerning Interim Marketing Authorizations to address concerns raised by the Standing Joint Committee on the Scrutiny of Regulations. These amendments were referred to the Standing Committee on Health at the end of 2004–2005.

RPP Commitments 2004–2005	Report on Results
International regulatory cooperation to maximize benefits of international approaches	Significant progress was made on the identification of key principles that will govern Health Canada's strategic engagement in international regulatory cooperation. This has been complemented by work on international regulatory cooperation in specific branches. First, Bill C-9, the *Jean Chrétien Pledge to Africa* legislation was completed on May 14, 2005 with final regulations published in *Canada Gazette*, Part II on June 1, 2005. Canadian generic drug companies can now begin to seek compulsory licenses to export drugs for HIV/AIDS, tuberculosis, malaria and other public health emergencies to designated countries in need. Second, a regulatory package amending the Patented Medicines (Notice of Compliance) Regulations and the data protection provisions of the Food and Drug Regulations was prepublished in *Canada Gazette*, Part I. Health and Industry officials are evaluating comments received from stakeholders and expect to move forward over the summer months. Third, Health Canada is collaborating with Industry Canada in the work of the OECD and of CBAC to address issues for the health care system associated with the patenting of human genetic material.
Activities relating to assisted human reproduction (AHR)	With regard to the governance of the ethical conduct of research involving humans, Health Canada is continuing policy work in this area, and has provided support for the National Council of Ethics of Human Research to prepare an options paper for an accreditation system of human research protection programs, and to begin preparing draft standards to promote consistent, high quality protections for Canadian health research participants. Health Canada continued to work on the establishment of the new Assisted Human Reproduction Agency of Canada, pursuant to its enabling legislation, *An Act respecting assisted human reproduction (AHR) and related research*. The legislation aims to protect and promote human health, safety, dignity and rights in the use of AHR technologies; prohibits unacceptable activities, such as human cloning; and places controls over AHR-related research. To fulfil these aims, the Department is making progress towards developing a comprehensive framework of regulations under the Act, through an open and consultative process. In 2004–2005, departmental officials provided 16 technical briefings in 11 major centres across Canada to inform the provinces, stakeholders and the general public about the new Act and the regulatory process. Information gathering workshops were organized to support policy development for counselling and reimbursement of AHR-related expenditures. Health Canada also carried out national consultations on specific proposals for the application of free and informed consent in the use of human reproductive material/in vitro embryos, which has informed the drafting of regulations in preparation for pre-publication in *Canada Gazette*. Preparatory work was completed for the recruitment and selection of candidates for the Agency's Board of Directors, including the positions of President and Chairperson. The Agency's preliminary business plan and human resources strategy were drafted and work began towards building the Agency's business systems and tools to prepare it for its anticipated start-up in early 2006 in Vancouver.

PRIORITY 5: ONGOING

International collaboration

Health Canada continued to develop and maintain bilateral and multilateral relationships with key international organizations and countries. In addition, we continued working to ensure that our Department's international policies and programs are consistent and coherent with Government-wide policies as well as Canada's foreign policy positions.

RPP Commitments 2004–2005	Report on Results
Involvement in health organizations and with other countries	We remained active in the World Health Organization (WHO) and the Pan-American Health Organization (PAHO), particularly in helping to shape key policies and advocate for Canada's priorities. In both these organizations, we supported key resolutions of importance to Canada, including ones related to pandemic preparedness, high-burden poverty-related diseases, and non-communicable diseases. We led the negotiations in collaboration with the Public Health Agency of Canada on the revision of the WHO International Health Regulations, which aim at preventing, protecting against, controlling and responding to the international spread of infectious diseases, such as SARS. We worked to strengthen our relationships with the European Union in a number of priority areas for the Government of Canada, for example, consumer safety and healthy environment issues. Bilaterally, we signed a letter of intent with the Mexican Ministry of Health to develop bilateral activities, the first of which focuses on indigenous people's health. We also renewed our Action Plan for Health Cooperation with China.
Global HIV/AIDS efforts	Our Department strengthened the Global Engagement component of the Federal Initiative to Address HIV/AIDS in Canada as part of the overall strategy renewal process. This included grants to support learning events and the development of new resources and sharing of best practices between Canada's domestic and international partners. One example was the support for the 2nd Canadian Microbicides Symposium. We also provided financial and programmatic contributions to the 2004 International AIDS Conference in Bangkok, and input to the drafting of numerous United Nations decisions and resolutions related to HIV/AIDS.
Global Health Security Initiative	We continued a leadership and coordination role by serving as Chair of the Global Health Security Initiative (GHSI) Action Group of senior officials (G7 plus Mexico), as the Secretariat for the GHSI, and being responsible for operating the Initiative's secure Web site. The GHSI activity culminated in a December 2004 international meeting where Ministers approved actions and charted future work to improve global health security related to chemical, biological, radiological and nuclear terrorism and pandemic influenza preparedness and response.
Global tobacco control	Our continued leadership and work in global tobacco control issues resulted in the successful ratification of the WHO's Framework Convention on Tobacco Control, the first ever global public health treaty designed to reduce tobacco-related deaths and disease around the world. In addition to this, we provided grants to international organizations as well as individual countries to help advance their tobacco control research and programs.

Strategic Outcome:
Healthier First Nations and Inuit through Collaborative Delivery of Health Promotion, Disease Prevention and Health Care Services

Relevant Outcomes in "Canada's Performance":
Improved Health of Aboriginal People

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, and in collaboration with the provinces and territories.

Financial Information

2004–2005 (MILLIONS OF DOLLARS)			
	Planned Spending	Total Authorities	Actual Spending
Gross expenditures	1,707.4	1,714.6	1,688.6
Revenues	(5.5)	(5.5)	(4.0)
Net expenditures	1,701.9	1,709.1	1,684.6*
FTEs	1,714	1,738	1,893

** This represents 59.8 percent of the Department's actual spending (excluding the Public Health Agency of Canada).*

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

- additional funding for the Named Contribution to the Province of Ontario for the construction of the Meno Ya Win Health Centre; the Federal Contaminated Sites Accelerated Action Plan II; Non-Insured Health Benefits Program; and Indian Residential Schools Program
- funding for First Nations' construction and restoration of on-reserve facilities being shown in the Departmental and Administration business line

The actual spending is $24.5 million lower than total authorities mainly due to:

- a reduction in Non-Insured Health Benefits planned spending attributable to such factors as the increased use of generics
- lower than anticipated uptake of services provided by the Indian Residential Schools Program
- year end adjustments and lower than expected expenditures in various programs

Intermediate Outcomes

- Increased healthy behaviours
- Improved access, availability and quality of health programs and services
- Reduced incidence and/or prevalence of illness, disease and/or drug and alcohol abuse
- Increased capacity to manage and deliver First Nations and Inuit health programs and services
- Effective and sustainable First Nations and Inuit health system
- Increased community and individual awareness of the health determinants that affect health and of preventive actions to minimize effects
- Client satisfaction with program and service levels and quality
- Effective and efficient management of access to health benefits that is based on client needs
- Effective health planning and management capabilities in communities

Immediate Outcomes

- Increased capacity to deliver programs and services
- Increased community and individual awareness
- Culturally sensitive programs and services
- Quality programs and services delivered
- Effective policies and management frameworks developed and implemented

Priorities

- Enhance health promotion and prevention programs
- Improve the quality, accessibility and effectiveness of health care services
- Cooperate and collaborate with First Nations and Inuit communities, provinces and territories, and service providers to modernize and adapt the health service system for First Nations and Inuit
- Improve information and knowledge management to improve delivery of health care services and programs
- Implement effective evaluation and accountability mechanisms that will improve the management practices of Health Canada and First Nations and Inuit communities

Program, resources and results linkages

Program	Actual Expenditures[1] ($M)	Result Linkage
First Nations and Inuit Community Health Programs	205.6	Community Programs support child and maternal-child health; mental health promotion; addictions prevention and treatment; chronic disease prevention and health promotion services.
First Nations and Inuit Health Protection	46.4	Communicable Disease and Environmental Health and Research programs facilitate preparedness to implement measures in the control, management and containment of outbreaks of preventable diseases and improve management and control of environmental hazards.
First Nations and Inuit Primary Health Care	294.6	Primary Health Care services include urgent and community medicine, nursing services, home and community care and oral health.
Non-Insured Health Benefits (NIHB)	814.1	The NIHB Program provides approximately 765,000 registered Indians and recognized Inuit with a limited range of medically necessary health-related goods and services which supplement those provided through other private or provincial/territorial health insurance plans. Benefits include drugs, dental care, vision care, medical supplies and equipment, short-term crisis intervention. Mental health services and medical transportation to access medical services not available on-reserve or in the community of residence.
Governance and Infrastructure Support to First Nations and Inuit Health System	323.9	Governance and Infrastructure Support to First Nations and Inuit Health System government in implementing the Inherent Right Policy, improving First Nations and Inuit capacity to generate and access health information and knowledge and to ensure First Nations and Inuit health programs and services infrastructure by increasing First Nations and Inuit control over health programs and services. The activities undertaken include health planning and strengthening management capacity in First Nations and Inuit communities, capacity building of First Nations and Inuit communities to manage and deliver health programs and services, integration and coordination of health services between F/P/T, stewardship and health research, knowledge and information management.

[1] *The title has been changed from Resources to Actual Expenditures for clarification.*

Executive Summary

The objectives of the First Nations and Inuit Health program activity include improving health outcomes; ensuring the availability of, and access to, quality health services; and supporting greater control of the health system by First Nations and Inuit. The goal of providing efficient, effective and sustainable health services and programs that contribute to better health outcomes is guided by four working principles: First Nations and Inuit should be supported to have an effective role in the planning and delivery of their health services; First Nations and Inuit should receive services in a seamless way through integration of federal/provincial/territorial programs; First Nations and Inuit should have access to the same quality and availability of service as the rest of the population living in similar geographic areas; and reform of the First Nations and Inuit health system should be undertaken to shift the emphasis "upstream" to create stronger capacity for prevention of illness and promotion of good health.

There continue to be significant disparities in health outcomes when compared to the general Canadian population in areas of life expectancy, prevalence of chronic and infectious disease, and injury. Diabetes rates are three to four times higher, and potential years of life lost due to injury are three and a half times higher. Rates of First Nations youth suicide are six times the rate for other Canadian youth. In addition, tuberculosis infection rates are six times higher than the Canadian general population. Since 1992, the proportion of AIDS cases among Aboriginal people climbed from 1.7 percent of all cases in Canada to 7.2 percent in 2001.[4] Despite these disparities, the Department continued to make strides in addressing the health status of First Nations and Inuit. For example, life expectancies have risen—13.1 percent for males and 12.6 percent for females—among Registered Indians over a 20 year period. Similarly, the First Nations infant mortality rate has been steadily declining since 1979 when it was 2.5 times the Canadian rate. In 2000, the First Nations rate dropped to approximately 1.2 times higher than the Canadian rate.

The Department faces many of the same challenges as other Canadian health systems such as, increasing costs, health human resource shortages and servicing the needs of an aging population. In addition, the First Nations and Inuit health system has additional challenges in program delivery and increasing costs due to a rapidly growing population with a higher rate of injuries, disease burden and populations living largely in remote and rural areas of the country.

A range of medically necessary benefits (drugs, dental care, vision care, medical supplies and equipment, short-term crisis intervention mental health services and medical transportation to access medical services not available on-reserve or in the community of residence) is provided under the NIHB Program to approximately 765,000 First Nations and Inuit, regardless of residency. During 2004–2005, we continued to meet ongoing responsibilities to address the challenges to the health of First Nations people and Inuit and to the First Nations and Inuit health system. Efforts were aided by the initial allocation of funds from the Budget 2003 commitment to invest $1.3 billion over five years to build the foundation for a more effective and sustainable First Nations and Inuit health system. This commitment included funds for NIHB; capital reinvestment to improve health facilities; an Immunization Strategy for First Nations children on-reserve; a comprehensive Nursing Strategy; and pilot programs to improve the integration of services with those of the provinces and territories. In 2004–2005, the Government also announced $700 million in new commitments to improve Aboriginal health. Confirmed in Budget 2005, these include funds for an Aboriginal Health Transition Fund to enable integration and adaptation of health services; the Aboriginal Health Human Resources Initiative to increase the number of Aboriginals choosing health care professions and funds to enhance health promotion and disease prevention programs focusing on suicide prevention, diabetes, maternal and child health and early childhood development.

During the year, we continued to address a number of specific challenges and risks faced in delivering programs and services that include: the need to increase prevention

[4] Health Canada, A Statistical profile of the Health of First Nations in Canada, 2000.

efforts at the community level to improve health and decrease the burden on the health care system; the need to build capacity for First Nations and Inuit to have a more effective role in the planning and delivery of health services; the need to maintain clear and effective accountability for health outcomes in relation to both health services and health status; and the challenges associated with balancing cost effectiveness while contributing to optimal health impacts.

Together with First Nations and Inuit, the Department works to enhance the reach and effectiveness of programs and services, and to deliver public health and community health programs on reserves. These programs include environmental health and communicable and noncommunicable disease prevention. Primary health care services are also provided in remote and isolated communities where often no provincial services are readily available.

PRIORITY 1: ONGOING

Enhance health promotion and prevention programs

During the year, our Department invested in programs designed to collectively improve the spiritual, emotional, intellectual and physical growth and development of First Nations and Inuit infants and children, and to support pregnant women, caregivers, families and communities in raising healthy children who are able to meet their full potential. Programs targeted towards maternal, infant and child health, increasing children's knowledge of language and culture, and increasing children's readiness for school were the focus. To close the gap in health status between Aboriginal and non-Aboriginal Canadians, we put in place several health promotion and disease prevention activities and worked with partners to improve health care delivery. Specific initiatives include a targeted immunization program, an expansion of the Aboriginal Head Start program, and an expansion of programs to address fetal alcohol spectrum disorder in Aboriginal communities. To complement the federal/provincial/territorial (F/P/T) Early Childhood Development (ECD) Initiative, Health Canada, working in close collaboration with the Public Health Agency of Canada (PHAC), Human Resources and Skills Development Canada (HRSDC), Indian and Northern Affairs Canada (INAC), and Social Development Canada (SDC), moved forward in implementing the ECD Strategy for First Nations, Inuit and other Aboriginal children.

RPP Commitments 2004–2005	Report on Results
Implementation of an ECD Strategy for First Nations and Inuit — "single window" approach	We assessed the viability of a "single window" approach to ECD program delivery, within the context of a national Early Learning and Child Care Initiative. Among other activities that took place, federal departments met with community representatives who work with children with special needs to identify potential strategies. These activities were complemented by National Aboriginal Organizations' (NAO) led community dialogues that produced discussion papers on how to apply the ECD "QUAD" principles (quality, universally inclusive, accessible and developmental) in Aboriginal communities.

RPP Commitments 2004–2005	Report on Results
Investment of $74.2 million in programs designed to improve the health and well-being of First Nations and Inuit infants and children and to support pregnant women, caregivers, families and communities through the Aboriginal Head Start On-Reserve (AHSOR), Fetal Alcohol Spectrum Disorder (FASD) Program and the Canada Prenatal Nutrition Program (CPNP) that results in improved health and well-being of infants, pregnant women, children, families and communities	Elements of the AHSOR Program were delivered in 338 communities, which served approximately 9,100 children. In 2004–2005, AHSOR convened a workshop to discuss future program developments. We also facilitated parent focus groups in communities to obtain their feedback on barriers to parental involvement and strategies to address them. FASD Program: First Nations and Inuit component provided regions with training in Asset Mapping which is a capacity development tool that enables communities to identify their strengths and develop a plan to address FASD. To increase community awareness, training and education sessions on the causes and effects of FASD were provided to over 500 professionals, para-professionals and caregivers. Several mentoring projects were also established in 2004–2005. These projects began to demonstrate the benefits in preventing FASD which result from pairing pregnant at-risk women with a trusted support worker. In 2004–2005, approximately 6,000 women participated in CPNP: First Nations and Inuit component at approximately 450 project sites, serving more than 600 First Nations and Inuit communities. The capacity of CPNP to deliver effective programs was strengthened by more than 500 workers who received in-depth training on relevant topics such as gestational diabetes and infant nutrition. Resource and reference material was also developed and distributed. AHSOR 2004–2005 expenditures: $41,462,356 FASD 2004–2005 expenditures: $10,729,173 CPNP 2004–2005 expenditures: $8,902,031 **AHSOR AND FASD:** Full annual funding could not be expended in this fiscal year. All available funding was allocated to meet regional health program needs, including to those services that First Nations have identified as priorities. **CPNP:** The expenditures above are the allocations and include grants and contributions; and operations and management costs. Data on the number of sites and women reached is estimated. Up to 50% of projects have been included in Health Services Transfer Agreements in which the community has greater flexibility in the management of its resources and final reporting to this level of detail is not mandatory.
Investment of $32 million over five years to increase immunization rates among First Nations children, under the age of six, who live on-reserve, and to ensure access to newly recommended vaccines Implementation of Immunization Strategy through partnerships with F/P/T colleagues and Aboriginal organizations and communities	We provided access to three newly recommended vaccines (meningococcal conjugate, pneumococcal conjugate and varicella vaccine) to the on-reserve population. We also supported work in some communities for the enhancement of the immunization program either through staffing or access to specific educational opportunities, some of which were done in partnership with provinces. The targeted Immunization Strategy with participation from several First Nations community nurses and National Aboriginal Organizations (NAOs) was implemented. Our Department enhanced partnerships with provinces in vaccine management and delivery, resulting in streamlined services. Benchmark data were collected on immunization coverage for two-year-olds living on-reserve, as well as information on knowledge, attitudes and beliefs around immunization practices among caregivers and nurses who provide immunizations on-reserve. Immunization Strategy expenditures: $691,744

RPP Commitments 2004–2005	Report on Results
Investment of $28.6 million in programs that will: Increase awareness of healthy behaviours such as healthy eating, active living and healthy body weight Increase awareness of the harmful effects of tobacco and substance misuse	Through the Aboriginal Diabetes Initiative (ADI), communities received culturally appropriate information on healthy behaviours including the provision of a nationally distributed health and nutrition magazine. More than 600 communities and/or tribal councils received funding for projects that raised awareness of healthy behaviours such as walking clubs, cooking classes, school-based prevention projects, and camps for children and caregivers. Thirty diabetes prevention and health promotion projects were funded in communities to increase healthy behaviours among off-reserve Aboriginal populations, Métis, and Inuit living in urban centres. Mobile diabetes screening units were employed in British Columbia and Alberta. These units provided a safe and effective means of increasing access to services for remote First Nations communities. In addition to raising awareness about diabetes, the units provided retinopathy, neuropathy, and blood pressure monitoring services. A national social marketing campaign was launched in First Nations and Inuit communities to provide information on the dangers of second-hand smoke and to encourage First Nations and Inuit to make their homes smoke-free. Aboriginal focused television and radio campaigns aired to emphasize the importance of smoke-free areas at work and at home, especially in the presence of children. A follow-up media campaign focusing on tobacco cessation strategies was also prepared for delivery in 2005. Support for over 100 projects in 309 First Nations and Inuit communities to raise awareness about tobacco misuse and cessation was provided. First Nations' led discussions were initiated with the Assembly of First Nations (AFN) to develop a strategy to address the need for smoke-free areas on-reserve. ADI expenditures: $13,918,676 Tobacco Control Strategy expenditures: $6,899,184
Increased community capacity to reduce injuries	An injury prevention training manual and an adapted preschool education guide relating to hazardous materials and symbols were developed and distributed to First Nations and Inuit communities. A partnership with Transport Canada was established regarding their Personal Flotation Device Loaner Program in order to work with Aboriginal communities to reduce the number of marine-related fatalities in Western Canada. Injury Prevention Program expenditures: $5,746,306
Launch social marketing campaign on HIV/AIDS and provide support for the educational activities of NAOs and communities Provision of health information and prevention and harm reduction strategies to increase community knowledge of HIV/AIDS	Canadian Aboriginal AIDS Network (CAAN) and Pauktuutit Inuit Women's Association conducted enhanced AIDS awareness campaigns. Over 20,000 posters, pamphlets and information sheets on HIV/AIDS were distributed in First Nations communities and 1,500 copies of the pamphlet and information sheets were translated into Inukititut. Several communities engaged in awareness campaigns in conjunction with their local or regional Aboriginal AIDS service agencies. All prevention education efforts on HIV/AIDS were presented within a harm-reduction framework, and in some regions, over 90 percent of the on-reserve First Nations communities hosted at least one educational workshop. HIV/AIDS expenditures: $3,790,708

RPP Commitments 2004–2005	Report on Results
Development and implementation of the strategic community risk assessment and planning tool for the elimination of tuberculosis in First Nations and Inuit communities and report on future directions of the Tuberculosis Strategy	The strategic community risk assessment tool for tuberculosis elimination (SCRAP-TB) was piloted in six communities and was helpful in supporting communities with their TB prevention and control program planning. In response to experts' recommendations to discontinue routine use of the BCG vaccine and replace it with an enhanced disease and infection detection and treatment program, our Pacific, Alberta and Quebec regions have discontinued routine use after consultation with individual communities. Manitoba and Ontario regions have initiated discussions with communities about the appropriateness of the vaccine use and their plans for replacement with an enhanced detection program. The existing Tuberculosis Elimination Strategy will be updated in 2005–2006 to reflect latest tuberculosis and public health expert recommendations. Tuberculosis expenditures: $4,774,878
Number of drinking water quality programs in place in First Nations communities and the results of these programs Increase in frequency of sampling and testing of drinking water quality in First Nations communities Increase in the number of communities that have portable laboratory kits for testing Training for First Nations communities to increase their capacity to monitor their drinking water quality and detect potential problems	Common definitions and a database were developed to ensure that performance information on water quality is collected and measured in a consistent manner in the future to enable comparative assessments. Our drinking water quality programs south of the 60th parallel involved 82 Environmental Health Officers providing data analysis reports. In total, 97,111 samples were taken in First Nations communities and analyzed. A total of 533 community sites had access to portable laboratory kits for testing during 2004–2005. Of these community sites, 441 utilized the kits to test at least one of their water systems. Capacity building in First Nations communities to monitor their drinking water quality and to detect potential problems was facilitated through the Community-Based Water Monitor program. In 2004–2005, 492 community sites had trained community-based water monitors. Drinking Water expenditures: $6,890,700

PRIORITY 2: ONGOING

Improve the quality, accessibility and effectiveness of health care services

Our Department works in collaboration with First Nations and Inuit communities to improve their quality of life and work towards closing the health outcomes gaps between Aboriginal and non-Aboriginal Canadians. The long-term goal is to shift the focus from treatment to "upstream" investments in public health, prevention and promotion services and to move towards improved equity in access and quality of health services. During the year, we focused on increasing the number of certified health professionals, enhancing health facilities to improve First Nations and Inuit access to health programs and services, providing support in acquiring accreditation for treatment centres and ensuring First Nations and Inuit had access to Home and Community Care (HCC) services.

RPP Commitments 2004–2005	Report on Results
Increase the number of First Nations and Inuit health professionals working in the health system and improve the continuity of care by: Implementing the First Nations and Inuit component of the Health Human Resources (HHR) Strategy	The First Nations and Inuit component of the Pan-Canadian HHR Strategy was implemented. An Aboriginal youth-oriented educational module Health Careers in the Classroom, was developed by the National Aboriginal Achievement Foundation for delivery to Aboriginal high school students to increase their awareness and knowledge of health careers. Funding was also provided to support a series of regional career fairs with an increase in health career focus. A national baseline survey on youth awareness of health careers was completed, which will form the baseline information for future social marketing awareness campaigns and for an overall evaluation of the health careers initiative. Work was initiated with the Association of Faculties of Medicine of Canada and the Indigenous Physicians Association of Canada to make recommendations for improvement to medical schools' curricula to make them more culturally appropriate. Work was also initiated with the National Indian and Inuit Community Health Representative Organizations to establish plans for developing core competencies, standards and certification processes for para-professional community health representatives. HHR expenditures: $4,243,238
Number of nursing positions staffed (committed to 123 new full nursing positions, of which 74 will augment staffing in nursing stations) and support of professional development for nurses in First Nations and Inuit communities as a result of implementation of the Nursing Strategy Improvements in nursing retention and recruitment, enhanced professional competency, adoption of evidence-based practices and improved client and system outcomes	Approximately 58 of the 123 new nursing positions targeted under the Nursing Strategy investment have been filled, including the contribution agreement funds targeted for transferred nursing positions. An aggressive recruitment campaign has resulted in a number of excellent candidates for all regions. Interviews are under way and hiring to current investment levels will be on target by fall 2005. Professional development initiatives resulted in a number of nurses developing competencies in mandatory training in clinical nursing practice, as well as other continuing education and training skills such as mandatory training in clinical skills and community health program competencies; certification in life saving skills; immunization competency training and skills enhancement for health surveillance. Early signs of improved recruitment are demonstrated by a higher number of applicants to new nursing positions and nurse vacancy rates that are relatively lower than during the pre-investment period. We expect to see more use of evidence-based practices and improved client and system outcomes as some of the impacts of the new investments. Nursing Strategy expenditures: $60,366,461
Improve the living and working conditions of nursing staff and increase the Department's ability to recruit and retain qualified health professionals by: Improved operations, and maintenance of on-reserve health facilities and professional staff residences Major structural repairs and replacement/upgrade of building systems Construction of nine health facilities Construction of 16 residential units	Repairs, upgrades and replacements of building systems improved the safety and operating efficiency at Health Canada hospitals and other health facilities. These projects included fuel distribution system upgrades, furnace and heating system repairs, and installation of efficient lighting systems and solar energy equipment. We constructed 11 health facilities, including five health stations, four health centres and two nursing stations. This ensures that health services are accessible to First Nations and Inuit communities through modern and sustainable health facilities. Our Department constructed 16 residential units to accommodate nursing staff in remote and isolated communities. Health Facilities and Capital expenditures: $9,510,584

RPP Commitments 2004–2005	Report on Results
HCC: Percentage increase from 2003–2004 to 2004–2005 of communities delivering HCC services Work with INAC to develop an approach and framework for long-term and ongoing care in First Nations and Inuit communities Options to address First Ministers' agreements on home care for First Nations and Inuit communities	Eighty-five percent of First Nations and Inuit communities have access to home and community care services, a 2 percent increase from 2003–2004. Health Canada continues to work in partnership with INAC and First Nations and Inuit in the development of a framework on long-term and continuing care in First Nations and Inuit communities. Work is ongoing for the development of options to address First Ministers' agreements on home care for First Nations and Inuit communities. Home and Community Care expenditures: $95,248,945
Effective use of medical transportation resources to meet the needs of clients in a sustainable manner by: Implementation of the NIHB Medical Transportation Policy Framework	The goal of the Medical Transportation Policy Framework is to establish policy infrastructure which allows for nationally consistent, accessible and cost-effective provision of medical transportation benefits. The revised version of the Medical Transportation Policy Framework will be completed in July 2005.
Improve the quality of First Nations and Inuit health services by: Finalizing the accreditation standards for First Nations community health programs Accrediting nine more program locations Providing support to these programs in acquiring accreditation and providing enhanced training and professional development for personnel working in both residential treatment centres and community-based programs	To ensure the accreditation standards for community health programs are culturally relevant, several standards have been field-tested in communities and enhanced with cultural and traditional elements. Six new organizations began the accreditation process, bringing the total to over 40 First Nations and Inuit organizations that included addiction treatment centres, community health centres, home care and small hospitals. Three additional National Native Alcohol and Drug Addiction Program (NNADAP) treatment centres achieved accreditation. In total to date, there are 18 NNADAP and Youth Solvent Abuse Program (YSAP) treatment centres were fully accredited, five centres were involved in the accreditation process, and three centres were in the process of regaining their accreditation status. At present, there are 58 NNADAP and YSAP treatment centres across Canada. Certified training provided by recognized training institutions was established as a standard procedure within NNADAP. We continued to support treatment centres and their efforts to offer a range of certified training opportunities to their employees. NNADAP expenditures: $44,539,914 YSAP expenditures: $12,072,244

PRIORITY 3: ONGOING

Cooperate and collaborate with First Nations and Inuit communities, provinces and territories, and service providers to modernize and adapt the health service system for First Nations and Inuit

Our Department worked closely with key partners, including First Nations and Inuit, the provinces and territories, health professional associations, national non-governmental organizations and the health research community to develop strong partnerships at the national, regional and community levels. During the year, work continued with a variety of organizations to implement initiatives funded through the Aboriginal component of the Primary Health Care Transition Fund (PHCTF) such as midwife training programs, health and social services projects and telehealth and to improve the coordination and integration of federal Aboriginal ECD programs.

RPP Commitments 2004–2005	Report on Results
Report on work with provinces and territories in a collaborative approach with NAOs to identify common priorities and opportunities for collective action, through the F/P/T advisory committee structure	On September 13, 2004 at a Special Meeting of First Ministers and Aboriginal Leaders, agreement was reached to work together to develop an Aboriginal Blueprint. The focus of the Blueprint is to improve the health status of Aboriginal peoples and health services in Canada through concrete initiatives. We continued to work with provinces and territories and Aboriginal groups on the development of the Blueprint on Aboriginal Health. In December 2004, federal, provincial and territorial Deputy Ministers of Health met and approved the Aboriginal Health Reporting Framework which allows for the engagement of Aboriginal groups in the development of a comprehensive framework.
Report on ongoing work with a variety of organizations to implement initiatives funded through the Aboriginal component of the PHCTF, such as midwife training programs, health and social services projects and telehealth	Our Department began the Health Integration Initiative, which explores, develops and analyzes models for better integration of health service delivery to First Nations and Inuit. The overall objective is to improve access and quality of services, to make better use of existing capacity, create economies of scale, respond to community priorities, and produce “win-win” solutions for First Nations and Inuit and provincial/territorial partners. We facilitated and signed agreements with eight First Nations communities to begin integration projects in partnership with the respective regional, district authorities and provincial/territorial governments. The Department continues to analyze and describe models of primary health care for First Nations and Inuit. Some of these activities include: analysis of provincial/territorial primary health care policies including quality improvement models and their linkages to First Nations and Inuit health systems; discussions with First Nations and Inuit stakeholders to describe options for a quality improvement approach; support of continuous quality improvement through accreditation in the First Nations health system environment, and coordination to integrate quality improvement and health planning at the community level.
Integration of federal ECD programs by working with INAC, HRSDC and SDC to improve the coordination and integration of federal Aboriginal ECD programs	Health Canada, HRSDC and INAC worked together to develop a plan to facilitate joint planning, training, and co-location of the First Nations and Inuit Child Care and AHSOR programs. Health Canada, HRSDC and the Public Health Agency of Canada (PHAC) collaborated to develop the first joint national training event for ECD workers, Growing Together under One Sky. This brought together 1,000 participants from AHSOR, Aboriginal Head Start in Urban and Northern Communities, and First Nations and Inuit Child Care Initiative (FNICCI) projects to share knowledge and tools to improve ECD community programs and services.

RPP Commitments 2004–2005	Report on Results
Development of community health plans to increase First Nations and Inuit communities' capacity to meet the health needs of members, increase accountability and achieve integration of services where viable	Seven communities developed community health plans, which we reviewed and assessed. The communities reflected a broad mix of community type, population and remoteness, in various regions across the country.
Increase awareness, uptake and access to mental health and emotional support services by: Ensuring access to the Indian Residential Schools Resolution Canada (IRSRC) Mental Health Support Program to identify and maximize services required for IRS claimants who are actively resolving a legal claim against Canada Work in partnership with Indian Residential Schools Resolution Canada (IRSRC)	Since the Program was established in 2003, 203 claimants have accessed 715 counselling sessions with mental health professionals. Our Department established nine regional coordinator positions and continued to provide support to Aboriginal or Aboriginally-affiliated organizations to deliver 12 front-line regional health support worker positions. We supported national and regional staff training and information sharing activities. Training efforts focused on client skills and their roles within a larger support system. The program provided support to the Aboriginal Healing Foundation's final National Gathering in July 2004. This event brought together thousands of former residential school students, their families, mental health professionals, and researchers to discuss and share information about the IRS healing movement. Indian Residential Schools expenditures: $1,980,146

PRIORITY 4: ONGOING

Strengthen information and knowledge management to improve delivery of health care services and programs

Health Canada faces diverse challenges in harmonizing business needs and health care service delivery requirements with information and communications technologies. In 2004–2005, the Department introduced the new Home and Community Care (HCC) and Diabetes Information Systems and piloted the National Native Addictions Information Management System (NNAIMS) in two treatment centres in the Atlantic region.

RPP Commitments 2004–2005	Report on Results
Focus on health system renewal by: Implementing the e-Health strategic vision and policy framework Implementing the new Home Care and Diabetes Information Systems Piloting of a new communicable disease and immunization reporting system Rolling out the National Native Addictions Information Management System (NNAIMS)	The e-Health strategic vision and policy framework was finalized and will be approved in 2005–2006. The administrative component of the HCC application has been successfully deployed to 286 First Nations communities and is mandatory for use in reporting on home care contribution agreements for First Nations and Inuit communities. The diabetes component is currently under review. The Public Health Strategy for the new Communicable Disease and Immunization reporting system was adopted. A technical review of NNAIMS was successfully completed and piloting of the system began in all regions. Following the pilot phase, NNAIMS will be deployed to additional treatment centres throughout 2005–2006.

RPP Commitments 2004–2005	Report on Results
Development of a national Aboriginal ECD service providers network	The Aboriginal Children's Circle of Early Learning was established to facilitate information sharing on best practices, training and professional expertise among ECD workers and professionals. Launched in November 2004, this on-line network is updated regularly in an ongoing effort to better meet the needs of its target audience.
Continue to build and support capacity in First Nations and Inuit communities to identify, understand and control the impact of exposure to environmental contaminants through community-based research, monitoring and analysis activities by delivering the National First Nations Environmental Contaminants Program (NFNECP) and the Northern Contaminants Program	We continued to work in partnership with the AFN in the administration and delivery of community-based environmental health research projects with First Nations communities and organizations. We supported 10 scientific projects with cumulative funding of $1.3 million.

PRIORITY 5: ONGOING

Implement effective evaluation and accountability mechanisms that will improve the management practices of Health Canada and First Nations and Inuit communities

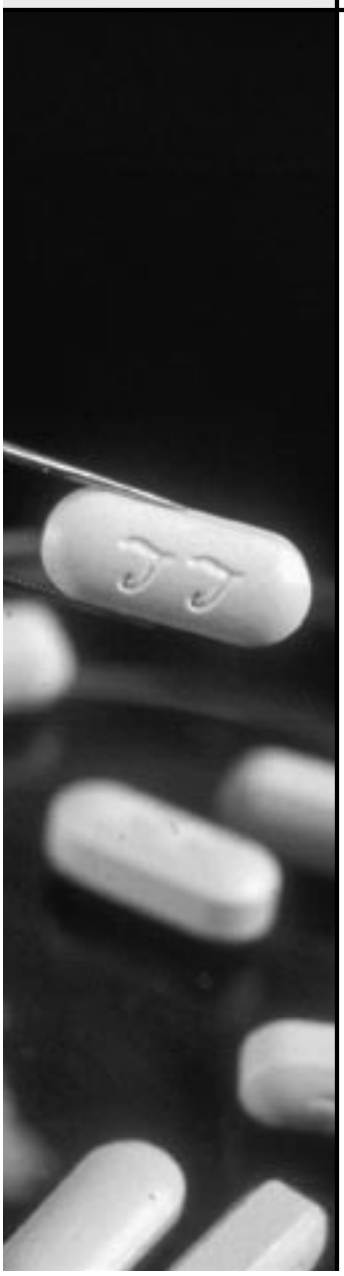
The Department is committed to the principles of due diligence and public accountability by putting in place tools and mechanisms to measure progress and report on results. This includes establishing clear benchmarks of success and implementing effective accountability models for First Nations and Inuit health programs and services. Accountability and responsibility are shared across multiple jurisdictions, between federal and provincial governments, as well as First Nations and Inuit communities. Health Canada works on accountability for compliance with existing laws, regulations and standard accounting practices regarding the use of public funds and, in addition, on accountability as it pertains to performance and reporting on results. We developed new contract management tools, updated the First Nations and Inuit funding agreements templates, further streamlined and reduced duplication of First Nations and Inuit reporting requirements and strengthened management and administrative capacity in First Nations and Inuit contribution agreement recipients.

RPP Commitments 2004–2005	Report on Results
Implementation of a plan for contract management to provide guidance on contracting procedures	Contract management tools were developed that included a contracting process map, a contract process guide and contracting fact sheets.
Report on the annual agreement update process to fine-tune First Nations and Inuit funding agreements	Results of the second phase of the streamlining of First Nations and Inuit reporting requirements were incorporated into the 2005–2006 agreement templates. Revisions were made to clarify and streamline capital facilities and moveable assets clauses.
Strengthen capacity in the management and administration of funding agreements: Implement the Capacity Development Strategy	Work began on developing a Contribution Agreement Handbook and a Contribution Agreement Toolbox for First Nations and Inuit contribution agreement recipients to strengthen their management and administrative capacity.

RPP Commitments 2004–2005	Report on Results
Strengthen the evaluation function among First Nations and Inuit programs and services by: Evaluation of Health Services Transfer Policy and the Aboriginal Diabetes Initiative (ADI) Report on the evaluation initiated for the ECD Strategy, the HCC and NNADAP	The evaluation of the Health Services Transfer Policy showed that overall, the policy has performed satisfactorily. The evidence of the evaluation demonstrates that: First Nations and Inuit organizations have thrived as a result of the policy; service responsiveness has improved; mandatory programs are delivered and the accountability of Chief and Council in health matters has improved from pre-transfer times. The evaluation also identified that several systemic issues such as sustainability, stove piping, reporting burden and capacity, while not directly related to the Transfer Policy itself, have an impact on its success. Based on the findings of the evaluation, the Department will review the Transfer Authority in 2005–2006 and complete the review of the transfer framework in 2006–2007 for implementation in 2007–2008. Preliminary findings from the ADI evaluation demonstrated that over 85 percent of communities have access to diabetes programming. Factors that have contributed to the successful implementation of ADI include: the involvement of First Nations, Inuit, Métis and other Aboriginal partners in the early stages; extensive national, regional and local consultations; and the establishment of relevant steering committees, sub-committees and advisory bodies. The evaluation also determined that the use of culturally relevant information and holistic approaches in programming helped to reach ADI's target audience, and that resources dedicated to strengthening both on and off-reserve capacity are producing more effective prevention and promotion activities. Challenges such as patient compliance with treatment and community remoteness were also identified. A review of the first phase of work under the ECD Strategy was completed and is informing the federal government's efforts to develop a comprehensive "single window" approach for ensuring better integration, coordination, accountability and reporting for federal Aboriginal ECD programs. Also under the ECD Strategy, in 2004–2005, work was pursued in consultation with various stakeholders to develop content for the Aboriginal Children's Survey (ACS). The ACS is to be conducted in fall 2006, and will provide data on Aboriginal children under the age of six which is meaningful to Aboriginal people, governments, and other interested parties. NNADAP set the groundwork for a program-wide evaluation that is scheduled to take place in 2005–2006. The first phase of this work included a comprehensive literature review that will provide the basis for an addictions evaluation framework. It will also support the development of a long-term addictions evidence-based strategy that will result in several research activities being conducted over time.
Report on streamlining of reporting requirements for First Nations and Inuit	Reporting schedules were grouped together to further streamline and reduce duplication resulting in a further reduction in data element reporting. The results were incorporated into the reporting schedules for 2005–2006 contribution agreements.

Strategic Outcome:
Safe Health Products and Food for Canadians

Relevant Outcome in "Canada's Performance":
Healthy Canadians with Access to Quality Health Care



Objective

Health Canada contributes to maintaining and improving the health of Canadians by evaluating and monitoring the safety, quality and effectiveness of drugs, vaccines, medical devices, natural health products and other therapeutic products, as well as the safety and quality of the foods available to Canadians. Our legislated mandate also includes evaluating and monitoring the safety, quality and effectiveness of veterinary drugs sold in Canada, and the safety of foods derived from animals treated with those drugs. Health Canada also provides authoritative health information and works to promote conditions that enable Canadians to make healthy choices and informed decisions related to health products, food and nutrition.[5]

Financial Information

2004–2005 (MILLIONS OF DOLLARS)			
	Planned Spending	Total Authorities	Actual Spending
Gross expenditures	224.1	238.8	218.7
Revenues	(40.7)	(40.7)	(34.7)
Net expenditures	183.4	198.1	184.0*
FTEs	1,953	1,971	1,849

** This represents 42.1 percent of Health Promotion and Protection actual spending (excluding the Public Health Agency of Canada).*

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

- additional funding for BSE in the areas of risk assessment and targeted research
- additional funding for the Therapeutics Access Strategy (TAS)
- transfers to other government departments for the Canadian Biotechnology Strategy

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

The actual spending is $14 million lower than total authorities mainly due to:

- TAS funding to be carried forward for future year requirements such as the Therapeutic Products Safety Initiative
- year end adjustments and lower than expected expenditures in various programs

Intermediate outcomes

- Positive health outcomes through safe and effective health products, and safe and nutritious food
- Canadian scientists, health professionals and industry contributing to public health and health innovation
- Public confidence and trust in the safety of health products, food and the regulatory system

Immediate outcomes

- Improved timeliness, transparency and predictability of the regulatory process
- Expanded international collaboration and national cooperation
- Enhanced information sharing with key health science and innovation partners and stakeholders
- Improved awareness and informed decisions concerning health products, food and nutrition by Canadians
- Enhanced public involvement in health products, food and nutrition policy, regulatory decision-making, program development and implementation
- Industry compliance with safety regulations and standards

Priorities

- Transforming our efficiency, effectiveness and responsiveness as a regulator
- Providing authoritative information for healthy choices and informed decisions by Canadians
- Increasing responsiveness to public health issues and greater vigilance concerning safety and therapeutic effectiveness in real world use
- Improving transparency, openness and accountability to strengthen public trust and stakeholder relationships

Program, resources and results linkages

Program	Actual Expenditures[1] ($M)	Result Linkage
Pre-market Regulatory Evaluation and Process Improvement	86.7	Conducts pre-market regulatory review of human and veterinary drugs, biologics, genetic therapies, medical devices, natural health products and foods. Through the Therapeutics Access Strategy, continues to improve the timeliness, transparency and predictability of its pre-market reviews of therapeutic products for human use, benchmarking them against leading international practices, while maintaining Health Canada's high safety standards.
Information, Education and Outreach on Health Products, Food and Nutrition	5.9	Supports informed decisions and healthy choices by consumers, patients and health professionals through a broad range of activities linked to health products and food, including nutrition policies and standards such as *Canada's Food Guide to Healthy Eating*.
Monitoring Safety and Therapeutic Effectiveness and Risk Management	82.9	Enhances post-market surveillance of safety and therapeutic effectiveness. This is done by exercising greater vigilance around safety and therapeutic effectiveness issues once products reach the market and by collecting information on adverse reactions to health products in Canada. Identifies and assesses health and safety risks and alerts the public to any problems; conducts compliance activities to ensure that health products available in Canada meet Canadian and international standards for safety, quality and efficacy.
Transparency, Public Accountability and Stakeholder Relationships	8.5	Strengthens transparency, openness and accountability through increased public involvement initiatives and improved annual plans and reports.

[1] *The title has been changed from Resources to Actual Expenditures for clarification.*

Executive Summary

Canadians continue to demonstrate a high level of satisfaction with the safety of the health products and food they consume. As the federal authority responsible for the regulation of health products and food, we evaluate and monitor the effectiveness of thousands of drugs (human and veterinary), vaccines, blood and blood products, biologics and genetic therapies, medical devices and natural health products, as well as the safety of the foods that Canadians eat. A key element of our work is to provide useful information about risks and benefits related to health products and food so that Canadians can make informed decisions about their health and well-being.

Our ongoing regulatory responsibilities span the life cycle of health products and food, from clinical trials to surveillance, compliance, and enforcement. The scope of our work is significant with more than 22,000 human drug products and 40,000 medical devices on the Canadian market. We also face challenges associated with rapid advances in technology and scientific breakthroughs. We meet these challenges by drawing on sound science and effective risk management in making evidence-based decisions to support safe health products and food for Canadians.

Our Department continued the implementation of the Therapeutics Access Strategy (TAS) which has led to substantial improvements in the timeliness and efficiency of our review process for therapeutic products.

We also continued the development of an international regulatory cooperation framework to forge stronger links and closer collaboration within the increasingly globalized environment. This forward looking strategy will increase the efficiency and effectiveness of international activities that help us keep pace with globalization, public health trends, and technological change. In turn, these improvements will inform and strengthen our domestic regulatory actions.

Another important initiative we began developing with Agriculture and Agri-Food Canada (AAFC), the Canadian Food Inspection Agency (CFIA), and others is the National Food Policy Framework (NFPF). This federal/provincial/territorial initiative intended to provide for more effective inter-governmental collaboration and cooperation on priority food policy issues. It will also facilitate implementation at the program level across the various jurisdictions and portfolios with responsibilities linked to food. Eventually it should result in improved food system management in Canada; strengthened food safety; increased contribution of Canada's food system to healthy eating; support for an innovative, sustainable, and prosperous food sector; and protection and promotion of consumer interests.

Prevalence of diabetes, by BMI category and sex, household population aged 18 or older, Canada excluding territories, 2004 (%)

Source: 2004 Canadian Community Health Survey Nutrition
* Significantly higher than estimate for normal ($p < 0.05$)
E Coefficient of variation 16.6% to 33.3% (interpret with caution)

Canadians, health professionals and educators are becoming more knowledgeable and sophisticated about managing health and are seeking more information to make decisions and healthy choices. It is important, therefore, that Health Canada's dietary guidance be up-to-date in light of current science and changes in our food environment. The revision of *Canada's Food Guide to Healthy Eating*, which continued throughout 2004–2005, will ensure that the Department continues to provide information that promotes a pattern of eating that meets nutritional needs, promotes health and minimizes the risk of nutrition-related chronic disease. Obesity, which has gained prevalence in Canada over the past 25 years, is an important factor that puts people at a greater risk for developing such diseases as Type II diabetes.[6]

Canadians expect their governments to be responsive, open, transparent and accountable. To this end, we

[6] http://www.statcan.ca/english/research/82-620-MIE/82-620-MIE2005001.htm

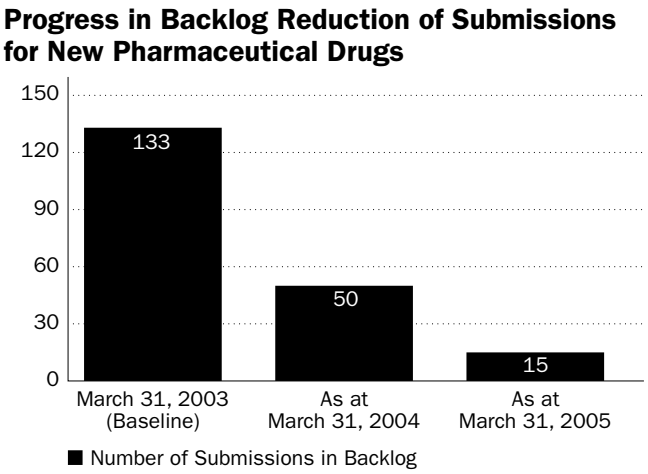
developed and implemented effective mechanisms to ensure that Canadians and stakeholders are appropriately informed, that their views are heard and that governments are held accountable for how public expertise and advice are used.

Collectively, these and other actions were framed within four priorities in 2004–2005 towards the safety of health products and food for Canadians.

PRIORITY 1: ONGOING

Transforming our efficiency, effectiveness and responsiveness as a regulator

Canada, as with all leading industrialized nations, faces challenges and opportunities as technology and science rapidly advance. Canadians expect timely access to innovative therapeutic products and safe food. This has placed enormous pressure on our regulatory system and scientific capacity to keep pace so that Canadians have confidence in our high standards of safety, and industry can benefit from an internationally comparable regulatory environment. Making good use of resources and knowledge from other agencies and governments contributes to more informed, consistent and timely decisions. It can also lead to joint standards and practices, promote technological innovation, and ultimately, support greater access for Canadians to the latest therapeutic products and methods. In 2004–2005, we made significant progress towards regulatory efficiency, effectiveness, and responsiveness as demonstrated through our performance on commitments.

RPP Commitments 2004–2005	Report on Results
Meet performance targets on review of new drug submissions 90 percent of the time in 2005–2006 for pharmaceuticals and in 2006–2007 for biologics and genetic therapies, including elimination of backlogs. We will do this without reducing public safety by re-engineering review processes, increasing our science capacity and applying project management and other quality systems to review processes. We will also apply these systems to submissions of generic drugs, veterinary drugs and novel foods	New investments through TAS led to a reduction in the backlog of reviews of new pharmaceutical drug submissions by 89 percent from April 2003 to March 2005. In biologics, the backlog of submissions for new drugs was reduced by 7 percent over the same time period. In 2004, 25 percent of regulatory decisions for new pharmaceutical drug submissions were made within time targets, almost doubling from 13 percent in 2003. http://www.hc-sc.gc.ca/hcs-sss/pubs/care-soins/2005-therap-strateg/index_e.html  Management tools and approaches for improvement continue to be implemented to meet performance targets.

RPP Commitments 2004–2005	Report on Results
	We also exceeded our 90 percent performance target to review all veterinary drug submission data packages older than 18 months as of April 1, 2004 in keeping with our RPP commitment to apply tools and approaches to submissions that are not funded by TAS. We're in the process of working on quality systems in novel food reviews, becoming more transparent in terms of making Web postings and engaging external experts in Food Rulings.
Implement strategies that support earlier engagement with industry, patient and consumer groups, and other stakeholders in drug development	Actions taken included a wider representation in pre-clinical trial application meetings with industry stakeholders through the inclusion of clinical, quality/chemistry and manufacturing scientific reviewers.
Implement Good Guidance Practices to help industry improve the quality of submissions as well as Good Review Practices to ensure high-quality reviews	As part of Good Review Practices, new review templates and standard operating procedures have been aligned to enable the acceptance of submissions using the International Conference on Harmonization Common Technical Document format (CTD). The CTD format is used by several countries, including Canada, the United States, Europe, Japan, and Australia. A common international format makes it easier for submissions to be filed in various countries at the same time, helping to reduce the regulatory burden on manufacturers. http://www.hc-sc.gc.ca/dhp-mps/brgtherap/applic-demande/guides/qualit/prod/index_e.html A Good Guidance Practices Framework is under development to support high quality submissions by industry. A process map and standard operating procedures for developing guidance documents have been drafted and are under review. A guidance needs assessment was conducted via internal and external consultations in summer 2004. http://www.hc-sc.gc.ca/dhp-mps/prodpharma/activit/consultation/ggp_grp_notice_bpld_bpe_avis_e.html
Continue to support scientific research in emerging technology areas such as genetic therapies and novel drug delivery systems to inform regulatory guidance to industry and review practices	We conducted research in the areas of genetic therapies to reduce blood clots and novel drug delivery systems. Scientific papers of our research results were published in peer-reviewed international scientific journals such as Biochemical and Biophysical Research Communications.
Develop a biotechnology stewardship framework to enable responsible introduction of new discoveries through novel and appropriate regulatory mechanisms and evaluate the establishment of a Code of Practice for all stakeholders conducting policy, regulation and research activities	The Department received $360,000 from the Canadian Biotechnology Strategy Fund to support the development of a framework and to investigate a Canadian Code of Practice for Biotechnology. In 2004–2005, federal consultation on a draft framework was completed. A Code of Practice has been proposed as a means of implementing the framework to enable policy, regulatory and research activities. An initial government workshop has been held to address the scope and direction of the Code. The initiative is targeted for completion by 2007.

RPP Commitments 2004–2005	Report on Results
Implement a new Memorandum of Understanding (MOU) with the US Food and Drug Administration (FDA) to support a more efficient therapeutic product evaluation process that allows faster public access to important new therapies and quicker identification of risks associated with marketed health products	Within the MOU Implementation Plan, the Department identified several priorities: • retrospective comparison of drug application reviews in Canada and the US; • pilot project on Sharing of Review Packages; • keep each other informed of Clinical Trials conducted in each jurisdiction; and • share information on drug safety, including public advisories on COX-2 inhibitor nonsteroidal anti-inflammatory drugs (NSAIDs). These drugs are used for controlling pain and inflammation associated with rheumatic diseases and other less severe conditions.
Pilot a joint product submission review project with Australia's Therapeutic Goods Administration (TGA), which will allow the Department to share information while safeguarding our high safety, efficacy and quality standards	In April 2004, a MOU for general information-sharing was signed with the TGA to facilitate the exchange of software designed to reduce medical errors and to initiate discussions on the development of the joint product submission review. The project could be a model for future cooperation between the two agencies on regulation of high risk medicines. In addition, an expanded MOU was signed with Food Standards Australia/ New Zealand to work cooperatively on matters of mutual interest. These include evaluations of novel foods, quantitative microbial risk assessment, and health claims for foods and food fortification.
Develop an international regulatory cooperation strategy in 2004–2005 to provide a longer-term approach to our international collaboration efforts in such areas as food, nutrition and health products	We consulted other departments (e.g. Department of Foreign Affairs and International Trade, Privy Council Office) and other policy stakeholders (e.g. Policy Research Institute) in the development of a framework for release in fall 2005. This tool will enable us to carry out international activities in a more strategic and outcomes-based approach in support of the TAS.
Implement an electronic scientific Laboratory Information Management System (LIMS) supporting biologics and genetic therapies work to achieve accreditation for our laboratories in accordance with international quality standards	We launched LIMS pilot lab testing activities, providing an inventory of information concerning testing for biological products that may present high risks.
Continue working with Japan, the European Union and the United States to reduce duplication and testing of new medicines, including collaboration with the UK's National Institute for Biological Standards and Control (NIBSC) to improve information-sharing on research and testing methodologies	To reduce duplication, we continued to work on ICH (International Conference on Harmonization) expert Working Groups, particularly related to the Quality of Biotechnology Products, where a key guideline is in the process of being posted on our Web site. We were also involved in ICH working groups in the Department, including one on post-marketing and an emerging one. This work will directly impact drug product databases, the exchange of drug product information and drug safety. Discussions began on an MOU with NIBSC to transfer some technologies/ methodologies regarding the testing of new medicines; however, the MOU has not yet been finalized due to a variety of factors, including a restructuring at NIBSC and priorities such as Peer Review within Health Canada. Efforts will be made to finalize the NIBSC MOU by the end of 2005–2006.

RPP Commitments 2004–2005	Report on Results
Implement an electronic review system to modernize our approach to health product submissions and improve accessibility to information during the review process and over the product life cycle	E-Review represents a multi-year initiative designed to establish a fully automated electronic system to support the submission and review of drugs and therapeutic products and to ensure that we maintain pace with other leading regulatory agencies, International Conference on Harmonization (ICH), pharmaceutical industries, and health care associations. In 2004–2005, we rolled out the tracking system and began to test the Records and Document Information Management System. There was also ongoing development of the new veterinary drugs Emergency Drug Release system. Data migration of approximately 15,000 records dating back to 1980 has been successfully completed from the current to the new system.
Develop a new regulatory framework that implements cutting-edge ICH standards for drug manufacturing practices that will result in greater regulatory oversight of the quality of the active pharmaceutical ingredients in drugs used by Canadians	As part of an ongoing commitment to develop, adopt, and implement international technical standards for the development, registration, and control of pharmaceuticals, we continued to actively participate in the ICH. A number of draft guidance documents were also released for industry consultation in 2004–2005. http://www.hc-sc.gc.ca/dhp-mps/prodpharma/applic-demande/guide-ld/ich/index_e.html
Begin to implement the Natural Health Products (NHPs) Regulations, which were introduced in January 2004	We spent over $10 million in the implementation of the framework to provide Canadians with access to NHPs that are safe, effective, and of high quality, while respecting freedom of choice and philosophical and cultural diversity. The consumer will benefit from having more information on NHP labels to make informed decisions. As well, having the products go through the regulatory review system will increase consumer confidence in the safety and efficacy of NHPs and assure consumers that health claims are supported by appropriate levels of evidence. http://www.hc-sc.gc.ca/dhp-mps/prodnatur/faq/question_consum-consom_e.html
Implement a new guideline that sets out the regulatory expectations for the inclusion of children in clinical trials for therapeutic products	The number of medicinal products currently labelled for paediatric use is limited. Accordingly, the Department is developing new guidelines to encourage manufacturers to file submissions with paediatric usage information where this information exists in the labelling in other jurisdictions. In 2004–2005, we began to receive paediatric labelling data. This initiative will lead to enhanced safety and efficacy by providing more appropriate labelling information for use of medicinal products in the paediatric population. In addition, amendments to the Food and Drug Regulations were published in *Canada Gazette*, Part I. The proposed changes involve a provision for manufacturers of an extended period of data protection if they have conducted paediatric clinical studies or can provide data from their own paediatric studies elsewhere.

PRIORITY 2: ONGOING

Providing authoritative information for healthy choices and informed decisions by Canadians

Canadians continue to be active in their search for reliable, evidenced-based information for making healthy choices. Nutritional information can make a positive contribution to the protection and promotion of health. Accordingly, in 2004–2005, we increased efforts to provide timely, evidence-based information about food, nutrition and health products. This included the distribution of two million copies of *Canada's Food Guide to Healthy Eating* (CFGHE). The CFGHE Web page also registered a 15 percent increase in visits and was the most visited page on the Health Canada Web site.[7]

Canadians are among the highest consumers in the world of trans fatty acids which science has shown to increase the risk of heart disease. To assist consumers in reducing their intake, we announced mandatory labelling of trans fat on food products on January 1, 2003, becoming the first country in the world to do so. In 2004–2005, we remained committed to implementing new Nutrition Labelling Regulations which require that trans fats be listed on the labels of most pre-packaged foods by December 12, 2005. Nutrition facts tables have already begun to appear on food labels, and will be mandatory in December 2005. Additionally, in 2004–2005, we spent $300,000 to establish a multi-stakeholder task force to investigate and make recommendations to significantly reduce trans fats in the diet of Canadians and facilitate healthy food choices.[8]

As a result of these and other efforts, over 70 percent of Canadians have rated the Department as doing a good-to-excellent job in preparing the CFGHE, and 67 percent see the Department as encouraging Canadians to live healthy lifestyles.[9]

RPP Commitments 2004–2005	Report on Results
Review dietary guidance, including CFGHE, to ensure it continues to promote a pattern of eating that meets nutrient needs, promotes health and minimizes the risk of nutrition-related chronic disease. The review will ensure that this guidance reflects the most current scientific evidence concerning the relationships between diet and health and provides authoritative information to help Canadians make healthy choices about the food they eat	We conducted research to provide input on how to make our dietary guidance, including the CFGHE, more widely applicable and appealing to Canadians. Food pattern modelling was conducted to guide the inclusion of quantities and types of food groups in the CFGHE. http://www.hc-sc.gc.ca/fn-an/food-guide-aliment/revision/index_e.html Two new infant feeding recommendations were published and approximately 40,000 copies of resource materials were disseminated to health professionals through print materials, the Web site and inserts in professional journals. http://www.hc-sc.gc.ca/fn-an/nutrition/child-enfant/infant-nourisson/infant_feeding-nutrition_nourrisson_e.html
Continue to raise awareness about the new nutrition labelling requirements on food that came into effect in 2003 and how the labels can be used to make healthy food choices	New regulations published on January 1, 2003 made nutrition labelling mandatory on most food labels. Over 300,000 copies of the nutrition labelling tearsheet for consumers and over 30,000 posters were distributed, including distinct resources for First Nations and Inuit. A series of articles was also produced for distribution to the media. http://www.healthcanada.gc.ca/nutritionlabelling http://www.phac-aspc.gc.ca/guide/

7 http://www.hc-sc.gc.ca/home-accueil/tour/questions_e.html#7

8 http://www.hc-sc.gc.ca/food-aliment/e_trans_fat.html

9 A Report to Health Canada: 2005 Annual Performance Survey, The Strategic Counsel, March 2005.

RPP Commitments 2004–2005	Report on Results
Make documents available to the public that outline the scientific and risk-based reasons for our decisions regarding health products and food and nutrition	The Summary Basis of Decision (SBD) explains the reasons for granting market authorization based on scientific evidence and a review of risks and benefits. We completed a pilot project in May 2004 to publish information on how decisions were made to grant market authorization for two new drug products and a medical device. In June 2004, we consulted with stakeholders on the overall initiative. The launch of the first phase of the SBD project occurred in January 2005. It included the development, publication, and Web site posting of SBDs. http://www.hc-sc.gc.ca/dhp-mps/prodpharma/activit/proj/sbd-smd/index_e.html We also published four issues of the *Canadian Adverse Reaction Newsletter*. It reached 64,000 Canadian physicians, as well as 1,300 US and 404 foreign physicians. In addition, 28,000 copies were mailed to pharmacists and other interested parties. It was posted on our Web site and sent via the Health Product Information electronic mailing list to 10,000 subscribers. http://www.hc-sc.gc.ca/dhp-mps/medeff/bulletin/index_e.html We strengthened the Health Canada education campaign through distribution of food safety messages on magnets to consumers who could be at high risk. These include university students living away from home and, in some cases, learning to cook for the first time. We also continued to promote the basic "Fight Bac!" campaign messages on how to minimize risks from food-borne bacteria. A TV spot promoting these messages and the proper cooking techniques for hamburger, which was launched in 2002, was reissued in 2004. http://www.canfightbac.org/english/indexe.shtml
Improve product monograph requirements for drugs, beginning in 2004, including a new consumer information section	This was finalized and reported on in Health Canada's Departmental Performance Report for the period ending March 31, 2004.
Implement an enhanced biotechnology Web site in 2004–2005 to more effectively address the needs of consumers	We finalized an Information Architecture (IA) for our biotechnology Web site. It covers biotechnology with a focus on the regulatory system for food, health, environment, and drugs and health products, made through biotechnology. Over half of the content for the Web site has been drafted and edited.
Continue to use other communication tools, such as fact sheets, brochures and exhibits to improve awareness of and confidence in health-related biotechnology	The biotechnology exhibit travelled to three venues where target audiences were mainly industry and academia. Fact sheets and promotional material regarding our biotechnology Web site were distributed.
Invest $240,000 over the next three years to create a research network to investigate the use of herbal medicines by the Cree Nation to prevent and potentially treat Type II diabetes	We consulted with the Canadian Institutes of Health Research (CIHR) and the Institute of Aboriginal Peoples' Health (IAPH). Funding was made to facilitate IAPH's involvement in future research partnerships and to allow for larger investment by the Natural Health Products Research Program (NHPRP) in future research projects.
Allocate $300,000 over three years to a research network on natural health products that brings together leading academic researchers and natural health practitioners	The Canadian Interdisciplinary Network on Complementary and Alternative Medicine (INCAM) is two years into a five-year funding envelope. In partnership with the CIHR, the NHPRP invested $50,000 in 2004–2005 as part of a multi-year investment totalling $300,000 to establish a research network on natural health products. http://www.cihr-irsc.gc.ca/e/16458.html

PRIORITY 3: ONGOING

Increasing responsiveness to public health issues and greater vigilance concerning safety and therapeutic effectiveness in real world use

Canadians expect that the food and therapeutic products for sale in Canada are safe. To achieve this, we engaged in a number of ongoing activities to strengthen our surveillance capacity and to become more responsive to public health issues, including those impacting children. We also increased awareness of adverse reaction reporting and risk communications through a number of tools such as newsletters and advisories. An extensive public opinion survey conducted in December 2003 of consumers and health professionals[10] continued to inform improvements needed to increase the effectiveness of current methods used to communicate health product safety information. Not only did this enable us to further minimize risk and maximize safety for Canadians, but it increased our ability to support informed decision-making on health issues.

When external reports indicated findings of higher-than-average levels of chemical fire retardants in farmed salmon than in wild salmon, we conducted research to better understand the toxicological effects of these substances on humans through various sources of exposure. Based on data gathered from these studies, we concluded that the levels found in food, and specifically farmed fish, did not pose an unacceptable health risk. We will continue our surveillance work at national and international levels to ensure that the intake of these substances does not represent a health risk.

Our collaboration with the CFIA will significantly strengthen Canada's Bovine Spongiform Encephalopathy (BSE) safeguards, placing us in a much stronger position to prevent future crises, protect animal health and keep our food safe. Our work to set MRLs for veterinary drugs in food derived from animals ensures that residues of these drugs in the tissues of treated animals pose no risk if ingested daily by humans over a lifetime.

As a result of these and other efforts, Canadians have responded positively to our efforts with over 70 percent indicating that the Department is doing a good-to-excellent job in ensuring the safety of pharmaceutical and food products.[11]

RPP Commitments 2004–2005	Report on Results
Identify and assess product health and safety risks, alert the public and manage those risks in a manner that shares responsibility appropriately with industry, stakeholders and Canadians	We maintained the Health Product Information electronic mailing database with 10,000 subscribers, an 18 percent increase over the previous year. http://www.hc-sc.gc.ca/dhp-mps/medeff/subscribe-abonnement/index_e.html Included in this mail-out is the quarterly *Canadian Adverse Reaction Newsletter* to alert health professionals to adverse reactions reported in Canada. It is seen as an authoritative source with citations in other medical/health professional journals as well as the media which demonstrates a high interest in drug safety issues. http://www.hc-sc.gc.ca/dhp-mps/medeff/bulletin/index_e.html In a continued effort at risk communication for human health products, 115 advisories were posted on the departmental Web site—60 health professional advisories and 55 public advisories, including one on COX-2 inhibitor NSAIDs. This represents a 51 percent increase compared to the previous year. http://www.hc-sc.gc.ca/ahc-asc/media/advisories-avis/2004/2004_69_e.html

[10] http://www.hc-sc.gc.ca/dhp-mps/medeff/research-recherche/decima_2003_final_rep-rapp_e.html

[11] A Report to Health Canada: 2005 Annual Performance Survey, The Strategic Counsel, March 2005.

RPP Commitments 2004–2005	Report on Results
Take action to further protect the food supply against the risk of BSE or "mad cow disease" by banning specified risk materials from entering the human food chain	The Department spent approximately $2 million on BSE measures including risk assessment and research on the risks to Canadians from eating domestically produced beef and beef products. Along with the CFIA, we enacted new feed controls and intensified surveillance, which will significantly strengthen Canada's BSE safeguards, placing us in a much stronger position to prevent future crises, protect animal health and keep our food safe.
Increase overall responsiveness to public health and safety issues associated with food, nutrition and health products, as well as develop a new program to assess the therapeutic effectiveness of health products on the market	We used a database for the storing, assessment and retrieval of adverse reaction reports. Causality assessments were performed on 1,000 of these reports. Also, we enhanced activities regarding the assessment of Periodic Safety Update Reports (PSURs) related to veterinary health products, and have begun incorporating the use of these documents in pre-market and post-market evaluations. PSURs are documents produced by drug manufacturers, which summarize the worldwide post-market safety and efficacy experience of a health product. We initiated the development of quarterly reports outlining the nature and potential causality of adverse drug reaction reports received. http://www.hc-sc.gc.ca/dhp-mps/vet/advers-react-neg/index_e.html We developed and completed an analysis on the availability of comprehensive information concerning the effectiveness and safety of health products for use in children and on safe and nutritious food for them to consume. This work laid the foundation for the new Office of Paediatric Initiatives which serves as the focal point for an integrated approach to a number of issues affecting children. These issues range from food and nutrition to drug and immunization safety and the safe use of other therapeutic and diagnostic products. We also funded and participated in the development of national standards for blood safety and published guidance for Good Manufacturing Practices for radio-pharmaceuticals and for reducing medical error through the "look-alike/sound-alike" initiative. The Department is working with provincial and territorial partners under the National Pharmaceuticals Strategy to strengthen real-world safety and effectiveness of human drugs.
Strengthen risk communications to patients, the public and health professionals through greater cooperation with internal and external partners, new guidance to industry on communication with health professionals and the public and by informing Canadians about food and nutrition-related health risks	We continued to provide timely and informative risk communications for dissemination to the public and health professionals. http://www.hc-sc.gc.ca/ahc-asc/media/advisories-avis/index_e.html

RPP Commitments 2004–2005	Report on Results
Continue to play a critical leadership role in the delivery of the Food Safety component of the Agricultural Policy Framework focusing on the development of policies and intervention strategies to address public health hazards at the farm level and collaborate with AAFC and the CFIA to review industry-developed, on-farm food safety programs and assist industry to effectively address public health hazards such as food-borne diseases, by investments of $32.5 million over five years	Under the Agricultural Policy Framework, we continued to work closely with AAFC, CFIA and the Public Health Agency of Canada to develop policies and standards by 2007–2008 to enhance on-farm food safety and assist industry to effectively address public health hazards. In this regard, more than 40 policy, standard-setting and research projects were begun. Key projects were: • strategy development for enhancing the safety of raw foods of animal origin; • on-farm policy coordination and support to policy development; • communication and education related to on-farm food safety systems; • an integrated national system that addresses food safety by enhancing the engagement of stakeholders towards development of a National Food Policy Framework; and • review of industry developed on-farm food safety plans. We participated in one technical review. Preparations by industry for six technical reviews are in the queue. Twenty-one national producer organizations have expressed interest in technical reviews by the Department. There were also five key research projects such as the development of rapid molecular techniques to detect *E. coli* in foods and development and validation of analytical methods for a natural toxin in milk.
Continue to set MRLs for veterinary drugs in foods derived from animals	We established five additional MRLs bringing the total to 184, a level comparable to other international bodies. http://www.hc-sc.gc.ca/dhp-mps/vet/mrl-lmr/index_e.html
Continue to conduct the Total Diet study, and make data from the study publicly accessible on our Department's Web site	We spent $500,000 on Total Diet studies to monitor the amount of nutrients as well as contaminants (e.g. lead, mercury, arsenic) and other chemicals in the food supply, since ingestion of excessive amounts of contaminants can have detrimental effects on consumers' health. http://www.hc-sc.gc.ca/fn-an/surveill/total-diet/index_e.html
Work with Statistics Canada and the Canadian Institute for Health Information to improve surveillance activities that provide reliable, timely information about Canadians' dietary intake and nutritional well-being	With an investment of more than $350,000, we jointly developed and implemented the Canadian Community Health Survey (CCHS), Cycle 2.2, and Nutrition Focus. The CCHS is a federal survey aimed at providing health information at the regional and provincial levels. It is the data source for many of the health indicators generated by Statistics Canada and the Canadian Institute for Health Information. http://www.hc-sc.gc.ca/fn-an/surveill/nutrition/index_e.html
Establish new regional centres across the country for reporting adverse drug reactions and increase efforts to communicate adverse drug reaction information to the public in a timely fashion	Two new Adverse Reaction Centres in Manitoba and Alberta were added to the five Regional Centres in April 2005. They serve as points-of-contact for the Canadian Adverse Drug Reaction Monitoring Program. http://www.hc-sc.gc.ca/dhp-mps/medeff/advers-react-neg/fs-if/fact_cadrmp_e.html We completed initial work on a medication incident reporting system called "MedEffectCanadaMedEffet". This single window Internet portal will be used to gather information on adverse reactions, medication problems, and provide updated information to the health care community on safe product use.
Develop a new post-approval program to monitor therapeutic effectiveness	We are building a new program to assess the therapeutic effectiveness of health products after they reach the market. One component of that program is the purchase of effectiveness data through a contract with Intercontinental Medical Statistics (IMS) to conduct targeted, post-market assessments.

RPP Commitments 2004–2005	Report on Results
Continue work to establish a medication incident reporting system	In cooperation with the US FDA and the European Medicines Agency, we continued work on the implementation of an improved adverse drug reaction information system for Canada called the Adverse Reaction Reporting Database. A strong external program is maintained through a national network of regional reporting centres across Canada. Linkages with all levels of government are in place to ensure coordination of reporting and allied data dissemination activities.
Evaluate wireless technology as a tool to report adverse reactions and medical incidents and to broadcast critical safety and effectiveness information	A handheld computer tool was built to Canadian Adverse Drug Reaction Monitoring Program specifications to support the reporting of adverse reactions and the communication of time sensitive information through the Canadian Adverse Drug Reaction Information System. Research testing will be undertaken on this tool in 2005–2006. http://www.hc-sc.gc.ca/dhp-mps/medeff/databasdon/agreement_accord_e.html
Examine new surveillance mechanisms to identify serious and life-threatening adverse drug reactions in children. Conduct a two-year study to determine the feasibility of active surveillance to identify serious and life-threatening adverse drug reactions in children 0–18 years	In January 2004, the Department, in collaboration with the Canadian Paediatric Society and the Pharmaceutical Outcomes Programme of the Children's and Women's Health Centre of British Columbia, initiated a two-year study to investigate the feasibility of using active surveillance methods to generate additional data on serious and life-threatening adverse reactions in children under 18 years of age. This survey, the first of its kind in Canada, will help inform the new Office of Paediatric Initiatives. As well, it could inform the establishment of a network of dedicated surveillance staff in children's hospitals across the country. http://www.cps.ca/english/CPSP/Studies/drugreactions.htm
Implement a feasibility study along with a computer application that will screen for "look-alike/sound-alike" (LA/SA) similarities with the possibility of sharing the software with the US FDA	The Department continues to monitor LA/SA health product names. Similarities between LA/SA drug names may pose a risk to health by contributing to medical errors in prescribing, dispensing or administration of a product. http://www.hc-sc.gc.ca/dhp-mps/brgtherap/activit/fs-fi/lasa-pspcs_factsheet-faitsaillant_e.html Pre- and post-market guidelines were published, but we were unable to move ahead at the anticipated pace with the acquisition/implementation of a computer application to screen for LA/SA drug names as privacy concerns created an indefinite delay in signing the agreement between Canada and the United States.
Pursue improved regulatory compliance by industry through post-market inspections. Implement the Medical Device Inspection Program and increase Adverse Drug Reaction Reporting compliance activities	Twenty-four inspections of a target of 50 establishments were carried out for manufacturer compliance with the reporting of adverse drug reactions and unusual failure in efficacy of new drug submissions. Results showed establishments were almost completely compliant with regulations. In response to the 2004 Report of the Auditor General on Medical Devices, the first year of the Medical Device Establishment Inspection Program resulted in more than 45 inspections (target of 70) in 2004–2005. Findings identified a number of areas for establishments to improve to be fully compliant with the regulations. Our inability to meet the desired targets was mainly due to the increased complexity of carrying out inspections for these first-time programs and manufacturers learning what was expected. Over time, we will apply these lessons to improve forecasting as is done with other established programs. http://www.oag-bvg.gc.ca/domino/reports.nsf/html/20040302ce.html

RPP Commitments 2004–2005	Report on Results
Implement a program for compliance inspections of establishments as part of the National Review for Cells, Tissues, and Organs (CTOs)	Following notification to the provinces, compliance inspections for the National Review for CTOs began in March 2005 with five of a total of 120 completed.

PRIORITY 4: ONGOING

Improving transparency, openness and accountability to strengthen public trust and stakeholder relationships

Canadians expect appropriate information, that their views will be heard, and that governments are held accountable for how they use public expertise and advice. 80 percent of Canadians would have a more positive view of government decision-making if they knew it was informed by public input.[12] This is particularly true where the actions and decisions taken by governments have real effect on their lives and on their ability to manage their health. Health Canada recognizes the fundamental importance of public involvement and engagement and the need to build government capacity to support it. In response to these challenges, we developed and implemented many initiatives to support improved public involvement activities, improved public understanding of and input into decision-making processes, including how risks and benefits are weighed and the complexity of the issues involved, and strengthened public trust and stakeholder relationships.

RPP Commitments 2004–2005	Report on Results
Improve transparency, openness, shared responsibility and accountability	The Department continued to review legislative priorities in the area of health protection in order to improve transparency, openness and accountability. We developed a Voluntary Statement of Information Policy for public involvement activities to promote awareness and understanding among participants during consultation activities. The policy will be piloted and assessed for process and outcomes before systematic implementation. http://www.hc-sc.gc.ca/ahc-asc/pubs/cons-pub/vsi_pvi_intro_e.html As well, we developed fact sheets to better communicate our activities to external audiences. This information was developed to give a better understanding of Health Canada's role and our approach to minimizing health risks and maximizing the safety of health products and food. http://www.hc-sc.gc.ca/ahc-asc/branch-dirgen/hpfb-dgpsa/3kit-fiche/index_e.html We are poised to establish an Office of the Public Ombudsman to hear concerns and resolve complaints from the public and industry stakeholders regarding the administration of the *Food and Drugs Act*. http://www.hc-sc.gc.ca/ahc-asc/media/nr-cp/2005/2005_24_e.html In 2004–2005, we established the Office of Paediatric Initiatives to coordinate safety issues pertaining to children, and provided a publicly accessible drug information database.

[12] A Report to Health Canada: 2005 Annual Performance Survey, The Strategic Counsel, March 2005.

RPP Commitments 2004–2005	Report on Results
	In February 2005, the Department announced that we would seek input from patients, doctors, stakeholders and the public on the risks and benefits of selective COX-2 inhibitor NSAIDs. We also announced intentions to establish a permanent Safety Board to provide us with advice on these issues on an ongoing basis. http://www.hc-sc.gc.ca/ahc-asc/media/nr-cp/2005/2005_stmt-dec_cox2_e.html In 2004–2005, at an estimated cost of $703,000, we undertook 163 public involvement activities, mainly through mail-outs and Web postings for feedback. Consultation took place on subjects such as: • policy development process—24 activities; • regulatory process—21 activities; and • other, such as transparency measures, good manufacturing practices, build stakeholder capacity etc. This is exemplified through consultations on the Environmental Impact Initiative. This work responds to the *Canadian Environmental Protection Act* (1999) which requires that all new substances be assessed for their impact on human health and the environment. As well, Canadians have been kept current on our progress on blood and blood components and cells, tissues, and organs. http://www.hc-sc.gc.ca/dhp-mps/brgtherap/reg-init/cell/cto_presentation_2_e.html Our Department continued to meet its one-day turnaround time in responding to information requests through a generic e-mail account. One of the main objectives is to educate and inform citizens and clients about different resources available through the Health Canada Web site. We responded to approximately 2,580 requests in 2004, up from 1,773 in 2003. Nearly half of these inquiries (48 percent) were from the Canadian public, 38 percent from industry and the remainder from academia (6 percent), health professionals (4 percent), federal, provincial and territorial governments (3 percent) and foreign governments (1 percent). We developed and distributed an information sheet: *Safe Disposal of Pharmaceutical Products*. With Environment Canada, we invested $230,000 in collaborative research into the effects that substances in *Food and Drugs Act* regulated products, such as pharmaceuticals and personal care products, may be having on the environment, particularly water. Funds for these projects came from Health Canada's *Canadian Environmental Protection Act* Integrity Fund which provides nearly $2 million annually to support work toward the development of appropriate environmental assessment regulations for substances in *Food and Drugs Act* products, as well as some assessments. Collaboration within Health Canada also resulted in the approval of an Options Analysis Paper: An Environmental Assessment Regime for New Substances in Products Regulated under the *Food and Drugs Act*. This document is expected to be released to stakeholders in spring 2005. http://www.hc-sc.gc.ca/ewh-semt/contaminants/person/impact/index_e.html

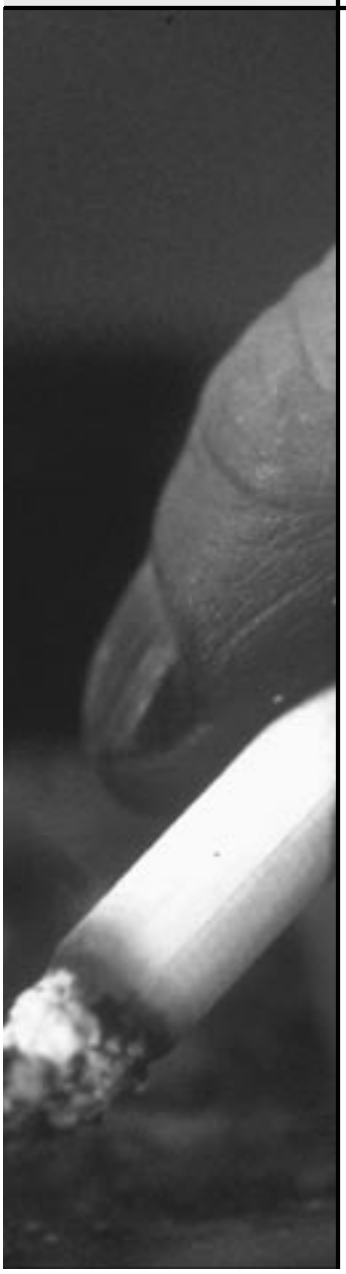
RPP Commitments 2004–2005	Report on Results
	In 2004–2005, we developed a comprehensive biotechnology logic model, along with performance indicators and a data collection template. In addition, we conducted research on improving the quality and quantity of biotechnology information available to the public electronically. Insufficient human resources and a slow approval process for new Web material continued to pose challenges. We also strengthened our audit and evaluation capacity to deliver on the accountability and stewardship expectations under the Government's Management Accountability Framework and related commitments. Results of audit and evaluation activities are being more strongly linked with policy and program development, planning, and performance measurement and management. As part of our assessment of the food safety activities of the CFIA, we completed an Evaluation Framework on CFIA's Modernized Poultry Inspection Program. The Fish Quality Management Program draft report was completed on schedule in May 2004 and was published in June 2005.
Develop and begin implementing a Public Involvement Strategy that will optimize public understanding of, and input into, decision-making processes, strengthen Department-stakeholder relationships and support more effective and efficient public involvement activities	We created a Public Involvement Framework (PIF) to ensure that our public involvement activities are consistent, valuable and effective. It drew on the results of workshops held with 134 participants in 11 cities between September and November 2004. The PIF reflects an appropriate balance between public involvement obligations and regulatory responsibilities, while ensuring that input from the broad spectrum of stakeholders allows for fully informed decision-making. http://www.hc-sc.gc.ca/ahc-asc/pubs/cons-pub/piframework-cadrepp_e.html
Make the regulatory process for therapeutic products and food more accessible to stakeholders, including patient and consumer groups	To improve accessibility, the Department piloted a forum to provide an opportunity for members of the public, including patients, consumers, and the media, to observe presentations made by industry, leading experts, and our officials as part of a regular expert advisory panel meeting. As well, our Advisory Committee on Management now includes patient and consumer representatives. We also collaborated with patient and consumer organizations to deliver the first information session for these groups on key topics as identified through a formal needs assessment. http://www.hc-sc.gc.ca/ahc-asc/pubs/hpfb-dgpsa/info-prog_e.html
Update standards and regulatory frameworks for blood and blood components, and for cells, tissues and organs (CTOs)	The Department updated the National Standards for blood and for CTOs. These were published by the Canadian Standards Association to address demands from stakeholders and the Krever Commission for National Standards. The updates included new safety information and emerging technologies around transfusion and transplantation. We developed an "Outline for Discussion" document for our consultations with stakeholders. It provided a summary of options to facilitate adverse event reporting and compliance and enforcement and to foster informed participation in identifying preferred options. We also made substantial progress on the development of the regulatory framework for CTOs and communicated the progress to stakeholders. There have, however, been delays in completion of all the necessary components of the CTO framework due to the complexity of drafting the regulations. The Canadian Standards Association standards for blood safety were adopted as national standards for blood and blood components.

RPP Commitments 2004–2005	Report on Results
	Substantial progress was made on the drafting of a revised regulatory framework for blood and blood components and we released a guidance to establishments on the prevention of West Nile virus and SARS transmission through transplantation. http://www.hc-sc.gc.ca/dhp-mps/brgtherap/reg-init/blood-sang/blood_qa_sang_qr_e.html http://www.hc-sc.gc.ca/dhp-mps/brgtherap/reg-init/cell/cto_let_stakeholders-intervenants_e.html http://www.hc-sc.gc.ca/dhp-mps/brgtherap/activit/forums/wnv-vno/2004/wnv-vno_2004_cto_gui-dir_e.html http://www.hc-sc.gc.ca/dhp-mps/brgtherap/activit/forums/wnv-vno/2004/wnv-vno_2004_min-pv_06-15_cto_telecon_e.html
Evaluate strategies to allow the public to provide input into the review of new novel food submissions	We jointly conducted a pilot project with the CFIA in cooperation with CropLife Canada, an industry association representing developers of biotechnology-derived plants. It consists of posting Web site "notices" upon receipt of new submissions, to describe the product and summarize the scientific information provided for regulatory review. For the first time, the public has 60 days to provide input on scientific matters relevant to the evaluation of each of these new product submissions. We continue to build stronger relationship and trust among the public and stakeholders.
Seek input from partners and stakeholders as we update policies and guidance such as *Canada's Food Guide to Healthy Eating*, through a process designed to engage Canadians in better understanding the importance of healthy eating and their shared responsibility in maintaining and improving their nutritional health and well-being	In February 2005, we hosted a stakeholder forum to share information and start an early dialogue on key initiatives. The discussions focused on the implications of the Smart Regulation Initiative and Health Canada Legislative Renewal for food safety and nutritional quality policy. We consulted with a broad range of stakeholders on the review of *Canada's Food Guide to Healthy Eating*. These consultations included meeting with consumers, academia, industry, non-governmental organizations and other levels of government. Two committees were created to provide advice and guidance in the revision of the Food Guide: an Interdepartmental Working Group and an external Food Guide Advisory Committee with expertise in the areas of public health, health policy, nutrition education, disease prevention, industry and communication. http://www.hc-sc.gc.ca/fn-an/food-guide-aliment/revision/index_e.html
Establish clear, internationally comparable performance targets for all stages of the regulatory review process for therapeutic products, and revise performance measurement approaches to ensure consistency with other leading regulators	The Department participated in a Centre for Medicines Research international benchmarking study that focused on new drug submission reviews (NDS) performance targets. The study showed Canada's targets to be comparable. It also showed that an international comparison of performance standards within the review process is difficult as regulatory processes, submission types and service standards are not identical across regulatory agencies. To gain a better understanding of the differences and similarities, we initiated the development of a methodology to allow for the comparison of fee structures, performance standards, and regulatory processes with other jurisdictions while meeting the requirements of the *User Fees Act*.

RPP Commitments 2004–2005	Report on Results
Improve accountability to the public by providing more useful and understandable annual plans and reports on our performance for health products, food and nutrition-related activities	The first *Report on Priorities and Achievements* of our Food Directorate was released. This Report outlines the Directorate's strategic priorities, describes its areas of work over 2003–2004 with a focus on specific priorities, presents key activities and achievements, and highlights some challenges and new priorities in realizing our vision of becoming "the most trusted authority providing policies, standards, advice and information on the safety and nutritional value of food." http://www.hc-sc.gc.ca/ahc-asc/pubs/hpfb-dgpsa/fd-da/rpt_priorities_achievements-priorites_realisations_dec_2003_01_e.html The Department also released the second *TAS Progress Report*. http://www.hc-sc.gc.ca/hcs-sss/pubs/care-soins/2005-therap-strateg/index_e.html We developed a new performance report on the regulatory review of pharmaceuticals, biologics, and medical devices to streamline and enhance the reporting of therapeutic product submission review performance. This report also includes information concerning the influence of other key players on access to new drugs in Canada (e.g. Patented Medicine Prices Review Board).

Strategic Outcome:
Healthier Environments and Safer Products for Canadians

Relevant Outcome in "Canada's Performance":
Healthy Canadians with Access to Quality Health Care



Objective

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

Financial Information

2004–2005 (MILLIONS OF DOLLARS)			
	Planned Spending	Total Authorities	Actual Spending
Gross expenditures	248.1	226.5	222.2
Revenues	(12.7)	(13.6)	(10.5)
Net expenditures	235.4	212.9	211.7*
FTEs	1,272	1,290	1,363

** This represents 48.4 percent of Health Promotion and Protection actual spending (excluding the Public Health Agency of Canada).*

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

- funding reduction related to the new advertising management process announced by Cabinet in March 2004
- internal funding provided to First Nations and Inuit Health Branch towards the Named Contribution to the Province of Ontario for the construction of the Meno Ya Win Health Centre

Intermediate Outcomes

- Reduced health and environmental risks from products and substances; safer living and working environments
- Improved health-related decision-making for Canadians, health practitioners and industry
- People of Canada have increased confidence in health-related programs and strategies

Immediate Outcomes

- Enhanced compliance with regulations, standards and guidelines
- Increased awareness and knowledge of key health and regulated products issues relating to healthy and safe living, working and recreational environments
- Enhanced involvement of stakeholders
- Improved scientific knowledge and capacity (research, data) in order to support evidence-based decision-making

Priorities

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

Program, resources and results linkages

Program	Actual Expenditures[1] ($M)	Result Linkage
Workplace Health and Public Safety	29.2	Enhances productivity and quality of life by contributing to the health and safety of federal and other Canadian workers, visiting dignitaries and the travelling public in Canada, through the following: • administers the Public Service Health Program on behalf of Treasury Board; • water, food and general sanitation inspections on common carriers (air, rail, marine) and their ancillary services; • a pan-Canadian strategy for workplace health; • health contingency planning for international state visits, summits or events.
Safe Environments	62.1	Promotes healthy living, working and recreational environments by: • identifying and assessing health risks to Canadians posed by environmental factors; • developing national risk management strategies that are supported by scientific research and align with Health Canada's Sustainable Development Strategy.
Product Safety	23.9	Assists in the protection of Canadians by identifying, assessing, researching and managing the health risks associated with: • consumer products; • cosmetics; • workplace chemicals; • new chemical substances; • products of biotechnology; • environmental noise; and • radiation-emitting devices.

[1] *The title has been changed from Resources to Actual Expenditures for clarification.*

Program	Actual Expenditures[1] ($M)	Result Linkage
Tobacco Control	47.9	Reduces the health and safety risks associated with tobacco consumption by: • regulating tobacco; developing and implementing initiatives to reduce or prevent the harm associated with tobacco use. The goal of the Federal Tobacco Control Strategy is to: — reduce smoking prevalence rate to 20% — decrease number of cigarettes sold annually by 30% — increase compliance with sales to youth laws to 80% — reduce second-hand smoke in public places — explore ways to reduce tobacco toxicity
Drug Strategy and Controlled Substances	48.6	Reduces the health and safety risks associated with the abuse of drugs, alcohol and other controlled substances by: • managing the *Controlled Drugs and Substances Act* and its Regulations; • providing national leadership for Canada's Drug Strategy; • regulating access to controlled substances and preventing the diversion of these substances for illegal purposes; • managing programs that reduce and preventing the harm associated with controlled substances; • providing Canadians with information to facilitate knowledgeable health and lifestyle decisions; • partnering with provinces/territories to facilitate access to treatment and rehabilitation services; • delivering drug analysis services and materials in support of the criminal justice system.

[1] *The title has been changed from Resources to Actual Expenditures for clarification.*

Executive Summary

Under this strategic outcome, Health Canada has a mandate to address many elements of day-to-day living that have an impact on the health of Canadians. These include drinking water safety, air quality, radiation exposure, substance use and abuse (including alcohol), consumer product safety, tobacco and second-hand smoke, workplace health, and chemicals in the workplace and in the environment. We are also engaged in other health and safety related activities, including the Government of Canada's public safety and anti-terrorism initiatives, inspection of food and potable water for the travelling public, and health contingency planning for visiting foreign dignitaries. Our broad national mandate flows from legislation including the *Food and Drugs Act*, the *Controlled Drugs and Substances Act*, the *Hazardous Products Act*, the *Radiation Emitting Devices Act*, the *Canadian Environmental Protection Act*, the *Tobacco Act*, and others.

Our work is important in reducing many of the threats to the health of Canadians. Every year, for example, more than 45,000 Canadian deaths are attributable to tobacco use; 230,000 preventable injuries involve consumer products at an estimated cost to the economy of over $7 billion; over $9 billion in health, social, and economic costs can be attributed to alcohol and drug abuse; tobacco use causes a staggering $3.5 billion in direct health care costs, and $11.5 billion more in indirect costs; and the cost to Canada of illness caused by environmental hazards has been estimated to be as high as $50 billion annually, including costs to the health care system, the economy and individuals.

In 2004–2005, we continued to carry out all of our responsibilities, generally meeting or exceeding the commitments made in the Report on Plans and Priorities for the year, consistent with planned resources. We undertook science, research, policy, regulatory, and prevention/promotion initiatives to achieve results. We collaborated extensively with partners and stakeholders inside and outside the country and had an active presence in every region. We fulfilled our responsibilities in accordance with the principles of sustainable development, to promote economic, social, cultural and environmental objectives.

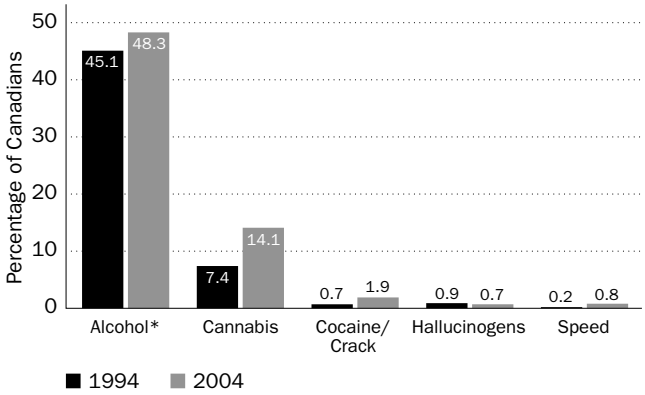
Science and research provide the underpinning for many of our achievements. Health Canada scientists continued to address environmental contaminants in our air, water, and soil by performing assessments and developing new strategies, guidelines, methodologies and tools. Notably, we completed the health-based National Air Quality Index and an integrated, source-to-tap approach to drinking water quality in collaboration with provinces, territories, and other stakeholders. We also conducted research on the health impacts of climate change, and made progress as the lead on the future Canadian Climate Change and Health Vulnerability Assessment 2007. We continued to assess and categorize substances under the *Canadian Environmental Protection Act* and are on track to meet the 2006 legislative deadline to characterize 23,000 existing substances. This important work improves our understanding and management of the health risks of human exposure to toxic substances in the environment. Health Canada continues to improve the Federal Nuclear Emergency Plan (FNEP) response structure in order to enhance the protection of Canadians in nuclear emergencies.

To enhance product safety for Canadian consumers, Health Canada tested products, ranging from bath seats to stuffed toys to chemical products for dangers such as flammability, toxicity and mechanical hazards. We investigated complaints, performed inspections, and assessed new substances, resulting in identification of unsafe products and consequent issuing of warnings, advisories, and product recalls. Our scientists conducted research and developed tools, methods, and standards to manage the health risks associated with a variety of potential hazards, from the use of cellular phones to ionizing radiation. We completed significant regulatory work to require identification of ingredients on cosmetic product labels and restrict the lead content of children's jewellery. We also took steps to implement the Globally Harmonized System (GHS) for labelling and classifying chemicals, a commitment Canada made at the World Summit on Sustainable Development.

Analysis of the Canadian Addiction Survey undertaken in 2004 shows that illicit cannabis and other drug use is up significantly in the past decade, particularly among youth and young adults, with almost 30 percent of 15–17 year-olds and over 47 percent of 18–19 year-olds having used cannabis within the last year. As part of the renewed Canada's Drug Strategy, we conducted

research and implemented health promotion/prevention measures, with a particular focus on youth and young adults, to reduce drug and alcohol abuse and the resultant harms. While continuing with our important drug analysis work in support of law and enforcement efforts, we also launched the Drug Strategy Community Initiatives Fund, which addresses problematic substance abuse through promotion/prevention and harm reduction initiatives, and provides funding to a wide range of non-governmental agencies.

Selected Indicators of Alcohol and Other Drug Use in Canada, 1994 and 2004

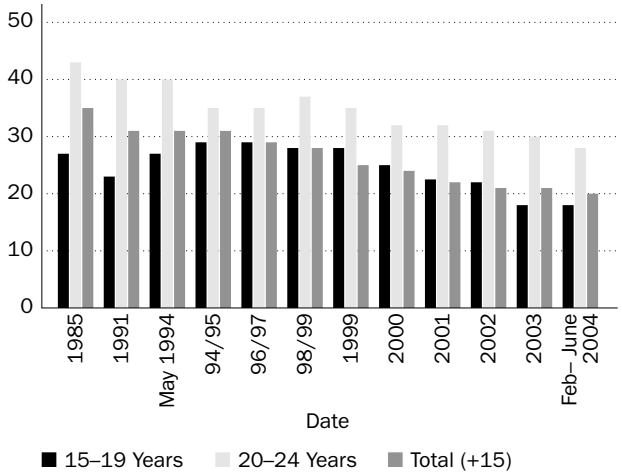


Source: Canada's Alcohol and Other Drugs Survey 1994; Canadian Addiction Survey, 2004.
* Alcohol: having had five or more drinks on one occasion.
All data are for use in the past 12 months.

The Canadian Tobacco Use Monitoring Survey shows that the smoking rate among all Canadians over age 15 has fallen from 25 percent to 20 percent since 1999. While these rates are indicative of the overall success of the Federal Tobacco Control Strategy, we continued our efforts with targeted measures to maintain and potentially extend the gains we have made to date, particularly among some segments of the population, e.g. young adults (men in particular) and rural and low income populations, where the rate of tobacco use and exposure remains significantly higher than the average.

This year, we worked on developing a coordinated, evidence-based approach to smoking cessation. We took steps to reduce the harm caused by tobacco, such as the Cigarette Ignition Propensity Regulations which will reduce the number of cigarette-lit fires in Canada. Our tobacco control measures are considered a model internationally. Canada was instrumental in developing, and was among the first nations to ratify, the World Health Organization's Framework Convention on Tobacco Control, which came into force in February 2005. This first-ever global public health treaty will strengthen tobacco control initiatives around the world.

Long-Term Trends in the Prevalence of Current Smokers (%)



Source: 1985–1988/89 various surveys; 1999–2004 CTUMS

The Department continued to address the health and safety of federal public sector workers, visiting dignitaries and the travelling public in Canada, delivering our services in a manner that exceeds standards and expectations. We explored approaches to position comprehensive workplace health as a strategic means to improve health, reduce health costs, and enhance productivity. To improve workplace health, we conducted research and developed guidelines, best practices, and tools that were highly sought after on our Web site, by employers across the country in both public and private sectors. We also expanded our emergency preparedness response capacity by addressing the psycho-social needs of federal employees faced with terrorist events. In the face of unprecedented tsunami-caused destruction in southeast Asia, Health Canada staff provided immunization and other health services to federal workers who took part in the relief mission.

Health Canada worked closely with partners and stakeholders in all sectors, both domestically and internationally, to enhance healthy environments and consumer safety. Notable achievements of our horizontal endeavours include the development of a National Framework for Action on Substance Use and Abuse under Canada's Drug Strategy; the sustained partnerships

across jurisdictions to maintain and enhance tobacco control; the national commitment to implementing the Globally Harmonized System of Classification and Labelling of Chemicals; the coordinated management of cross-border air quality issues between Canada and the US; and the broad collaboration among all levels of government under the public security and anti-terrorism initiative.

Finally, we continued to modernize management practices in accordance with the principles of Treasury Board's Management Accountability Framework. In particular, we made strides in the development and implementation of outcome-focused performance measurement frameworks for our programmes, aimed at strengthening stewardship of resources and accountability for results.

PRIORITY 1: ONGOING

Reduce risks to health and safety, and improve protection against harm associated with workplace and environmental hazards, consumer products (including cosmetics), radiation-emitting devices, new chemical substances and products of biotechnology

Work under this priority focused on Health Canada's broad range of ongoing regulatory activities for identifying, assessing and managing health risks to Canadians posed by hazards in our environment, homes and workplaces. Many of these activities reflect commitments made under our Departmental Sustainable Development Strategy.

Managing environmental health risks is an ongoing task. This year, we analyzed more than 470,000 dosimeters for radiation exposure, covering 95,000 Canadian workers. Under the *Canadian Environmental Protection Act*, we characterized the human health risks of some 1,900 chemical substances on the Domestic List. In support of the effort to clean up federal contaminated sites, we peer-reviewed 70 health risk assessments and provided health advice for nine environmental assessments. We also provided advice on human health impacts for 437 large-scale projects, including highways and mines. Our continuing work on the health effects of climate change included, among other things, a survey of related international program, research, and policy activities.

We carried out research and worked with provinces, territories, and other partners to address air and water quality issues, with a particular focus on the protection of vulnerable groups such as children. We performed 11 air quality assessments relating to, for example, acid rain and carbon dioxide, completed the National Air Quality Index for implementation, and, as part of the Canada/US Border Air Quality Strategy, continued with the two airshed pilot projects in Georgia Basin/Puget Sound and the Great Lakes Basin to explore the impact of air pollution on human health. Our scientists collaborated with Johns Hopkins University and successfully developed new methodologies for calculating human health effects from air pollution. We developed an integrated, source-to-tap approach to drinking water quality, developed four new guidelines for contaminants in water (e.g. arsenic), and produced a comprehensive guidance document for federal personnel to ensure the safety of drinking water on federal and First Nations lands and in federal facilities. We participated in planning for the next generation of International Emergency Exercises and continued to work with provincial governments to improve safeguards to protect the health of Canadians during nuclear emergencies.

Health Canada continued to improve product safety for consumers, examining products ranging from bath seats to strollers to tents to stuffed toys to chemical products. In our laboratories, we tested 329 consumer products and completed 29 research projects related to consumer complaints investigations and laboratory methodology development. We issued 10 warnings or advisories regarding unsafe products. We performed 7,534 inspections, recalled 183 unique product lines, and carried out 157 seizures. We responded to 233 enquiries from the print and broadcast media. We assessed 900 new substances for human health risks and 25 ingredients of pharmaceutical and personal care products for risk to the Canadian public and environment. We imposed two-year prohibitions on four new polymers deemed to have significant risk to human health, to allow industry to develop safer versions of these widely used substances. In the area of consumer clinical and radiation protection, we inspected more than 400 radiation-emitting devices used for medical, dental, industrial, commercial, research, and security applications.

Our scientists developed inexpensive and reliable tools and methods for identifying emissions from cellular phone base stations, to support the safe use of this popular communication device. They also worked to establish an internationally standardized approach to assess individual exposure to ionizing radiation in a nuclear emergency. We amended the regulations to require the listing of all ingredients on cosmetic product labels in accordance with the International Nomenclature for Cosmetic Ingredients. Harmonized labelling is also expected to lower trade barriers and increase trade opportunities for Canadian manufacturers. New Children's Jewellery Regulations were completed to restrict the lead content and reduce the risk of exposure of children to lead.

This year, Health Canada, through the operation of a 24/7 crisis referral centre for Employee Assistance Services (EAS), responded to 37,000 calls from clients employed by 122 public sector organizations, including federal departments and agencies. Over 95 percent of all federal departments use EAS, with over a 98 percent satisfaction rating from both clients and client departments. We provided occupational health and safety services to federal departments and agencies and Canadian missions abroad, and delivered approximately 15,500 health assessments, 2,400 immunizations, 1,100 workplace investigations and 3,650 office ergonomic services. We were also on call to provide health services in support of disaster relief. Our Physical and Psycho-Social Emergency Preparedness personnel are ready to respond to a major terrorist event: equipment testing, personnel training and the development of procedures/guidelines have been completed.

There were 200,000 visits and 90,000 document downloads at our Workplace Health Web site which provides information ranging from guidelines, to best practices, to tools which support employers to improve workplace health and productivity. To protect the health of millions of travellers who come to Canada, we conducted some 1,200 inspections of food, water, and general sanitation on rail and marine conveyances.

RPP Commitments 2004–2005	Report on Results
Safe Environments Programme Health Canada has a mandate to address many elements of day-to-day living that have an impact on health, by performing and accessing high quality science	*Environmental Health Sciences Research* Developed innovative tools for human health risk assessment to study the relative risk of exposure to and hazard identification of toxic substances. *Protection against Radiation in the Environment* Health Canada partnered with University of Ottawa staff to revise the risk assessment regarding developing lung cancer from exposure to radon in homes. http://www.hc-sc.gc.ca/iyh-vsv/environ/radon_e.html *Environmental Contaminants* Health Canada has worked extensively with partners, particularly Environment Canada, on tools to measure the health benefits of interventions to improve air quality. Improvements have been made in our ability to measure health and socio-economic effects of air pollution and improve estimates of associated mortality.
The Department will contribute to healthier environments and safer products for Canadians through new and ongoing initiatives which integrate the principles of sustainable development. We will generate new research, more partnerships and stronger federal leadership to improve health outcomes, particularly for vulnerable populations, such as children	*Environmental Health Sciences Research* This critical research is the foundation for development of key guidelines in indoor air, performance of CEPA-mandated assessments and revision/development of water quality guidelines. ($11.2 M) *Health Impacts of the Environment* Collaborative agendas were developed and implementation has begun among federal, provincial and territorial governments on reducing risks to human health posed by environmental factors related to water quality, air quality and children's environmental health. Includes development of indicators of children's environmental health. The development of a federal Health and Environment Strategy is a departmental priority. ($.9 M)

RPP Commitments 2004–2005	Report on Results
	Water Quality and Health Target of four Guidelines for Canadian Drinking Water Quality (as approved by the F/P/T Committee on Drinking Water for consultation) was achieved. ($3.5 M) http://www.hc-sc.gc.ca/ewh-semt/water-eau/index_e.html
Health Canada will continue to identify and reduce risks to human health posed by environmental factors such as water quality, air quality, radiation and environmental contaminants. Our work includes health risk assessments and development of guidelines and standards	*Health Impacts of the Environment* *Canadian Environmental Assessment Act* (CEAA) assessments and Federal Contaminated Sites (CS) assessments reviewed: 2003–04 180 CEAA 150 CS 2004–05 437 CEAA ($1.0 M) 70 CS ($3.1 M) CS staff also contributed to nine site-related environmental assessments. http://www.hc-sc.gc.ca/ewh-semt/eval/index_e.html *Protection against Radiation in the Environment* Analysis of dosimeters for radiation exposure: 2003–04 460,000 dosimeters 2004–05 470,000 dosimeters ($4.7 M) http://www.hc-sc.gc.ca/ewh-semt/occup-travail/radiation/regist/index_e.html
Intensify our work on the human health impacts of climate change and air pollution	*Health Impacts of the Environment* Release of Climate Change and Health Research Report, a survey of international climate change and health research and policy development activities. The Climate Change and Health Office has also made progress in leading the Canadian Climate Change and Health Vulnerability Assessment 2007. ($0.8 M) http://www.c-ciarn.ca/health *Environmental Contaminants* Outdoor air quality assessments: 2003–04 10 assessments 2004–05 11 assessments ($0.2 M) (particulate matter, ozone, acid rain, ethanol, bio-diesel, mortality, formaldehyde, NO2 and CO; progress on manganese and MMT.) Progress made on the Air Health Indicator to reflect the long-term changes in the burden of illness from reductions in air pollution. Link established between daily mortality counts and pollution levels. http://www.hc-sc.gc.ca/ewh-semt/air/index_e.html Health Canada identified 5,900 +/- 2,100 deaths attributed to air pollution in eight Canadian cities. http://www.hc-sc.gc.ca/ahc-asc/media/nr-cp/2005/2005_32_e.html *Environmental Health Sciences Research* Design of epidemiological research on risks from emerging chemicals and investigation of the success of mitigation strategies.
Under the Canada/US Border Air Quality Strategy, we will develop a health-based Air Quality Index (AQI)	*Environmental Contaminants* Work on the AQI is proceeding on schedule. Subject to provincial acceptance, this reformulated AQI will be piloted in summer 2005–2006 for planned implementation in 2007–2008. ($0.35 M) http://www.hc-sc.gc.ca/ewh-semt/air/index_e.html

RPP Commitments 2004–2005	Report on Results
The Department will make additional progress under the 1999 *Canadian Environmental Protection Act* (CEPA) by assessing and categorizing additional substances to better manage and eliminate human exposure to toxic substances Consult on the selection process and solicit additional information on 849 substances determined to require closer study, which are on the Domestic Substances List	*Environmental Contaminants* Characterization of CEPA existing substances: ($0.8 M) 2003–04 2,000 substances 2004–05 approximately 1,900 CEPA existing substances categorized On track to meet 2006 CEPA legislated deadline to characterize 23,000 existing substances. 1,900 substances on the Domestic Substances List identified for further consideration in categorization and screening assessment.
Approximately 20 screening assessments will be carried out in 2004–2005	*Environmental Contaminants* Assessments of CEPA existing substances: 2003–04 0 assessments 2004–05 10 assessments ($0.4 M) As well, draft screening health assessments released for public comment on a group of 50 perfluoroalkyl compounds (PFOS) and a group of seven Polybrominated Diphenyl Esters (PBDEs). ($1.2 M) http://www.hc-sc.gc.ca/exsd-dse
Participate in planning for the next generation of International Nuclear Emergency Exercises	*Protection against Radiation in the Environment* Health Canada has worked with international partners to develop the INEX-3 exercise. ($3.2 M) http://www.hc-sc.gc.ca/ed-ud/prepar/nuclea/index_e.html
We will work with provincial governments to improve safeguards to protect the health of Canadians during nuclear emergencies	Health Canada has successfully filled three gaps in the Federal Nuclear Emergency Plan (FNEP) response structure to enhance the protection of Canadians in nuclear emergencies, including developing decision support software for real time surveillance, a standardized method for biological dosimetry, and an annual exercise for federal field response to radiological incidents.
Product Safety Programme Continue to obtain the science necessary to identify, assess and manage the health and safety hazards to Canadians associated with: consumer products; hazardous workplace materials; cosmetics; new chemical substances; products of biotechnology; radiation produced by radiation-emitting devices; environmental noise; and solar UV radiation	Two-year prohibitions were imposed on four notified new polymers and longer-term control measures are in development. Significant risks to human health were identified for the breakdown products. Industry is actively developing less harmful versions of these widely used substances. ($6.2 M) http://www.hc-sc.gc.ca/ewh-semt/contaminants/lead-plomb/leadrisk_e.html http://www.ec.gc.ca/substances/nsb/eng/index_e.htm We continued to improve product safety for Canadian consumers: • performed 7,534 inspections • recalled 183 unique product lines (e.g. plastic bags, cradles, tents, lighters) • carried out 157 seizures http://www.hc-sc.gc.ca/ewh-semt/contaminants/person/impact/index_e.html In our laboratories: • tested 329 consumer products (e.g. flammability of futons, lead in kettles) • completed 29 research projects

RPP Commitments 2004–2005	Report on Results
	We issued 10 warnings or advisories regarding unsafe products. We inspected more than 400 radiation-emitting devices used for medical, dental, industrial, commercial, research, and security applications. http://www.hc-sc.gc.ca/ewh-semt/pubs/radiation/tan-bronzage/index_e.html http://www.bccdc.org/content.php?item=196 In response to the concern of Canadians regarding the risks and issues surrounding the use of cellular telephones, Health Canada has designed, built and extensively tested equipment which provides an inexpensive and reliable means of verifying emissions. Examples of the simple maps that can be created using the information from this device can be found at: http://www.hc-sc.gc.ca/ewh-semt/pubs/radiation/cell_base_stations/index_e.html Collaborations such as that recently completed with the Government of British Columbia wherein they were loaned a device and performed surveys in the Vancouver area, are being actively sought with other F/P/T agencies. In collaboration with Environment Canada, we published proposed amendments to the New Substances Notification (NSN) Regulations (chemicals and polymers) in *Canada Gazette*, Part I on October 30, 2004, and have begun preparations for multi-stakeholder consultations on amending the Living Organisms portion of the NSN Regulations. We negotiated and signed a Memorandum of Understanding with the Department of Fisheries and Oceans (DFO) and Environment Canada outlining the roles and responsibilities of each department regarding the notification and assessment of aquatic organisms with novel traits, in anticipation of regulations to be developed under the *Fisheries Act* for these organisms by DFO. In the event of a nuclear emergency, for individuals exposed to high doses of ionizing radiation, assessment is an important first step to determining the correct treatment method. To ensure a common approach, we are working to establish an internationally standardized method for biological dosimetry as the preferred method. The standard used can be found at: http://www.iso.org/iso/en/CatalogueDetailPage.CatalogueDetail?CSNUMBER=33759&ICS1=17&ICS2=240&ICS3=&scopelist=
We will enhance our support for the Lead Risk Reduction Strategy by undertaking key regulatory actions that would restrict the lead content of children's jewellery and prohibit the import, advertisement or sale of candles with lead-core wicks. This will help protect the health of Canadians by reducing health risks related to lead exposure. Performance will be based on the removal of children's leaded jewellery and lead-core wick candles from the Canadian marketplace	Completed final publication of Children's Jewellery Regulations. ($46.6 K) http://canadagazette.gc.ca/partII/2005/20050601/html/sor132-e.html

RPP Commitments 2004–2005	Report on Results
The Department will also seek an amendment to the Cosmetics Regulations to require manufacturers and distributors of cosmetic products to disclose ingredients on their product labels	Health Canada amended its regulations (published in *Canada Gazette*, Part II on December 1, 2004) to require the listing of all ingredients on cosmetic product labels, in accordance with the International Nomenclature for Cosmetic Ingredients system (INCI). Mandatory ingredient labelling will make relevant information available to Canadians concerning the composition of all cosmetic products sold in Canada. The aim is to help the Canadian public be better informed in order to avoid cosmetic products that contain ingredients to which they may be sensitive. Furthermore, harmonized labelling requirements are expected to lower trade barriers and increase trade opportunities for Canadian manufacturers. ($59.0 K) http://www.hc-sc.gc.ca/cps-spc/person/cosmet/cosmetics-reg-cosmetiques_e.html Final publication of amendment requiring ingredient disclosure published; implementation effective November 2006. www.healthcanada.gc.ca/ghs
Progress to support implementation of the hazard communication system known as the Globally Harmonized System (GHS) of Classification and Labelling of Chemicals to meet a 2008 time-line for a fully operational system	Ongoing consultations on how to implement the GHS with stakeholders, which include labour and trade unions/organizations, consumer associations, provincial/territorial governments and other federal departments. ($.4 M)
Workplace Health and Public Safety Programme (WHPSP) Frameworks to guide physical and psycho-social emergency response initially developed under the Government of Canada's Public Security and Anti-Terrorism Initiative are being expanded to include health emergencies such as SARS	The WHPSP Physical EPR (Emergency Preparedness and Response) program is focused on contingency planning to ensure continuity of government operations. Psycho-Social EPR is in place to help increase the resilience of federal employees faced with a threatened or actual terrorist event, and to help prevent and/or mitigate the effects of such an event.
We will intensify efforts to build capacity to support the emergency responders and federal workers who provide services during and immediately following critical incidents or public health emergencies	Psycho-Social EPR has published *Preparing for and Responding to Workplace Trauma: A Manager's Handbook* and it is being distributed to departmental managers. The *Handbook* and a more comprehensive *eGuide* are available on the Health Canada and PubliService Web sites. *Coping with Workplace Trauma: A Self-Help Guide for Employees* is being finalized and will be available electronically by winter 2005–2006. ($0.8 M)
The Department will continue to provide water and food inspection and sanitation services to over 10 million travellers who come to Canada annually by air, rail and marine travel	Approximately 1,200 inspections/audits, based on estimates of the risk to health, were undertaken across Canada. ($2.0 M) Inspections: • 95 percent of all cruise ships that come to Canada were inspected once per season • 95 percent of passenger trains/flight kitchens were inspected once on a pre-determined schedule Percentage passing: • cruise ships 97 percent • on board trains 97 percent • off board trains 100 percent • flight kitchens 99 percent

RPP Commitments 2004–2005	Report on Results
Continue to provide the Public Services Health Program (PSHP) to more than 20 federal departments comprising approximately 250,000 people	Over 700 deratification certificates were issued, and no incidences of rats were found on board marine vessels across Canada. The program is fully cost-recovered from the conveyance operators ($1.55 million in 2004–2005). The operators participate in a stakeholder meeting each year, at which service costs are discussed. Operators report that they are satisfied and that they are receiving fair value from the program. http://www.hc-sc.gc.ca/hl-vs/travel-voyage/general/inspection/index_e.html During the year, PSHP delivered to federal departments approximately: ($17.2 M) • 15,500 health assessments • 2,400 immunizations • 1,100 workplace investigations • 3,650 office ergonomic services WHPSP successfully negotiated national MOUs with Canada Revenue Agency, the Canadian Food Inspection Agency and Parks Canada for ongoing provision of occupational health services on a cost recovery basis. This coincided with the transfer by Treasury Board of $3.932 million from Health Canada, in the fall update of the departmental Annual Reference Level Update (ARLU) effective April 1, 2004.
Operate a 24/7 Crisis Referral Centre for Employee Assistance Services. The Centre deals with 37,000 calls annually from clients employed by 122 public sector organizations, including federal departments and agencies	Over 95 percent of all departments use EAS. Client satisfaction is 98.5 percent (users of the service); customer (departments) satisfaction is 98.7 percent with a 100 percent retention of all customers from the previous year. Five major departments still have their own internal employee assistance programs; discussion is ongoing with some to have EAS become their provider of choice. ($4.5 M)
Partner with provincial and territorial governments, stakeholder groups and other government departments to support research to develop better science and understanding of health risks directly and indirectly related to the workplace in order to continue the development of a workplace health agenda	Health Canada continues to explore comprehensive workplace health approaches to develop knowledge, identify best practices, and map out a workplace health agenda. ($0.29 M) http://www.hc-sc.gc.ca/sr-sr/finance/hprp-prpms/complet-term/index_e.html http://www.hc-sc.gc.ca/ewh-semt/index_e.html
Focus on dissemination of information on workplace health issues and promote successful practices	The Workplace Health System, a comprehensive approach to health promotion programming, provides employers with a set of guiding principles and a seven-step process for implementing workplace health policies and practices. Public demand was evidenced by over 200,000 Web site visits and over 90,000 document downloads between May 2004 and January 2005.

PRIORITY 2: ONGOING

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

Commitments under this priority guided our actions to provide comprehensive programs for education, health promotion, regulation, research and surveillance, aimed at reducing Canadians' exposure to the health and safety risks associated with tobacco consumption, and the abuse of drugs, alcohol, and other controlled substances.

The Canadian Tobacco Use Monitoring Survey shows that the smoking rate for Canadians aged 15 and over, measured in the first half of 2004 at 20 percent, is little changed from 2003. Over the last five years, however, smoking rates among Canadians have declined significantly, down from 25 percent in 1999, and even more dramatically among youth (15–19 year-olds), from 28 percent in 1999 to 20 percent for the first half of 2004. The percentage of children under age 12 who were regularly exposed to tobacco smoke in their homes has also declined in the same period, from 26 percent to 12 percent. Our work during 2004–2005 was oriented toward helping to continue these overall positive trends. Future progress will depend on continued effort and measures targeted to address relatively high rates of smoking which persist among segments of the population, such as young men, Aboriginal people, residents of rural areas and certain regions, and those of low socio-economic status.

Continued emphasis was directed towards the development and implementation in communities across Canada of a national coordinated approach to tobacco cessation. A pilot cessation initiative has been undertaken in partnership with the provincial governments of Prince Edward Island and British Columbia, and with the University of Waterloo. Study participants have been recruited and the study is now under way, with an anticipated completion date in 2006.

Regulatory measures designed to change tobacco products so that health hazards will be reduced have also been undertaken. Cigarette Ignition Propensity Regulations were reviewed and approved by the House of Commons Standing Committee on Health, and final publication is anticipated in 2005. This measure will reduce the number of deaths and harm due to cigarette-lit fires.

The WHO Framework Convention on Tobacco Control (FCTC), ratified by Canada, came into force in February 2005. Our approach to tobacco control is generally consistent with the FCTC. We have proposed new regulations regarding warnings on tobacco advertising, which would bring Canada into compliance with article 13 of the FCTC, and we conducted consultations with stakeholders on these proposed new regulations.

In 2004–2005, we carried out approximately 35,000 compliance and enforcement checks over some 65,000 retail establishments across Canada, under both the *Tobacco Act* and provincial tobacco control legislation. We contributed over $12 million to support surveys, research and monitoring of compliance with anti-tobacco laws. In 2004, research showed that for the first time since monitoring began in 1995, national retailer compliance levels regarding youth access to tobacco have exceeded the Federal Tobacco Control Strategy's 10-year target objective of 80 percent or better; the current level stands at 82.3 percent.

In support of Health Canada's leadership role in Canada's Drug Strategy, we initiated the development of a National Framework for Action on Substance Use and Abuse, through formal consultations or information sharing with stakeholders and thematic workshops. We developed a National Research Agenda, and established an overall governance structure for the Strategy. With $3 million from the Drug Strategy Community Initiatives Fund, we provided funding for 51 community-based projects. Priorities were also identified and a call was issued for proposals to be funded in 2005–2006.

In our continued administration of the *Controlled Drugs and Substances Act*, we worked with law enforcement agencies to identify more than 91,000 seized samples of controlled substances, and provided expert advice and aid in dismantling 50 illicit drug labs. To ensure access to controlled substances for approved, legitimate purposes, we provided 2,759 methadone exemptions and 821 authorizations/exemptions for the use of marihuana for medical purposes. We developed Marihuana Medical Access Regulations amendments to the second phase and continued our involvement in related projects.

We published a full report as well as a highlights report on the results of the Canadian Addiction Survey (CAS) which provides key information on prevalence rates in Canada. As the CAS shows, the use of alcohol, cannabis, and other drugs is particularly prevalent among youth and young adults in Canada. We undertook health promotion and other demand reduction activities targeted toward youth, such as a marihuana messaging campaign, and developed dissemination mechanisms through established media avenues. To continue to ensure access to treatment for youth and women suffering from substance abuse problems, we funded provincial governments under the 50-50 cost-shared Alcohol and Drug Treatment and Rehabilitation Program, and we provided data collection, data analysis and knowledge dissemination. A plan has been developed to re-focus the program to ensure that the target populations of youth and women with substance abuse problems will continue to have access to innovative treatments.

RPP Commitments 2004–2005	Report on Results
Drug Strategy and Controlled Substances Programme Lead Canada's Drug Strategy and work in partnership with the provinces and territories, municipalities, non-governmental organizations and stakeholder groups	http://www.hc-sc.gc.ca/ahc-asc/activit/strateg/drugs-drogues/index_e.html
Continue to administer the *Controlled Drugs and Substances Act* and its regulations, devise harm reduction and promotion strategies to combat alcohol and drug abuse, provide expert scientific advice and drug analysis services to law enforcement agencies and manage Health Canada's medical marihuana program	• Developed Marihuana Medical Access Regulations (MMAR) changes Phase 2 and continued involvement on related projects, such as a pharmacy pilot project. http://www.hc-sc.gc.ca/dhp-mps/marihuana/index_e.html • Initiated scheduling of a number of controlled substances and the development of other proposed amendments to the Precursor Control Regulations (PCR). http://www.hc-sc.gc.ca/dhp-mps/substancontrol/index_e.html • Conducted analysis for scheduling of substances of emerging concern such as ketamine and red and white phosphorous. • Monitored the production and distribution of medical marihuana (the Prairie Plant System). http://www.hc-sc.gc.ca/dhp-mps/marihuana/supply-approvis/index_e.html • Worked with law enforcement agencies to identify more than 91,000 seized samples of controlled substances, and provided expert advice and aid in dismantling 50 illicit drug labs. • Provided 2,759 methadone exemptions and 821 authorizations/exemptions for the use of marihuana for medical purposes. http://www.hc-sc.gc.ca/dhp-mps/substancontrol/analys-drugs-drogues/index_e.html
Canada's Drug Strategy activities will continue to be directed to reducing the supply of and demand for drugs through prevention, harm reduction, treatment and enforcement programming	http://www.hc-sc.gc.ca/ahc-asc/activit/strateg/drugs-drogues/index_e.html

RPP Commitments 2004–2005	Report on Results
In May 2003, the Government announced a $245 million investment over five years for Canada's Drug Strategy. Health Canada will target its new funding towards increasing the federal leadership role in the Strategy, developing a national action plan through consultation or in information-sharing with all stakeholders and reporting on progress to Parliament	• Initiated the development of a National Framework for Action on Substance Use and Abuse including 10 formal consultations with stakeholders and nine thematic workshops. http://www.hc-sc.gc.ca/ahc-asc/activit/strateg/drugs-drogues/nfa-can/index_e.html • Initiated the development of a National Research Agenda including four discussion papers and the hosting of a national workshop. http://www.hc-sc.gc.ca/ahc-asc/activit/strateg/drugs-drogues/nat-res-rech/index_e.html • Established an overall governance structure for Canada's Drug Strategy.
We will also increase research done in Canada on drug and alcohol abuse, fund the treatment component of Drug Treatment Courts, develop a new grants and contribution program for innovative community programs and expand health promotion and prevention activities	• Conducted research in a number of key areas including: cannabis main stream/side stream smoke; and avoidable cost study (e.g. those amenable to public policy initiatives and behavioural changes). • Initiated collaborative research projects and surveys, including: — abuse of psychotropic pharmaceuticals in Canada; — characterization of oxycondone abuse; — prevalence survey in the Northwest; and — substance abuse among street youth.
In 2004–2005, Health Canada will build a strong foundation for the renewed Strategy and begin funding innovative projects through the Drug Strategy Community Initiatives Fund (DSCIF)	• Supported 51 projects with approximately $3 million. • Established priorities and launched call for DSCIF proposals for 2005–2006. http://www.hc-sc.gc.ca/dhp-mps/substan/fond-comm-fund/index_e.html
We will also complete development of a comprehensive evaluation framework, establish health promotion activities targeted at youth, analyze and report on the results of the Canadian Addiction Survey (CAS) and conduct a review and amend the Marihuana Medical Access Regulations (MMAR)	• Obtained Treasury Board approval of the CDS Horizontal Results-Based Management and Accountability Framework (RMAF). • Launched marihuana messaging campaign, booklet for parents and youth on marihuana, a youth Web site and developed dissemination mechanisms through established media avenues, such as News Canada. http://drugwise-droguesoisfute.hc-sc.gc.ca/index_e.asp http://www.hc-sc.gc.ca/ahc-asc/pubs/drugs-drogues/index_e.html • Analyzed CAS data and published a full, as well as a highlights report on the nature of the key results on prevalence rates in Canada. http://www.hc-sc.gc.ca/dhp-mps/substan/alc-can/overview-apercu/index_e.html
The Alcohol and Drug Treatment and Rehabilitation Program (ADTR) will continue to improve treatment for women and youth suffering from substance abuse problems	• Negotiated and monitored cost-shared funding agreements with provinces for ADTR programs and services. • Developed plan to re-focus ADTR Program in keeping with agreement established with Treasury Board. http://www.hc-sc.gc.ca/dhp-mps/substan/treat-trait/index_e.html

RPP Commitments 2004–2005	Report on Results
Tobacco Control Programme Work on tobacco cessation to encourage people who currently smoke to quit smoking. We will work with the University of Waterloo and the provincial governments of Prince Edward Island and British Columbia to evaluate a coordinated approach to cessation. This initiative will be one part of our work in 2004–2005 to support implementation of a national coordinated approach to cessation in communities across Canada	Expected completion in March 2006. BC: Recruitment completed with just under 1,200 participants. ($180 K) PEI: A total of 1,211 study participants have been recruited. All have received some form of cessation counselling. ($128 K) Both sites have noted an increase in awareness among the general population of cessation options.
The best evidence of the success of these and other initiatives will be based on the ongoing data from the Canadian Tobacco Use Monitoring Survey	The latest results from the Canadian Tobacco Use Monitoring Survey (CTUMS), for data collected between February and June 2004, indicated just over five million people, representing 20 percent of the population age 15 years and older, were current smokers, of which 15 percent reported smoking daily. This is similar to the rate for the first half of 2003 (20 percent for current smoking and 16 percent for daily smoking). Approximately 23 percent of men age 15 years and older were current smokers, slightly higher than the proportion of women (17 percent). ($1.37 M) http://www.hc-sc.gc.ca/hl-vs/tobac-tabac/research-recherche/stat/ctums-esutc/index_e.html
Pursue regulations that would mandate changes to cigarettes to decrease the number of cigarette-lit fires and their associated harm and deaths	Final publication expected in June 2005: ($250 K) In 2004–2005: • Cigarette Ignition Propensity Regulations, and Regulations Amending the Tobacco Reporting Regulations were pre-published in *Canada Gazette* Part I; • Reviewed and approved by the House of Commons Standing Committee on Health. http://www.hc-sc.gc.ca/hl-vs/tobac-tabac/legislation/reg/ignition-alllumage/index_e.html
Ratification of the Framework Convention on Tobacco Control	Canada was among the first 40 countries to successfully ratify and bring into force the World Health Organization's Framework Convention on Tobacco Control (FCTC), the first-ever global public health treaty. The FCTC, which came into force on February 27, 2005 is designed to protect present and future generations from the health, social, environmental and economic consequences of consumption and exposure to tobacco smoke by strengthening tobacco control initiatives around the world. http://www.hc-sc.gc.ca/ahc-asc/media/nr-cp/2005/2005_07bk1_e.html http://www.who.int/tobacco/framework/en/

Strategic Outcome:
Sustainable Pest Management Products and Programs for Canadians

Relevant Outcome in "Canada's Performance":
Healthy Canadians with Access to Quality Health Care

Objective
To prevent unacceptable risks to people and the environment from the use of pest control products.

Financial Information

2004–2005 (MILLIONS OF DOLLARS)			
	Planned Spending	Total Authorities	Actual Spending
Gross expenditures	45.3	48.7	47.5
Revenues	(7.0)	(7.0)	(6.1)
Net expenditures	38.3	41.7	41.4*
FTEs	541	546	475

* *This represents 9.5 percent of Health Promotion and Protection actual spending (excluding the Public Health Agency of Canada).*

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

- funding for West Nile virus through the Pan-Canadian Public Health System Treasury Board submission.

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

Immediate outcomes

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

Priorities

- Ensure safe and effective pest control products
- Ensure compliance with PCPA
- Ensure sustainable pest management practices that reduce reliance on use of pesticides

Program, resources and results linkages

Program	Actual Expenditures[1] ($M)	Result Linkage
New Pest Control Product Registration and Decision-Making	20.0	Conduct human health, safety and environmental risk assessments, efficacy and value assessments, establish Maximum Residue Limits (MRLs) and make regulatory decisions within specified performance standards on applications to register new pest control products.
Registered Pest Control Product Evaluation and Decision-Making	8.2	Re-evaluate older pesticides on the basis of updated data and information, to determine whether, and under what conditions, their continued registration is acceptable (meet modern safety standards).
Compliance	6.8	Promote, maintain and enforce compliance with the PCPA through investigations and inspections that are coordinated with provincial and territorial governments and other federal departments.
Pesticide Risk Reduction	2.7	Develop and implement policies and guidelines related to sustainable pest management and develop innovative approaches through partnerships.
Regulatory Improvement	3.7	Develop strategic initiatives for information technology, policy development, legislative/ regulatory change and communication that support commitments to improve performance and transparency and reduce costs, while maintaining a high level of protection of health and the environment.

[1] *The title has been changed from Resources to Actual Expenditures for clarification.*

Executive Summary

To help prevent unacceptable risks to people and the environment, Health Canada regulates the importation, sale and use of pesticides under the federal authority of the PCPA and Regulations. Ongoing regulatory responsibilities constitute the majority of the work, all of which contribute to our strategic outcome. Using internationally accepted approaches and protocols, we conduct science-based health, environmental and value assessments. Pesticides are registered only if the health and environmental risks are considered acceptable, and if the product is effective. We set pesticide MRLs for food commodities under the *Food and Drugs Act*. Older pesticides are re-evaluated to determine if their use continues to be acceptable under current scientific approaches. We also facilitate, encourage and maximize compliance with the PCPA and the conditions of registration.

Health Canada is leading a successful effort with other science-based federal government departments to improve the coordination of pesticide research and regulatory activities.[13] We work closely with Mexico, the United States and the Organization for Economic Co-operation and Development (OECD) countries to harmonize regulatory approaches for evaluating pesticides. Our compliance activities often involve collaboration with the Canadian Food Inspection Agency (CFIA) and provincial governments. Our Department will continue to work with Agriculture and Agri-Food Canada (AAFC) to develop risk reduction strategies for the agricultural sector, and improve access to specialized pest control products that are priorities for Canadian growers.

PRIORITY 1: ONGOING

Ensure safe and effective pest control products

Through the evaluation of new pesticides and the re-evaluation of older pesticides, Health Canada helped protect the health of Canadians and their environment from the risks associated with pesticides. We continued to improve timeframes for the registration of new pesticides, and made progress in meeting our re-evaluation targets. Improving access to reduced-risk products as alternatives to traditional pesticides remained a priority. Health Canada contributed to the competitiveness of the Canadian agri-food sector by improving access to "minor use" pesticides—those that would not otherwise be available in Canada because of small projected sales.

RPP Commitments 2004–2005	Report on Results
Publish new regulations to bring the new PCPA[14] into force. The regulations will require pesticide companies to: • establish a database to gather and track pesticide sales • report potential adverse effects • provide safety information through Workplace Hazardous Materials Information System (WHMIS) to workplaces.	Implementation of the new PCPA remained a high priority. The new Act will help strengthen health and environmental protection, improve transparency of the regulatory system and strengthen post-registration controls of pesticides. Where we have the authority, the intent of the new PCPA has already been implemented as a matter of policy. For example, we conduct cumulative risk assessments, re-evaluate older pesticides and publish proposed regulatory decisions for public consultation. This year, we published three proposed regulations in *Canada Gazette*, Part I for public consultation (Pesticide Adverse Effects Reporting Regulations; Sales Information Reporting Regulations; and Safety Information Regulations). Ongoing activities included drafting the final regulations and revising the existing regulations in light of the new PCPA. We are preparing the internal operational infrastructure, including an electronic environment, to support implementation of the Act in 2005–2006.

[13] Horizontal Initiatives Table (http://www.tbs-sct.gc.ca/rma/eppi-ibdrp/hrdb-rhbd/bpcpr-rcprp/description_e.asp).

[14] *Pest Control Products Act* (http://laws.justice.gc.ca/en/P-9.01/92455.html).

RPP Commitments 2004–2005	Report on Results
Improve the coordination of pesticide research and regulatory activities	Health Canada facilitated information exchange with the other government departments responsible for conducting pesticide research and monitoring. Ongoing projects to improve pesticide risk assessment and mitigation methods include new exposure scenarios for aquatic organisms; agriculture spray drift models; species at risk policy; drinking water exposure assessments. Details regarding the plans, spending and results of this initiative are available on the TBS Web site: http://www.tbs-sct.gc.ca/rma/eppi-ibdrp/hrdb-rhbd/bpcpr-rcprp/description_e.asp
Review applications for the registration of new pesticides in as timely a manner as possible. As well, continue to pursue work sharing and harmonization of data requirements with international regulatory bodies	Health Canada registered nine new active ingredients, seven of which were completed within performance standards (78 percent). The workload remained high, with over 3,250 regulatory decisions made for new pesticide registrations and amendments. As a result of our continued harmonization efforts, there were 16 submissions undergoing joint or work share review. Approximately 50 percent of all new active ingredient submissions are joint reviews. This results in increased efficiencies, timely access to new pesticides and reduced trade irritants between borders. All major regulatory decisions are available at: http://www.pmra-arla.gc.ca/english/pubs/newpesticides-e.html New Pest Control Product Registration and Decision-Making Expenditures: $20.1 M.
Re-evaluate 401 active ingredients registered prior to 1995, using modern risk assessment methods and current scientific data (2006 for food use pesticides, and 2008 for non-food uses). Report to Parliament on progress, and publish decision documents	This program will help ensure that only safe, sustainable pest management products continue to be available for use in Canada. Significant progress was made towards the target. This year alone, we finalized 33 decisions and proposed 35 other decisions. To date, we have completed re-evaluations for 182 (45 percent) of the 401 active ingredients. As of March 31, 2005, re-evaluation decisions have been made or proposed for 182 active ingredients. A progress update was provided to the Standing Committee on Agriculture and Agri-Food, as well as to stakeholder committees. The re-evaluation workplan and all re-evaluation decisions are available at: http://www.pmra-arla.gc.ca/english/pubs/reeval-e.html Registered Pest Control Product Evaluation and Decision-Making Expenditures: $8.2 M.
Provide timely access to reduced-risk pesticides, and report on the registration results	Providing Canadians with access to safer pesticides, including reduced-risk pesticides is a priority. Reduced-risk pesticides present an improved health or environmental risk scenario compared to existing products of the same use. More than 69 percent of reduced-risk active ingredients registered or pending registration in the United States are registered or pending registration in Canada. Eight of the nine new active ingredients registered in 2004–2005 were reduced-risk; one of which was registered through the joint review program. Published a list of all the reduced-risk active ingredients, end-use products and uses available in Canada: http://www.pmra-arla.gc.ca/english/pdf/rr/rr2005-01-e.pdf

RPP Commitments 2004–2005	Report on Results
Health Canada and AAFC will facilitate access to reduced-risk products for agricultural use, including minor use pesticides	Health Canada reviewed 117 AAFC and provincial/forestry presubmission consultation proposals and reviewed 43 submissions generated by AAFC and provinces for minor use registrations. In all, 65 new minor crop uses were registered, including 42 reduced-risk uses. As a result of this program, Canadian farmers have improved access to newer, cost-effective pesticides necessary for sustainable agriculture.

PRIORITY 2: ONGOING

Ensure compliance with the *Pest Control Products Act*

We have the ongoing responsibility to help protect the health of Canadians and their environment by facilitating, encouraging and maximizing compliance with the PCPA and conditions of registration. Focused on the inspection and investigation of those who manufacture, sell, distribute and use pesticides, the compliance program is conducted through a network of Health Canada regional officers and CFIA inspectors across Canada.

RPP Commitments 2004–2005	Report on Results
Report on the number of investigations, inspections and enforcement actions taken	Health Canada conducted 574 investigations and 1,110 inspections across the country, to help ensure pesticides are manufactured, sold and used safely. As a result of these activities, we detained 125 products; denied four unregistered products entry into Canada; took 381 education actions; and issued 19 administrative monetary penalties (AMP) Notices of Violations. Compliance Expenditures: $6.8 M
Review how comparable Canadian and international organizations target, measure and report their compliance activities and adjust our business procedures accordingly by the end of 2007	Using federal and departmental Integrated Risk Management Frameworks, we updated the compliance and enforcement policy to target compliance programs/activities to areas of higher risk. The updated policy will be published in 2005–2006. The Department is also considering options to enhance federal-provincial collaboration on compliance. Health Canada is organizing an OECD compliance workshop for June 2006 to advance risk-based targeting, measuring of outcomes and reporting of compliance and enforcement activities.

PRIORITY 3: ONGOING

Ensure sustainable pest management practices that reduce reliance on the use of pesticides

In response to Canadians' growing interest in minimizing the risks associated with pesticides, we are committed to integrating the principles of sustainable development into pest management. The goal is to inform Canadians of reduced-risk practices, which will lead to reduced reliance on the use of traditional pesticides and increase the use of alternative approaches. We continued to develop and promote sustainable pest management products and practices in cooperation with other federal departments, provinces and territories, growers, the pesticide industry and non-governmental organizations. (http://www.pmra-arla.gc.ca/english/spm/spm-e.html)

RPP Commitments 2004–2005	Report on Results
With AAFC, continue to develop crop profiles and implement risk reduction strategies for agricultural commodities With federal and provincial colleagues, Health Canada will develop a pesticide risk indicator to assess risk reduction. Health Canada and AAFC will develop an indicator to evaluate Integrated Pest Management (IPM) adoption in agriculture	In collaboration with AAFC, Health Canada completed 20 crop profiles, initiated two new risk reduction strategies and continued work on six other strategies. Ongoing activities included developing a pesticide risk indicator to assess risk reduction, and working with provinces to seek adoption of the indicator. The risk reduction strategies will improve the availability of effective risk reduction products, practices and tools for Canadian farmers, with the goal of sustainable agriculture. In 2004–2005, Health Canada invested approximately $4 million for this initiative.
Promote lawn IPM to homeowners and improve risk reduction information on pesticide labels. As well, we will pursue a harmonized pesticide classification system for Canada	Ongoing efforts included negotiation on a national classification system for domestic pesticides, as well as progress on communication outreach and label improvement projects. Bi-annual progress reports were provided to stakeholders. Since 2001, three of the seven Healthy Lawn strategies have been completed. The goal of the program is to reduce reliance on lawn care pesticides and promote the safe use of pesticides. http://www.healthylawns.net/
The new PCPA supports the objective of risk reduction in a variety of ways. Health Canada will develop and consult on new policies to facilitate the use of reduced-risk strategies and products. As well, we will consult with stakeholders on regulations regarding pesticide minor uses	Although the new Act will provide the authority to pursue these risk reduction activities, they are not mandatory for successful implementation of the new PCPA. There are no deliverables against these planned activities since our efforts were focused on the essential provisions of the Act.

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

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

Strategic Outcome:
Improved Evidence-Base and Increased Use of Information and Communications Technologies to Support Health Decision-Making

Relevant Outcome in "Canada's Performance":
Healthy Canadians with Access to Quality Health Care

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.

Financial Information

2004–2005 (MILLIONS OF DOLLARS)			
	Planned Spending	Total Authorities	Actual Spending
Gross expenditures	98.7	107.9	107.3
Revenues	0	0	0
Net expenditures	98.7	107.9	107.3*
FTEs	608	614	629

** This represents 3.8 percent of the Department's actual spending (excluding the Public Health Agency of Canada).*

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

- increase funding for the Strategic Outcome "Access to Quality Health Services for Canadians for the Primary Health Care Transition Fund, Official Languages Minority Communities Program
- decrease in authorities as a result of direct funding related to the Public Health Agency of Canada (PHAC) being reflected in the Agency's own Performance Report

The actual spending is $0.6 million lower than total authorities mainly due to:

- year end adjustments of Department of Justice expenditures

Intermediate outcomes

- Improved health policies and programs
- Improved health decision-making and services
- More efficient delivery of Health Canada programs

Immediate outcomes

- Improved understanding of health issues and health system performance
- Increased use of e-technology in the health sector
- More reliable Information Management/Information Technology/Knowledge Management (IM/IT/KM) services

Priorities

- Accelerate the use of information and communications technologies in the health sector
- Develop a pan-Canadian framework to protect the privacy and confidentiality of personal health information
- Increase access to health evidence/information and its use in support of decision-making and accountability
- Implement the Information Management and Information Technology Strategy

Program, resources and results linkages

Program	Actual Expenditures[1]	Result Linkage
Activities under this strategic outcome generally consist of ongoing corporate support services rather than defined programs	Not applicable	Not applicable

[1] *The title has been changed from Resources to Actual Expenditures for clarification.*

Executive Summary

Improved evidence-base and increased use of information and communications technologies to support health decision-making

Our Department has two major areas of work under this strategic outcome. The first is the ongoing responsibility to provide information technology (IT) and information and knowledge management services to Health Canada, which is where we spend most of the resources listed in the chart above. During 2004–2005, in addition to our normal day-to-day operations, we developed and/or implemented strategies designed to enable us to meet needs in areas such as improved telecommunications capacity and IT security in the most cost-effective ways.

We also serve as Health Canada's focal point for addressing, with our partners, key policy issues, such as standards development and telehealth, that must be resolved in support of eHealth and the increased use of information and communications technologies in the health care system. As well, we are increasing access to the evidence that health decision makers need to make more informed decisions. In addition, we work with others to develop and report on performance measures that are

enabling governments and the health system to better demonstrate accountability to Canadians.

In general, we met or exceeded our targets during 2004–2005 in all these areas. For example, since Canadians expect privacy and confidentiality issues to be addressed in the use of information technology in the health field, we worked with many partners on addressing the relevant policy issues. We also conducted and funded health policy and administration research that is supporting better decision-making in the health system. Finally, we led the federal contribution to meeting the commitment by federal and provincial governments to report to Canadians on how the health system is performing.

PRIORITY 1: ONGOING

Accelerate the use of information and communications technologies in the health sector

The increased adoption of information and communications technologies in the health sector is essential to creating a sustainable health system that provides better access to services for Canadians, now and in the future. Since 2001, Canada Health Infoway Inc. (*Infoway*) has been allocated $1.2 billion in federal funding to work with provinces and territories in developing pan-Canadian eHealth solutions for electronic health records (EHR), telehealth and health surveillance. For example, *Infoway*, in collaboration with the provinces and territories, has set the goal of having the basic elements of an interoperable EHR in place across 50 percent of Canada (by population) by the end of 2009. Health Canada, in support of these goals, continued to focus on key policy issues that must be resolved so that an effective pan-Canadian approach to eHealth can be implemented.

RPP Commitments 2004–2005	Report on Results
Support Canada Health Infoway Inc.: Health Canada will continue to support *Infoway*'s progress through policy work including intergovernmental collaboration through the Federal/Provincial/Territorial Advisory Committee on Information and Emerging Technologies Resolve eHealth policy issues: Health Canada, in its role both as leader and partner on health issues, will continue to work with the provinces, territories, *Infoway*, and other health stakeholders, over the next three years, to develop strategic policy options that would begin to address eHealth policy concerns of those partners and Canadians	Health Canada continued to support *Infoway* through policy work in areas such as standards development and telehealth, working in partnership with the provinces and territories in support of the development and implementation of a pan-Canadian eHealth system. A Key Informants Session on eHealth and Primary Health Care Renewal generated information for use in Health Canada policy development and for *Infoway*.

PRIORITY 2: ONGOING

Develop a pan-Canadian framework to protect the privacy and confidentiality of personal health information

Ensuring privacy and confidentiality of individual information is critical to earning public support for EHR and other aspects of any pan-Canadian approach to eHealth. During 2004–2005, our major emphasis was on working with partners to identify how best to meet these legitimate expectations as new technologies are put to work.

RPP Commitments 2004–2005	Report on Results
Develop a harmonized approach to the privacy and confidentiality of personal health information: Health Canada will work with its partners to develop, by fall 2004, a pan-Canadian privacy and confidentiality framework that will establish harmonized and consistent approaches to personal health information handling practices	Recognizing the importance of privacy to Canadians, the Pan-Canadian Health Information Privacy and Confidentiality Framework was completed at the end of 2004 and endorsed by the F/P/T Conference of Deputy Ministers of Health in January 2005 (with Quebec and Saskatchewan abstaining). The Framework is intended as a guide rather than a prescription since legislators have the ultimate authority to determine the type of privacy legislation they wish to adopt. It harmonizes a set of rules for the collection, use and disclosure of personal health information while enabling the flow of information, where appropriate, to support effective health care, the management of the health system and an interoperable health record.

PRIORITY 3: ONGOING

Increase access to health evidence/information and its use in support of decision-making and accountability

Given the importance of health to Canadians and the need to put public resources to the best use, First Ministers have agreed to accountability measures such as the use of comparable indicators. Governments and the health system are also seeking out much more extensive health data to make more informed policy and program choices, as well as for performance management purposes. During 2004–2005, our Department was the focal point for this work in the Government of Canada and had a lead role in working with other governments to meet these expectations. This was demonstrated by the First Ministers' September 2004 commitment to the 10-Year Plan to Strengthen Health Care, which included commitments to improve performance reporting to Canadians in priority areas such as wait times, home care, health human resources, primary health care reform and health innovation. Our Department's central role was also demonstrated through our work to develop a new performance measurement framework and enhance our program evaluations.

RPP Commitments 2004–2005	Report on Results
Report on Comparable Health Indicators: Health Canada will continue to work with provinces and territories to identify additional comparable indicators and will report by November 2004	As part of a commitment to increased accountability and to provide better reporting to Canadians on health system performance, federal, provincial and territorial governments have agreed to provide comprehensive and regular public reporting on progress in achieving the reforms set out in the 2000 Health Communiqué and the 2003 First Ministers' Accord on Health Care Renewal. The Federal Report on Comparable Health Indicators was released on November 30, 2004 after being audited by the Auditor General who indicated satisfaction with the data quality.

RPP Commitments 2004–2005	Report on Results
Improving Health Statistics: In 2004–2005, priorities were to: Analyze and understand the latest results from Statistics Canada's Canadian Community Health Survey, which will provide the first comprehensive portrait of Canadian nutrition; and	The Canadian Community Health Survey was released in June 2004 and made available to Health Canada and the Public Health Agency of Canada (PHAC) for analysis and data sharing.
Continue ongoing collaboration with Statistics Canada in planning the first ever Canadian Health Examination Survey, which will offer the first comprehensive physical measures, such as blood pressure, of the health of Canadians	We worked with the PHAC and provided regular feedback to Statistics Canada on priorities for the Canadian Health Examination Survey including the physical measures to be collected, the wording of the survey, the survey logistics and overall survey funding. The survey will be completed in 2007–2008.
Addressing Policy Research Gaps: Identify key policy research gaps that will be the focus of future work and establish the terms and specific projects for subsequent research	Through a collaborative process involving all line branches, four priority policy research areas were identified and endorsed by the departmental executive: Innovation in Health; Healthy Communities; First Nations and Inuit Health System Sustainability; and Regulation Research. These multi-year research programs, which involve both internal and external research, are under way. We published two Health Policy Research Bulletins: *Health Human Resources: Balancing Supply and Demand*; and *Child Maltreatment: A Public Health Issue*. http://www.hc-sc.gc.ca/sr-sr/pubs/index_e.html#3
Improving the Health Canada Performance Management Framework: Obtain performance measurement information where it is currently lacking and improve on early performance information where possible	Our first set of performance data was produced in 2004–2005, beginning a process of at least two more years, to provide enough data to enable meaningful interpretation. We used our Performance Management Framework to facilitate development of our departmental Program Activity Architecture.
Strengthen Evaluation: Make evaluations more useful to departmental and central agency decision-making and strengthen departmental performance and accountability	We continued to develop and implement new tools, standards and guidelines to strengthen our program evaluation stewardship role. This included a risk-based process to assist in planning and identifying key evaluations, as well as tools to assess the quality of evaluation project workplans, evaluation reports, and results-based management and accountability frameworks and to conduct evaluability assessments.
Expanding the Canada Health Portal (CHP): The Department will seek to expand its partnerships beyond the 17 federal departments and agencies that already contribute resources to the CHP, the Government On-Line Initiative, accessed through the Government of Canada site, that provides health information	Site visits to the Canada Health Portal increased by 38 percent since last year. • Operating costs are currently $635.1 K. • During the year, we negotiated with the City of Toronto and the governments of Manitoba and Ontario on their participation in the Canada Health Portal.

PRIORITY 4: ONGOING

Implement a Departmental Information Management/Information Technology (IM/IT) Strategy

Because of the importance of information and communications technologies, but also the reality of limited funding, we emphasized the development of clear priority-setting processes; for example, by completing a final draft departmental Information Management/Information Technology Strategy, to guide spending and technology choices, particularly for our growing information management and telecommunications needs.

RPP Commitments 2004–2005	Report on Results
Improve IM Practices and further define the IM Framework: The Department will identify how best to improve IM practices, and further define the Department-wide IM Framework	We identified information management priorities and a departmental records management model. The technical feasibility of initiating deployment of the Government-wide Records/Document/Information Management System (RDIMS) in Health Canada beginning in 2006–2007 was explored. Both an information management capacity check and an information management sustainability plan were developed.
Maintaining and evolving the technological infrastructure: Address priority areas over the next few years including telecommunications capacity, in response to requirements for telehealth services, storage area networks that accommodate provincial/stakeholder information exchange, and security, with respect to privacy and threat mitigation	Telecommunications Capacity: Working with Public Works and Government Services Canada, we provided more communities across Canada with the ability to access telehealth services by providing network connectivity through the Converged Network Services. Storage Area Networks: Efforts were focused on telecommunications in 2004–2005 as noted above. Future directions with regards to Health Canada's Storage Area Networks include a more consolidated environment by expanding upon our existing infrastructure. This will allow for full redundancy, as well as alternate power sources achieved by moving storage offsite as part of the facilities and disaster recovery consolidation efforts. IT Security: The Way Forward project, a centralized approach to IT management in Health Canada, was approved in February 2005. The project scope includes establishing an ongoing IT risk-based security program that will ensure compliance with the Treasury Board Management of Information Technology Security (MITS) Standard by the December 2006 target date. Implementing the standard will help us to identify and deal with IT security risks.

Strategic Outcome:
Effective Support for the Delivery of Health Canada's Programs

Relevant Outcomes in "Canada's Performance":
Healthy Canadians with Access to Quality Health Care; Inclusive Society that Promotes Linguistic Duality and Diversity

Objective
To improve core management practices and support functions; to provide effective support for the delivery of Health Canada's programs and sound management practices across the Department.

Financial Information

2004–2005 (MILLIONS OF DOLLARS)			
	Planned Spending	Total Authorities	Actual Spending
Gross expenditures	199.3	251.0	231.7
Revenues	(0.7)	(0.7)	(0.5)
Net expenditures	198.6	250.3	231.2*
FTEs	1,378	1,149	1,341
** This represents 8.2 percent of the Department's actual spending (excluding the Public Health Agency of Canada).*			

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

- funding related to support for First Nations' construction and restoration of on-reserve facilities
- funding for the implementation of specific advertising initiatives
- direct funding related to the Public Health Agency of Canada (PHAC) being reflected in the Agency's own Performance Report

The actual spending is $19.1 million lower than total authorities mainly due to:

- timing issues related to the implementation of certain advertising initiatives and litigation and settlements for blood products
- setting aside of funds to cover increased costs of the employee benefit plan
- year end adjustments and lower than expected expenditures in various programs

Intermediate outcomes

N/A

Immediate outcomes

N/A

Priorities

- Improving accountability to Canadians through continuous improvement of management practices and rigorous stewardship of resources
- Effective regional delivery of Health Canada programs tailored to meet local conditions
- Improve the Department's capacity to perform, harness, translate and use sound science to support evidence-based decision-making, thereby optimizing health outcomes and minimizing health risk for Canadians
- Implement Health Canada's component of the Federal Government's Official Languages Action Plan for increasing access to services by Official Language Minority Communities

Program, resources and results linkages

Program	Actual Expenditures[1]	Result Linkage
Activities under this strategic outcome generally consist of ongoing corporate support services rather than defined programs	Not applicable.	Not applicable.

[1] *The title has been changed from Resources to Actual Expenditures for clarification.*

Executive Summary

This strategic outcome includes the full range of corporate service activities with the exception of information technology and information management, which are addressed under Improved Evidence-Base and Increased Use of Information and Communications Technologies to Support Health Decision-Making.

During 2004–2005, in addition to our ongoing activities, we acted in many ways to improve accountability for our use and management of resources, complementing that by new risk management initiatives and a strengthened internal audit function. We also extended the activities that are improving our management of human resources. As a Department with an important presence in all of Canada's regions, our regional staff worked with communities, provincial and territorial governments, and many other partners to ensure that Health Canada programs and services would respond to specific needs and opportunities in those regions.

This strategic outcome also includes the departmental commitment to the creation and use of high-quality science across our strategies and activities. The Office of the Chief Scientist continued to be the focal point for science leadership in Health Canada and was responsible for an extensive range of efforts to ensure that our Department has the science capacity needed to ensure sound policies and programs. That Office did a great deal to link the Health Canada science community to the science community beyond the Department.

Activities in support of Official Language Minority Communities' health form part of the work under this strategic outcome. Our Department continued to support

specific measures to improve access to health services for those communities in their own language and to meet other goals under the Government of Canada Official Languages Action Plan.

PRIORITY 1: ONGOING

Improving accountability to Canadians through continuous improvement of management practices and rigorous stewardship of resources

For 2004–2005, this priority was a consistent theme of the corporate service functions to become an effective, accountable organization. Efforts to reach the goals of the Modern Management Strategy Action Plan included activities to strengthen accountability and stewardship throughout Health Canada. In support of our efforts to promote sound management practices, the Department adopted the Management Accountability Framework (MAF), introduced by the TBS in 2003. We are using the MAF as a lens to assess management practices and identify areas for further improvement. The Department remains engaged in supporting a modern management culture by encouraging management excellence within its complex operating environment.

The Department has been active in the development of its new Program Activity Architecture (PAA) with associated performance measures and input to the TBS Expenditure Management Information System (EMIS) database.

Also, our Department has made steady progress in implementing an Integrated Risk Management Framework, as evidenced by the development of the Departmental Corporate Risk Profile and the recent completion of the internal environmental scanning exercise. Risk is a factor in decision-making at Health Canada and good progress has been made in integrating risk management into strategic and operational planning.

Human resources and workplace strategies focused on evolving to a workplace that demonstrates "ethics in action" and is a model of effective human resources management. An expanded focus on the internal audit and special investigations functions reinforced our capacity to identify and act on risks and potential problems, as does our work to improve security of assets.

The Department's commitment to integrate sustainable development in our operations was part of an ongoing, Government-wide recognition that federal departments can be leaders in applying the principles of sustainable development to operations, as well as to policy and program activities.

RPP Commitments 2004–2005	Report on Results
Following through on the Modern Management Strategy (MMS) Action Plan Further implementation of the MMS Action Plan Implement the MAF	In moving forward on the management improvement agenda, the assessment of the Department's management capabilities and practices in the context of the MAF was completed. Important progress has been achieved in improving management practices and strengthening stewardship and accountability throughout the complex operating environment of the Department. Health Canada is pursuing in its efforts to develop a culture where managers at all levels focus on improving transparency and openness and strengthening stewardship and accountability.
Strengthening Accountability and Stewardship Define an effective regime to actively monitor and assess financial management practices and controls	Health Canada began to implement a new Financial Management and Control Framework. It is addressing many related priorities for action throughout the Department and is based on a clear Financial Management Vision that we relaunched in 2004–2005. A permanent office has been created that is now overseeing and identifying continuous improvements in financial management in the Department and making training on it mandatory for all managers. The Department continues to train managers on their respective financial management responsibilities and on the tools they need to use, including updating our financial delegation authorities. It is through these processes that we have clarified and emphasized the financial stewardship responsibilities of all our managers.

RPP Commitments 2004–2005	Report on Results
	We reinforced these actions with other improvements that streamlined and updated the terms and conditions that govern our grants and contributions programs and strengthened the management of departmental contracting. Health Canada continued to enhance its performance measurement systems to better enable us to define the results that we want to achieve and make the best use of our resources, while also expanding our use of risk management analysis and tools across departmental planning and operations.
	Treasury Board approved all but one of the updated sets of terms and conditions for our Department's programs by March 31, 2005. This renewal process enabled us to consolidate management of 47 programs under eight general sets of terms and conditions, with just six other sets of terms of conditions for unique programs. This change will streamline the management of these programs for both our Department and partner organizations. It complements our new departmental grants and contributions management framework launched in 2002. Oversight, monitoring and review systems, and processes for contracts and grants and contributions, are reinforcing accountability and stewardship for Health Canada, organizations receiving grants and contributions and those receiving contracts. Health Canada has made steady progress in implementing Integrated Risk Management as evidenced by the development of the first Departmental Corporate Risk Profile and the recent completion of the first Internal Environmental Scan exercise, which complements the External Environmental Scan. The information garnered from these two undertakings will be used to support the strategic priority setting exercise.
	We continued our efforts on implementation of the Contract Management Control Framework and Action Plan that would improve Health Canada contract management practices. By the end of 2004–2005, 98 percent of the recommendations identified in the Contract Management Framework Action Plan have been implemented. It is anticipated that 100 percent completion will be achieved by November 2005. The Action Plan centres on a number of elements including: engagement of senior management; improvement of management systems, practices and controls; a governance structure to clarify roles, responsibilities and accountabilities of individuals and committees involved in the management of contracting processes; four-day mandatory training for Contract and Requisition Control Committee members and employees involved in the quality assurance function and, a revised, strengthened delegation instrument that explains the conditions attached to the delegation of authorities, including a one-day mandatory training requirement for all Cost Centre Managers and Cost Centre Administrators.
People Management Provide employees with opportunities for values and ethics dialogue, guidance, support and tools through the Centre for Workplace Ethics (CWE)	Provided generic ethics learning (Ethics 101, Everyday Ethics and Ethical Leadership) to branches, agencies and regions. Developed customized learning products for specific communities of practice (Nursing, Financial Management, Regulators, Science Managers etc.) Developed generic ethics competencies for all staff and ethics performance requirements for executives. Continued research to develop a model to measure departmental performance with respect to values and ethics.

RPP Commitments 2004–2005	Report on Results
Promote a healthy work environment for employees by creating the Ombudsman Service which provides a confidential, informal and neutral resource to facilitate resolution of work related concerns	Continued promotion of the Ombudsman Service by providing on-site service and presentations at staff and management meetings across the country. As part of the overall plan to measure effectiveness of the Ombudsman Service: conducted a survey relating to employee awareness of the Service, and released the *Ombudsman Service 2004 Annual Report*, identifying trends and observations on the issues being raised by employees.
Implement initiatives under our Workplace Health and Human Resources Modernization (WHAHRM) Action Plan	Under the WHAHRM umbrella, Health Canada implemented significant improvements in priority areas, including: Leadership and Accountability: people management objectives were added to the Performance Discussion Process, as well as a corporate 100 percent completion rate goal; a leadership (management) development framework was developed, a continuous learning policy is now in place; and, a progress report to employees was issued with quarterly updates provided to the WHAHRM oversight committee. Workload: WHAHRM produced studies on the use of overtime and on Executive Work-Life Balance. The popular *Worksmarts* and *Innovative Practices* publications were shared with the Association of Public Service Executives (APEX), with a view to helping management across the public service cope with workload issues. The Healthy Cafeteria Program continued to expand to new sites and awareness raising campaigns on smoking, nutrition, mental health and physical activity were held. The policy on the Duty to Accommodate was reinforced and recommunicated widely.
	Parliament passed the *Public Service Modernization Act*, which reforms human resources management in the federal government. To improve responsiveness of programs to the needs of the public and to provide for a more efficient and effective staffing process, we obtained approval to use staffing tools such as pre-qualified pools (PQPs), recruitment without competition from outside the public service, and a science and technology inventory. These actions will help Health Canada to be representative of the population we serve, and be responsive to human resource requirements in the critical areas of management, science and technology. Several audits and evaluations of Human Resources Management took place in 2004–2005. These audits/evaluations resulted in suggested improvements/action plans for implementation in 2005–2006. For more information, please visit: http://www.hc-sc.gc.ca
Strengthened Internal Audit and Special Investigation Functions Implement the multi-year risk-based internal audit plan	Our internal audit work was guided by risk principles and focused on the three key results areas identified in the Treasury Board Policy on Internal Audit (risk management strategy and practices, management control frameworks and practices and information used for decision-making and reporting). The Audit and Accountability Bureau (AAB) developed and tabled a risk-based audit plan for 2004–2005. To view summaries of audit reports tabled before Health Canada's Departmental Audit and Evaluation Committee in 2004–2005, please visit: http://www.hc-sc.gc.ca/ahc-asc/performance/audit-verif/index_e.html

RPP Commitments 2004–2005	Report on Results
	To enhance the Special Investigation (SI) Function within the Bureau, AAB established a separate SI Division. The SI Division implemented a Memorandum of Understanding (MOU) with Indian and Northern Affairs Canada, Health Canada, and the Royal Canadian Mounted Police. This MOU encourages and facilitates cooperation among the departments on the referral of allegations of potential wrongdoing. This demonstrates to staff, partners, stakeholders and Canadians as a whole, that the Department is managing for results, as well as ensuring rigorous stewardship of resources.
Improving Security of Health Assets Implement a three-year business plan to enhance the protection of employees, sensitive departmental assets and information	The departmental security program for employee and asset security was maintained at a Level II—Heightened State of Security commensurate with the requirements of TBS's Government Security Readiness Standard.
Adopt an integrated security program	Implementation of the year two recommendations of the Departmental National Security Review Project, continued to lead to a fully integrated departmental security program in Health Canada facilities nationally. This program results in a departmental management framework in which safety, emergency and security considerations are part of program and employee planning and decision-making and, contributes to the continuity of essential service delivery to employees, as well as asset protection.
Business Continuity Program Enhance the management structure for Business Continuity Planning (BCP)	Consultations led to an upgrading of the Departmental BCP database. A BCP progress report template was developed as an audit tool to monitor BCP program performance. A 1-877 Department-wide Business Continuity Hotline was initiated for employees to call to determine the status of service disruptions during major emergency situations.
Integration of Sustainable Development into our operations Integrate sustainable development into decision-making and management processes Adopt a pollution prevention approach and identify, prioritize and propose mitigation/remediation steps in addressing Department-specific issues	Health Canada's Sustainable Development Strategy is reported in Table 14 of this Report and on the Office of Sustainable Development Web site. For more information please visit: http://www.hc-sc.gc.ca/ahc-asc/activit/strateg/sus-dur/index_e.html

PRIORITY 2: ONGOING

Effective regional delivery of Health Canada programs tailored to meet local conditions

The policies, programs and services of Health Canada remain responsive to the varied needs of the many communities it serves across the country. Through partnerships and collaborative relationships, as well as the engagement of key stakeholders and citizens, Health Canada's regional offices are well-informed as to local priorities and provide the expertise and flexibility to respond to the unique needs of our communities. The leadership demonstrated by Health Canada's regions in furthering horizontal relationships, facilitating multi-partnered initiatives and fostering innovation continues to be an important asset to the Department as provincial and territorial approaches to managing the health care agenda evolve.

Health Canada Regions also enhance the profile and presence of the Department through the strategic use of the Health Canada Innovation Fund. This Fund allows Regions to maximize and leverage partnership opportunities through the development of projects in direct response to local needs. The outcomes of a number of these Innovation Fund projects, among other Regional Initiatives, are featured in the information which follows.

NOTE: Given the multi-sectoral and collaborative nature of the Regional Initiatives to be described, this narrative does not provide resource details.

RPP Commitments 2004–2005	Report on Results
Enhanced relationships with other jurisdictions	**Quebec:** Follow-up on Harmonization Committee of Perinatal Programs for At-Risk Families in Local Community Services Centres. We participated in making changes to the pregnancy and childbirth information sheet used by the CLSCs so that information could be gathered on the clients served in the children's programs. The information will provide us with evidence and show the results of our actions. **Ontario/Nunavut:** Virtual Circle of Officials The Virtual Circle of Officials was established in 2003–2004 as a unique partnership between Health Canada, the Government of Nunavut, and the territories land claims Inuit organization, Nunavut Tunngavik Incorporated (NTI), to draw on information and communications technologies to support collaboration. Outcomes for the first year include enhanced communication between partners, community outreach and awareness of Health Canada's programs, as well as an environmental scan of family health in Nunavut.
Targeted research	**British Columbia/Yukon:** Urban Design and Health The BC and Yukon Region provided seed funding to a local community organization for a multi-sectoral research project entitled: Healthy Livable Communities: the Population and Urban Form Connection. The project involved consultation with key stakeholders and the development of an inventory of available data. Project outcomes included a literature review which highlighted a strong correlation between urban form and population health, as well as the development of a conceptual model to further research and analysis.
Strengthened stakeholder networks	**Ontario/Nunavut:** Great Lakes Public Health Network In 2004, the Ontario and Nunavut Region worked in partnership with the provincial Ministry of Health and Long-Term Care to design a structure for a Great Lakes Public Health Network. The Network is intended to facilitate information-sharing on environmental health issues among those federal and provincial governments mandated to protect public health in the Great Lakes Basin. The initiative is proceeding with a call for membership set for summer 2005. **Atlantic:** Atlantic Wellness Strategy The four Atlantic provincial Health Departments and Health Canada's Atlantic Region had been working together to develop an Atlantic Wellness Strategy, aimed initially at improving nutrition and activity levels in Atlantic Canada, with a focus on children and youth. Due to a number of factors, including structural changes within the Department and personnel changes among the partners, progress on the initiative has been slower than anticipated. However, work in relation to wellness continues on individual tracks within the four provinces, the Public Health Agency of Canada and Health Canada. Support for the initiative remains and an updated implementation strategy will be developed over 2005–2006.
Improved client service and reach	**Alberta/Northwest Territories:** SuperNet Pilot Project In collaboration with the Big Stone First Nations community, the Alberta/NWT Region will shortly connect the reserve's health centre to the provincial SuperNet, a high speed, broadband fibreoptic network. This connection to the broadband network allows for more reliable and less costly access to the Internet than the previous satellite link and will facilitate access to electronic health information and other services previously unavailable on-reserve.

RPP Commitments 2004–2005	Report on Results
	Manitoba/Saskatchewan: Comprehensive Evaluation The Manitoba/Saskatchewan Region's initiative to streamline the administration of financial and evaluation reporting for Early Childhood Development groups having multiple sources of funding was undertaken by the Population and Public Health Branch, now the Public Health Agency of Canada. For more information on Public Health Agency initiatives, visit their Web site at: http://www.phac-aspc.gc.ca/new_e.html

PRIORITY 3: ONGOING

Improve the Department's capacity to perform, harness, translate and use sound science to support evidence-based decision-making, thereby optimizing health outcomes and minimizing health risk for Canadians

The Chief Scientist provides science advice to the Deputy Minister and brings leadership, coherence and expertise to the overall strategic direction of Health Canada's scientific responsibilities. The Chief Scientist works to strengthen the Department's capacity to conduct quality science and provide science advice and to ensure that science informs the policies, programs and services that lead to better health for Canadians.

In 2004–2005, the Chief Scientist focused his efforts on:

Promoting effective use of science in policy making through the employment of quality scientific advice in policy and regulatory decisions.

Enhancing science capacity and quality to ensure that Health Canada has the capacity to meet current and emerging challenges for Canadians.

Raising awareness and understanding of science conducted at Health Canada.

Formalizing science policy and management in Health Canada, thereby enhancing its credibility as a scientific organization and enabling it to play a strong role with partners in advancing the federal Science and Technology Agenda.

RPP Commitments 2004–2005	Report on Results
Promoting Effective Use of Science in Policy Making: Development of a Framework for Science which will be used to enhance the quality and use of science to inform decisions about policies, regulations, and programs relevant to the health of Canadians	The Office of the Chief Scientist (OCS) sponsored an intra-departmental roundtable event to discuss science/policy interface. A diverse group of experts and policy makers discussed issues related to science policy gaps and building social capital. Participants identified strengths, obstacles and gaps. Discussions will be required to understand the challenges and further enhance science policy. An inventory of Health Canada's science programs and activities was developed. Lessons learned from the mapping exercise and further consultation with the scientific community highlighted areas for improvement in the performance and management of science. The Framework will also provide the basis for science planning and priority-setting and the establishment of integrated science partnerships. The Framework for Science will identify principles for science roles, and responsibilities for effective science management and use of science resources, as well as the operating conditions critical to the conduct of excellent science and technology.
Expert Science Advice	The OCS has begun to explore methods and databases that can assist the Department to identify appropriate external experts and facilitate the production of timely expert science advice for issues of critical importance. The OCS coordinated two sample case studies using external experts (for health/safety of Citronella and Drug Safety) and will analyze these to better determine methods of identifying experts, verifying credentials and identifying conflicts of interest, producing standard operating procedures and developing a database of known experts.

RPP Commitments 2004–2005	Report on Results
	The Science Advisory Board (SAB) provides a valued source of expert, independent advice to the Minister of Health on science performed and used by Health Canada, focusing on the future direction of scientific programs, emerging health sciences and scientific trends, scientific partnerships and linkages. The pervading theme for the Board's work in 2004–2005 was Managing Science in Times of Change and this was reflected in its provision of advice on public health issues related to the new Public Health Agency of Canada. The Board advised on departmental science needs and capacity, risk management strategies, and the need for openness and transparency in decision-making. Science conducted in the Department must meet ethical standards for research involving human subjects. With a mandate to make certain that "all research involving humans carried out by Health Canada meets the highest scientific ethical standards," the Research Ethics Board (REB) supports the Chief Scientist and Deputy Minister in proposing modifications or recommending approval, rejection, or termination of any proposed or ongoing research involving humans. The REB is active and its Secretariat which is located in the OCS, has developed a review process highly respected by departmental researchers. In 2004–2005, the REB reviewed 75 protocols.
Enhancing science capacity and quality	The Chief Scientist focused on science quality through the development of the Post-Doctoral Fellowship program which offers research opportunities to highly trained and qualified young professionals. The program exposes fellows to career opportunities at Health Canada, resulting in a pool of new scientific minds to serve the Department. The program currently supports 10 fellows, three of whom joined the program last year.
Raising awareness and understanding of science conducted at Health Canada through partnerships with stakeholders	The Chief Scientist is committed to working in partnership. The OCS is actively building partnerships to spur scientific advances that improve health. Most notable among the partnerships is the bond between Health Canada and the Canadian Institutes of Health Research (CIHR). The Chief Scientist fosters and facilitates that partnership by acting as a catalyst for collaborative research initiatives in areas of strategic importance. For example, in 2004–2005, Health Canada was an active scientific and funding partner in projects to reduce health disparities among Canadians. In addition, the OCS co-sponsored the Policy Forum on Health Disparities, which brought together researchers and federal and provincial officials to begin drafting policy. Other partnerships active throughout 2004–2005 include: The Safe Food and Water initiative with CIHR, the Severe Acute Respiratory Syndrome consortium with the Public Health Agency of Canada and CIHR, and innovative exchange programs with the Department of Foreign Affairs and International Trade. Canada has special expertise in coordinating efforts in global health research, demonstrated by the activities of the new Global Health Research Initiative (GHRI). GHRI is a unique partnership which brings together four federal agencies (Canadian International Development Agency, CIHR, Health Canada and International Development Research Centre), deploying their distinctive strengths to increase Canada's contributions to global health research and its use.

RPP Commitments 2004–2005	Report on Results
	Internationally, the Chief Scientist has been involved in forging partnerships with Africa, the UK, France and Spain. For example, he attended an Africa-Canada-UK seminar held in London, UK. This seminar was designed to explore how Canada and the UK could work together more effectively to build science and technology capacity with African partners. He also attended a bilateral meeting with the UK National Science Advisor and key UK scientists to discuss Canada-UK bilateral relations. These activities enable the Chief Scientist to build international linkages which cement innovative approaches for departmental scientists and scientists in developed and developing countries.
	The Science Forum has grown into a national showcase for Health Canada's innovative science. The 2004 Forum, which focused on Current Health Challenges Facing Canadians, included experts in law, environmental health, biotechnology, pharmacology and medicine. Discussions centred on science-based solutions to important health issues. The diversity of health-related disciplines provided a broad perspective, enriching the foundation for evidence-based decision-making affecting the health of Canadians. The 2004 Forum included a team of Russian scientists, adding an international perspective and opening the door for the sharing of research results and best practices at a global level. Science is key to helping Canadians maintain and improve their health. The OCS is committed to meeting the challenges of the 21st century with solid, effective and quality science.

PRIORITY 4: ONGOING

Implement Health Canada's component of the Federal Government's Official Languages Action Plan for increasing access to services in Official Language Minority Communities

During 2004–2005, our Department continued our responsibilities under the *Official Languages Act* and the Official Languages Action Plan, both in terms of responding to health system issues facing members of Official Language Minority Communities and in terms of ensuring our capacity to consult effectively with those communities.

RPP Commitments 2004–2005	Report on Results
Address the concerns of English and French-speaking minority language groups about access to health-related services	To date, through a combination of funding and collaborative effort, 27 community networks have been established across Canada; 140 post-secondary students from universities and colleges graduated from health programs in French; and, procedures have been put in place to begin language training for health professionals in fall 2005 in Quebec.
Develop a new policy on official languages	On December 1, 2004, Health Canada implemented a new policy to support Official Language Minority Communities (OLMC). This policy reflects the federal government's priority regarding access to health services for all Canadians, as outlined in the Prime Minister's response to the 2004 Speech from the Throne. Branches and regional offices will report on their activities and progress under this policy in Health Canada's annual *Status Report on the Implementation of Section 41 of the Official Languages Act*. Mechanisms implemented to encourage consultations include: updates of contact lists and regional databases containing OLMCs; invitation to OLMCs to participate in submitting project proposals under various programs and activities; participation of Health Canada officials on committees, subcommittees and working groups related to OLMCs; and in community workshops; and, participation of Health Canada employees at internal information sessions on the *Official Languages Act*.

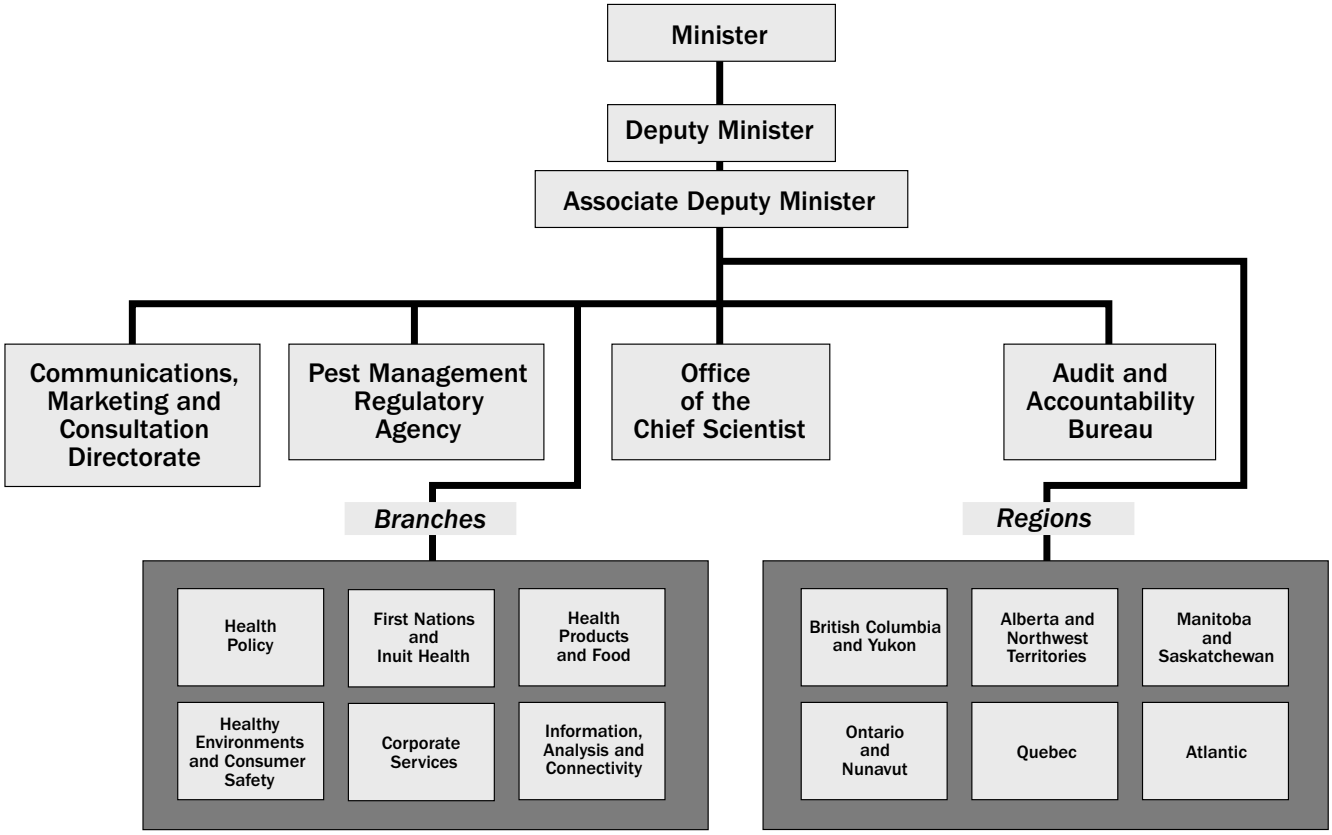
Section III

Supplementary Information

Organizational Chart

This organizational chart indicates the major division of responsibilities, accountabilities and corresponds to the Business Lines structure within Health Canada as of March 31, 2005.

There was one major change during 2004–2005. The former Population and Public Health Branch became the basis of the new Public Health Agency of Canada (PHAC), effective September 24, 2004. This change is described in detail in Section I of this Report in the Summary of Performance.



For more information: http://www.hc-sc.gc.ca/ahc-asc/branch-dirgen/index_e.html

Crosswalk between Business Lines and Program Activities Main Estimates 2005–2006

(MILLIONS OF DOLLARS)

Business Lines	Program Activities					Total
	Health Policy, Planning and Information (HPPI)	Health Products and Food (HPF)	Healthy Environments and Consumer Safety (HECS)	Pest Control Product Regulation (PCPR)	First Nations and Inuit Health (FNIH)	
Health Care Policy (HCP)	356.4					**356.4**
Health Promotion and Protection (HPP)		184.0	211.7	41.4		**437.1**
First Nations and Inuit Health (FNIH)					1,684.6	**1,684.6**
Information and Knowledge Management (IKM)	50.3	14.3	14.4	3.3	25.0	**107.3**
Departmental Management and Administration (DMA)	15.3	41.2	41.6	9.3	123.8	**231.2**
Main Estimates —Net Program Spending	**422.0**	**239.5**	**267.7**	**54.0**	**1,833.4**	**2,816.6**

Financial Table 1: Comparison of Planned to Actual Spending (incl. FTEs) (MILLIONS OF DOLLARS)

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

The $141.2 million increase from Main Estimates to Planned Spending is due to anticipated funding for such initiatives as the Pan-Canadian Public Health System, Canadian Diabetes Strategy, Labrador Innu Healing Strategy, and Assisted Human Reproduction Agency.

The $424.2 million decrease from Planned Spending to Total Authorities is mainly due to the creation of the Public Health Agency of Canada (PHAC) on September 24, 2004 and the subsequent transfer of funds. Also of significance was the funding reduction related to the new advertising management process announced by Cabinet in March 2004.

The $66.7 million difference between Total Authorities and Actual Spending is mainly the result of:

- Therapeutics Access Strategy (TAS) funding to be carried forward for future year requirements;
- decrease in Non-Insured Health Benefits planned spending;
- delays in Indian Residential Schools Program;
- delays in the implementation of certain advertising initiatives;
- year end adjustments of Department of Justice (DOJ) expenditures;

The $1,375.8 million increase in spending from 2002–2003 to 2003–2004 is mainly the result of funding for SARS/WNv/BSE and the payment of four large grants (Province of Ontario for SARS, Canada Health Infoway Inc., Canadian Health Services Research Foundation, and Canadian Institute for Health Information).

Business Lines	2002–2003 Actual Spending	2003–2004 Actual Spending	2004–2005			
			Main Estimates	Planned Spending (1)	Actual Authorities (2)	Actual Spending (2)
Health Care Policy	133.1	324.4	369.7	378.4	363.3	356.4
Health Promotion and Protection	802.2	1,173.9	825.3	929.9	452.7	437.1
First Nations and Inuit Health	1,465.4	1,553.9	1,677.3	1,701.9	1,709.1	1,684.6
Information and Knowledge Management	111.1	767.1	98.4	98.7	107.9	107.3
Departmental Management and Administration	206.1	274.4	195.6	198.6	250.3	231.2
Total	**2,717.9**	**4,093.7**	**3,166.3**	**3,307.5**	**2,883.3**	**2,816.6**
Less: Non-Respendable Revenue	-35.2	-56.0	0.0	-8.6	-8.6	-51.3
Plus: Cost of services received without charge*	78.5	89.5	0.0	86.8	86.8	58.9
Net Cost of Department	**2,761.2**	**4,127.2**	**3,166.3**	**3,385.7**	**2,961.5**	**2,824.2**
Full-Time Equivalents	**8,833**	**9,572**	**9,020**	**9,133**	**7,778**	**8,026**

1) from the 2004–2005 Report on Plans and Priorities

2) from the 2004–2005 Public Accounts

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

Financial Table 2: Use of Resources by Business Lines

(MILLIONS OF DOLLARS)

This table reflects how resources are used within Health Canada by appropriation and by business line.

Business Lines	Operating	Capital	Grants and Contributions	Total Gross Expenditures	Less: Respendable Revenues	Total Net Expenditures
Health Care Policy						
(Main Estimates)	75.7		294.0	369.7		369.7
(Planned spending)	84.4		294.0	378.4		378.4
(Total authorities)	*85.8*		*277.5*	*363.3*		*363.3*
(Actual spending)	**82.9**		**273.5**	**356.4**		**356.4**
Health Promotion and Protection						
(Main Estimates)	618.4		267.3	885.7	-60.4	825.3
(Planned spending)	712.8		277.5	990.3	-60.4	929.9
(Total authorities)	*470.8*		*43.2*	*514.0*	*-61.3*	*452.7*
(Actual spending)	**445.5**		**42.9**	**488.4**	**-51.3**	**437.1**
First Nations and Inuit Health						
(Main Estimates)	943.1		739.7	1,682.8	-5.5	1,677.3
(Planned spending)	950.4		757.0	1,707.4	-5.5	1,701.9
(Total authorities)	*932.6*	*0.3*	*781.7*	*1,714.6*	*-5.5*	*1,709.1*
(Actual spending)	**908.9**	**0.3**	**779.4**	**1,688.6**	**-4.0**	**1,684.6**
Information & Knowledge Management						
(Main Estimates)	76.4		22.0	98.4		98.4
(Planned spending)	76.7		22.0	98.7		98.7
(Total authorities)	*80.1*		*27.8*	*107.9*		*107.9*
(Actual spending)	**79.8**		**27.5**	**107.3**		**107.3**
Departmental Management & Administration						
(Main Estimates)	171.6	3.9	20.8	196.3	-0.7	195.6
(Planned spending)	174.7	3.9	20.7	199.3	-0.7	198.6
(Total authorities)	*195.7*	*3.0*	*52.3*	*251.0*	*-0.7*	*250.3*
(Actual spending)	**176.4**	**3.0**	**52.3**	**231.7**	**-0.5**	**231.2**
Total						
(Main Estimates)	1,885.2	3.9	1,343.8	3,232.9	-66.6	3,166.3
(Planned spending)	1,999.0	3.9	1,371.2	3,374.1	-66.6	3,307.5
(Total authorities)	*1,765.0*	*3.3*	*1,182.5*	*2,950.8*	*-67.5*	*2,883.3*
(Actual spending)	**1,693.5**	**3.3**	**1,175.6**	**2,872.4**	**-55.8**	**2,816.6**

The variance in the Health Promotion and Protection Business Line between Planned Spending and Total Authorities is mainly due to the creation of the Public Health Agency of Canada (PHAC) on September 24, 2004 and the subsequent transfer of funds (Operating, Grants & Contributions) as well as a funding reduction related to the new advertising management process announced by Cabinet in March 2004.

The variance in Departmental Management and Administration between Planned Spending and Total Authorities is mainly related to funding (contributions) to support First Nations' construction and restoration of on-reserve facilities and funding for the implementation of specific advertising initiatives.

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

Financial Table 3: Voted and Statutory Items (MILLIONS OF DOLLARS)

This table basically replicates the summary table listed in the Main Estimates. Resources are presented to Parliament in this format. Parliament approves the voted funding and the statutory information is provided for information purposes.

Vote		2004–2005			
		Main Estimates	Planned Spending (1)	Total Authorities (2)	Actual Spending (2)
Health Canada					
1	Operating Expenditures	1,702.4	1,814.9	1,602.3	**1,542.7**
5	Grants and Contributions	1,343.8	1,371.2	1,182.6	**1,175.7**
(S)	Minister's Salary and Car Allowance	0.1	0.1	0.1	**0.1**
(S)	Payments for insured health services and extended health care services	—	—	-0.1	**-0.1**
(S)	Canada Health Infoway Inc.	—	—	0.0	**0.0**
(S)	Spending of proceeds from the disposal of surplus Crown assets	—	—	0.3	**0.1**
(S)	Refunds from previous years' Revenue	—	—	0.1	**0.1**
(S)	Collection agency fees	—	—	0.0	**0.0**
(S)	Contributions to employee benefit plans	120.0	121.3	98.0	**98.0**
Total Department		**3,166.3**	**3,307.5**	**2,883.3**	**2,816.6**

1) from the 2004–2005 Report on Plans and Priorities
2) from the 2004–2005 Public Accounts
S) indicates expenditures the Department is required to make that do not require an appropriation act.

Financial Table 4: Net Cost of Department (MILLIONS OF DOLLARS)

	2004–2005
Total Actual Spending	2,816.6
Plus: Services without Charge	
Accommodation provided by PWGSC	10.3
Contributions covering employer's share of employees' insurance premiums and expenditures paid by TBS	44.5
Workers' compensation coverage provided by Social Development Canada	0.8
Salary and associated expenditures of legal services provided by Justice Canada	3.3
Less: Non-Respendable Revenue	*-51.3*
2004–2005 Net Cost of Department	**2,824.2**

Financial Table 5: Contingent Liabilities

The Department is involved in individual and class action suits against the Government, mainly involving allegations of negligence relating to the regulation of medical devices, blood and drug products. Because of the early stage of the litigation in these cases, and the complexity of the issues, it is not possible to provide a reasoned assessment of contingent liability at this time.

Financial Table 6: Sources of Respendable and Non-Respendable Revenue (MILLIONS OF DOLLARS)

Reflected in this table is the collection of respendable revenues by business line/service line and of non-respendable revenues by classification and source.

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

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

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

	2002–2003 Actual Revenues	2003–2004 Actual Revenues	2004–2005			
			Main Estimates	Planned Revenues	Total Authorities	Actual Revenues
RESPENDABLE REVENUES						
Business Lines/Service Lines						
Health Promotion and Protection						
Population and Public Health	0.1	0.1	0.0	0.0	0.0	0.0
Health Products and Food	32.2	34.2	40.7	40.7	40.7	34.7
Healthy Environments and Consumer Safety	7.5	8.6	12.7	12.7	13.6	10.5
Pest Management Regulation	6.8	6.6	7.0	7.0	7.0	6.1
First Nations and Inuit Health						
First Nations and Inuit Health	5.9	3.5	5.5	5.5	5.5	4.0
Departmental Management and Administration						
Corporate Services	0.4	0.5	0.7	0.7	0.7	0.5
Total Respendable Revenues	**52.9**	**53.5**	**66.6**	**66.6**	**67.5**	**55.8**
NON-RESPENDABLE REVENUES						
Main Classification and Source						
Non-tax revenues						
Refunds of expenditures	27.0	43.9				41.8
Sales of goods and services	0.7	6.1				2.5
Other fees and charges	7.2	5.8		8.6	8.6	6.8
Proceeds from the disposal of surplus Crown assets	0.3	0.2				0.2
Miscellaneous non-tax revenues	0.0	0.0				
Total Non-Respendable Revenues	**35.2**	**56.0**	**0.0**	**8.6**	**8.6**	**51.3**
Total Revenues	**88.1**	**109.5**	**66.6**	**75.2**	**76.1**	**107.1**

The variance between 2002–2003 and 2003–2004 for actual respendable revenues in First Nations and Inuit Health is due to the transfer to provincial jurisdiction of $3.6 million in revenue authorities related to the Sioux Lookout Hospital.

The variance between 2003–2004 and 2004–2005 for actual respendable revenues in Healthy Environments and Consumer Safety is due to an increase in the respendable authority for Medical Devices.

Financial Table 7: Resource Requirements by Branch

(MILLIONS OF DOLLARS)

Comparison of Main Estimates, 2004–2005 (RPP) planned spending and total authorities to actual spending by organization and business line.

Organization	Business Lines					
	Health Care Policy	Health Promotion and Protection	First Nations and Inuit Health	Information and Knowledge Management	Departmental Management and Administration	Total
Health Policy						
(Main Estimates)	369.7					369.7
(Planned spending)	378.4					378.4
(Total authorities)	*363.3*					*363.3*
(Actual Spending)	**356.4**					**356.4**
Population and Public Health						
(Main Estimates)		375.2				375.2
(Planned spending)		472.8				472.8
(Total authorities)						*0.0*
(Actual Spending)						**0.0**
Health Products and Food						
(Main Estimates)		179.9				179.9
(Planned spending)		183.4				183.4
(Total authorities)		*198.1*				*198.1*
(Actual Spending)		**184.0**				**184.0**
Healthy Environments and Consumer Safety						
(Main Estimates)		232.0				232.0
(Planned spending)		235.4				235.4
(Total authorities)		*212.9*				*212.9*
(Actual Spending)		**211.7**				**211.7**
Pest Management Regulatory Agency						
(Main Estimates)		38.2				38.2
(Planned spending)		38.3				38.3
(Total authorities)		*41.7*				*41.7*
(Actual Spending)		**41.4**				**41.4**
First Nations and Inuit Health						
(Main Estimates)			1,677.3			1,677.3
(Planned spending)			1,701.9			1,701.9
(Total authorities)			*1,709.1*			*1,709.1*
(Actual Spending)			**1,684.6**			**1,684.6**
Information, Analysis and Connectivity						
(Main Estimates)				98.4		98.4
(Planned spending)				98.7		98.7
(Total authorities)				*107.9*		*107.9*
(Actual Spending)				**107.3**		**107.3**

Financial Table 7: Resource Requirements by Branch (cont'd)

Organization	Business Lines					
	Health Care Policy	Health Promotion and Protection	First Nations and Inuit Health	Information and Knowledge Management	Departmental Management and Administration	Total
Corporate Services						
(Main Estimates)					92.7	92.7
(Planned spending)					93.6	93.6
(Total authorities)					*107.9*	*107.9*
(Actual Spending)					**94.5**	**94.5**
Departmental Executive						
(Main Estimates)					102.9	102.9
(Planned spending)					105.0	105.0
(Total authorities)					*142.4*	*142.4*
(Actual Spending)					**136.7**	**136.7**
Total						
(Main Estimates)	369.7	825.3	1,677.3	98.4	195.6	3,166.3
(Planned spending)	378.4	929.9	1,701.9	98.7	198.6	3,307.5
(Total authorities)	*363.3*	*452.7*	*1,709.1*	*107.9*	*250.3*	*2,883.3*
(Actual Spending)	**356.4**	**437.1**	**1,684.6**	**107.3**	**231.2**	**2,816.6**
% of Total	**12.7%**	**15.5%**	**59.8%**	**3.8%**	**8.2%**	**100.0%**

Note: *The creation of the Public Health Agency of Canada (PHAC) on September 24, 2004 and the subsequent transfer of funds to PHAC from the Population and Public Health Branch (PPHB), as well as related corporate support services, resulted in total authorities and actual spending being reported in the PHAC 2004–2005 DPR.*

Financial Table 8A: *User Fees Act*

HEALTH PRODUCTS AND FOOD BRANCH (HPFB)											
A.				2004–05					Planning Years		
User Fee	Fee Type	Fee Setting Authority	Date Last Modified	Forecast Revenue[1] ($000)	Actual Revenue[1] ($000)	Full Cost[2] ($000)	Performance Standard	Performance Results	Fiscal Year	Forecast Revenue[1] ($000)	Estimated Full Cost[2] ($000)
Authority to Sell Drugs Fees	Regulatory (R)	*Financial Administration Act* (FAA)	December 1994	$7,926	$8,001	$25,726	Standard to be developed.	Not applicable.	2005–06 2006–07 2007–08	$7,985 $8,039 $8,094	Not available.
Certificate of a Pharmaceutical Product (Drug Export) Fees	Other (O)	Ministerial authority to enter into contract	May 2000	$119	$120	$189	5 working days	10 working days	2005–06 2006–07 2007–08	$120 $120 $120	Not available.
Drug Establishment Licensing Fees	Regulatory (R)	*Financial Administration Act* (FAA)	December 1997	$5,972	$4,212	$9,911	Standard to be developed.	Not applicable.	2005–06 2006–07 2007–08	$5,031 $5,141 $5,195	Not available.
Drug Master File Fees	Other (O)	Ministerial authority to enter into contract	January 1996	$81	$101	$402	Standard to be developed.	Not applicable.	2005–06 2006–07 2007–08	$98 $98 $98	Not available.
Drug Submission Evaluation Fees	Regulatory (R)	*Financial Administration Act* (FAA)	August 1995	$17,373	$16,811	$56,671	**Pharmaceuticals[3,6]**		2005–06 2006–07 2007–08	$18,584 $18,693 $18,802	Not available.
							NDS: Priority NAS = 180	178			
							NDS: Priority Clin/C&M = 180	369			
							NDS: NOC-C NAS & Clin/C&M = 200	278			
							NDS: NAS = 300	367			
							NDS: Clin/C&M = 300	407			
							NDS: Clin only = 300	462			
							NDS: Comp/C&M = 180	203			
							ANDS: Comp/C&M = 180	231			
							ANDS: C&M/Labelling = 180	305			
							SNDS: Priority Clin Only = 180	155			
							SNDS: Clin/C&M = 300	359			
							SNDS: Comp/C&M = 180	222			
							SNDS: Clin only = 300	311			
							SNDS: C&M/Labelling = 180	191			
							SNDS: Rx to OTC (switch) —no new indication = 180	317			
							SNDS: Labelling only = 60	49			

Financial Table 8A: *User Fees Act* (cont'd)

A. User Fee	Fee Type	Fee Setting Authority	Date Last Modified	2004–05 Forecast Revenue[1] ($000)	2004–05 Actual Revenue[1] ($000)	2004–05 Full Cost[2] ($000)	2004–05 Performance Standard	2004–05 Performance Results	Planning Years Fiscal Year	Planning Years Forecast Revenue[1] ($000)	Planning Years Estimated Full Cost[2] ($000)
							SANDS: Clin only = 300	297			
							SANDS: Comp/C&M = 180	227			
							SANDS: C&M/Labelling = 180	164			
							SANDS: Labelling only = 60	115			
							DIN with data = 210	289			
							DIN form only = 180	183			
							Biological Products[3,6]				
							NDS: Priority NAS = 180	743			
							NDS: NAS = 300	888			
							NDS: Clin/C&M = 300	908			
							SNDS: Clin/C&M = 300	669			
							SNDS: Comp/C&M = 180	101			
							SNDS: Clin only = 300	763			
							SNDS: C&M/Labelling = 180	403			
							DIN with data = 210	185			
							DIN form only = 180	103			
Medical Device Licence Application Fees	Regulatory (R)	*Financial Administration Act* (FAA)	August 1998	$2,688	$3,482	$8,562	**Medical Devices[4]**		2005–06 2006–07 2007–08	$3,244 $3,352 $3,460	Not available.
							Class II = 15	17			
							Class III = 75	67			
							Class III Significant Change = 75	69			
							Class IV Priority = 45	16			
							Class IV = 90	78			
							Class IV Significant Change = 90	67			
Fees for Right to Sell a Licensed Medical Device	Regulatory (R)	*Financial Administration Act* (FAA)	August 1998	$2,150	$2,367	$7,249	Standard to be developed.	Not applicable.	2005–06 2006–07 2007–08	$1,622 $1,730 $1,784	Not available.
Medical Device Establishment Licensing Fees	Regulatory (R)	*Financial Administration Act* (FAA)	January 2000	$1,935	$2,131	$5,995	Standard to be developed.	Not applicable.	2005–06 2006–07 2007–08	$2,055 $2,163 $2,271	Not available.

Financial Table 8A: *User Fees Act* (cont'd)

A. User Fee	Fee Type	Fee Setting Authority	Date Last Modified	2004–05 Forecast Revenue[1] ($000)	2004–05 Actual Revenue[1] ($000)	2004–05 Full Cost[2] ($000)	2004–05 Performance Standard	2004–05 Performance Results	Planning Years Fiscal Year	Planning Years Forecast Revenue[1] ($000)	Planning Years Estimated Full Cost[2] ($000)
Veterinary Drug Evaluation Fees	Regulatory (R)	*Financial Administration Act* (FAA)	March 1996	$802	$665	$7,252	**Veterinary Drug Products[5,6]** NDS, ABNDS = 300 SNDS, SABNDS = 240 Admin = 90 DIN = 120 NC = 90 INDS/ESC = 60 Labels = 45 Emergency Drug Release = 2	Veterinary Drugs Directorate had targeted to issue decisions on 90% of data packages more than 24 months old as of April 1, 2003, and to issue decisions on 90% of data packages more than 18 months old as of April 1, 2004; these targets were met.	2005–06 2006–07 2007–08	$716 $776 $806	Not available.
HPFB Subtotal	Regulatory (R)			$38,846	$37,669	$121,366			2005–06 2006–07 2007–08	$39,237 $39,894 $40,412	
HPFB Subtotal	Other (O)			$200	$221	$591			2005–06 2006–07 2007–08	$218 $218 $218	
HPFB TOTAL				$39,046	$37,890	$121,957			2005–06 2006–07 2007–08	$39,455 $40,112 $40,630	

PEST MANAGEMENT REGULATORY AGENCY (PMRA)

A. User Fee	Fee Type	Fee Setting Authority	Date Last Modified	2004–05 Forecast Revenue[1] ($000)	2004–05 Actual Revenue ($000)	2004–05 Full Cost[7] ($000)	2004–05 Performance Standard	2004–05 Performance Results	Planning Years Fiscal Year	Planning Years Forecast Revenue ($000)	Planning Years Estimated Full Cost ($000)
Fees to be paid for Pest Control Product Application Examination Service	Regulatory (R)	*Pest Control Products Act* (PCPA)	April 1997	2,657	2,285	20,380	Target is 90% of submissions in all categories to be processed within the time shown. http://www.pmra-arla.gc.ca/english/pdf/pro/pro9601-e.pdf		2005–06 2006–07 2007–08	8,000 8,000 8,000	46,554 46,157 46,820

Financial Table 8A: *User Fees Act* (cont'd)

A. User Fee	Fee Type	Fee Setting Authority	Date Last Modified	2004–05 Forecast Revenue[1] ($000)	2004–05 Actual Revenue ($000)	2004–05 Full Cost[7] ($000)	2004–05 Performance Standard	2004–05 Performance Results	Planning Years Fiscal Year	Planning Years Forecast Revenue ($000)	Planning Years Estimated Full Cost ($000)
							Category A* includes Standard (550 days); User Request Minor Use Registration (URMUR) (365 days); Joint reviews (variable); and Reduced-risk (variable) Category B* includes Standard/priority (365 days); and Reduced-risk (variable) Category C* includes Standard (180 or 225 days); and Priority (98 days) *Includes deviations from the Management of Submission Policy	Category A = 70% Category B = 93% Category C = 94%			
Fees to be paid for a Right or Privilege to Manufacture or Sell a Pest Control Product in Canada and for Establishing a Maximum Residue Limit in relation to a Pest Control Product	Regulatory (R)	*Financial Administration Act* (FAA)	April 1997	5,343	4,594	27,120	Not applicable.	Not applicable.			
PMRA	Subtotal ®) $8,000 Subtotal (O) $0 Total $8,000	Subtotal ®) $6,879 Subtotal (O) $0 Total $6,879							Subtotal 2005–06 Subtotal 2006–07 Subtotal 2007–08	$8,000 $8,000 $8,000 Total: $24,000	

Note: Full cost is based on reported actuals for PMRA in 2004–2005 and based on Main Estimates for subsequent years.

Financial Table 8A: *User Fees Act* (cont'd)

CORPORATE SERVICES BRANCH (CSB)											
A.				2004–05					Planning Years		
User Fee	Fee Type	Fee Setting Authority	Date Last Modified	Forecast Revenue ($000)	Actual Revenue ($000)	Full Cost ($000)	Performance Standard	Performance Results	Fiscal Year	Forecast Revenue ($000)	Estimated Full Cost ($000)
Fees charged for the processing of access requests filed under the *Access to Information Act*	Other (O)	*Access to Information Act*	1992	Not applicable. (See Note 8)	$20.3	$1,700 (See Note 9)	Framework under development by Treasury Board Secretariat (TBS). More information: http://lois.justice.gc.ca/en/a-1/8.html	Statutory deadlines met 73% of the time.	2005–06 2006–07 2007–08	Not applicable. (See Note 8)	$1,700 $1,700 $1,700 (See Note 9)

B. DATE LAST MODIFIED:

Not applicable.

C. OTHER INFORMATION:

Health Products and Food Branch (HPFB)

[1] *Forecast and actual revenue are reported as gross, based on a modified cash accounting basis.*

[2] *Under the External Charging Initiative, HPFB is in the process of implementing an external charging framework, which includes a new costing model that has been developed with stakeholder involvement. The new costing model and related methodology will result in revised cost estimates in 2005–06 and future reporting cycles.*

[3] *Drug Submission Review: performance standards and results reflect average calendar days for review completions (positive or negative outcome); performance results are for 2004 calendar year. Detailed performance targets for drug submission review can be found at http://www.hc-sc.gc.ca/dhp-mps/alt_formats/hpfb-dgpsa/pdf/prodpharma/mands_gespd_e.pdf*

Comprehensive information on performance results for drug review can be found at http://www.hc-sc.gc.ca/dhp-mps/prodpharma/applic-demande/docs/perform-rendement/ar-ra/index_e.html#2004

[4] *Medical Device Application Review: performance standards and results reflect calendar days to first review decision; performance results are from July 1, 2004 to March 31, 2005. Detailed performance targets for medical device application review can be found at http://www.hc-sc.gc.ca/dhp-mps/md-im/applic-demande/pol/mdlapp_demhim_pol_e.html*

[5] *Veterinary Drug Product Submission Review: performance standards reflect average calendar days for review completions (positive or negative outcome) for 2008–2009. Detailed performance targets for veterinary drug submission review can be found at http://www.hc-sc.gc.ca/dhp-mps/legislation/vet/pol/index_e.html Veterinary Drugs Directorate has committed to issuing a decision on 90% of data packages more than 12 months old as of April 1, 2005.*

[6] *Acronyms*

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

Pest Management Regulatory Agency (PMRA)

[7] *Full cost includes Employee Benefits Plan (EBP) plus 13% to account for other government departments'(OGD) services (Public Works and Government Services Canada).*

Corporate Services Branch (CSB)

[8] *Due to the nature and varying complexity of ATI requests, it is unknown what fees may be applicable until a request is processed. Under certain circumstances, fees may be waived.*

[9] *The Full Cost of Health Canada's ATIP Division. There are further expenses incurred in program areas to compile additional materials associated with ATI requests. Health Canada will assess these costs and report more fully in the 2005–2006 DPR. The ATIP revenue collected includes figures from PHAC. Health Canada will continue to report ATI revenue until PHAC has established an ATI operation. The ATI revenues have ranged between $20K–$50K over the past few years.*

Financial Table 8B: Policy on Service Standards for External Fees

HEALTHY ENVIRONMENTS AND CONSUMER SAFETY BRANCH (HECS)			
A. External Fee	Service Standards*	Performance Results*	Stakeholder Consultation
National Dosimetry Services (NDS)	Registration and verification of incoming dosimeters within 48 hours. Urgently needed dosimeters deliverable within 2 working days. Exposures over regulatory limits reported within 24 hours. Dosimeters leave NDS premises 10–13 working days prior to exchange date. Message call back within 24 hours. Updated account information within 48 hours. Additional dosimeters shipped within 24 hours. Exposure Reports sent out within 10 days of dosimeter receipt.	Provided timely, responsive and reliable customer service to 95,000 workers in 13,000 groups. The standards for dosimeters were met: • 99% for registration/ verification of incoming dosimeters within 48 hours; • 99% dosimeters urgently needed delivered within 2 working days; • 100% exposures over regulatory limits reported within 24 hours; • 95% dosimeters leave NDS premises 10–13 working days prior to exchange date; • 99% message call back within 24 hours; • 99% updated account information within 48 hours; • 99% additional dosimeters shipped within 24 hours; • 90% Exposure Reports sent out within 10 days of dosimeter receipt.	Following public consultation, and with Treasury Board approval, the new National Dosimetry Services user fees were implemented as of July 1, 2004. The public consultations were structured around the fee increase. The service standards remained the same. Public consultations indicated satisfaction with existing levels of service and a willingness to absorb higher user fees.
Deratting Services	Health Canada provides 7-day service in designated ports and responds to all requests within 48 hours. See Note 1 below.	100% of all requests received were responded to within 48 hours or less.	There were no changes to service standards in 2004–2005. Changes are anticipated within the next 2 to 5 years due to new International Health Regulations (WHO). Stakeholders will be consulted in advance.

Financial Table 8B: Policy on Service Standards for External Fees (cont'd)

A. External Fee	Service Standards*	Performance Results*	Stakeholder Consultation
Cruise Ship Inspection Program	Periodic inspections done a minimum of once a sailing season on ships in Canadian waters. Final reports submitted within 10 working days. Re-inspection on any ships with scores of less than 85%.	See Notes 2 and 3 below. 100% completion achieved.	There were no changes to service standards in 2004–2005. Health Canada meets with stakeholders on an annual basis to review and discuss any proposed changes to service standards. The standards are consistent with the U.S. Centers for Disease Control and Prevention Vessel Sanitation Program administrative guideline and criteria for inspections, and any changes would be synchronized to harmonize the process with the U.S.
Common Carriers Inspection (e.g. trains, ferries, airports/airlines, seaports/marinas)	See Note 3 below.	See Note 4 below.	Service standards are negotiated and included in MOUs and any changes would also need to be negotiated. A new MOU was created with Via Rail in 2004–2005 and these service standards are part of the MOU. All other service standards MOUs remain unchanged.

NOTE: *HECS fees are not subject the User Fees Act and hence are not included in Table 8A.*

* *As established pursuant to the Policy on Service Standards for External Fees:*

- *Service standards may not have received Parliamentary review*
- *Service standards may not respect all performance standard establishment requirements under the User Fees Act (UFA) (e.g. international comparison, independent complaint address)*

Performance results are not legally subject to UFA section 5.1 regarding fee reductions for failed performance.

Financial Table 8B: Policy on Service Standards for External Fees (cont'd)

Note 1: *In total, 704 Derat Certificates were issued in 2004–2005. See table below for details on service standards.*

Day of the week	***Prior Notification Required***
Weekday Service — Designated Ports	*24 hours*
Weekend Service — Designated Ports	*48 hours*
Regular Weekend Service Designated Ports	• *For service on Saturday, notice must be received Thursday by 1300 hours local time.* • *For service on Sunday, notice must be received Friday by 1300 hours local time.*
Holiday Weekend Service Designated Ports	When Friday is the statutory holiday: • *for service on Friday, notice must be received Wednesday by 1300 hours local time.* • *for service on Saturday or Sunday, notice must be received Thursday by 1300 hours local time.*
	When Monday is the statutory holiday: • *for service on Saturday, notice must be received Thursday by 1300 hours local time.* • *for service on Sunday or Monday, notice must be received Friday by 1300 hours local time.*
Prior Notice for Service — Non-designated Ports	*72 hours prior notice is requested for service at non-designated ports.*
NOTE: The fee for short notice service i.e. less than 24 hours for weekdays, less than 48 hours for weekends, at both designated and non-designated ports, will be the normal fee plus a 25% surcharge.	

Note 2: *Health Canada publishes scores obtained from the Cruise Ship Inspection Program on its Web site at http://www.hc-sc.gc.ca/hl-vs/travel-voyage/general/inspection/2004-cruise_ship_inspection-navires_croissieres_inspection_e.html*

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

Note 4: *Service Standards for Common Carrier Inspection Program*

Common Carrier Inspection Program	***Service Standards***	***Performance Results***
Passenger Train — On Board	*Periodic inspection done on each passenger train line as determined by MOU between Health Canada and passenger train industry.* *Final periodic inspection report provided to industry within 10 working days.*	*100% of all reports provided within 10 days.*
Passenger Train — Off Board	*Sanitation inspection done twice a year.* *Final sanitation report provided to industry within 10 working days.*	*100% of all reports provided within 10 days.*
Flight Kitchen	*Scheduled number of periodic announced audits per year based on size of kitchen.* *Final audit inspection report provided within 5 working days of inspection.*	*100% of all reports provided within 5 days.*
Ferry — On Board Food	*Unannounced inspections as per predetermined contractual obligations.* *Final inspection report provided within 10 working days of inspection.*	*100% of all reports provided within 10 days.*
Ferry — Potable Water	*Annual inspection as per Potable Water Regulations for Common Carriers.* *100% of all reports provided within 10 days.*	*100% of all reports provided within 10 days.*

Financial Table 9: Major Regulatory Initiatives

Regulations	Expected Results	Performance Measurement Criteria	Results Achieved
Health Products and Food Branch			
Food and Drug Regulations—Addition of Vitamins and Mineral Nutrients to Foods	Appropriate revision of regulations on the addition of vitamins and mineral nutrients to foods taking into account the role of nutrient addition to foods, consumer needs and expectations, and industry requests.	Improvement in the nutritional quality of the food supply. Greater variety of food products containing added vitamins and mineral nutrients available to consumers.	On March 31, 2005, Health Canada released a proposed new policy on food fortification entitled: Addition of Vitamins and Minerals to Food, 2005: Health Canada's Proposed Policy and Implementation Plans. This document informed all interested parties of the proposed policy, as well as plans for its implementation.
Food and Drug Regulations—Enhanced Labelling of Food Allergens	Mandatory labelling of specific food allergens, and sulphites when present at 10 parts per million or more, on the labels of prepackaged food products.	Reduced number of adverse reactions to foods containing specified allergens and sulphites used in the preparation of prepackaged foods.	A second letter of notification was sent to stakeholders in September 2004. This letter contained revised policy recommendations in regard to exempting fining agents from eggs, milk and fish used in the production of alcoholic beverages from the requirements for labelling at this time. The proposed regulatory amendments are anticipated to be in *Canada Gazette*, Part I in fall 2005.
Food and Drug Regulations (Food Irradiation)	Optional use of the food irradiation process for ground beef, poultry, shrimp and prawns and mangoes to control pathogens, reduce microbial load and insect infestation and extend shelf life.	Reduced levels of pathogens and insect infestations in irradiated food products. Extended shelf life for irradiated food products.	Health Canada examined all comments received as a result of publication in *Canada Gazette*, Part I in November 2002. Responses to comments are being finalized. A multi-stakeholder workshop was held on March 29, 2005 to discuss approaches to address consumer concerns about the absence of labelling requirements for irradiated foods served in food service and restaurant establishments.

Financial Table 9: Major Regulatory Initiatives (cont'd)

Regulations	Expected Results	Performance Measurement Criteria	Results Achieved
			The use of food irradiation by industry would remain optional. The results of this initiative would be measured after the use of food irradiation has been broadly implemented by industry.
Food and Drug Regulations — Revisions to Division 12 — Prepackaged Water and Ice	Modernization and expansion of the safety and labelling requirements for prepackaged water and ice products.	Compliance of bottled water products with the revised regulations.	Health Canada and the Canadian Food Inspection Agency (CFIA) conducted an additional targeted consultation with stakeholders on proposed limits for certain chemical contaminants and proposed scheme for classification of surface waters. The results of this consultation are being analyzed. Proposed regulations are anticipated for publication in *Canada Gazette*, Part I in winter 2006.
Environmental Assessment Regulations (EAR) for assessment of new substances in products regulated under the *Food and Drugs Act* for their impacts on human health and the environment will be developed as Health Canada's response to the *Canadian Environmental Protection Act* (CEPA 1999)	Regulations that are appropriate for new substances in range of products regulated under the *Food and Drugs Act*. CEPA's New Substance Notification Requirements currently apply to substances in *Food and Drugs Act* products. Strategy to deal with substances in *Food and Drugs Act* products already in commerce will also be considered as part of this work.	An increase in the information on the impacts and/or potential impacts new substances in *Food and Drugs Act* regulated products may be having on human health and the environment. An enhanced regulatory framework to enable Health Canada to deal more effectively with any such impacts identified.	Options Analysis Paper to permit stakeholders to provide comments on three possible regulatory options for these EAR regulations received Deputy Minister approval in March 2005. Consultation launched with stakeholders in spring 2005. In-depth discussions between Health Canada and stakeholders will follow in fall 2005, with identification of one or more workable options for the development of appropriate EAR regulations anticipated.

Financial Table 9: Major Regulatory Initiatives (cont'd)

Regulations	Expected Results	Performance Measurement Criteria	Results Achieved
Access to Medicines—Project 1402	Amendments to the *Food and Drugs Act* and Food and Drug Regulations and Medical Devices Regulations that will allow Health Canada to put in place a program to implement the World Trade Organization's General Council decision of August 30, 2004 to provide access to affordable medicines in developing and least developed countries.	Under this regime, these products will meet Canadian standards for safety, efficacy and quality. Canada's Access to Medicines Program and these regulations will not affect Canadians' access to drugs or medical devices, nor will they affect the established performance targets for product assessments. Canada's Access to Medicines Program seeks to achieve a humanitarian objective, and is intended to complement Canada's other contributions towards the global fight against HIV/AIDS, malaria, tuberculosis and other public health problems.	Published in *Canada Gazette*, Part II on June 1, 2005. These Regulations come into force on the day on which an Act to amend the *Patent Act* and the *Food and Drugs Act (Jean Chrétien Pledge to Africa)*, being chapter 23 of the Statutes of Canada, 2004, comes into force. These regulatory amendments create a new Division 7 to the Food and Drug Regulations, entitled: Sale of Drugs for the Purposes of Implementing the General Council Decision. As the World Trade Organization's General Council decision's definition of "pharmaceutical products" includes products that Canada also regulates as medical devices, regulatory changes have also been made to the Medical Devices Regulations.
Food and Drug Regulations—Miscellaneous Amendments to Division 15	New or revised Maximum Residue Limits (MRLs) for veterinary drugs in foods in the Food and Drug Regulations to ensure the safety of food products from animals treated with the veterinary drugs.	Food products, derived from animals, comply with prescribed MRLs.	Proposed regulatory amendments to the Food and Drug Regulations for MRLs for certain veterinary drugs were published in *Canada Gazette*, Part I on May 8, 2004. The final regulatory amendments will be published in *Canada Gazette*, Part II in 2005.
Food and Drug Regulations—Amendment to prohibit "personal use" importation of all drugs intended to be used in food-producing animals	Increase the scope of the prohibition on importation of veterinary drugs to include the personal importation of drugs intended to be used in animals in Canada and avoid potentially harmful residues in food products from animals treated with those drugs.	The absence of harmful drug residues in food products derived from animals treated with veterinary drugs imported under personal use circumstances.	Health Canada consulted with stakeholders on the intended changes to the importation of veterinary drugs for personal use. The results of the consultation have been analyzed.

Financial Table 9: Major Regulatory Initiatives (cont'd)

Regulations	Expected Results	Performance Measurement Criteria	Results Achieved
Food and Drug Regulations —Prohibition of the sale of Carbadox in Canada	Prohibition of the sale of products containing Carbadox in Canada to avoid potentially harmful residues in food products from animals treated with this substance.	The absence of Carbadox residues in food products derived from food-producing animals.	Proposed regulatory amendments prohibiting the sale of products containing Carbadox will be published in *Canada Gazette*, Part I in 2005–2006.
Healthy Environments and Consumer Safety Branch			
Amendments to the Cosmetic Regulations to require manufacturers to declare ingredients of all cosmetics Harmonization of labelling with international trading partners	Reduce adverse health effects due to cosmetics (e.g. skin diseases, etc.). Reduce associated health care costs due to repeated adverse reactions. Reduce cost of treating cosmetic-induced allergic reactions.	Decrease in the number of consumers reporting problems to Health Canada.	Published in *Canada Gazette*, Part II, December 1, 2004. These amendments will be promulgated November 16, 2006. With mandatory ingredient listing on cosmetics, consumers will be able to avoid products containing ingredients to which they are allergic.
Prohibition of baby walkers	Eliminate deaths and injuries associated with baby walkers.	Child morbidity and mortality data.	Published in the *Canada Gazette*, Part II, April 7, 2004. Baby walkers are no longer offered for sale.
Amendments to the Radiation Emitting Devices Regulations (Tanning Equipment) for safer technical requirements for tanning equipment and replacement parts	Reduction of adverse health effects due to Tanning Equipment (e.g. melanoma).	Decrease in the number of consumers reporting problems to Health Canada.	More stringent standards for UV lamps. Users will be better informed on the risks associated with tanning equipment since more complete and accurate information will accompany the equipment when sold.

Financial Table 9: Major Regulatory Initiatives (cont'd)

Regulations	Expected Results	Performance Measurement Criteria	Results Achieved
Amendments to standardize across Canada the dimensions and the terminology of the template to measure choking hazards for children in regulations for: • Carriages and Strollers • Cribs and Cradles • Playpens • Hazardous Products (Expansion Gates and Expandable Enclosures) • Hazardous Products (Pacifiers) • Hazardous Products (Toys)	Consistency for the dimensions and terminology related to the small parts cylinder (template). Reduce choking injuries and deaths among infants and children.	Reduce requests to Health Canada for clarification regarding the dimensions of the small parts cylinder.	Published in the *Canada Gazette*, Part II, April 21, 2004. Consistency in use of single small parts cylinder for determining choking hazards.
Introduction of new tobacco products labelling requirements focused on health warnings and health information	Increased awareness of tobacco-related hazards. Increased knowledge of tobacco products and their emissions. Reduce tobacco-related morbidity and mortality.	Regular tracking of public opinion through surveys to measure public awareness of health hazards related to tobacco use and knowledge of tobacco products and their emissions.	Health Canada released a consultation document in August 2004. Analysis of comments received was initiated. A Request for Proposal seeking a qualified contractor to undertake the development and design of new health warnings for tobacco products closed on March 1, 2005.
Tobacco Promotion Regulations prohibiting "light" and "mild" descriptors	Reduced confusion among smokers regarding these descriptors. Greater awareness that no class of cigarettes is a "safer" alternative.	Regular tracking of public opinion to measure greater awareness that no class of cigarettes is a safer alternative. Number of smokers who believe that "light" and "mild" cigarettes are less harmful than regular cigarettes will decrease.	Health Canada initiated a Request for Proposal on the Cost Assessment of Tobacco Regulations to conduct the necessary cost analysis. Health Canada continued policy development and review of scientific documents on this issue.

Financial Table 9: Major Regulatory Initiatives (cont'd)

Regulations	Expected Results	Performance Measurement Criteria	Results Achieved
Amendment of the Marihuana Medical Access Regulations (MMAR) to simplify the authorization process for patients and their physicians	On compassionate grounds, seriously ill persons residing in Canada will, with the support of their physicians, have reasonable access to marihuana for medical purposes, when conventional therapies have been unsuccessful.	Increased satisfaction with the medical marihuana program (i.e. decreased complaints) and decreased legal challenges to the Regulations.	Published in *Canada Gazette*, Part II, June 29, 2005. Regulations came into force June 7, 2005. No changes made to regulatory proposal pre-published in *Canada Gazette*, Part I based on comments received; 32 persons provided comments. Streamlined process for application for authorization to possess marihuana; avoidance of unnecessary law enforcement action because police officers can confirm if someone is authorized to possess or produce marihuana for medical purposes in advance of search. Limited authority for marihuana produced for Health Canada to be provided to authorized persons through pharmacies to allow for the conduct of pilot project to examine feasibility of using conventional pharmacy-based drug.

Financial Table 9: Major Regulatory Initiatives (cont'd)

Regulations	Expected Results	Performance Measurement Criteria	Results Achieved
Regulations under the *Controlled Drugs and Substances Act* (CDSA) to expand the authority for regulated health professionals to prescribe controlled substances where appropriate	Federal legislation will not unnecessarily restrict the professional practice of any health profession regulated by provincial or territorial (P/T) authorities, including practitioners of medicine, dentistry, veterinary medicine, podiatric medicine, midwifery, and nurse practitioners, with respect to the use of controlled substances in the treatment of their patients. This result will be achieved over the next 2 to 3 years as federal and P/T regulations are amended to allow health professionals to prescribe controlled substances in accordance with standards of professional practice defined by the their regulatory authorities.	Achievement will be measured by improved alignment of federal and P/T regulatory frameworks governing the appropriate use of controlled substances for medical purposes.	An advisory committee on Expanding the Authority to Prescribe Controlled Substances was formed in June, 2004. The Committee met in January, 2005 to discuss and reach consensus on the fundamental principles on which the policy framework and enabling regulations will be based.
Pest Management Regulatory Agency			
Update existing Pest Control Product Regulations in light of new *Pest Control Products Act* (PCPA)	Ensure that terminology is consistent with the new Act and that any provisions that have been moved to the Act are deleted from the Regulations.	Regulations are consistent with and support new PCPA.	Revised regulations in preparation.
Establishment of Pesticide Adverse Effects Reporting Regulations	Provide information for reevaluation and possible trigger for special review, resulting in removal of pesticides and uses of unacceptable risk.	Provision of pesticide adverse effects information by all registrants.	Proposed regulations pre-published in *Canada Gazette*, Part I, October 23, 2004. Draft adverse effect reporting forms published for comment October 25, 2004. Comments received from publication in *Canada Gazette*, Part I have been analyzed and responses developed. Final regulations being prepared.

Financial Table 9: Major Regulatory Initiatives (cont'd)

Regulations	Expected Results	Performance Measurement Criteria	Results Achieved
Establishment of Pesticide Sales Information Reporting Regulations	Facilitation of priority setting, assessment and mitigation of health and environmental risks, and tracking effectiveness of risk reduction efforts.	Annual submission of sales information by each registrant for each pesticide product.	Comments received from publication in *Canada Gazette*, Part I, Mar. 27, 2004 have been analyzed and responses developed. Final regulations being prepared.
Establishment of Pesticide Safety Information Regulations	Provide improved decision-making tools for pesticide workers and improved workplace safety through more complete information in the form of Material Safety Data Sheets.	Provision of safety data on pesticide products to all workers and users phased in over five years.	Proposed regulations pre-published in *Canada Gazette*, Part I, July 17, 2004. Comments received are being analyzed and responses developed.
Establishment of review panel Regulations Respecting Reconsideration of Pesticide Registration Decisions	Specify procedural and administrative details necessary to govern the reconsideration process.	Concerned parties have clear understanding of requirements and responsibilities. Smoothly functioning review panel process.	Draft regulations in preparation.
Update existing Agriculture and Agri-Food Administrative Monetary Penalties Regulations Respecting the PCPA and Regulations	Reflect additional violations under the new Act and regulations.	Regulations are consistent with and support new PCPA and regulations.	Revised regulations in preparation.
Establish regulations respecting data protection	Specify the circumstances and conditions under which data provided by registrants may be used or relied upon in relation to applications or registrations of other persons.	Protection of registrants' data from unfair commercial use and development, and registration of new, safer pesticides. Strengthened health and environmental protection and increased public and stakeholder confidence in pesticide regulation.	Health Canada continued policy development on this issue.
Food and Drug Regulations (Miscellaneous Amendments to Division 15 —Adulteration of Food)	New or revised MRLs for pest control products listed in the Food and Drug Regulations, as required, to ensure the safety of food following use of these products on crops or in food-producing animals.	Foods comply with prescribed MRLs.	Health Canada continues to assess and prescribe MRLs for specific pest control products in foods.

Financial Table 10: Details on Project Spending

(THOUSANDS OF DOLLARS)

Business Line	Current Estimated Total Cost	Actual 2002–03	Actual 2003–04	2004–2005			
				Main Estimates	Planned Spending	Total Authorities	Actual
Information and Knowledge Management							
First Nations & Inuit Primary Care Electronic Health Record Project Project Phase: Planning	739	238	197	376	376	376	304
First Nations & Inuit Primary Care Electronic Health Record Project Project Phase: Definition	1,848	596	493	940	940	940	760
First Nations & Inuit Primary Care Electronic Health Record Project Project Phase: Implementation	4,436	1,429	1,183	2,256	2,256	2,256	1,824
First Nations & Inuit Primary Care Electronic Health Record Project Project Phase: Close Out	370	119	99	188	188	188	152
First Nations & Inuit Primary Care Electronic Health Record Project **Total**	**7,393**	**2,382**	**1,972**	**3,760**	**3,760**	**3,760**	**3,040**

Table 11A: Summary of Transfer Payments by Program/Business Line

(MILLIONS OF DOLLARS)

This table reflects the break down of Transfer Payments (Grants, Contributions and Other Transfer Payments) by business line. For more details refer to table entitiled "Details on Transfer Payments Programs".

Business Lines	2002–2003 Actual Spending	2003–2004 Actual Spending	2004–2005			
			Main Estimates	Planned Spending	Total Authorities	Actual Spending
Grants						
Health Care Policy	3.5	31.9	41.0	41.0	50.8	50.7
Health Promotion and Protection	20.5	348.8	40.6	41.1	6.9	6.7
Information and Knowledge Management	0.0	670.0	0.0	0.0	0.0	0.0
Departmental Management and Administration	0.0	25.0	1.0	1.0	0.2	0.2
Total Grants	**24.0**	**1,075.7**	**82.6**	**83.1**	**57.9**	**57.6**
Contributions						
Health Care Policy	51.1	216.1	253.0	253.0	226.7	222.8
Health Promotion and Protection	189.3	213.6	176.6	186.3	36.3	36.2
First Nations and Inuit Health	677.9	702.2	739.7	757.0	781.7	779.4
Information and Knowledge Management	31.8	20.4	22.0	22.0	27.8	27.5
Departmental Management and Administration	36.7	45.7	19.8	19.7	52.1	52.1
Total Contributions	**986.8**	**1,198.0**	**1,211.1**	**1,238.0**	**1,124.6**	**1,118.0**
Other Transfer Payments						
Health Promotion and Protection	21.2	44.0	50.1	50.1	0.0	0.0
Total Other Transfer Payments	**21.2**	**44.0**	**50.1**	**50.1**	**0.0**	**0.0**
Total Transfer Payments	**1,032.0**	**2,317.7**	**1,343.8**	**1,371.2**	**1,182.5**	**1,175.6**

The increase in Health Care Policy expenditures is mainly due to the funding of initiatives as set out in the 2003 First Minister's Accord on Health Care Renewal such as Health Human Resources and the Health Council of Canada.

The decrease in Health Promotion and Protection expenditures in 2004–2005 is due to the creation of the Public Health Agency of Canada (PHAC) on September 24, 2004 and the subsequent transfer of funds. In 2003–2004 there was a one-time named grant to the Province of Ontario for Severe Acute Respiratory Syndrome (SARS).

The increase in First Nations and Inuit Health expenditures is mainly related to funding for the Named Contribution to the Province of Ontario for the construction of the Meno Ya Win Health Centre.

The decrease in Information and Knowledge Management expenditures is related to statutory grant payments to Canada Health Infoway and Canadian Institute for Health Information.

The decrease in Departmental Management and Administration expenditures is mainly related to a statutory grant payment to Canadian Health Services Research Foundation.

Financial Table 11B: Summary of Details on Transfer Payments Programs (TPPs)

GENERAL EXPLANATIONS:

- This is a summary of the Transfer Payment Programs included in the 2004–2005 Report on Plans and Priorities of Health Canada. For full details, refer to Annex A http://www.hc-sc.gc.ca/ahc-asc/performance/estim-previs/dpr-rmr/index_e.html
- All of the TPPs shown in this Table are voted programs. (All Health Canada statutory programs are either below the reporting threshold of $5 million or are reported elsewhere.)
- All financial figures are in millions of dollars.
- Due to the long-standing history and evolution of some programs, the Total Funding is not meaningful and/or cannot be determined without extraordinary effort. In such cases the Total Funding is left blank.
- The 2004–2005 RPP included several transfer payment programs of the Population and Public Health Branch (PPHB) that became the new Public Health Agency of Canada (PHAC) as announced by the Government of Canada on September 24, 2004. The following two grant programs, five contribution programs, and one other transfer payment program have been excluded from the 2004–2005 DPR because they are included in the report submitted by the new Agency:
  - Grants to persons and agencies to support health promotion projects in the areas of community health, resource development, training and skill development, and research;
  - Grants towards the Canadian Strategy on HIV/AIDS;
  - Contributions to persons and agencies to support health promotion projects in the areas of community health, resource development, training and skill development, and research;
  - Contributions to non-profit community organizations to support, on a long-term basis, the development and provision of preventive and early intervention services aimed at addressing the health and developmental problems experienced by young children at risk;
  - Contributions towards the Canadian Strategy on HIV/AIDS;
  - Contributions to incorporated local or regional non-profit Aboriginal organizations and institutions for the purpose of developing early intervention programs for Aboriginal pre-school children and their families; and
  - Payments to provinces and territories to improve access to health care and treatment services to persons infected with hepatitis C through the blood system.

GRANTS

Health Care Policy

HEALTH CARE STRATEGIES AND POLICY, FEDERAL/PROVINCIAL/TERRITORIAL PARTNERSHIP GRANT PROGRAM		
Start Date: October 21, 2002	End Date: March 31, 2008 and ongoing	Total Funding: $26.9 M and ongoing
Achieved results or progress made: **Health Technology Strategy:** In September 2004, Health Ministers approved the Canadian Health Technology Strategy. This Strategy represents a collaborative approach towards ensuring Canadians ongoing access to appropriate health care technology, within their publicly-funded health care system. It outlines a pan-Canadian approach to formulating evidence and policy advice on health technologies, including the establishment of structures and a transparent process to allow jurisdictions to share information and, where appropriate, work together for the better management of health technology. To support the development and implementation of the Strategy, Budget 2003 provided $45 million over five years to Canadian Coordinating Office for Health Technology Assessment (CCOHTA), Canada's national health technology assessment organization. This funding has increased the capacity and utility of health technology assessment information to support health technology policy decision-making across the country.		

Financial Table 11B: Summary of Details on Transfer Payments Programs (TPPs) (cont'd)

CCOHTA—Canadian Optimal Medication Prescribing Utilization Service (COMPUS):

On March 12, 2004, the Conference of Deputy Ministers of Health approved the creation of the COMPUS program. COMPUS has undertaken many activities to further the goals of the program. These involve stakeholder engagement and partnerships, collections of best practices information, quality assessment of evaluation methodologies and knowledge transfer, outreach and communication activities.

CCOHTA—Common Drug Review (CDR):

The program evaluation has been initiated and will focus on whether CDR is meeting its objectives. Stakeholders will be involved in the evaluation.

	Actual Spending 2002–03	Actual Spending 2003–04	Planned Spending 2004–05	Total Authorities 2004–05	Actual Spending 2004–05	Variance(s) between Planned and Actual
Total TPP	2.2	8.4	15.0	16.4	16.3	-1.3

GRANT FOR THE NORTHWEST TERRITORIES HEALTH SUPPLEMENT TO THE 2003 FIRST MINISTERS' ACCORD

Start Date: May 15, 2003	End Date: 2005–2006	Total Funding: $20.0 M over three years

Achieved results or progress made:

The territory reported to its residents on comparable health and health system indicators. The report was in accordance with the indicators developed by provincial/territorial and federal governments as part of the 2003 Accord commitments.

The territorial government has made progress in strengthening its care systems by recruiting additional physicians and other health professionals, increasing services to reduce in-territory waiting time, providing additional health and wellness programs.

	Actual Spending 2002–03	Actual Spending 2003–04	Planned Spending 2004–05	Total Authorities 2004–05	Actual Spending 2004–05	Variance(s) between Planned and Actual
Total TPP		6.7	5.6	6.7	6.7	-1.1

GRANT FOR THE NUNAVUT HEALTH SUPPLEMENT TO THE 2003 FIRST MINISTERS' ACCORD

Start Date: May 15, 2003	End Date: 2005–2006	Total Funding: $20.0 M over three years

Achieved results or progress made:

The territory reported to its residents on comparable health and health system indicators. The report was in accordance with the indicators developed by provincial/territorial and federal governments as part of the 2003 Accord commitments.

The territorial government has made progress in strengthening its care systems by recruiting additional physicians and other health professionals, increasing services to reduce in-territory waiting time, providing additional health and wellness programs.

	Actual Spending 2002–03	Actual Spending 2003–04	Planned Spending 2004–05	Total Authorities 2004–05	Actual Spending 2004–05	Variance(s) between Planned and Actual
Total TPP		6.7	5.5	6.7	6.7	-1.2

Financial Table 11B: Summary of Details on Transfer Payments Programs (TPPs) (cont'd)

GRANT FOR THE YUKON HEALTH SUPPLEMENT TO THE 2003 FIRST MINISTERS' ACCORD						
Start Date: May 15, 2003	End Date: 2005–2006		Total Funding: $20.0 M over three years			
Achieved results or progress made: The territory reported to its residents on comparable health and health system indicators. The report was in accordance with the indicators developed by provincial/territorial and federal governments as part of the 2003 Accord commitments. The territorial government has made progress in strengthening its care systems by recruiting additional physicians and other health professionals, increasing services to reduce in-territory waiting time, providing additional health and wellness programs.						
	Actual Spending 2002–03	Actual Spending 2003–04	Planned Spending 2004–05	Total Authorities 2004–05	Actual Spending 2004–05	Variance(s) between Planned and Actual
Total TPP		6.7	5.6	6.7	6.7	-1.1

GRANT TO THE CANADIAN PATIENT SAFETY INSTITUTE (CPSI)						
Start Date: December 10, 2003	End Date: March 31, 2008		Total Funding: $8 M annually			
Achieved results or progress made: The CPSI completed a strategic business plan built around three overarching themes: (1) define patient safety issues in health care; (2) identify leading practices and effective interventions; and (3) champion necessary change through partnerships, stakeholder engagement, and transparent communication. CPSI also developed an Action Plan with a Report on Progress 2004–2005 and Report on Priorities for 2005–2006.						
	Actual Spending 2002–03	Actual Spending 2003–04	Planned Spending 2004–05	Total Authorities 2004–05	Actual Spending 2004–05	Variance(s) between Planned and Actual
Total TPP		2.2	8.0	8.0	8.0	0

Health Promotion and Protection

GRANT TO THE CANADIAN BLOOD SERVICES—BLOOD SAFETY AND EFFECTIVENESS AND RESEARCH AND DEVELOPMENT						
Start Date: July 1998	End Date: ongoing		Total Funding: $5 M annually			
Achieved results or progress made: Through our efforts to support scientific research into blood safety, alternatives to transfusions and blood substitutes, risks to the health of Canadians are being reduced. http://www.bloodservices.ca/CentreApps/Internet/UW_V502_MainEngine.nsf/page/Safety+and+Testing?OpenDocument#06						
	Actual Spending 2002–03	Actual Spending 2003–04	Planned Spending 2004–05	Total Authorities 2004–05	Actual Spending 2004–05	Variance(s) between Planned and Actual
Total TPP	5.0	5.0	5.0	5.0	5.0	0

Financial Table 11B: Summary of Details on Transfer Payments Programs (TPPs) (cont'd)

CONTRIBUTIONS

Health Care Policy

CONTRIBUTIONS FOR THE PRIMARY HEALTH CARE TRANSITION FUND (PHCTF)		
Start Date: June 13, 2001 (TB submission approval)	End Date: September 30, 2006 (contribution funding ends); March 31, 2007 (program sunsets O&M evaluation etc.)	Total Funding: $749.3 M

Achieved results or progress made:

All funds have been allocated to over 70 initiatives, which are all progressing steadily. A six-month extension made available to all funded initiatives ensures that they can fully realize their expected results and affords more time for initiatives to complete their evaluations and final reports to the Department. The formative evaluation was conducted in 2004–2005 and the report will be finalized in 2005–2006. Two reports were released in June 2005: the PHCTF Summary of Initiatives and the PHCTF Interim Report. Six initiatives were completed in 2004–2005; 23 will conclude by March 31, 2005 and the remainder by September 2006.

	Actual Spending 2002–03	Actual Spending 2003–04	Planned Spending 2004–05	Total Authorities 2004–05	Actual Spending 2004–05	Variance(s) between Planned and Actual
Total TPP	48.2	209.2	244.7	212.1	210.8	33.9

HEALTH CARE STRATEGIES AND POLICY CONTRIBUTION PROGRAM		
Start Date: September 24, 2002	End Date: Ongoing	Total Funding: Over $171.6 M

Achieved results or progress made:

Health Human Resources (HHR) Strategy:

The HHR Database Development Project ($8 million) will result in improved quantity, scope and quality of information to support HHR planning and management. Enhanced data will support the development of comparable indicators and enhance the capacity for evidence-based HHR research and planning. In 2004–2005, Health Canada conducted four major Calls for Proposals for contribution projects under the HHR Strategy. Provincial/Territorial/Regional Project funding provided $4 million for P/T governments to address specific HHR priorities within their jurisdictions. Proposals under Cycle One of the Interprofessional Education for Collaborative Patient-Centred Practice Initiative ($13 million) were submitted in December 2004. Projects will be operational in 2005–2006 and will be designed to enable health professionals to gain the necessary knowledge and training to work in interprofessional teams, and will contribute to health system renewal, improved patient safety and increased health system efficiency and sustainability. To achieve and sustain an optimal supply, distribution, deployment and mix of health care providers, Health Canada assists international medical graduates to overcome the barriers to licensure which many face in Canada. In 2004–2005, the Department allocated approximately $3 million for P/T governments to increase their capacity to support additional assessments for international medical graduates. Finally, the Healthy Workplace Initiative received proposals for approximately $3.5 million in contribution projects that will be implemented in 2005–2006 to support health system organizations across Canada in creating and maintaining healthy work environments, a key factor in recruitment and retention of health care workers.

Financial Table 11B: Summary of Details on Transfer Payments Programs (TPPs) (cont'd)

Canadian Medication Incident Reporting and Prevention System (CMIRPS) Initiative:

Operations Committee Meetings and Conference Calls—3 meetings, 10 conference calls

Advisory Committee Meetings and Conference Calls—2 meetings, 2 conference calls

Canadian Coalition of Medication Incident Reporting Meetings and Conference Calls—1 meeting, 3 conference calls

Negotiations for strategic oversight and national coordination of CMIRPS (to be provided by the Canadian Patient Safety Institute) initiated

Canadian Institute for Health Information (CIHI) preliminary Privacy Impact Assessment completed

ISMP Canada Privacy Impact Assessment completed

CMIRPS Communications Framework developed

CMIRPS Operations Committee Memorandum of Understanding developed

Draft Root Cause Analysis tool developed, pilot testing initiated

CMIRPS Information Bulletins developed and disseminated

The following results have been achieved in the design and development of CMIRPS:

Environmental Scan i.e. ongoing investigation of Canadian and international medication incident reporting solutions

Draft Business Process Models for individuals and health service organizations reporting to CMIRPS

Draft Data Standards for medication incident reporting

Data submission and specifications

Evaluation of a build or buy option

Best Practices Contribution Program:

The Department funded a total of 11 projects under its Best Practices Contribution Program (BPCP), a federally funded program for which provincial/territorial governments and academic institutions are potential funding recipients. Health Canada released its second Call for Proposals in February 2005. It offers financial support to initiatives that evaluate best practices related to optimal prescribing and utilization of drug therapy, and that encourage the uptake of such best practices across jurisdictions.

National Prescription Drug Utilization Information System (NPDUIS):

Initiated as a result of First Ministers' Meeting 2000 commitments, the National Prescription Drug Utilization Information System (NPDUIS) is an information system managed by the Canadian Institute for Health Information (CIHI), with analytical capacity housed at the Patented Medicine Prices Review Board (PMPRB). It will provide accurate and timely prescription drug utilization information to support public drug programs in the establishment of sound pharmaceutical policies and the optimal management of drug plans as well as contribute to an increased understanding of the factors that drive drug expenditures. In 2004–2005, CIHI pursued data sharing agreements with public drug plans and explored ways to include private drug plan data.

	Actual Spending 2002–03	Actual Spending 2003–04	Planned Spending 2004–05	Total Authorities 2004–05	Actual Spending 2004–05	Variance(s) between Planned and Actual
Total TPP		4.3	5.5	11.9	9.4	-3.9

Financial Table 11B: Summary of Details on Transfer Payments Programs (TPPs) (cont'd)

Health Promotion and Protection

PAYMENTS TO PROVINCES AND TERRITORIES AND TO NATIONAL NON-PROFIT ORGANIZATIONS TO SUPPORT THE DEVELOPMENT OF INNOVATIVE ALCOHOL AND DRUG TREATMENT AND REHABILITATION PROGRAMS						
Start Date: April 1, 1997	End Date: Ongoing		Total Funding: $14.0 M annually			
Achieved results or progress made: Discussions with provinces and territories have been held to improve performance measurement of treatment and rehabilitation services cost-shared by the federal government under the Alcohol and Drug Treatment and Rehabilitation (ADTR) Program. Actions to improve performance measurement are being taken within the context of a broader review of the ADTR Program, which is being guided by a federal-provincial-territorial working group.						
	Actual Spending 2002–03	Actual Spending 2003–04	Planned Spending 2004–05	Total Authorities 2004–05	Actual Spending 2004–05	Variance(s) between Planned and Actual
Total TPP	15.6	17.2	14.0	14.2	14.2	-0.2

CONTRIBUTIONS IN SUPPORT OF THE FEDERAL TOBACCO CONTROL STRATEGY (FTCS)						
Start Date: 2001–2002	End Date: Ongoing		Total Funding: $169.65 M			
Achieved results or progress made: • Continued support of smoking cessation quitlines in the Atlantic provinces, Manitoba and Saskatchewan, ensuring access in all provinces. • National evaluation of smoking cessation quitlines. • Research to support implementation of a national coordinated approach to cessation in communities across Canada undertaken with the University of Waterloo and the provincial governments of Prince Edward Island and British Columbia to evaluate a coordinated approach to cessation. We will assess factors such as a smoker's level of addiction and provide referrals to the most appropriate source(s) of cessation support. Follow-up will determine the effectiveness of various interventions. • Strengthen the infrastructure for tobacco control at both the regional and national levels through funding of the National Clearinghouse on Tobacco Control, Physicians for a Smoke-Free Canada, National Smokers' Rights Association. • Public education through dissemination of tobacco control information. • Development and dissemination of school-based tobacco prevention resources e.g. Science, Tobacco and You; youth-engagement resources e.g. Advocating for Smoke-free Schools. • Development and dissemination of a teen tobacco cessation program "Quit 4 Life"/"Une vie sans fumer" which can be used in schools or as a Web-based self-help resource. • Strengthening F/P/T collaboration through the development of a joint Framework for Action on Youth and Young Adults. • A total of 33 mass media projects across the country which resulted in a variety of campaigns focused on reducing exposure to second-hand smoke, prevention of youth uptake or cessation. • Development and dissemination of more than 200,000 copies of On the Road to Quitting—an interactive self-help Web-based program (also available as a brochure—*Guide to becoming a non-smoker*). On the Road to Quitting is designed to help motivate smokers to quit, and to support them as they undergo the cessation process.						
	Actual Spending 2002–03	Actual Spending 2003–04	Planned Spending 2004–05	Total Authorities 2004–05	Actual Spending 2004–05	Variance(s) between Planned and Actual
Total TPP	9.1	15.5	22.2	16.4	16.4	5.8

Financial Table 11B: Summary of Details on Transfer Payments Programs (TPPs) (cont'd)

First Nations and Inuit Health

CONTRIBUTIONS FOR INTEGRATED INDIAN AND INUIT COMMUNITY-BASED HEALTH CARE SERVICES		
Start Date: Feb. 3, 1994	End Date: March 31, 2005	Total Funding:

Achieved results or progress made:

A total of 85 percent of First Nations and Inuit (FNI) communities have access to Home and Community Care Services, a 2 percent increase from 2003–2004.

Health Canada continues to work in partnership with Indian and Northern Affairs Canada and FNI in the development of a framework on long-term and continuing care in First Nations and Inuit communities.

At present, there are 58 NNADAP (National Native Alcohol and Drug Abuse Program) and YSAP (Youth Solvent Abuse Program) treatment centres across Canada.

In 2004–2005, approximately 6,000 women participated in Canada Prenatal Nutrition Program: First Nations and Inuit component at approximately 450 project sites, serving more than 600 First Nations and Inuit communities.

Canadian Aboriginal AIDS Network (CAAN) and Pauktuutit Inuit Women's Association conducted enhanced AIDS awareness campaigns. Over 20,000 posters, pamphlets and information sheets on HIV/AIDS were distributed in First Nations communities and 1,500 copies of a booklet and information sheets were translated into Inukititut. Several communities engaged in awareness campaigns in conjunction with their local or regional Aboriginal AIDS service agencies.

	Actual Spending 2002–03	Actual Spending 2003–04	Planned Spending 2004–05	Total Authorities 2004–05	Actual Spending 2004–05	Variance(s) between Planned and Actual
Total TPP	294.1	305.6	322.7	326.2	325.0	-2.3

PAYMENTS TO INDIAN BANDS, ASSOCIATIONS OR GROUPS FOR THE CONTROL AND PROVISION OF HEALTH SERVICES		
Start Date: June 29, 1989	End Date: March 31, 2006	Total Funding:

Achieved results or progress made:

Strengthened and enhanced accountability and capacity building for First Nations and Inuit and flexibility in the design and delivery of programs and services. The Health Plan Demonstration Project is another step towards increasing First Nations and Inuit communities' capacity to meet the health needs of members, increase accountability, and achieve integration of services where viable. Seven communities were involved in the Health Plan Demonstration Project at the end of 2004–2005. The communities reflected a broad mix of community type, population and remoteness, in various regions across the country. All seven completed their Health Plans and our Department reviewed and assessed them.

	Actual Spending 2002–03	Actual Spending 2003–04	Planned Spending 2004–05	Total Authorities 2004–05	Actual Spending 2004–05	Variance(s) between Planned and Actual
Total TPP	190.9	192.8	203.9	205.2	205.2	-1.3

Financial Table 11B: Summary of Details on Transfer Payments Programs (TPPs) (cont'd)

CONTRIBUTIONS TO SUPPORT PILOT PROJECTS TO ASSESS OPTIONS FOR TRANSFERRING THE NON-INSURED HEALTH BENEFITS (NIHB) PROGRAM TO FIRST NATIONS AND INUIT CONTROL						
Start Date: Sept.15, 1994	End Date: March 31, 2005		Total Funding:			
Achieved results or progress made: A review of the NIHB pilot projects was conducted in 2004 and a synthesis report on the findings and recommendations completed in March 2005. Of the 31 original pilot projects, one remained in operation in 2004. Authority to extend the pilot project was received in March 2005 and a Performance Review based on an audit will be initiated in 2005–2006.						
	Actual Spending 2002–03	Actual Spending 2003–04	Planned Spending 2004–05	Total Authorities 2004–05	Actual Spending 2004–05	Variance(s) between Planned and Actual
Total TPP	6.9	10.6	12.0	8.2	8.2	3.8
CONTRIBUTIONS TO INDIAN BANDS, INDIAN AND INUIT ASSOCIATIONS OR GROUPS OR LOCAL GOVERNMENTS AND THE TERRITORIAL GOVERNMENTS FOR NON-INSURED HEALTH BENEFITS (NIHB)						
Start Date: Nov. 8, 1979	End Date: March 31, 2005		Total Funding:			
Achieved results or progress made: A range of medically necessary goods and services (drugs, dental care, vision care, medical supplies and equipment, short-term crisis intervention mental health services and medical transportation to access medical services not available on-reserve or in the community of residence) are provided under the NIHB program to approximately 765,000 First Nations and Inuit, regardless of residency.						
	Actual Spending 2002–03	Actual Spending 2003–04	Planned Spending 2004–05	Total Authorities 2004–05	Actual Spending 2004–05	Variance(s) between Planned and Actual
Total TPP	124.4	128.3	105.8	130.0	130.0	-24.2
PAYMENTS TO THE ABORIGINAL HEALTH INSTITUTE/CENTRE FOR THE ADVANCEMENT OF ABORIGINAL PEOPLES' HEALTH						
Note: The Program was excluded from the DPR because actual spending was less than $200,000.						
CONTRIBUTIONS FOR FIRST NATIONS AND INUIT HEALTH PROMOTION AND PREVENTION PROJECTS AND FOR DEVELOPMENTAL PROJECTS TO SUPPORT FIRST NATIONS AND INUIT CONTROL OF HEALTH SERVICES						
Start Date: Nov. 3, 1994	End Date: March 31, 2005		Total Funding:			
Achieved results or progress made: To close the gap in health status between Aboriginal and non-Aboriginal Canadians, Health Canada put in place a First Nations health promotion and disease prevention strategy and worked with partners to improve health care delivery.						
	Actual Spending 2002–03	Actual Spending 2003–04	Planned Spending 2004–05	Total Authorities 2004–05	Actual Spending 2004–05	Variance(s) between Planned and Actual
Total TPP	17.7	18.8	46.6	29.0	29.0	17.6

Financial Table 11B: Summary of Details on Transfer Payments Programs (TPPs) (cont'd)

CONTRIBUTIONS ON BEHALF OF, OR TO, INDIANS OR INUIT TOWARDS THE COST OF CONSTRUCTION, EXTENSION OR RENOVATION OF HOSPITALS AND OTHER HEALTH CARE DELIVERY FACILITIES AND INSTITUTIONS, AS WELL AS OF HOSPITAL AND HEALTH CARE EQUIPMENT

Start Date: Feb. 1, 1979	End Date: March 31, 2005	Total Funding:

Achieved results or progress made:

Repairs, upgrades and replacements of building systems improved the safety and operating efficiency at Health Canada hospitals and other health facilities. These projects included fuel distribution system upgrades, furnace and heating system repairs, and installation of efficient lighting systems and solar energy equipment.

We constructed 11 health facilities, including five health stations, four health centres and two nursing stations. This ensures that health services are accessible to First Nations and Inuit communities through modern and sustainable health facilities.

Health Canada constructed 16 residential units to accommodate nursing staff in remote and isolated communities.

	Actual Spending 2002–03	Actual Spending 2003–04	Planned Spending 2004–05	Total Authorities 2004–05	Actual Spending 2004–05	Variance(s) between Planned and Actual
Total TPP	32.5	44.8	23.4	49.0	49.0	-25.6

CONTRIBUTION TOWARDS THE ABORIGINAL HEAD START ON-RESERVE (AHSOR) PROGRAM

Start Date: August 25, 1998	End Date: March 31, 2005	Total Funding:

Achieved results or progress made:

Elements of the AHSOR program were delivered in 338 communities, which served approximately 9,100 children. In 2004–2005, AHSOR convened a workshop on children's special needs in First Nations communities to discuss future program developments that address those needs. We also facilitated parent focus groups in communities to obtain their feedback on barriers to parental involvement and strategies to address those.

	Actual Spending 2002–03	Actual Spending 2003–04	Planned Spending 2004–05	Total Authorities 2004–05	Actual Spending 2004–05	Variance(s) between Planned and Actual
Total TPP	32.8	33.1	32.8	37.7	37.6	-4.8

CAPITAL CONTRIBUTIONS FOR NON-DEPARTMENTAL HEALTH FACILITIES FOR FIRST NATIONS AND INUIT

Note: This Program was included in the Health Canada 2004–2005 RPP with Planned Spending of $18.5 million in 2004–2005. The Program was excluded from the DPR because actual payments were made under the Departmental Management and Administration business line of the Construction and Renovation Contribution Program.

NAMED CONTRIBUTION TO THE PROVINCE OF ONTARIO FOR THE CONSTRUCTION OF THE MENO YA WIN HEALTH CENTRE

Start Date: 2004–2005	End Date: 2004–2005	Total Funding: $37.4 M

Achieved results or progress made: construction of the Meno Ya Win Health Centre.

	Actual Spending 2002–03	Actual Spending 2003–04	Planned Spending 2004–05	Total Authorities 2004–05	Actual Spending 2004–05	Variance(s) between Planned and Actual
Total TPP				37.4	37.4	-37.4

Note: This contribution was not included in the 2004–2005 RPP. This is one-time funding to the province of Ontario.

Financial Table 11B: Summary of Details on Transfer Payments Programs (TPPs) (cont'd)

CONTRIBUTIONS TO INDIAN AND INUIT ASSOCIATIONS OR GROUPS FOR CONSULTATIONS ON INDIAN AND INUIT HEALTH						
Start Date: July 23, 1980	End Date: March 31, 2005		Total Funding:			
Achieved results or progress made: Led First Nations and Inuit national and regional consultation and engagement process.						
	Actual Spending 2002–03	Actual Spending 2003–04	Planned Spending 2004–05	Total Authorities 2004–05	Actual Spending 2004–05	Variance(s) between Planned and Actual
Total TPP	4.7	5.2	1.0	5.6	5.4	-4.4
Note: This Program was not included in the 2004–2005 RPP because Planned Spending was $1.0 million in 2004–2005 but was added to the DPR because Actual Spending was over $5 million.						

Information and Knowledge Management

CONTRIBUTIONS PROGRAM TO IMPROVE ACCESS TO HEALTH SERVICES FOR OFFICIAL LANGUAGE MINORITY COMMUNITIES (OLMCs)						
Start Date: April 1, 2003	End Date: 2007–2008 and ongoing		Total Funding: $89 M over five years (2003–2008)			
Achieved results or progress made: To date, 27 community networks for both official language minority communities are in place across Canada. Also, for Francophone minority communities, 40 students graduated from universities and 100 graduated from colleges in June 2004. Health Canada funding supported the establishment of training programs in 10 post-secondary institutions. For the Anglophone minority communities, the second-language training programs for health professionals were established. Second-language training is planned to start in 2005–2006.						
	Actual Spending 2002–03	Actual Spending 2003–04	Planned Spending 2004–05	Total Authorities 2004–05	Actual Spending 2004–05	Variance(s) between Planned and Actual
Total TPP		8.0	13.0	14.8	14.8	-1.8
PRIMARY HEALTH CARE TRANSITION FUND (OLMC ENVELOPE)						
Start Date: April 1, 2001	End Date: March 31, 2007		Total Funding: $30 M over 42 months 2003–2006 (for the OLMC Envelope)			
Achieved results or progress made: To date, for Francophone minority communities, over 60 projects are currently under way. These projects were developed by community networks and are adapted to provincial, territorial and regional realities, aiming at providing concrete and clear direction. For Anglophone minority communities, over 20 transition projects have been implemented to create innovative models that will enhance primary health care and front-line social services, and break the isolation of English-speaking people in long-term care facilities.						
	Actual Spending 2002–03	Actual Spending 2003–04	Planned Spending 2004–05	Total Authorities 2004–05	Actual Spending 2004–05	Variance(s) between Planned and Actual
Total TPP				7.3	7.1	-7.1
Note: The Program was reported under Health Care Policy Contributions for the PHCTF in the 2004–2005 RPP (page 101). Planned Spending for 2004–2005 was reflected under the PHCTF.						

Financial Table 12: Conditional Grants (Foundations)

1) NAME OF FOUNDATION: **CANADIAN INSTITUTE FOR HEALTH INFORMATION (CIHI)**		
2) Start Date: Roadmap I March 31, 1999 Roadmap II April 1, 2002 Roadmap II+ March 31, 2002	3) End Date: Roadmap I March 31, 2003 Roadmap II March 31, 2007 Roadmap II+ March 31, 2007	4) Total Funding: Roadmap I $95 M Roadmap II $95 M Roadmap II+ $70 M

5) Purpose of Funding:

The Roadmap Initiative, which includes all three grants, provides the financial support for the Canadian Institute for Health Information to:

- serve as the national mechanism to coordinate the development and maintenance of a comprehensive and integrated health information system for Canada; and
- provide and coordinate the provision of accurate and timely information required for the establishment of sound health policy, the effective management of the Canadian health system and generating public awareness about factors affecting good health.

6) Objective(s), expected result(s) and outcomes:

CIHI plays a major role in supporting the reporting commitments of various First Ministers' Meetings and First Ministers' Accords on Health Care Reform.

The key areas identified for action include:

- consulting with stakeholders to confirm priority health information needs;
- developing health information standards to ensure the consistent collection, sharing and interpretation of health information;
- filling in gaps in information on health services and related costs and outcomes;
- filling in gaps in information on population health and factors that affect our health;
- creating a Canadian Population Health Initiative (CPHI) to provide new information and insights on health and the health system; and
- producing and disseminating regular, easy-to-understand public reports and conducting special studies on the health of Canadians and the health system.

7) Achieved results or progress made (within overall departmental results achieved):

The 2004–2005 Operational Plan and Budget were presented for approval to the Board of Directors at the February 2004 meeting, and then submitted to the Minister of Health. Key initiatives completed in 2004–2005 include:

- release of *Health Care in Canada, 2004* and development of the 2005 edition
- expanded range of collaborative and analytical activities
- development and implementation of new health indicators to address priority health information needs
- implementation of a long-range plan to develop analytical capacity and strengthen links with the research community
- special data quality studies
- release of a set of provincial data quality reports aimed at identifying data quality issues at the provincial level
- continuation of grouper redevelopment activities including production of ICD-10-CA/CCI grouping methodologies
- production and dissemination of policy-relevant analytical reports
- increase in the scope, relevance and usefulness of existing health human resources products
- continued work on the development of a Canadian Medication Incident Reporting and Prevention System
- continued development of a reporting system for home care services

Financial Table 12: Conditional Grants (Foundations) (cont'd)

	8) Actual Spending 2002–03 $70 M	9) Actual Spending 2003–04 $0	10) Planned Spending 2004–05 $0	11) Total Authorities 2004–05 $0	12) Actual Spending 2004–05 $0	13) Variance between 10) and 12) $0
14) Conditional Grant(s)	$70 M	$0	$0	$0	$0	$0

15) Comments on Variances: N/A

16) Significant Evaluation Findings and URL to last evaluation:
http://secure.cihi.ca/cihiweb/en/downloads/finalreportOct9execsum_e.pdf

17) URL to Foundation site: http://www.cihi.ca

18) URL to Foundation's Annual Report: The Minister does not table CIHI's Annual Reports.
2003–2004 Annual Report http://secure.cihi.ca/cihiweb/dispPage.jsp?cw_page=RC_1131_E&cw_topic=1131
2004–2005 Annual Report to be released in September 2005

1) NAME OF FOUNDATION: CANADIAN HEALTH SERVICES RESEARCH FOUNDATION (CHSRF)

2) Start Date: 1996–1997 3) End Date: N/A 4) Total Funding: $151.5 M

5) Purpose of Funding: CHSRF received $66.5 M from 1997–1999 (as an endowment) to set up the Foundation and another $35 M to support its participation in the Canadian Institutes of Health Research. CHSRF was provided with grants in 1999 and 2003 of $25 M each to (i) develop solutions to the challenges facing nurses (Nurses Using Research and Service Evaluations or NURSE); and (ii) enhance the skills of health system managers in using research to increase evidence-based decision-making (Executive Training for Research Application or EXTRA). CHSRF leverages funding by partnering with other organizations.

6) Objectives, expected results and outcomes:

CHSRF's goals for 2004 were to: (i) enhance research quality and quantity responding to health system decision makers' needs; (ii) get needed research to health system managers and policy makers; (iii) help health system managers and policy makers to obtain and apply relevant research; (iv) bring together researchers and decision makers to understand and influence each other's goals and work, and develop partnerships; and (v) strategically and effectively manage and align staff, technology and processes to achieve CHSRF's mission.

Some of the planned results include: funding new research on priority themes; the reappraisal of Listening for Directions; the launch of the EXTRA program; improving understanding of the nursing theme, creating a network to increase knowledge exchange and enhancing research dissemination.

The impact/effects of CHSRF's programs are to improve the scientific basis for decision-making in health services. CHSRF focuses on building bridges between applied health services researchers and decision makers to facilitate the use of research-based evidence. This involves making the information accessible, providing tools and training for its effective use, as well as creating the capacity needed to address health system needs.

7) Achieved results or progress made (within overall departmental results achieved):

Overall key achievements in 2004 include: leading an assessment of health services priorities (Listening for Directions II); developing a new granting program to maximize the impact of health services and nursing research on decision-making (Research, Exchange and Impact for System Support); and the successful launch of the EXTRA program. With regard to NURSE and EXTRA, the following were achieved:

NURSE: An external scan was conducted to improve understanding of the state of knowledge in the nursing theme; the resulting refinements provided direction for the new Research, Exchange and Impact for System Support competition. Work progressed on a network for increased knowledge exchange: the needs and priorities of the nursing community were identified; and complementary work was funded for a network in community health. Research dissemination activities increased knowledge exchange, including the translation of a nursing monograph on nursing human resources for decision makers.

EXTRA: The first cohort of 24 fellows was selected. The fellows finished two of the six modules of the program, including site visits to 24 health care organizations. Four regional mentoring centres were established, fellows were linked with mentors, and a Memorandum of Understanding was developed with the Canadian College of Health Service Executives to seek mentors annually. An Internet-based tool was developed to support communication and collaboration. Work progressed on the evaluation component: an evaluation team was established; a framework was designed; and interviews were completed with sponsor organizations, as well as a baseline survey of the 2004 fellows. Work has begun to identify further advancement of accreditation and certification options for the program.

Financial Table 12: Conditional Grants (Foundations) (cont'd)

CHSRF's work contributes to Health Canada's aim of strengthening the knowledge base to address health and health care priorities. More specifically, CHSRF's programs further the development of health human resources, provide health managers with tools to improve primary and continuing care, and support nursing research from a health system perspective.

	8) Actual Spending 2002 (Jan. 1 to Dec. 31)	9) Actual Spending 2003 (Jan. 1 to Dec. 31)	10) Planned Spending 2004 (Jan. 1 to Dec. 31)	11) Total Authorities 2004 (Jan. 1 to Dec. 31)	12) Actual Spending 2004 (Jan. 1 to Dec. 31)	13) Variance between 10) and 12)
14) Conditional Grants	$9,494,368	$7,845,209	$9,985,633	$9,985,633	$8,193,855	$1,791,778
Core Funds,	—	$3,653,976	$3,401,014	$3,401,014	$3,160,734	$ 240,280
NURSE and EXTRA	—	$1,377,576	$2,442,010	$2,442,010	$2,411,460	$ 30,550

15) Comments on Variances: N/A

Comments regarding the Core and NURSE Funds will be combined since programs under these funds are closely linked. EXTRA Fund comments will be handled separately.

Core Funds and NURSE Funds were under spent by just over $2 million.

Research Grants and Awards:
The Research Grants and Awards line item is made up exclusively of grants and awards that the Foundation makes to perform research (i.e. Open Grants Competition and Nursing Care Partnership), and "increase capacity" (i.e. Post-Doctoral Awards, Career Reorientation Awards, Chairs Awards and Regional Training Centres) within applied health services. This line item was under spent by approximately $879,000. This under expenditure is the result of grantees/awardees not providing sufficient information for the payments to be released. These factors which are outside of the CHSRF's control were coupled with the fact that a normal granting and awards cycle extends a fiscal budget cycle, resulting in funds not being expensed in 2004.

Under the CHSRF auditors' recommendation, the CHSRF payment to CIHR for its contribution to the Open Grants Competition (for files that were transferred to CIHR) has been removed from the CHSRF Statement of Operations and recorded as a reduction of deferred contributions. This approach represents proper accounting treatment for this transaction given that the risks and liability have been transferred to CIHR. The budget was not adjusted downward at the time of the transfer, accounting for an under expenditure of approximately $360,000. The remaining Open Grants Competition files retained at CHSRF were under spent by $191,665. The transfer of files to CIHR partially accounts for this under expenditure. If the files had remained with the Foundation, payments would have been made covering the period from July to December. Given the transfer, the initial payment to new grants was delayed until November, therefore resulting in an under expenditure for the four month period from July to October. Also, certain payments were delayed as CHSRF did not receive the required financial and progress reports from the researchers in a timely manner to trigger the subsequent payments.

The Commissioned Research line item was under spent by $112,837. There were two main reasons for this:

- the delays experienced with the Methods of Synthesis project (authors were very slow to submit their papers) which delayed expenses into 2005; and
- the limited internal resources available to lead further commissioned research projects given the redesign of the research programs that was undertaken when the new Director, Research Programs joined CHSRF, in combination with staff maternity leaves.

The budget for Career Orientation Awards was under spent by approximately $115,000. The reason for the under expenditure is that CHSRF only awarded three of four available awards in 2004 and the start dates for the three awards were June, September and November. With the later start dates, less money was spent in 2004. The surplus will be carried forward to 2005 to cover forward commitments.

Similar to the issues faced with the Career Reorientation Awards, the Post-Doctoral Awards were also under spent. While the Foundation awarded all eight awards in the 2004 competition, many recipients were not able to start as early as they had originally anticipated (i.e. they must complete all PhD requirements before they can commence the award and had until February 28, 2005 to do so—in academia, delays in thesis defense dates are common). In addition, we also had a few award holders from previous competitions who ended their awards early which also contributed to the under expenditure.

Financial Table 12: Conditional Grants (Foundations) (cont'd)

Linkage and Exchange
Linkage and Exchange expenditures are all the costs relating to the Knowledge Transfer and Exchange activities undertaken by the Foundation. The budget for this area of activity was under spent by approximately $488,000 due to difficulties in staffing a key position in this area earlier in the year.

This under expenditure was caused by a variety of projects that were not realized in 2004 due to other commitments. The research dissemination budget was under spent by approximately $76,000. It was anticipated that four fact sheets would be published for $20,000 but only one was realized. The primary care synthesis and funding of a research team to do the dissemination (with budgets of $30,000 and $18,000 respectively) were not accomplished.

The Knowledge Networks and Broker Training line item was under spent by $255,000. This under expenditure is mostly attributable to the activity associated with the knowledge broker demonstration pilots. The under expenditure is due to a timing issue, i.e. the funds were budgeted in 2004 but the expenses will only be recognized in 2005. The projects were to start earlier in 2004 but the six demonstration sites only started in December 2004. These are the knowledge broker demonstration projects that were reclassified to prepaid expenses during the course of the audit. In the networks section, approximately $50,000 was not spent due to staffing issues associated with maternity leaves.

Program Support and Development
Program support and development includes all costs to support the Foundation's core research and knowledge transfer and exchange mandate. This area of activity was under spent by $428,000—following are some of the explanations.

Regional and Scientific Officers—CHSRF is in transition in terms of how it uses the regional officers. As a result, the empty regional officer positions (in Quebec and Atlantic Regions) were not filled despite original intentions. Also, the availability of those on contract may also have been affected by their heavy level of involvement with the EXTRA program. These officers were not used to the extent outlined in the budget (i.e. the budget included three days a month but they invoiced the Foundation for less.)

CHSRF managed to streamline its Merit Review Process by completing it within one day instead of the budgeted two days. With regard to the Career Orientation Awards and the Post-Doctoral Awards, the merit review panel process was combined into one panel session instead of two individual panels, thus reducing the overall costs associated with this activity.

The realized savings as well as the realized time associated with a streamlined merit review process allowed staff to complete work that would have normally been done by consultants, thus reducing expenditures identified in the budget.

Administration
The Administration budget was under spent by $252,134, in part due to staff vacancies ($100,000). In 2004, a number of cost-saving initiatives reduced the overall administration costs.

EXTRA Program
Overall, the EXTRA program expenses came in under budget by $30,550. The EXTRA expenditures are made up of all costs related to running the EXTRA program. It was somewhat difficult to budget for a new program with no previous history.

16) Significant Evaluation Findings and URL to last evaluation:

The Foundation has completed a number of summative and qualitative evaluations of its respective programs. CHSRF commissioned an International Review Panel Report in 2001 and it anticipates that it will conduct another overall evaluation in 2007. Significant findings included: CHSRF has made notable gains in a short time; its focus should be on knowledge transfer; emphasis should also be placed on measuring its impact and expanding its communications efforts, partnerships, and work in the nursing community. The Report also concluded that CHSRF compares very well to similar international organizations that are more established and operate with larger budgets.

http://www.chsrf.ca/other_documents/irpr/

17) URL to Foundation site: www.chsrf.ca

18) URL to Foundation's Annual Report: http://www.chsrf.ca/other_documents/annual_reports/2004/

Financial Table 12: Conditional Grants (Foundations) (cont'd)

1) NAME OF FOUNDATION: CANADA HEALTH INFOWAY INC. (*INFOWAY*)

2) Start Date: March 9, 2001 3) End Date: N/A 4) Total Funding: $1.2 billion

5) Purpose of Funding:

Canada Health Infoway Inc. (*Infoway*) is an independent not-for-profit corporation with a mandate to foster and accelerate the development and adoption of electronic health information systems with compatible standards and communications technologies across Canada. *Infoway* is also a collaborative mechanism in which the federal, provincial and territorial governments participate as equals, toward a common goal of modernizing Canada's health information systems. This collaborative approach will reduce overall costs in various ways: by avoiding duplication of efforts; through economies of scale; by building once and replicating in other jurisdictions; by increasing system interoperability (connecting all systems together); and by maintaining a consistent and sustained approach which is based on the Electronic Health Record (EHR) Blueprint.

Funding has been provided to *Infoway* on three occasions: $500 million in 2001 in support of the First Ministers' Action Plan for Health System Renewal of September 2000 to work together to strengthen a Canada-wide health infostructure to improve quality, access and timeliness of health care for Canadians, with the EHR as the key priority; $600 million as part of the First Ministers' Health Accord of February 2003 to accelerate implementation of the EHR; and $100 million as part of Budget 2004 to support the development of a pan-Canadian health surveillance system, with a particular focus on infectious disease.

6) Objective(s), expected result(s) and outcomes:

Infoway is working in collaboration with the federal, provincial and territorial governments toward having the basic elements of an interoperable EHR in place across 50 percent of the population by the end of 2009. To achieve this, *Infoway* is co-investing with the provinces and territories to develop and implement nine programs: Infostructure, Registries, Diagnostic Imaging, Drug Information Systems, Lab Information Systems, Telehealth, Health Surveillance, Interoperable EHR, and Innovation and Adoption. The investments in EHR will have an impact on the health care system and its sustainability by improving the quality, productivity and timeliness of health care delivery. In addition, investments will enhance accessibility to health care services and improve patient safety.

7) Achieved results or progress made (within overall departmental results achieved):

In 2004–2005, *Infoway* committed $195 million in project investments. This represents 56 percent more investment than in the previous three years combined, for a total of $321 million since *Infoway* was created. *Infoway* initiated 52 new projects in 2004–2005, virtually doubling its project count and bringing its cumulative total to 105 projects. Nineteen of the new projects were based on reusing and adapting the results of successful diagnostic imaging, drug information, client registry and provider registry implementations from other parts of the country. *Infoway* has now approved investment strategies for all of their nine programs. There are now 62 jurisdictional projects jointly developed with the provinces and territories: 20 Registries, 17 Diagnostic Imaging, 6 Drug Information Systems, 6 Lab information Systems, 8 Telehealth and 5 Interoperable EHR projects. In addition, 44 pan-Canadian projects are under way.

As well, to make it easier for provinces and territories to provide their share of the funding for EHR projects, *Infoway* recently decided to increase their funding to cover an average of 75 percent of project costs, rather than 50 percent.

	8) Actual Spending 2002–03	9) Actual Spending 2003–04	10) Planned Spending 2004–05	11) Total Authorities 2004–05	12) Actual Spending 2004–05	13) Variance between 10) and 12)
14) Conditional Grant(s)	$18.3 M	$59.8 M	N/A	N/A	$73.7 M	

15) Comments on Variances: N/A

16) Significant Evaluation Findings and URL to last evaluation:

An evaluation to measure *Infoway*'s overall performance in achieving the outcomes identified in the Funding Agreement is due March 31, 2006.

17) URL to Foundation site: http://www.infoway-inforoute.ca/

18) URL to Foundation's Annual Report: http://www.infoway-inforoute.ca/resourcecentre/index.php?lang=en

Financial Table 13: Response to Parliamentary Committees, Audits and Evaluations

RESPONSE TO PARLIAMENTARY COMMITTEES
Health Canada did not table any responses to Parliamentary Committee reports during 2004–2005.
RESPONSE TO THE AUDITOR GENERAL
In November 2004, the Auditor General's Report, *Chapter 4 — Management of Federal Drug Benefit Programs* was tabled. The Report's findings deal with three main themes: coordination among federal departments; efficient management of public funds; and patient safety. The Department has established several goals to address the audit recommendations. In particular, Health Canada is committed to improving collaboration across drug programs, improving the efficiency and effectiveness of pharmacy provider audits, and enhancing the capacity of the Department to alert pharmacists to potential drug misuse. In February 2005, the Auditor General's Report *Chapter 4 — Accountability of Foundations* was tabled. Improvements were called for in oversight, and performance audits and evaluations; greater consistency in the governance regime for foundations; and greater clarity in the application of the transfer payment and alternative service delivery policies. Health Canada will continue to work with central agencies and foundations to comply with all applicable provisions regarding the oversight of foundations as recommended by the Auditor General's Report.
EXTERNAL AUDITS OR EVALUATIONS
Audits Conducted by the Auditor General: Management of Federal Drug Benefit Program Accountability of Foundations *Reports by the Commissioner of the Environment and Sustainable Development (CESD):* Chapter 4: Assessing the Environmental Impact of Policies, Plans and Programs Chapter 6: Environmental Petitions *Audit conducted by the Public Service Commission (PSC):* Special Audit on Federal Student Work Experience Program (FSWEP) *Monitoring by the Public Service Commission (PSC):* Questionnaire on the application of the Public Service Official Languages Exclusion Approval Order *Audit conducted by the Canadian Human Rights Commission:* Twelve Statutory Requirements of the *Employment Equity Act* *Audits conducted by the Office of the Commissioner of Official Languages:* Audit of Active Services to the Public — Part IV http://www.ocol-clo.gc.ca/archives/ar_ra/2004_05/health_sante_e.htm Health Canada's Official Languages Report Card http://www.ocol-clo.gc.ca/archives/ar_ra/2004_05/health_sante_e.htm
INTERNAL AUDITS OR EVALUATIONS
Internal audits completed by Health Canada in 2004–2005 are available on the departmental Web site: Audit of Moveable Assets http://www.hc-sc.gc.ca/ahc-asc/performance/audit-verif/2004-list/mov-mob_e.html Audit of Grants and Contributions Programs Within HECSB http://www.hc-sc.gc.ca/ahc-asc/performance/audit-verif/2004-list/hecs-dgsesc_e.html Audit of the Management Control Framework for Conflict of Interest http://www.hc-sc.gc.ca/ahc-asc/performance/audit-verif/2004-list/frame-cadre_e.html Audit of Sustainable Development http://www.hc-sc.gc.ca/ahc-asc/performance/audit-verif/2004-list/sus-dur_e.html Directed audit of the expenses incurred by the Société santé en français Inc. according to Contribution Agreements no 6799-15-2002/0370032 and 6799-15-2002/0370033 http://www.hc-sc.gc.ca/ahc-asc/performance/audit-verif/2004-list/SSF_e.html Audit of Emergency Preparedness

Financial Table 13: Response to Parliamentary Committees, Audits and Evaluations (cont'd)

Internal Evaluations completed by Health Canada in 2004–2005:
Aboriginal Head Start On-Reserve Program First Nations and Inuit HIV/AIDS Strategy Alcohol and Drug Treatment and Rehabilitation Program Contribution to the Canadian Council for Donation and Transplantation Labrador Innu Healing Strategy Federal Tobacco Control Initiative
NOTES:
For transparency purposes, Health Canada is including the following information in its response to the Auditor General's Report. In March 2004, the Auditor *General's Regulation of Medical Devices* Report was tabled. Report recommendations related to the assessment of risks in the conduct of investigational tests for medical devices; timely access to safe and effective medical devices; the management of post-market medical devices risks and benefits; the regulation of reprocessed single-use devices; cost-recovery program; adequate human and financial resources for the delivery of the medical devices program; reporting on progress and challenges in the program; and, evaluating, measuring and reporting on results of the program. In response, a number of actions have been completed and/or are under way. These include but are not limited to: issue and gap analysis, reviews and comparative studies; process mapping; the implementation of an inspection program; the development of safety signals; annual reporting on adverse reaction; staffing; implementation of a costing model; development of a logic model and performance measurement strategy for the medical devices program; development of a results-based management accountability framework for the post-market surveillance of medical devices. Remaining action items relate to long-term activities and involve provincial/territorial/stakeholder engagement and consultations, finalization of memoranda of understanding with international partners, and implementation of recommendations http://www.oag-bvg.gc.ca/domino/reports.nsf/html/20040302ce.html

Financial Table 14: Sustainable Development Strategy Commitments

Health Canada's Sustainable Development Strategy (SDS) for 2004–2007 was developed with three thematic areas and six related objectives to guide action and implementation as follows:

Helping to create healthy social and physical environments

Objective 1.1

Health Canada commits to strengthening partnerships on health, environment and sustainable development to contribute to healthier environments and safer foods and products for Canadians.

Objective 1.2

Health Canada commits to the collaborative delivery of health promotion, disease prevention and health care services for First Nations and Inuit.

Objective 1.3

Health Canada commits to strengthening partnerships with other federal departments and non-governmental organizations in order to contribute to a healthier population.

Integrating sustainable development into departmental decision-making and management processes

Objective 2.1

Health Canada commits to integrating sustainable development into departmental decision-making and management processes to contribute to the effective delivery of Health Canada's programs.

Minimizing the environmental health effects of the Department's physical operations and activities

Objective 3.1

Health Canada will contribute to healthier environments and safer products for Canadians through improved departmental activities and sustainable management of land and facilities.

Objective 3.2

Health Canada will contribute to promoting healthier environments and safer products for Canadians by adopting a pollution prevention approach.

Health Canada's third SDS 2004–2007 is based on the strategic outcomes outlined in the 2004–2005 Report on Plans and Priorities as well as key federal sustainable development reports, priorities, and initiatives.

The alignment of the SDS commitments with departmental planning is helping employees understand the relationship between sustainable development and the key mandated areas of focus for the Department. Clarifying this relationship brings together a better picture of how sustainable development is positioned in the Department and is instrumental in building the understanding needed to ensure progress in changing behaviours.

Financial Table 14: Sustainable Development Strategy Commitments (cont'd)

By fulfilling the commitments in the Strategy, Health Canada will make progress in ensuring that sustainable development is incorporated into program delivery, policy development, decision-making and the way in which the Department manages its operations.

SUMMARY OF KEY TARGETS*	
Target	**Progress Information**
1.1.1 In partnership with federal, provincial and territorial departments of health and environment, Health Canada will develop an integrated, source-to-tap approach to drinking water quality in Canada.	Drinking Water Guidelines and their supporting documents are being developed for chemical and microbiological contaminants on an ongoing basis. Three guidelines (Trihalomethanes, Bromodichloromethane, and Arsenic) were approved by the FPT Committee on Drinking Water for consultation in January 2005 and the fourth (chlorite/chlorate) was approved in April 2005.
1.1.2 Health Canada will work with other federal departments to develop a compliance framework for drinking water quality in areas of federal jurisdiction.	Health Canada leads an Interdepartmental Working Group on Drinking Water in the development of the document, Guidance for Providing Safe Drinking Water in Areas of Federal Jurisdiction. This 85-page document has been consulted on, edited, translated and approved by members of the Interdepartmental Working Group. It is expected that the document will be posted to the Health Canada Web site in 2005–2006.
1.1.3 Health Canada, in conjunction with other federal departments, will reduce cross-border air pollution by undertaking pilot projects that enable greater opportunities for coordinated air quality management between Canada and the United States.	The National Population Health Survey (NPHS) data are being analyzed for long-term exposure to air pollution. Each participant is being assigned a long-term exposure level based on his/her residential history. The next step will be the analysis of the associations between long-term exposure to air pollution and adverse health outcomes. Work on the Air Quality Index (AQI) is proceeding on schedule. Subject to provincial acceptance, this reformulated AQI will be piloted in summer 2005–2006 for planned implementation in 2007–2008.
1.1.4 Health Canada will collaborate with partners and other federal departments to assess climate change impacts on human health and well-being, and research and develop approaches to adaptation planning and implementation as part of the Climate Change Plan for Canada.	Work has started and a number of contracts are in place with departmental personnel and academics. Further information will be provided as developments occur.
1.1.5 Health Canada will work in consultation with stakeholders to develop and/or update science-based guidelines and standards to improve the safety of the food supply and reduce food-borne illness.	Health Canada is finalizing the preparation of drafting instructions for proposed regulatory amendments to enhance labelling requirements for added food allergens, gluten sources and sulphites.

Financial Table 14: Sustainable Development Strategy Commitments (cont'd)

Target	Progress Information
1.1.6 Health Canada will help prevent the exploitation of flora and fauna used for medicinal purposes.	The convention on International Trade in Endangered Species of Wild Fauna and Flora (cites) standards have been incorporated into guidance documents and assessment tools for natural health products. http://www.hc-sc.gc.ca/dhp-mps/prodnatur/legislation/docs/index_e.html
1.1.7 Health Canada will improve its process for making regulatory decisions for pest control products to provide access to safer products, and will provide information on pest control products and on sustainable pest management practices.	In October 2004, proposed Adverse Effects Reporting (AER) Regulations for pest control products were published in *Canada Gazette*, Part I and draft AER reporting forms were posted on Health Canada's Web site for comment.
1.2.1 Health Canada will work in collaboration with First Nations and Inuit and provinces and territories to better integrate health services for a sustainable, seamless system of health services for First Nations and Inuit.	First Nations and Inuit Health Branch has implemented health integration initiatives through pilot projects in order to identify, test and evaluate opportunities to incorporate and link program services between federal, provincial, territorial and local health organizations. In addition, Health Canada announced, in September 2004, an Aboriginal Health Transition Fund to enable federal, provincial and territorial governments and communities to devise new ways to integrate and adapt existing health services to better meet the needs of all Aboriginal peoples.
2.1.2 Health Canada will improve the integration of SD considerations within the Department by effectively integrating SD into key departmental policies, legislation and contracts where appropriate, and establishing a formal process to evaluate this integration by March 31, 2007.	As part of the legislative renewal process, sustainable development considerations have been incorporated into the drafting of the *Canada Health Protection Act*.
3.1.1 By March 2005, Health Canada commits to conducting a comprehensive impact assessment and developing a departmental guidebook and action plan, for use by all Health Canada facility managers, to identify, prioritize and propose mitigation/remediation steps in addressing Department-specific issues regarding the sustainable operation and management of Health Canada's facilities (laboratories, hospitals, health care centres and leased space).	Health Canada developed a draft guidebook for use by all departmental facility managers. The guidebook is being edited and revised prior to distribution and departmental implementation.

Financial Table 14: Sustainable Development Strategy Commitments (cont'd)

Target	Progress Information
3.2.1 By March 2005, Health Canada commits to conducting an environmental impact assessment and developing a departmental guidebook and action plan, for use by Health Canada program staff, to identify, prioritize and propose Department-specific issues to be addressed for adopting a pollution prevention approach in administering programs.	Health Canada developed a draft guidebook for use by all departmental staff. The guidebook is being edited and revised prior to distribution and departmental implementation.

* *This table represents a summary of progress made against key commitments in 2004–2005. For more details on progress, please consult the Sustainable Development Strategy 2004–2007 First Annual Report on Progress available at http://www.hc-sc.gc.ca/ahc-asc/activit/strateg/sus-dur/index_e.html*

Health Canada's current Sustainable Development Strategy entitled: Becoming the Change We Wish to See is a three year strategic plan that tells Canadians and Parliament what general and specific commitments Health Canada has made to sustainable development. Whereas the Department's first strategy contained over 100 commitments, this Strategy focuses on 20 commitments, highlights how employees are an integral part of the overall plan, and identifies a number of practical tools to help incorporate sustainable development at work and at home.

Since the first strategy, Health Canada has made progress in creating a culture that recognizes the importance of sustainable development through the approval, by senior management, of its Sustainable Development Policy in December 2000. This enabled the integration of five key principles outlined in the Policy (shared responsibility, integrated approaches, equity, accountability, and continuous improvement) into the third Sustainable Development Strategy and specifically in the areas of: workplace health; human resource modernization; values and ethics; modern comptrollership; program evaluation and performance measurement; and risk management.

Building on previous experiences and incorporating best practices in our work will achieve sustainable development in the long term.

Financial Table 15: Procurement and Contracting

1. Role played by procurement and contracting in delivering programs	Procurement plays a central role in the program delivery of this Department. It enables the Department to obtain highly specialized research and analytical advice in support of its policy and program delivery.
2. Overview of how the Department manages its contracting function	The Department operates in a decentralized environment with specialized procurement personnel at headquarters and in the regional offices. Contracting authority is delegated to all cost centre managers throughout the Department with delegation of financial authorities based on responsibility of managers. This reflects the Department's aim to have the delegations necessary to help managers deliver quality services and programs to Canadians and achieve the right balance between program knowledge and knowledge of key procurement related administrative regulations and policy. Materiel Management Division, as the functional authority for procurement, provides training, advice and guidance to managers on policy procedures with regards to acquisition of goods and professional services. Contract Requisition and Control Committees (one per branch and region) review and approve all service contracts above $10,000 and all requisitions for goods. Mandatory training on the acquisition of goods and services is provided across Canada to all managers involved in the acquisition process.
3. Progress and new initiatives enabling effective and efficient procurement practices	The Department launched a new Contract Management Framework in 2003. Key initiatives this year are the development of a Performance Measurement tool to measure contract performance, a template for Procurement Planning for the acquisition of goods and services, and a Risk Management tool to mitigate against identified types of contract risks including a matrix used to determine the source of expertise. The development of a new Contract Requisition and Reporting System is in progress and will be used by the Department to track acquisitions of goods and services and streamline the approval process. The Department has setup source lists for counseling services, communication services, and technical training. Work is in progress to prepare the Department for Government of Canada Marketplace and its emphasis on mandatory use of standing offers throughout the federal government. *Key Accomplishments:* Exceeded our targets for Aboriginal procurements on a consistent basis. Worked in partnership with Indian and Northern Affairs Canada to develop a supply arrangement specifically to address the Procurement Strategy for Aboriginal Business. Updated the matrix for the Delegation of Financial Signing Authorities
	Instrument for procurement authority. Implemented training program for departmental senior managers on procurement planning and responsibility. Developed an action plan for implementation of the Government of Canada Marketplace initiative at Health Canada.

Financial Table 16: Service Improvement Initiative

The Service Improvement Initiative (SII) applies to departments with significant direct service delivery to Canadians, and its purpose is to improve Canadians' satisfaction with the services they receive. Health Canada has been identified as one of these departments and is actively participating in implementing the SII.

1. Programs and services covered by the SII:

The Department currently has four key services actively involved in the SII. They are: the National First Nations and Inuit Health Branch (FNIHB) Drug Exception Centre; It's Your Health general health information fact sheets; Pest Management 1-800 Information Line; and Health Canada 1-800 General Inquiries Line in Pacific Region (which is new this year). The Canadian Health Network has moved to the Public Health Agency of Canada. The Health Canada 1-800 General Inquiries Line in Ontario, also one of the original initiatives, was subsequently rolled into regular operations, so no longer exists as an SII project. Part of the feedback strategy is to periodically perform follow-up client satisfaction surveys. The analysis of these surveys assists in understanding client needs and expectations and identifies where service improvements can be made.

2. Development of baseline client satisfaction levels and progress toward achieving satisfaction targets:

Baseline client satisfaction levels were set in 2002–2003. This fiscal year, a third follow-up client satisfaction survey was completed using the Common Measurement Tool for the National FNIHB Drug Exception Centre. The baseline score for overall client satisfaction for this initiative was 3.7 out of 5 in the 2002 survey. The score fell to 3.28 in the 2003 survey, but rebounded to 3.71 in the 2005 survey. The survey results have been submitted to the Common Measurement Tool Bench Marking Database at the Institute for Citizen-Centred Services.

The Pest Management Information Line and *It's Your Health* did not do another client satisfaction survey because changes in their overall client satisfaction results were negligible over the previous year.

The baseline satisfaction level for the 1-800 General Inquiries Line in Pacific Region has been completed. Analysis of the results are still in progress. Follow-up surveys have been compared to the original baseline results.

3. Service standards for all key public services—setting of standards and performance against those standards:

It's Your Health has established service standards which will be published on their Web site. The standards will be implemented immediately for all new fact sheets, and will be put in place over time for the existing fact sheets.

Service standards in FNIHB and the Pest Management Regulatory Agency (PMRA) are in the process of being reviewed and revised, and will be published once they are complete.

4. Main achievements in improving service from a citizen-centred perspective:

FNIHB Drug Exception Centre has made noteworthy changes since the last survey. They have increased their staff complement by five, improving their accessibility and waiting time ratings. They have shifted more staff to cover off the evening hours to accommodate pharmacists in western Canada.

It's Your Health consulted with clients to obtain feedback on their content preferences for future publications.

Financial Table 16: Service Improvement Initiative (cont'd)

Overall Client Satisfaction Scores

Based on the Common Measurement Tool Overall Satisfaction Scale from 1 to 5 where 1 is very dissatisfied and 5 is very satisfied.

Initiative	Baseline Results	Second Survey	Third Survey
It's Your Health fact sheets	4.0	4.18	—
PMRA—1-800 Information Line General Public Registrants	 4.63 4.15	 4.63 4.19	
Canadian Health Network	3.3	Unavailable	—
Non-Insured Health Benefits National Drug Exception Centre	3.7	3.28*	3.71
1-800 General Inquiries Line Pacific Region	4.58		

* *A key event that affected service was the Ontario power blackout during summer 2003, resulting in a significant backlog of requests. Unfortunately, the blackout coincided with the annual anniversary of pharmacists requesting renewals for funding approvals. These two factors undoubtedly had a significant impact on the timeliness and accessibility of the service.*

Service Improvement Initiative—Five Year Report

The Service Improvement Initiative (SII) applies to departments with significant direct service delivery to Canadians, and its purpose is to improve Canadians' satisfaction with the services they receive. Health Canada has been identified as one of these departments and is actively participating in implementing the SII.

1. Programs and services covered by the service improvement initiative:

The Department started this initiative in May 2001 with five key services. These were: the National First Nations and Inuit Health Branch (FNIHB) Drug Exception Centre; *It's Your Health* general health information fact sheets; Pest Management 1-800 Information Line; Health Canada 1-800 General Inquiries Line in Ontario; and the Canadian Health Network. In December 2001 the proposed National 24/7 Emergency Call Management System was added as the sixth initiative, however, this initiative was transferred to the Public Health Agency of Canada and is no longer part of the SII at Health Canada.

In March 2004, the Health Canada 1-800 General Inquiries Line in Ontario was rolled into regular operations, so is no longer reported as a Service Improvement Initiative.

In fall 2004, the Health Canada 1-800 General Inquiries Line for Pacific Region was added as a new initiative.

With the restructuring of the federal Health Portfolio, the Canadian Health Network was moved to the recently created Public Health Agency of Canada.

2. Development of baseline client satisfaction levels and progress toward achieving satisfaction targets:

Owing to the varying degrees of readiness and available resources within each program area for the SII, each of the projects is moving at its own pace, carrying out its respective surveys cyclically, rather than on an annual basis.

3. Service standards for all key public services: setting of standards and performance against those standards:

It's Your Health has established service standards, and these will be published on their Web site.

Service standards in FNIHB and PMRA are in the process of being reviewed and revised, and will be published once they are complete. www.healthcanada.gc.ca/iyh

Financial Table 16: Service Improvement Initiative (cont'd)

4. Main achievements in improving service from a citizen-centred perspective:

FNIHB Drug Exception Centre has made noteworthy changes since the last survey. They have increased their staff complement by five, improving their accessibility and waiting time ratings. They have shifted more staff to cover off the evening hours to accommodate pharmacists in western Canada.

It's Your Health consulted with clients to obtain feedback on their content preferences for future fact sheets.

SII progress by initiative

- **It's Your Health *are fact sheets used to convey general health information to Canadians.***

In early spring 2002, a client survey of distributors and users established a satisfaction baseline of 4 out of 5.

In fall 2003, the second survey of users was completed. Suggestions for improvement were again identified in this survey which scored satisfaction at 4.2 out of 5.

In 2004, action was taken to implement the improvements recommended in the survey of 2003.

In spring 2005, service standards were completed, approved and are awaiting publication.

As the difference in the overall client satisfaction results of the previous surveys has been negligible, *It's Your Health* will now be conducting cyclical client satisfaction surveys. The next survey is due in 2006.

- ***Canadian Health Network (CHN) is a national, bilingual Internet-based health information service.***

In February 2002, the first client satisfaction survey established an overall client satisfaction baseline of 3.3 out of 5.

In February 2004, the second on-line client satisfaction survey was conducted.

Later in 2004, with the restructuring of the federal Health Portfolio, the Canadian Health Network was moved to the Public Health Agency of Canada and is no longer considered a Health Canada SII.

http://publiservice.tbs-sct.gc.ca/rma/dpr1/04-05/index_e.asp

- ***National FNIHB Drug Exception Centre processes limited use and exception drugs under the Non-Insured Health Benefits Program.***

In June 2002, the initiative established a client satisfaction baseline of 3.7 out of 5 by conducting a random survey of 1,000 pharmacists.

In fall 2003, the second survey of pharmacists was completed. The score fell to 3.28. A key event that could have contributed to this result was the Ontario power blackout during summer 2003, resulting in a significant backlog of requests.

In early 2005, a third follow-up client satisfaction survey was completed and the overall satisfaction score rebounded to 3.71.

- ***Pest Management 1-800 Information Line answers routine inquiries concerning human health and environmental risks associated with pest control products.***

In June 2002, approximately 100 clients were surveyed via phone calls, personal letters and faxes to establish an overall client satisfaction baseline. The baseline was established at 4.63 out of 5 for the general public and 4.15 out of 5 for registrants.

In 2003, a second survey was completed with an overall client satisfaction score of 4.63 out of 5 for the general public and 4.19 out of 5 for registrants.

This initiative will now be conducting cyclical client satisfaction surveys, as the difference in the overall client satisfaction results of the previous surveys has been negligible.

Financial Table 16: Service Improvement Initiative (cont'd)

Service standards are being reviewed and revised and will be published in 2005.

The next survey will be conducted in 2006.

- ***Health Canada 1-800 General Inquiries Line was established in Toronto in October 2002 as a six-month pilot project.***

On April 1, 2004, this project was rolled into regular regional operations and is no longer a Service Improvement Initiative.

- ***Health Canada 1-800 General Inquiries Line for Pacific Region.***

In fall 2004, the Line came on board as a new initiative.

In February 2005, the first client satisfaction survey established an overall satisfaction baseline of 4.58 out of 5.

Financial Table 17: Horizontal Initiatives

The Horizontal Initiatives being reported were led or participated in by Health Canada.

A Horizontal Initiative template is completed for all major horizontal initiatives where Health Canada is the lead and:

- have been allocated federal funds that exceed $100 million for the entire initiative; or
- are key to the achievement of Government priorities; or
- have a high public profile.

More complete information on each initiative for which Health Canada is the lead, is available on Treasury Board Secretariat's Horizontal Results Database (www.tbs-sct.gc.ca/rma/eppi-ibdrp/hrdb-rhbd/profil_e.asp).

INITIATIVES FOR WHICH HEALTH CANADA IS LEAD DEPARTMENT		
Initiative	**Partners**	**Description**
Building Public Confidence in Pesticide Regulation and Improving Access to Pest Management Products	Agriculture & Agri-Food; Fisheries and Oceans; Environment; Natural Resources; Canadian Food Inspection Agency	The initiative will increase public and stakeholder confidence in the pesticide regulatory system; protect health and environment as well as increase the competitiveness of the agri-food and forestry sectors.
Canada's Drug Strategy (CDS) Renewed	Solicitor General; Royal Canadian Mounted Police; Correctional Services; Foreign Affairs; Justice	Renew CDS to reduce substance use and abuse, especially among vulnerable populations such as youth. The Strategy includes the creation of two new classes of Health Canada contributions: Drug Strategy Community Initiatives Fund for community projects particularly aimed at vulnerable segments of the population such as women, Aboriginals, and youth; and a Contribution in Support of the Canadian Centre on Substance Abuse.
Early Childhood Development (ECD) for First Nations and Other Aboriginal Children	Social Development; Indian and Northern Affairs	Enhance programs that support ECD, with particular focus on First Nations children on reserves, and reduce incidence of Fetal Alcohol Syndrome/Effects in First Nations communities. Improve existing federal ECD programs; strengthen capacity/networks; develop a research/knowledge strategy; improve integration, coordination, accountability and reporting in federal ECD programming.
Federal Tobacco Control Strategy (FTCS)	Solicitor General; Royal Canadian Mounted Police; Justice; Canada Revenue Agency	The FTCS is designed to achieve significant reductions in disease and death due to tobacco use. FTCS builds upon the four reinforcing components of protection, prevention, cessation and harm reduction.

Financial Table 17: Horizontal Initiatives (cont'd)

Initiative	Partners	Description
Health Information Contribution Program	Statistics Canada	Support the Canadian Institute for Health Information (CIHI) (the sole recipient of the Program) in its mandate as established by the Conference of Federal/ Provincial/Territorial Ministers of Health in 1992.
Therapeutics Access Strategy (TAS)	Patented Medicine Prices Review Board; Canadian Coordinating Office for Health Technology Assessment; Canadian Institute for Health Information	Help Canadians maintain and improve their health by ensuring that human drugs and other therapeutic products are safe, of high quality, therapeutically effective, appropriately used, and accessible in a timely and cost-effective fashion.
2003 First Ministers' Accord on Health Care Renewal	Provincial/Territorial Governments	Creates an action plan that will ensure Canadians have timely access to quality health care on the basis of need and not ability to pay. Initiative programs include establishment of the Health Council of Canada and the Canadian Patient Safety Institute; development of a strategy for Health Technology Assessment and improvement of Health Human Resources planning and coordination.
KEY HORIZONTAL INITIATIVES FOR WHICH HEALTH CANADA IS A PARTNER		
Initiative	**Partners**	**Description**
Budget 2003 Investment for Delivering the Canadian *Environmental Protection Act* (CEPA)	Environment (lead)	Improve the capacity of Environment Canada and Health Canada to meet legislative obligations established under CEPA.
Climate Change Horizontal Framework	Environment (lead); seven other departments participating	The Framework will help make it possible to measure the extent to which technological advances have made a difference in emissions; federal funding has levered support from stakeholders in public and private sectors; the co-benefits of investing in climate change are understood, and achieved; Canada is working to develop the knowledge base needed for future climate change negotiations.
Federal Contaminated Sites	Environment (lead); 10 other departments participating	Funding for a number of projects for which funding was sought under the Federal Contaminated Sites Accelerated Action Plan.
Implementation of the First Nations Water Management System	Indian and Northern Affairs (lead)	Improve the quality of water and wastewater treatment on reserves.

Financial Table 18: Travel Policies

Comparison to the TBS Special Travel Authorities
Health Canada follows the TBS Special Travel Authorities.
Comparison to the TBS Travel Directive, Rates and Allowances
Health Canada follows the TBS Travel Directive, Rates and Allowances.

Section IV

Other Items of Interest

Advancing Science

To meet our mandate, "to help the people of Canada maintain and improve their health and safety," our Department must have access to the highest quality scientific and technological advice. We need an adaptable in-house capacity to perform independent science, and to facilitate and interpret the science conducted by our partners. These enable us to develop policy in emerging technology areas, regulate increasingly sophisticated products and provide the services, information and management of issues essential to the health of Canadians.

To enhance the quality of science and science advice, our Department has a Chief Scientist, who established three priorities for the office in August 2004: ensuring effective use of science in policy-making; enhancing science capacity and quality; and, raising awareness and understanding of the science conducted at Health Canada.

In support of these priorities, the Chief Scientist had several notable accomplishments during 2004–2005:

- enhancement of science and technology partnerships within and outside of the Department;
- introduction of the Scientist Emeritus Program to maximize scientific corporate memory and mentor new scientists;
- introduction of new mechanisms to secure external science advice; and
- delivery of a successful Health Canada Science Forum.

The Chief Scientist is committed to working in partnership to spur scientific advances that improve health. Most significant among the partnerships is the bond between Health Canada and Canadian Institutes of Health Research (CIHR). The Chief Scientist fosters and facilitates that partnership by acting as a catalyst for collaborative research initiatives in areas of strategic importance. For example, Health Canada has been an active scientific and funding partner in projects to reduce health disparities among Canadians. In addition, the Office of the Chief Scientist co-sponsored the Policy Forum on Health Disparities, which brought together researchers and federal and provincial officials.

Other partnerships in progress include: The Safe Food and Water Initiative with CIHR; the Severe Acute Respiratory Syndrome Consortium with the Public Health Agency of Canada and CIHR; and an innovative exchange program with the Department of Foreign Affairs. Canada has special expertise in coordinating efforts in global health research. This is demonstrated by the activities of the new Global Health Research Initiative, which is a unique partnership of four federal agencies, Health Canada, CIHR, the Canadian International Development Agency and the International Development Research Centre,

deploying their distinct strengths to increase Canada's contributions to global health research and its use.

The Scientist Emeritus Program involves welcoming back retired Health Canada scientists in a volunteer capacity to mentor and coach young scientists in their fields of expertise. Our first Scientist Emeritus, Dr. Tony Myers, was announced in 2005.

The Science Advisory Board (SAB) provides a valued source of expert, independent advice to the Minister of Health on the science performed and used by Health Canada, focusing on the future direction of scientific programs, emerging health sciences and scientific trends, and scientific partnerships and linkages. The pervading theme for the Board's work in 2004–2005 was Managing Science in Times of Change and this was reflected in its provision of advice on public health issues related to the new Public Health Agency of Canada. The Board also considered departmental science needs and capacity, risk management strategies, and the need for openness and transparency in decision-making.

The Science Forum has grown into a national showcase for Health Canada's innovative science. The 2004 Forum, Current Health Challenges Facing Canadians, included experts in law, environmental health, biotechnology, pharmacology and medicine. Discussions focused on science-based solutions to important health issues. The diversity of health-related disciplines provided a broad perspective, enriching the foundation for evidence-based decisions affecting the health of Canadians. The 2004 Forum included a team of Russian scientists, adding an international perspective and opening the door for the sharing of research results and best practices at a global level.

Improving Management Practices

In addition to items discussed elsewhere in this Report, there are three focal points of attention as Health Canada improves management practices.

Progress on the Management Accountability Framework

Building on progress in implementing our vision of a modern organization, as established in the Modern Management Strategy developed under the Modern Comptrollership Initiative, the Department has continued to integrate the principles of modern comptrollership into management processes and systems, establishing the foundation for sound management.

When the Treasury Board Secretariat introduced the Management Accountability Framework (MAF) in 2003, our Department was ready to adopt it as we saw it as an integration tool for management. We first put our focus on strengthening stewardship and accountability as a means to enhance the capacity of the Department to deliver on our priorities. This led to improvements to management systems, processes and practices and changing the way managers and staff operate. The challenge for the last year was to sustain these changes, measure their impact and continue to adopt sound management practices.

We are using the MAF as a lens to assess management practices and identify areas for further improvement. Managers at all levels have been exposed to the concepts and principles of the MAF through management courses and presentations. During 2004–2005, Health Canada branches and regions began examining their strengths and gaps using the MAF, with some aligning their respective planning and management activities with the 10 elements of the MAF.

Support from senior management, particularly through the Department's Executive Sub-Committee on Operations (DEC-Ops), was key in ensuring that management improvement remained the focus of attention. By monitoring and approving a number of important changes in management practices and systems in the Department, DEC-Ops is playing an important role in operationalizing the MAF.

In fall 2004, DEC-Ops adopted the MAF as a guide to establish its own forward agenda. In December 2004, DEC-Ops also approved the creation of the MAF Network to further enhance the capacity of the Department to meet the expectations of the MAF. The MAF Network, comprised of representatives from all branches, regions and key functional areas provides: a forum to exchange information on management practices across the Department; a quick response to Treasury Board Secretariat reporting

requirements related to the MAF; and an opportunity for discussion on issues related to the operationalization of the MAF.

Integrated Risk Management

Now in its second year of activities, the Department made steady progress on implementing an Integrated Risk Management Framework. Key activities completed to date include: a risk management lens incorporated in the Priority Setting Exercise; corporate risk information included in the Report on Plans and Priorities; the development of a Corporate Risk Profile and the completion of the first departmental Internal Environmental Scan. For further information, please visit the Health Canada Web site http://www.healthcanada.gc.ca/riskmanagement

Workplace Health and Human Resources Modernization

A number of initiatives to improve management practices were undertaken in 2004–2005 in support of the People element of the MAF under the Workplace Health and Human Resources Modernization Initiative as mentioned in Section II of this Report. An example of this is the inclusion of people management objectives for all supervisors and managers in the Department. A number of other strategies to improve management practices were also implemented during this period including management capacity building and increased monitoring and reporting.

Financial Improvements

During the last year, Health Canada has taken several concrete measures to support the Stewardship element of the MAF. A great deal of effort has been made by departmental officials to demonstrate that Health Canada is continuing its efforts to develop a culture where managers focus more on financial management.

The Department has implemented several measures to strengthen financial analysis and management including: the renewal of the Management Variance Report process, the implementation of Financial Management Performance Measures for Executives, improved integration of activities of human resources and financial advisors, Expenditure Review Committee Exercise, Program Activity Architecture and Horizontal Reviews Analysis, extensive financial management review and user requirements for Therapeutics Access Strategy, creation of the Financial Management and Advisory Services division, the use of the OAG's Financial Management Capability Model as a vision for financial management at Health Canada, and the adoption of new Delegation of Financial Signing Authorities Instrument.

A Health Approach to Sustainable Development

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

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

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

Within these three thematic areas or goals, organizational commitments were classified further using objectives and targets and, as of March 31, 2005, considerable progress has been made towards completion of the 20 target commitments. Additional information can be found in Table 14 of this document. For a complete report on Health Canada's third Sustainable Development Strategy, please consult the Office of Sustainable Development at http://www.hc-sc.gc.ca/ahc-asc/activit/strateg/sus-dur/index_e.html

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

First Nations Health — Follow-Up in Response to the Public Accounts Committee 2001

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. This document highlights some of the progress made by the Department since the release of the PAC/OAG reports.

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 made 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 and recommendations 5, 9, 11, 16, 19, 23 and 24, Health Canada reported with an electronic link to the 2002–2003 Departmental Performance Report and will continue with subsequent reports until 2005.

Community Health Programs (CHP) accountability

Key Actions Taken

A review of reporting requirements for funding agreements was initiated to rationalize and streamline the reporting demands on First Nations and Inuit communities. With the participation of First Nations, Health Canada has initiated a process to streamline reporting with a focus on outcome related information. Health Canada has completed the two phase process to streamline reporting, with First Nations participation. Phase I was completed in December 2003 and resulted in nearly a 20 percent overall reduction in reporting. Phase II was initiated in April 2004 with reporting schedules grouped together to further streamline and reduce duplication, and the result was a further reduction in data elements. The results were incorporated into the reporting schedules

for new 2005–2006 agreements. Supporting templates and other documentation will be developed in 2005–2006.

Supporting capacity development

Key Actions Taken

Health Canada developed pilot health plan demonstration sites that will improve 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 improve/enhance programs and services, management information and reporting. Seven demonstration projects are under way which is a step towards increasing First Nations and Inuit communities' capacity to meet the health needs of members, to increase accountability, and to achieve integration of services where viable.

Measuring performances, outcomes achievement, and managing information

Key Actions Taken

Health Canada worked with the National Aboriginal Health Organization (NAHO) to support the First Nations Regional Longitudinal Health Survey (RHS). The survey provides health information about the on-reserve First Nations population. Data collection is complete, with over 80 percent of the targeted 28,405 respondents participating. The official release of RHS findings is expected in fall 2005. An independent review is currently under way to evaluate the RHS, including all phases of the project: initial consultation, questionnaire development, sampling, data collection, analysis and dissemination.

To support evidence-based decision-making, Health Canada completed the first phase of the Home and Community Care evaluation, Health Services Transfer Policy evaluation, Brighter Futures and Building Healthy Communities evaluations and a review of the Youth Solvent Abuse Program.

Non-Insured Health Benefits (NIHB) Program control and prevention measures

Key Actions Taken

Health Canada enhanced the quality of the management of services provided to First Nations and Inuit. We continued to conduct regular analysis of pharmacists' overrides of warnings, conducted audits on providers and continued to generate quarterly reports on the number of Drug Utilization Review (DUR) claims submitted, accepted and rejected. Health Canada reviews information and instructs the claims administrator to contact providers who are consistently overriding DUR rejected claims.

Health Canada adopted a new approach to consent in February 2004 that restricts the consent requirement to clients who may be at risk or who are engaged in inappropriate claims. In a few instances, where client safety or inappropriate use of the system may be a concern, Health Canada will seek the express consent of clients to share their personal information with health care providers.

The Department is committed to implementing greater measures to improve the management of First Nations and Inuit programs and services. More detailed information on follow-up actions can be found in the electronic Annex B of the DPR: http://www.hc-sc.gc.ca/ahc-asc/performance/estim-previs/dpr-rmr/index_e.html

Section V

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