ESTIMATES

Health Canada

Performance Report

For the period ending
March 31, 2000

Canada

Improved Reporting to Parliament
Pilot Document

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

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

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

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Foreword

On April 24, 1997, the House of Commons passed a motion dividing on a pilot basis the *Part III of the Estimates* document for each department or agency into two separate documents: a *Report on Plans and Priorities* tabled in the spring and a *Departmental Performance Report* tabled in the fall.

This initiative is intended to fulfil the government's commitments to improve the expenditure management information provided to Parliament. This involves sharpening the focus on results, increasing the transparency of information and modernizing its preparation.

The Fall Performance Package is comprised of 83 Departmental Performance Reports and the President's annual report, *Managing for Results 2000*.

This ***Departmental Performance Report,*** covering the period ending March 31, 2000 provides a focus on results-based accountability by reporting on accomplishments achieved against the performance expectations and results commitments as set out in the department's *Report on Plans and Priorities* for 1999-00 tabled in Parliament in the spring of 1999.

Results-based management emphasizes specifying expected program results, developing meaningful indicators to demonstrate performance, perfecting the capacity to generate information and reporting on achievements in a balanced manner. Accounting and managing for results involve sustained work across government.

The government continues to refine its management systems and performance framework. The refinement comes from acquired experience as users make their information needs more precisely known. The performance reports and their use will continue to be monitored to make sure that they respond to Parliament's ongoing and evolving needs.

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

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

Planning, Performance and Reporting Sector
Treasury Board Secretariat
L'Esplanade Laurier
Ottawa, Ontario, Canada
K1A OR5
Tel: (613) 957-7167
Fax (613) 957-7044

HEALTH CANADA

Departmental Performance Report

For the period ending
March 31, 2000

Allan Rock
Minister of Health

This Report

Health Canada is proud to present to Parliament and to all of Canada this report on its performance for the fiscal year ending March 31, 2000.

This document is an overview of how Health Canada has used tax dollars to benefit all Canadians. The Department is large and complex and to report on every achievement in every program would take much more space than we have here.

So we will look at those accomplishments that we feel are of interest to Parliament and the public.

Health Canada's programs are managed by six Business Lines as follows:

- Management of Risks to Health
- Promotion of Population Health
- Aboriginal Health
- Health System Support and Renewal
- Health Policy, Planning and Information
- Corporate Services

Every effort has been made to make this report as clear and concise as possible. If you have further questions or want more detailed information on a particular program or service, please contact:

Health Canada
General Enquiries
0913A, 13th Floor, Brooke Claxton Building
Ottawa, Ontario K1A 0K9
(613) 957-2991

Web site: < http://www.hc-sc.gc.ca/english/feedback.htm#general General Enquiries >

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SECTION I: MESSAGES

Minister's Message

Health is a fundamental Government of Canada priority – because Canadians know that a high standard of health is linked to a high quality of life.

To achieve that priority, our government's objectives are clear: to promote and protect the health of Canadians, and to work with the provinces and territories to ensure that every one of us enjoys timely access to quality health care. Health Canada is the focal point for fulfilling these objectives, and as shown by this Departmental Performance Report,1999-2000 was a year for many important accomplishments.

The government recognized that Canadians were concerned about maintaining a modern health care system that would continue to reflect the principles set out in the Canada Health Act. Accordingly, in Budget 1999 the Government of Canada made its single largest investment by committing an additional $11.5 billion to the Canada Health and Social Transfer (CHST). Also, the Innovations Fund was established, allowing us to work with the provinces, territories, and other partners to address important challenges in the health system, for example, the needs of rural Canada, or the escalating costs of prescription drugs.

At the same time, we knew that more could and should be done to bring innovation and renewal to a health care system that Canadians strongly support. During the year, I met on many occasions with my provincial and territorial counterparts to discuss key issues and identify shared priorities. The September 11, 2000 meeting of First Ministers resulted in a landmark agreement between the federal government and the provinces and territories. Over the next five years, the federal government will invest an additional $21 billion into the CHST. Furthermore, $1 billion will be made available for new medical equipment, $800 million will be used to support primary care reform, and $500 million will go towards using information technology, such as electronic patient records, to improve care and health system management.

As part of this agreement, the First Ministers have stated their belief that, "the key goals of the health system in Canada are to: preserve, protect and improve the health of Canadians; ensure that Canadians have reasonable and timely access to an appropriate, integrated, and effective range of health services anywhere in Canada, based on their needs, not their ability to pay; and, ensure its long-term

sustainability so that health care services are available when needed by Canadians in future years." They also agreed to develop common performance measures and report regularly to Canadians on health status and outcomes, and the quality of publicly funded health services.

First Ministers also made a commitment to strengthen their investments in policies that recognize the determinants of health, enhance disease prevention and improve public health. Of course, this is the daily work of Health Canada on many fronts: regulating to ensure safe food and drugs, promoting good nutrition, fostering practical health, building a knowledge base to manage disease more effectively, to mention some. In addition to continuous improvement of these ongoing functions, we also focussed on environmental health actions and on an expanded commitment to reduce tobacco use rates among Canadians. This starts with our youngest citizens, helping them get off to the best possible start in life. Under the F/P/T agreement on early childhood development, the Government of Canada is making a substantial investment of $2.2 billion over five years through the CHST. This new transfer will complement existing federal investments for children and families.

Our government has an important and historic relationship with Canada's First Nations and Inuit. It is characterized by partnership with Aboriginal people and organizations on health issues and programs. This past year, our collaborative work included the implementation of a new home and community care program, a diabetes initiative, and early childhood development initiatives. The federal Budget 2000 earmarked additional funds to respond to increases in the cost of providing health care services for First Nations and Inuit people. Our collaborative effort this year resulted in the incorporation and funding of the Organization for the Advancement of Aboriginal Peoples' Health. We have also continued transfer of the control of health programs and resources to First Nation and Inuit communities, consistent with our government's commitments in Gathering Strength: Canada's Aboriginal Action Plan.

We succeeded this year in creating a new approach to health research, embodied in the Canadian Institutes of Health Research (CIHR). CIHR is about bringing the benefits of health research to Canadians. Its objective is to excel, according to internationally recognized standards of scientific excellence, in the creation of new knowledge and its translation into improved health for Canadians, more effective health services and products, and a strengthened Canadian health care system.

Through its own initiatives and its work with the provinces and territories, with other government departments, and with an extensive range of partners, Health Canada has made valuable progress towards achieving the government's commitment to enhance the quality of life that all Canadians expect.

The Honourable Allan Rock, P.C., M.P.

Minister of Health

Executive Summary

Because quality of life starts with quality of health, Canadians believe health must be a priority for all governments in Canada. They expect their federal government to show leadership and contribute to health improvement, while recognizing the primary responsibility of the provinces and territories for direct health care services.

Health Canada plays an important role in achieving health results — whether through encouraging the modernization of the health care system or in providing national programs and services. During 1999-2000, this Department acted on our direct responsibilities in the health system. We also played our role as a leader, partner and catalyst for action. We summarize highlights by Business Line below.

Management of Risks to Health

While Canadians experience fewer risks to health than do people in many other countries, the nature and number of risks is constantly evolving. During 1999-2000, global health issues, our disease surveillance and product monitoring activities, as well as other trends, helped us to identify new issues for action. These built on our ongoing activities and the increased funding announced in the 1999 budget. To ensure sustained strength, we also continued work to modernize our structures and approaches.

- We addressed risks to Canadians from pathogens linked to food products. High profile examples of this work included analysis of Belgian food imports for dioxin and PCB contamination, as well as investigations into health concerns about seed sprouts and Guatemalan berries. To strengthen our ability in this area, we identified more rapid methods to detect *E. coli* O157, *Cyclospora* and other food-borne threats to the health of Canadians.
- We facilitated the transition to the new Canadian Blood Services and Héma-Québec operations, with a special focus on computer systems.
- We made progress with the provinces to create standardized surveillance systems that will help public health officials gather and assess information more effectively, including a National Diabetes Surveillance System and a pilot system on blood-borne diseases.
- We supported regulatory work on emerging priorities such as the medicinal use of marijuana, natural health products and foods derived from biotechnology.
- We began a comprehensive reevaluation of all older pesticides now permitted for use in Canada.
- We updated our structure to better meet new needs by adding the Office of Natural Health Products and the Office of Consumer Affairs and Public Involvement.

Promotion of Population Health

Income levels, smoking, physical activity and family supports are just some of the social, economic and behavioural determinants that deeply influence the health status of Canadians at all stages of life. Accordingly, we centre our population health approaches on working with partners across Canadian life. With those partners, we help individuals, families and communities to better understand the factors and decisions that lead to healthier lives. That work continued in many ways during 1999-2000.

- We announced proposed changes to tobacco product warning labels and launched new advertising campaigns on tobacco issues, based on evidence about what works to help reduce tobacco use.
- We launched the Canadian Diabetes Strategy to address all facets of this growing health concern, in collaboration with the provincial and territorial governments, Aboriginal organizations and health, community, professional and other organizations.
- We improved the Canadian Breast Cancer Initiative, with a focus on support for effective, client-centred early detection and screening programs, primary prevention and stronger community-based information and support.
- We launched the Canadian Health Network, a Web site that helps Canadians get trustworthy information on healthy lifestyles, disease prevention and other health issues.
- We produced new publications and guidelines for health professionals and other tools on subjects including maternal health, health impacts of separation and divorce and physical activity for older adults.

Aboriginal Health

Consistent with the new relationship being built under Gathering Strength: Canada's Aboriginal Action Plan, Health Canada works in partnership with First Nations and Inuit, supporting the goal of First Nations and Inuit control of their health programs, services and resources. The transfer of control of health programs and resources continued during 1999-2000, as did efforts to provide services through programs such as the Non-Insured Health Benefits (NIHB) Program and community-based health programs. Health Canada is working with First Nations and Inuit and provincial and territorial governments to renew the First Nations and Inuit health system.

- We signed 16 new transfer agreements and 10 new integrated agreements as well as 10 self-government final agreements with First Nations communities to provide communities with the flexibility to take control of their health services at a pace which best suits their needs.
- We provided funding to all First Nations and Inuit communities for planning and training activities related to implementing the Home and Community Care Program.

- We completed extensive Aboriginal Diabetes Initiative (ADI) consultations with First Nations, Inuit, Métis, and urban Aboriginal national organizations and communities resulting in an ADI program framework. 12 community diabetes programs were funded.
- We implemented five telehealth pilot research projects in isolated First Nations communities, developing the administrative processes to link the isolated community nursing station to a distant provincial hospital.
- We funded 203 Aboriginal Head Start On-Reserve Program projects intended to enhance child development and school readiness of First Nations children living in First Nations communities on-reserve.
- We improved management processes to enhance accountability. The Accountability Framework will outline the roles and responsibilities of communities and Health Canada and ensure visibility and transparency in decision-making.
- We improved efficiency in the Non-Insured Health Benefits Program by connecting almost all relevant pharmacy providers to the Point of Service system.
- We worked in collaboration with the five national Aboriginal organizations to create and implement the new Organization for the Advancement of Aboriginal Peoples' Health.
- We deployed the First Nations and Inuit Health Information System (FNIHIS) to 114 health facilities. The FNIHIS provides data collection, management and reporting tools, a comprehensive, flexible and powerful platform for case management and evidence-based planning and decision-making for Canadian Aboriginal peoples.

Health System Support and Renewal

Health Canada works closely with its provincial and territorial counterparts to address Canada-wide health system needs in order to strengthen health care services and, over the longer term, provide a full range of high quality, integrated, patient-centred services. During 1999-2000, this produced many results.

- We worked with the provinces and territories on common concerns including home and community care, health human resource planning issues, population health approaches and information technologies.
- We funded 141 projects through the Health Transition Fund. These projects test ideas that could help to shape future health policy and service choices. Priority areas for projects are home care, pharmacare, primary care and integrated service.
- We supported specific telehealth and tele-homecare projects to explore ways to better meet the special circumstances of people living in rural and remote communities.
- We reinforced our attention to nursing issues by creating an Office of Nursing Policy that is helping to focus research and attention on nursing issues.

Health Policy, Planning and Information

Growing federal support for health research is part of the Government of Canada commitment to improved decision-making and policy-setting across Canada's health system. The commitment to research is matched by a commitment to put in place the kinds of information and communications technology that can facilitate faster knowledge-sharing and more effective service delivery.

- We provided the financial, secretariat and policy support that helped to create the Canadian Institutes of Health Research.
- We reoriented the National Health Research and Development Program to more clearly reflect health priorities, such as home care, children and youth, aging and health care financing.
- We supported 36 projects to foster innovative applications of information and communications technology in the health system, of which many focused on telehealth, electronic patient records and electronic health information.
- We worked with the provinces and territories through a new F/P/T Advisory Committee on Health Infostructure to bring about coordinated approaches to emerging health infostructure issues including privacy and confidentiality, health surveillance, electronic health records and telehealth.
- We launched the National Health Surveillance Network that will provide public health officials with Internet access to information, enabling them to prevent disease, react faster to public health issues and develop policies to reduce health hazards.
- We funded implementation of the First Nations and Inuit Health Information System.

Realignment

On July 1, 2000, Health Canada realigned the departmental structure to better meet the goals of:

- continuously improving Health Canada services to Canadians;
- working more effectively with internal and external partners;
- ensuring that resources go to the areas where Health Canada can make the biggest impact on the health of Canadians;
- innovation, responsiveness, flexibility, continuous learning and results orientation.

The realigned structure does not alter the Health Canada mission or mandate. It features:

- Seven branches (Population and Public Health, Health Products and Food, Healthy Environments and Consumer Safety, First Nations and Inuit Health, Information, Analysis and Connectivity, Health Policy and Communications, and Corporate Services) with a reallocation of many responsibilities from the previous six-branch structure;
- Six regions (Atlantic, Quebec, Ontario and Nunavut, Manitoba and Saskatchewan, Alberta and Northwest Territories, British Columbia and Yukon) with a reallocation of many responsibilities to the regional level and growth from the former four-region structure;
- Continuation of two existing agencies (Pest Management Regulatory Agency and Occupational Health and Safety Agency).

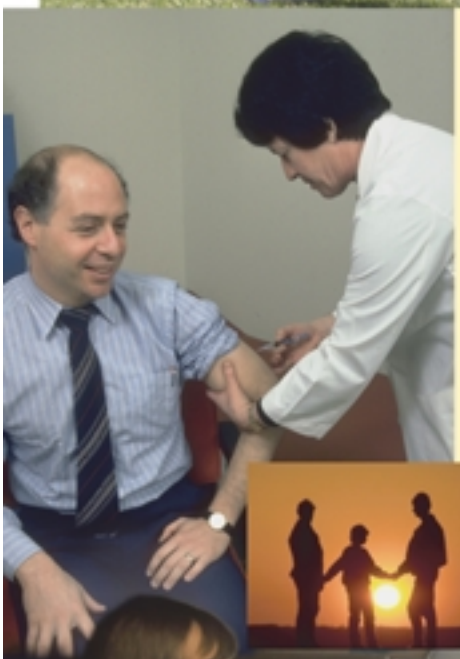
The realignment is designed to improve service to Canadians, ensure better coordinated work across the Department and strengthen our capacity to be an innovative, results-oriented organization. As part of our intention to work more effectively with our many partners, especially in the provinces and territories, we are better focussing our presence at the regional level.

Health Canada's realignment responds to rapid advances and growth in health knowledge and technology, the changing expectations of Canadians and their desire to be more informed and involved in the decision-making process, and a need to fundamentally shift the way the Department works with its partners. The Department consulted extensively with staff and external stakeholders before finalizing the realignment.

Health Canada Santé Canada

OUR MISSION

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



SECTION II: DEPARTMENTAL OVERVIEW

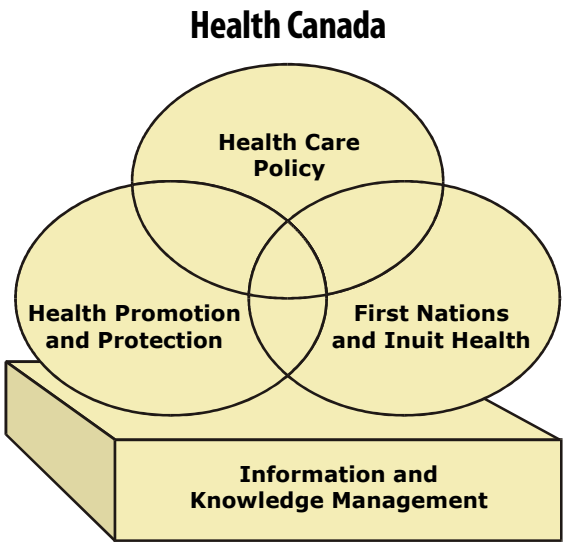
Mandate

Health Canada's formal mandate is set out in the *Department of Health Act*, which is summarized in the mission statement on the facing page. The departmental mandate also derives from responsibilities under legislation such as the *Food and Drugs Act, the Hazardous Products Act,* and the *Controlled Drugs and Substances Act*.

More fundamentally, the mandate that the Government of Canada has given to Health Canada reflects the very high priority that Canadians and their government place on health. Good health is central to how Canadians see their quality of life. It goes beyond the absence of illness or disease to encompass an overall sense of physical, mental and spiritual wellness.

That comprehensive sense of health and wellness helps to define Health Canada's responsibilities that centre largely on three interrelated components:

- **health promotion and protection** which includes providing individuals, groups, communities and the general population with information and tools (or access to them) so that they can make informed decisions about their health and preventing and reducing the incidence of illness and injury by direct regulatory or other action to manage risks over which individuals have little or no control by themselves;



- **First Nations and Inuit health** which ensures the provision of First Nations and Inuit health services to the First Nations people on reserves and the Inuit;
- **health care policy** which provides pan-Canadian leadership in support of the provinces as they seek ways to renew their individual health care systems, policies and processes, ensuring the most effective use of health resources consistent with achieving the best possible health results for Canadians.

All three components are supported by Information and Knowledge Management through the generation, organization and dissemination of information and knowledge for improved health policy and program decision making both within Health Canada, and across the health system.

Societal Context

Health of Canadians

Canadians enjoy a high level of health, and Canada ranks in the top three developed countries in the world in measures of life expectancy, mortality rates, and self-rated health status.

- Life expectancy in Canada has steadily risen, from 59 years in the early 1920s to over 79 years by 1998.
- Canada's infant mortality rate declined from 18.8 infant deaths per 1,000 live births in 1970 to 5.5 in 1997.
- In 1998-1999, approximately 92 percent of Canadians rated their health as good, very good or excellent.

However, these levels of health status are not shared equally by all Canadians.

- Health status is correlated with gender. Women are more likely to live longer than men because of gender differences in mortality rates from heart disease, cancer, suicide attempts and injuries. Women, however, are more likely to suffer from chronic conditions, such as arthritis, hypertension and migraines.
- Canadians at lower income and education levels are more likely to suffer from chronic conditions. Fewer Canadians at lower income and education levels rate their health as excellent or very good, compared with Canadians at higher income and education levels.
- Canada's Aboriginal people are at a higher risk for poor health and early death than the Canadian population as a whole. Life expectancy is lower than the national average, infant mortality rates are higher, and there is a greater prevalence of chronic conditions, including hypertension, arthritis, heart disease and diabetes.

The health of a population is determined by many factors, and only partly the result of government actions. Nevertheless, information on government programs affecting health can be better interpreted when placed in the context of the overall health status of Canadians.

Measuring Health in Canada provides this context, including information on:

- general indicators of life expectancy and mortality;
- general indicators of health status and morbidity;
- behaviours and preventative measures;
- HIV/AIDS; and
- First Nations and Inuit health.

(See also page 111 Annex A: *Measuring Health in Canada - more results relating to Health Status of Canadians*.) For a coloured version refer to < http://www.hc-sc.gc.ca/estimates/ >

Health Spending

In 1999, Canadians spent about $86 billion on health care – approximately $2,815 per capita. Canada's ratio of total health care spending to Gross Domestic Product, was approximately 9.2 percent in 1999 – fourth among G7 countries. Approximately 70 percent of spending was publicly funded, and 30 percent was privately funded. The WHO *World Health Report 2000, Health Systems: Improving Performance* indicates that given the level of Canada's health expenditures, there appears to be room for improvement in the performance of our health system.

Since the mid-1970s, there has been a shift in the disbursement of health dollars. The share of total health care dollars devoted to hospitals, which continues to be the largest category of health expenditures, has dropped every year. In 1997, spending on drugs overtook spending on physicians' services, to become the second largest component of health expenditures.

An Ongoing Evolution

There are many factors that are changing the nature of the health system and health services.

- **Technological advances**, such as those in diagnostic techniques, primary prevention, surgery, biotechnology and genetics, are changing our definition of health, as well as how we deliver health services.
- **Pharmaceuticals** are being used to a greater extent. Drug therapy is, increasingly, a viable alternative to some traditional treatments, and contributes to the shift of patients from hospital settings to community care.
- **Information systems** are becoming increasingly necessary to effectively manage transactions, patient records, the volume of information, and system performance.
- **Changing expectations** of educated and informed consumers are affecting the demand for and use of health services.

An Aging Population

The aging of Canadian society, a product of declining fertility rates and increased life expectancy, will be a significant trend in Canada in the twenty-first century. In particular, the aging of the post-World War II baby boom generation will place temporary but enduring pressures on the health care system from around 2020. These include:

- substantial increases in the fraction of the population with age-related chronic conditions such as senile dementia, heart disease, and the effects of stroke;
- increased demand for health care workers, particularly those providing continuing care;
- the need for increased public spending on health care to maintain existing levels of service.

These changes are posing challenges for all players in the health system including Health Canada. The federal Budget 2000 recognized the high priority Canadians place on their health and health care, and built on the significant investments in Budget 1999 to strengthen and renew the system. Health Canada continues to work with its many partners, including provinces and territories, First Nations and Inuit, other federal departments, international partners, professional associations, community organizations, and the voluntary sector, to address these issues and to realize the opportunities created by the need for reform.

Business Line Descriptions

Management of Risks to Health

This business line is responsible for anticipating, preventing and responding to health risks posed by food, water, drugs, medical devices and other therapeutic products, occupational and environmental hazards, diseases, consumer products, pest control products, blood and blood products, peacetime disasters and certain determinants of health such as personal behaviour, family, social and economic circumstances.

Promotion of Population Health

The business line provides a broad integrated approach to population health, taking into account the social, behavioural, and economic determinants of health. It addresses health inequalities among Canadians through the development and support of policies and programs to support disease prevention and health promotion in collaboration with key partners in other government departments, provinces, territories and the non-government sector. The business line supports action to promote health by addressing determinants that fall both within and outside of the health sector throughout the life cycle. It recognizes and emphasizes the importance of investment in early childhood as a means to better health throughout life. The delivery of this business line is carried out through a life cycle framework characterized under the three stages of life: i) Childhood and Adolescence, ii) Early to Mid-Adulthood, and, iii) Later Life.

Aboriginal Health

The principle that health status inequalities and health service concerns among First Nations will be addressed more effectively when decisions are made by themselves is widely accepted by health experts and Aboriginal people. This business line works toward increased control and management of community-based health services by Aboriginal people through transfer, integrated contribution agreements and other health funding arrangements, capacity building and training. The business line also supports actions on health inequalities affecting First Nations and Inuit People.

Health System Support and Renewal

This business line provides support for leadership in all areas of Canada's health system. It uses knowledge and action from across the Department to ensure the viability and affordability of Medicare and a more appropriate balance in Canada's health system across health care, promotion, prevention and protection. The focus is on increasing efficiency and effectiveness in collaboration with the provinces and territories.

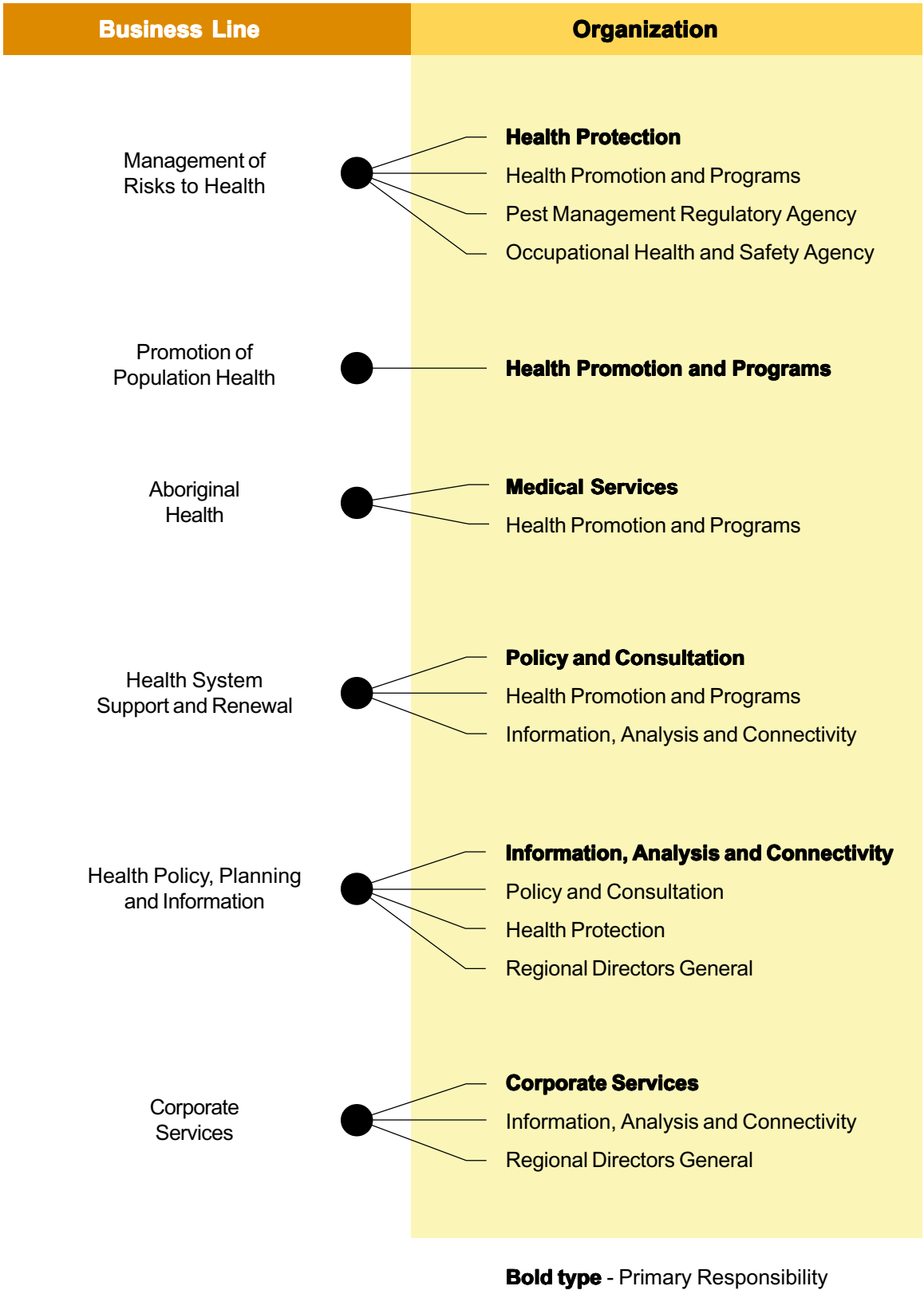
Health Policy, Planning and Information

This business line contributes to the achievement of federal health objectives by: internally, drawing together activities and levers (surveillance, research, policy, communications, federal/provincial and international relations, legislation, consultation, planning and review) used across all business lines, into a cohesive, cost-effective way to deliver the government's health agenda and core Health Canada responsibilities; externally, contributing to the generation, provision and use of health information, taking into account the roles of our health information partners.

Corporate Services

Corporate Services provides services and advice to departmental senior managers in support of program needs related to the management, use and reporting of financial and human resources, facilities and assets, information technology, and audit services.

Business Line Relationship to Organizational Structure 1999-2000



Bold type - Primary Responsibility

SECTION III: DEPARTMENTAL PERFORMANCE

A: Chart of Key Results Commitments

This chart of key results commitments reflects continuing efforts to improve the articulation of Health Canada's results commitments and measurement techniques.

To provide Canadians with:	To be demonstrated by:
Management of Risks to Health Health protection and assistance in improving their health by defining, advising on and managing risks and benefits to health.	1.1 Safe and nutritious food. 1.2 Safe and effective drugs, medical devices and other therapeutic products, including blood and blood products. 1.3 Safe consumer and commercial products. 1.4 Safe living and working environments. 1.5 Effective disease prevention and control. 1.6 Effective occupational health and safety services available and accessible to federal departments. 1.7 Effective response to natural and man-made disasters. 1.8 Safe and effective pest control products.

To provide Canadians with:	To be demonstrated by:
Promotion of Population Health An approach to improving health that acts on the determinants of health to promote healthy behaviours and attitudes and prevent disease and injury.	2.1 Public awareness and understanding of the factors that determine individual and collective health and the actions to take to maintain and/ or improve health. 2.2 A reduction in health inequalities for specific population groups and improvements in health status for the population. 2.3 The impacts on health of existing or new policies, practices, programs and services are assessed and taken into account by the private, public and voluntary sectors. 2.4 A reduction in tobacco-caused illness and death.
Aboriginal Health Sustainable health services and programs for First Nations and Inuit communities and people that addresses health inequalities and disease threats so that they may attain a level of health comparable with that of other Canadians, within the context of First Nations and Inuit autonomy and control.	3.1 Improvements in First Nations and Inuit people's health and a reduction in health inequalities between them and other Canadians. 3.2 A First Nations and Inuit population that is informed and aware of the factors that affect health and what actions can be taken to improve health. 3.3 Effective health care services available and accessible to First Nations and Inuit people. 3.4 Increased First Nations and Inuit management of and accountability for health care services and the Non-Insured Health Benefits Program.
Health System Support and Renewal Leadership that contributes to the long-term sustainablility of a health system that has significant national character and meets the needs of Canadians.	4.1 Publicly funded hospital and physician services consistent with the principles of the *Canada Health Act (CHA)*. 4.2 An integrated health system embodying efficient health services.

To provide Canadians with:	To be demonstrated by:
Health System Support and Renewal (continued)	4.3 Innovative national and international initiatives that strengthen the health system. 4.4 A better understanding of the fundamental issues relating to health care, and better tools and mechanisms for improving access to a range of high quality, equitable services. 4.5 Strengthened partnerships among federal, provincial and territorial governments, key stakeholders, Canadians and international partners.
Health Policy, Planning and Information Effective national health policies and plans, and current, reliable health information to support strategic and evidenced-based decision-making in Health Canada, throughout the health system and by Canadians.	5.1 National policies and plans that effectively address emerging health challenges and/or changes to existing health priorities. 5.2 A health system that is more effective, efficient and accountable and which includes a well functioning national health information and health research infrastructure. 5.3 Canadians accessing and using reliable information to maintain and improve their health. 5.4 International health policies, programs and strategies which contribute to the Department's ability to fulfil its national and international objectives.
Corporate Services Effective support for the delivery of Health Canada's programs and sound management practices across the Department.	6.1 Continuous improvement in the provision of corporate administrative services. 6.2 Continuous improvement in the promotion of sound management practices.

B: Accountability

The accountability vision for Health Canada is one of a corporate culture focussed on outcomes and performance, that credibly engages and informs Canadians of the impact of its policies and programs on the health of the people of Canada. Health Canada has a number of initiatives under way to improve accountability measures, to embed the principles of results-based management, and to foster a continuing culture shift to outcomes-oriented decision-making and program management. These initiatives are consistent with Treasury Board's *Managing for Results* and improved management practices.

Strategy 1

Improve the quality and use of performance information across the Department, including improving linkages between planned key results, actual performance, resource utilization and health outcomes.

Accomplishments

- Launched a three year $43 million Federal Accountability Initiative Focussing on Health Canada's Policies and Programs to provide Canadians with improved information about the Department's roles, responsibilities and program performance; to improve information management and accountability; and to improve the evidence base and outcomes orientation of policies and programs. To this end, Health Canada has:
  - used the Applied Research and Analysis Directorate to foster strategic and evidence-based decision-making by:
    a) enhancing the analytical underpinnings of accountability through an improved understanding of the diverse factors that affect health outcomes,
    b) providing better quantitative data and data access tools throughout Health Canada,
    c) improving departmental performance reporting;
  - launched a three year pilot Performance Measurement Development Project to provide Health Canada managers with tools and expertise in performance measurement and management and shared funding for the development and use of performance frameworks for existing programs.
- Began implementation of the government-wide Financial Information Strategy (FIS) to better support expenditure management, business planning, budgeting, program review, and other management and decision-making processes. The FIS will facilitate accountability for program and financial results and improve estimates and performance reporting. Other accountability initiatives included linking individual performance to results-based management and modernizing the departmental evaluation function.

- Completed the first cycle of the Program Impact Assessment Project (PIAP), a major organizational and cultural change initiative that involved an outcomes-focussed analysis of six key activity areas at Health Canada. Analytical tools and approaches to guide priority setting, resource allocation and support evidence-based decision-making were developed. Commitments to strengthen performance measurement and accountability regimes were made and this work is under way. PIAP was a catalyst in the transformation of Health Canada into an organization that is more innovative, continuously learning, accountable and driven by a focus on outcomes.

Strategy 2

Improve public involvement in developing accountability frameworks relative to the effectiveness of health policy decisions, health system performance and the results of direct federal expenditures in health.

Accomplishment

- Developed a policy, guidelines and tool kit to assist the Department in the design and implementation of strategies for public involvement in developing health policies and programs (See also page 34 regarding the establishment of the Office of Consumer Affairs and Public Involvement).

Strategy 3

Improve accountability and reporting in health care.

Accomplishments

- Published, disseminated and tabled in the House of Commons the annual report on administration of the *Canada Health Act*. The report provides information to Canadians on compliance by provinces and territories with the principles and conditions of the *Canada Health Act*. Provincial and territorial governments supply the required information.
- Pledged, in a public response to the Auditor General's report in November 1999, to work with the provinces and territories to strengthen reporting on compliance with the principles and conditions of the *Canada Health Act*. Improved reporting will provide timely, relevant and understandable information to Canadians. It will also assist in monitoring and administering compliance with the Act.
- Commissioned a research study, on behalf of F/P/T health ministries, on "Accountability Frameworks and Performance Indicators for Mental Health Systems and Supports", as part of a multi-phase initiative to build evidence-based services and supports in this sector. This builds on earlier work to document best practices in mental health system reform, and emphasizes approaches to improve accountability.
- Identified key program areas for reporting in the context of the Social Union Framework Agreement in Treasury Board's *Managing for Results 2000*. For details see SUFA Accountability Templates at < http://socialunion.gc.ca/news/020499_e.html >.

These initiatives complement the broader work of the Canadian Institute for Health Information and Statistics Canada in reporting on the performance of the overall health system, its outcomes, and the health of Canadians.

C: Performance Accomplishments

Business Line 1: Management of Risks to Health

Financial Information

(millions of dollars)

	1999-2000 Planned Spending	1999-2000 Total Authorities	1999-2000 Actual Spending
Gross expenditures	$316.7	$332.1	$318.5
Expected revenue	($44.9)	($55.8)	($53.8)
Net expenditures	$271.8	$276.3	$264.7*

* This represents 13.0 percent of the Department's actual spending. This percentage is based on total departmental spending excluding the one-time court ordered Hepatitis C payment of $855.3M in Promotion of Population Health to allow for comparability with previous year.

The actual spending is $11.5M lower than the total authorities as planned activities related to resources received late in fiscal year 1999-2000 for "Sustaining the Federal Health Protection Capacity" initiative through Budget 2000 were not fully carried out. Resources will be carried forward to fiscal year 2000-2001 when remaining expenses will be incurred.

Web site: < http://www.hc-sc.gc.ca >

Objective

To improve health surveillance and the capacity to anticipate, prevent, and respond to health risks posed by diseases, food, drugs, medical devices, and other therapeutic products, pest control products, environmental hazards, consumer goods, and upstream determinants of health (personal behaviour, family, social and economic circumstances).

Key Results Commitments (KRC), Strategies and Accomplishments

For more information in regards to these Key Results Commitments, refer to the Service Lines that follow.

Key Results Commitments

KRC 1.1	**Safe and nutritious food**
KRC 1.2	**Safe and effective drugs, medical devices and other therapeutic products, including blood and blood products**
KRC 1.3	**Safe consumer and commercial products**
KRC 1.4	**Safe living and working environments**
KRC 1.5	**Effective disease prevention and control**
KRC 1.6	**Effective occupational health and safety services available and accessible to federal departments**
KRC 1.7	**Effective response to natural and man-made disasters**
KRC 1.8	**Safe and effective pest control products**

Strategy 1

Update the risk management framework for assessing health and environmental risks**.**

Accomplishments

- Developed Health Canada's Decision-Making Framework for Identifying, Assessing and Managing Health Risks to help the Department identify, analyze and make decisions related to managing risks for the health of Canadians.
- Developed detailed plans to ensure that the science capacity of the Department is both strengthened and refocused so that high priority health risks are addressed more effectively.
- Established the Office of Consumer Affairs and Public Involvement (OCAPI) in the Health Products and Food Branch. The creation of the OCAPI is a response to the desire of Canadians for more information about health protection issues and more involvement in the development of policies and programs designed to protect their health and safety. OCAPI will provide Canadians with more information on health programs, and enable participation in the decision-making process with greater knowledge and understanding of how the health system works. OCAPI is developing a wide range of interactive information, consultation and engagement tools designed to reach and promote participation from key audiences.

Strategy 2

Update and streamline the legislative foundation for risk management**.**

Accomplishments

- Developed a proposal for a renewed federal health protection legislative framework (at the centre of which could be a new *Health Protection Act)* to:
  - clearly articulate the role of the federal government concerning health protection;
  - provide overall policy direction;
  - modernize the existing legislation and integrate it into a coherent system.
- Established the basis for a second round of consultations to produce a draft of the new *Health Protection Act* for tabling in the year 2000. The Department will also be working closely with the Canadian Food Inspection Agency (CFIA) and consulting with stakeholders on a review of the food-related regulations associated with the former *Food and Drugs Act* to allow for effective implementation of the *Canada Food Safety and Inspection Act*.

Strategy 3

Establish a new regulatory authority that will assume primary responsibility for assessing the safety of natural health products.

Accomplishment

- Created a new Office of Natural Health Products (ONHP) that will provide Canadians with the assurance of safety while enhancing consumer access and choice to a full range of natural health products.

Service Line A: Food Safety, Quality and Nutrition

Financial Information

(millions of dollars)

	1999-2000 Planned Spending	1999-2000 Total Authorities	1999-2000 Actual Spending
Gross expenditures	$56.7	$43.2	$40.5
Expected revenue	($1.3)	($1.3)	($1.1)
Net expenditures	$55.4	$41.9	$39.4*

* This represents 14.9 percent of the Management of Risks to Health actual spending.

Web site: < http://www.hc-sc.gc.ca/food-aliment/english/ >

Objective

To protect and improve the health and well-being of the Canadian public by defining, advising on and managing risks and benefits associated with the food supply.

Key Results Commitment (KRC) and Accomplishments

KRC 1.1 Safe and nutritious food

Accomplishments

Nutrition

- Reviewed 47 submissions for infant formulas, novel foods and addition of vitamins and minerals to foods to ensure the safety and nutritional quality of these products.
- Nutrition Labelling: conducted extensive consultations involving interested Canadians in the review of nutrition labelling policy with the goal of improving the usefulness of nutrition labelling, increasing its availability, and broadening public education on its use. Through the use of consultation kits and the Health Canada Web site, over 950 individual Canadians and organizations provided their views. These have been analyzed and will be used in the development of the

new policy. Further information can be found at < http://www.hc-sc.gc.ca/food-aliment/english/subjects/food_labelling_and_claims/nutrition_labelling_and_nutrie.html >

- Developed a policy recommendations proposal to permit changes in food fortification to reflect developments in scientific knowledge about the role of vitamins and minerals in health. The recommendations aim for more regulatory flexibility while meeting public health needs and protecting the population from the harmful effects of excessive or imbalanced intakes.
- Sponsored a review by the Food and Nutrition Board of the US National Academy of Sciences of scientific data on the requirements and tolerable upper levels of nutrients and other food components. The review is intended to produce a series of Dietary Reference Intakes which will ultimately replace the current Canadian Recommended Nutrient Intakes.

Food-borne Illnesses

- Undertook a pilot project to develop a model to link and integrate surveillance data from food, water, animal, environmental and human sources. Analyses of the data will provide a means to assess the influence of animal and environmental risk factors on human health outcomes, and to develop appropriate intervention strategies.
- Researched and developed rapid methods for the detection of food-borne pathogens such as *E. coli* O157 to support the identification of the source of infection in contaminated products during outbreak investigations, and science-based policy development for high risk food-borne pathogens.
- Conducted research projects, risk assessments and policy development work on several plant product issues (unpasteurized juices, Guatemalan berries, seed sprouts) in the area of the safety of raw foods of plant origin in partnership with the Canadian Food Inspection Agency (CFIA) and the provinces and territories. An example of one research project is the Development of a Rapid Method for the Detection of *Cyclospora* in Guatemalan Berries.
- Conducted collaborative studies on surveillance of antimicrobial use and antimicrobial resistance, in partnership with government and university researchers, food animal producers, the veterinary profession and the pharmaceutical industry, as well as other sectors of the agriculture and agri-food industry.

Chemical Safety

- Conducted projects to address the link between chemicals in food and chronic diseases, such as cancer and neurological and genetic effects, focussing on identifying early or intermediate biomarkers. Preliminary results of these long-term projects were presented to the scientific community.
- Managed the Canadian risk assessment of the Belgian food crisis in partnership with CFIA. Analyzed over 100 Belgian food samples for both dioxins and PCBs and responded to public and media concerns. Transferred technology to private laboratories to increase national capacity to manage future food safety issues.

- Under the Total Diet Food Program for the measurement of long-term exposure of Canadians to a variety of chemicals, new data was generated on PCBs, dioxins, metals and pesticides for hundreds of foods; this data is widely used by a variety of clients e.g. CFIA, US Food and Drug Administration, US Environmental Protection Agency.

In the area of pre-market review of chemical substances, the Department evaluated approximately 160 food additive submissions and some 2,600 submissions involving food packaging materials and other chemical substances used in food processing areas.

- Responded to several thousand inquiries relating to chemicals in food. As well, completed some 40 risk assessments involving various chemical contaminants and natural toxins in the food supply. Specific examples included:
  - dioxins in foods imported from Belgium (see previous page);
  - microcystins in blue-green algae products sold as food;
  - mercury and other heavy metals in seafood products;
  - various organochlorines including dioxins, furans and PCBs in various country foods.

Biotechnology

- Promulgated the Novel Food Regulations under the *Food and Drugs Act*, a key step towards ensuring that foods derived from biotechnology are subject to appropriate regulatory oversight. This regulation requires that Health Canada be notified prior to the marketing of any food derived from biotechnology in Canada so that a thorough safety assessment can be conducted on each product.

Food Safety Assessment

- Issued the first assessment report on the effectiveness of CFIA's activities related to food safety. The report, which addressed CFIA's Food Emergency Response System, identified areas of strength and potential for improvement. Those areas identified for improvement have either been addressed or are being addressed.

Service Line B: Therapeutic Product Regulation

Financial Information

(millions of dollars)

	1999-2000 Planned Spending	1999-2000 Total Authorities	1999-2000 Actual Spending
Gross expenditures	$61.6	$75.8	$77.9
Expected revenue	($34.7)	($39.3)	($38.7)
Net expenditures	$26.9	$36.5	$39.2*

* This represents 14.8 percent of the Management of Risks to Health actual spending.

Web site: < http://www.hc-sc.gc.ca/hpb-dgps/therapeut/ >

Objective

To ensure that the drugs, medical devices, and other therapeutic products available to Canadians are safe, effective and of high quality. Health Canada also provides legislative policy and support to law enforcement activities in the control of illicit drugs.

Key Results Commitment (KRC), Strategies and Accomplishments

KRC 1.2 Safe and effective drugs, medical devices and other therapeutic products, including blood and blood products

Strategy 1

New legislative, regulatory and supervisory initiatives

Accomplishments

- Completed initial development of the regulatory framework for natural health products. < http://www.hc-sc.gc.ca/hpb/onhp >
- Developed regulations to provide for improved and more efficient access, with appropriate safeguards, to therapeutic products prior to their approval in both the clinical trials and special access program.
- Developed amendments and guidance to permit the use of marijuana for medicinal purposes. < http://www.hc-sc.gc.ca/hpb-dgps/therapeut/htmleng/cds.html >

- Drafted amendments to Semen Regulations to introduce provisions for alternative safety testing of donor semen and special access. < http://www.hc-sc.gc.ca/hpb-dgps/therapeut/htmleng/guidmain.html#semen >
- Published guidelines to further clarify and streamline the premarket registration process to provide a "single window" approach for disinfectant products, in cooperation with the Pest Management Regulatory Agency (PMRA). < http://www.hc-sc.gc.ca/hpb-dgps/therapeut/zfiles/english/consult/disinfct/disgdlnx_2_e.html >

Strategy 2

Safety of the blood system

Accomplishments

- Reviewed and approved test kits that could be used by health care professionals in the early detection of HIV, as well as guidance documents for their appropriate use.
- Ensured continuity of service to Canadians during the transition to two new Blood establishments in Canada (**Canadian Blood Services** and Héma-Québec), focussing on computer systems and potential Year 2000 problems.
- Developed a policy to defer blood donors who had lived or travelled in the United Kingdom for six months or longer during the period from 1980-1996 in order to reduce the risk of Creutzfeldt-Jakob Disease contamination of the blood supply.

Strategy 3

International harmonization and regulatory cooperation
< http://www.hc-sc.gc.ca/hpb-dgps/therapeut/htmleng/intagree.html >

Accomplishments

- Implemented a Standard Operating Procedure to define the process of consultation, implementation and maintenance of International Conference on Harmonization technical requirements for therapeutic products to ensure that regulatory decisions continue to serve the needs of the Canadian public.
- Completed confidence-building activities in support of Mutual Recognition Agreements (MRAs) with the European Union and Switzerland. Inspected pharmaceutical manufacturing establishments in each partner's regulatory jurisdiction.
- Signed a Plan of Action for exchanging regulatory information with the State Drug Administration of China.

Strategy 4

Fiscal responsibility, program efficiency and accountability

Accomplishments

- Developed a public involvement strategy for both general and specific interests e.g. xenotransplantion, medicinal use of marijuana etc.
- Improved communications tools and initiatives e.g. Fact Sheets, TPP Newsletter. < http://www.hc-sc.gc.ca/hpb-dgps/therapeut/htmleng/fact-sht.html >

  < http://www.hc-sc.gc.ca/hpb-dgps/therapeut/htmleng/aboutus.html >
- Identified gaps and challenges within the drug review process that need to be addressed in order to improve its timeliness and responsiveness. This major review was carried out in conjunction with the HIV/AIDS Working Group.

  < http://www.hc-sc.gc.ca/hpb-dgps/therapeut/zfiles/english/advcomm/wg/hiv/minutes/drp-rec_e.pdf >

  < http://www.hc-sc.gc.ca/hpb-dgps/therapeut/zfiles/english/strategy/postapproval1999-2003_e.pdf >

  < http://www.hc-sc.gc.ca/hpb/science/drg_e.html >
- Issued comprehensive and detailed regular performance reports on the drug approval process. < http://www.hc-sc.gc.ca/hpb-dgps/therapeut/htmleng/aboutus.html >
- Implemented a new management system, including enhanced knowledge management infrastructure, new operational planning system, revised organizational roles and responsibilities and the associated support mechanisms.

Grants Program over $5M:

(indicated in bold in text)

Canadian Blood Services: Transition

Drug Review Times for New Active Substances (NAS)

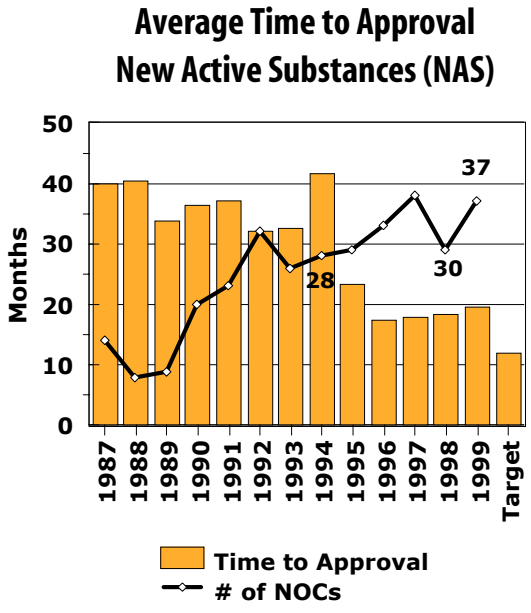
Review times improved

1988: 8 NAS approved in average 1,235 days
1994: 28 NAS approved in average 1,269 days
1999: 37 NAS approved in average 595 days

Priority Reviews (Fast Tracking)

1997: 8 drugs in 569 days
1998: 8 drugs in 396 days
1999: 18 drugs in 347 days

Targets are 355 and 235 days respectively; lack of resources limits ability to meet targets. New resources from Budget 2000 will help meet targets.



Service Line C: Environmental Health

Financial Information

(millions of dollars)

	1999-2000 Planned Spending	1999-2000 Total Authorities	1999-2000 Actual Spending
Gross expenditures	$57.2	$61.9	$57.3
Expected revenue	($3.3)	($3.3)	($2.1)
Net expenditures	$53.9	$58.6	$55.2*

* This represents 20.9 percent of the Management of Risks to Health actual spending.

Web site: < http://www.hc-sc.gc.ca/ehp/ehd/ >

Objective

To improve safety and the safe use of products, and reduce health risks by identifying, assessing and managing the risks and benefits of natural and human-made environments while contributing to sustainable development.

Key Results Commitments (KRC) and Accomplishments

KRC 1.3 Safe consumer and commercial products

KRC 1.4 Safe living and working environments

Accomplishments

- Conducted international, national and regional studies:
  - collected data on the long-term health effects of air pollution on adolescent health (with Harvard School of Public Health);
  - researched infant health and early exposures to aero-allergens (with PEI agencies, Central Mortgage and Housing Corporation);
  - analyzed air pollution and cardiorespiratory emergency department visits (Saint John);
  - analyzed daily time series studies of air pollution and health effects (cardiorespiratory) on mortality and morbidity, disability days (national), and usage of health facilities;

- analyzed effects of natural radionuclides on human and animal genetic material.

- Funded 81 research projects through the **Toxic Substances Research Initiative** which will provide more scientific and health effects information on persistent organic pollutants, metals, endocrine disrupting chemicals, urban air quality and cumulative environmental effects.
- Continued development of national standards on mammography quality to maintain and enhance the quality of mammography for the improved diagnosis of breast cancer.
- Promoted awareness of the mammography accreditation program of the Canadian Association of Radiologists to improve the proper and safe usage of effective mammography equipment.
- Under responsibilities defined in the *Hazardous Products Act*, the Program:
  - carried out national enforcement activities for toys, lighters, matches, charcoal, carbonated beverage glass containers and teethers;
  - promoted voluntary programs designed to ensure compliance with the flammability standards for upholstered furniture and with baby walker standards;
  - took enforcement actions against companies with noncomplying products;
  - carried out interventions to reduce lead content in children's products, including issuing 7,855 letters to manufacturers, distributers and importers of jewellery, requesting that lead content be limited to 65 mg/kg total lead.
- Monitored activities under the *Tobacco Act* and Youth Access Regulations resulting in 69 percent retailer compliance.
- Started a Youth Advisory Committee (YAC) to provide advice and relay the concerns and views of youth on tobacco issues to the Secretary of State for Children.
- Introduced a proposed health warning message that would occupy 50 percent of the cigarette package, during National Non-Smoking Week.
- Aired anti-smoking messages on TV, and ran ads in selected youth magazines during fall 1999, targeting youth aged 13-19.
- The new Commercial Products Office (CPO) made proposals for the *Canada Health Protection Act* on environmental health priorities and for the existing legislation of the *Hazardous Products Act, Canadian Environmental Protection Act, Radiation Emitting Devices Act* and the *Canadian Environmental Assessment Act*. CPO officials met with industry, provinces, laboratories, health associations, regional and municipal governments to determine their legislative needs and provide information to the Environmental Health Program.
- Collaborated with provinces and published a federal safety code for electromagnetic radiation (including telecommunication frequencies).

  < http://www.hc-sc.gc.ca/ehp/ehd/catalogue/rpb_pubs/99ehd237.pdf >

As the Canadian government lead in the development of the Globally Harmonized System (GHS) for classification and labelling of hazardous chemicals:

- established hazard criteria for pure chemical substances;
- agreed on hazard communication part of the GHS;
- agreed on certain criteria for classifying chemical mixtures.
- Under the Federal Nuclear Emergency Plan:
  - Hosted CANATEX 3/INEX 2, a major international nuclear emergency exercise, with more than 50 agencies from Canada, as well as the United States, France and over 30 other nations.
  - Developed national guidelines for control of food and water contaminated by a nuclear accident, for other nuclear emergency interventions, and for control of naturally occurring radioactive materials.
- Under the Comprehensive Test Ban Treaty:
  - Registered Vancouver as the first Canadian site survey for the radioactivity portion of the International Monitoring System, with the CTBT office in Vienna.
  - Established a National Radionuclide Laboratory capacity to monitor radiation fall-out in sites across Canada.

Contributions Program over $5M:
(indicated in bold in text)

Toxic Substances Research Initiative

Service Line D: Disease Prevention and Control

Financial Information

(millions of dollars)

	1999-2000 Planned Spending	1999-2000 Total Authorities	1999-2000 Actual Spending
Net expenditures	$53.6	$50.0	$43.3*

* This represents 16.3 percent of the Management of Risks to Health actual spending.

Web site: < http://www.hc-sc.gc.ca/hpb/lcdc/ >

Objective

To enable the Department to evaluate the efficacy and effectiveness of various prevention, screening/diagnosis, treatment and palliation methodologies for a wide range of human diseases.

Key Results Commitment (KRC) and Accomplishments

KRC 1.5 Effective disease prevention and control

Infectious Diseases

Accomplishments

- Developed a pilot integrated blood-borne disease surveillance system with standardized data analysis and interpretations in partnership with the provinces of British Columbia, Quebec and Prince Edward Island.
- Provided laboratory diagnostic support for comprehensive national and international surveillance of prion diseases; and scientific/technical services and advice regarding prion diagnostics and disease prevention/control for departments and external centres. Resulted in comprehensive epidemiologic data to support risk assessment, regulatory decision-making and policy that minimizes the impact on Canadian public health.
- Developed the Canadian Contingency Plan for pandemic influenza in conjunction with the provinces and territories. The Plan will continue to evolve with the purpose of mitigating the impact of the anticipated influenza pandemic.

Non-Infectious Diseases, Conditions and Injuries

Accomplishment

- Initiated development of the National Diabetes Surveillance System. Resulted in improved quality of surveillance information nationally. Assumed a leadership role in Asthma Control Task Force; and the identification and assessment of other chronic non-communicable disease areas that may benefit from intervention strategies.

Laboratory Surveillance and Support

Accomplishments

- Notified public health officials regarding emerging global public health events, and subsequently collaborated and shared knowledge about these events. Clients have used this information to reduce health risks to Canadians, whether at home or abroad, from globally-occurring public health related events. World Health Organization has acted on information provided by the Global Public Health Information Network (GPHIN) to coordinate a global early response to public health risks and hazards. Domestic clients use GPHIN outputs to assess health risks and make better decisions to protect the health of Canadians.
- Developed a national surveillance system to detect outbreaks of enteric diseases, and established an electronic outbreak alert system that permits the rapid acquisition of data on enteric, food-borne and water-borne diseases. The system also supports public health actions at local, provincial and federal government levels by facilitating early detection and intervention. This has resulted in a national surveillance database to identify national and provincial disease trends.
- Provided national surveillance databases on reported cases of HIV and AIDS, and semi-annual reports, Epi Updates, and other publications to interested parties. This information has been used to more effectively guide prevention and control programs including the development of a better ability to address the HIV/AIDS problem of First Nations communities.

Progress on the Implementation of the Auditor General's Recommendations, Chapter 14, September 1999 - National Health Surveillance

- Refer to the Health Policy, Planning and Information Business Line (See page 73) for information on progress in regards to the National Health Surveillance Infostructure (NHSI) network.
- In June 1999 the Conference of Deputy Ministers provided support to proceed with the Network for Health Surveillance in Canada (NHSC), together with an F/P/T coordinating body (Health Surveillance Working Group).

- Signed a protocol with the Canadian Food Inspection Agency to manage food-borne illness outbreaks. The protocol has been used in a number of outbreaks. Currently provinces and territories are being consulted with a view to signatures by all jurisdictions.
- Established operational procedures at four major international airports for intercepting travelers with potentially dangerous infectious diseases.
- Put FPT plan in place for dealing with transport of level 4 agents (e.g. Anthrax, Multiple Drug Resistant Tuberculosis and Smallpox). Every province is trained in how to respond and ship these materials.
- Established a formal agreement between the Laboratory Centre for Disease Control and the provinces and territories concerning breast screening programs, such as the Canadian Breast Cancer Screening Database, to support program evaluation and monitoring.

Service Line E: Occupational Health and Safety Agency

Financial Information

(millions of dollars)

	1999-2000 Planned Spending	1999-2000 Total Authorities	1999-2000 Actual Spending
Gross expenditures	$28.2	$29.7	$28.9
Expected revenue	($5.3)	($5.3)	($4.5)
Net expenditures	$22.9	$24.4	$24.4*

* This represents 9.2 percent of the Management of Risks to Health actual spending.

Web site: < http://www.hc-sc.gc.ca./ohsa/nehsi.htm >

Objective

To provide a broad range of direct occupational and public health and safety services and advice to all levels of the public sector, as well as federally regulated and non-governmental organizations. To continue to work with other parts of Health Canada to protect the health of the Canadian population from incoming quarantinable diseases. To protect the health of visiting VIPs in Canada.

Key Results Commitment (KRC), Strategy and Accomplishments

KRC 1.6 **Effective occupational health and safety services available and accessible to federal departments**

Strategy

Work with federal government departments to define a new "business relationship"

Accomplishments

The Occupational Health and Safety Agency (OHSA) has been working with federal clients to improve the effectiveness of program delivery through bilateral planning of requirements and timing of service delivery. Memoranda of Agreement including work planning, budget forecasting and utilization and feedback to departments on numbers and types of services received from the Agency have been instituted.

- Established a Management Advisory Board.
- 16 agreements signed with departments.

- 67 presentations given by the CEO across Canada to managers in all federal departments regarding due diligence and planning good OSH programs. Regional staff participated in numerous others meetings aimed at increasing knowledge on emerging issues and improving existing services.
- Implemented an Assignment Management System.
- Provided quarterly reports on services to clients.
- Evaluated OSH capabilities in client departments.
- Protected the health of VIPs during the Francophone and First Ladies Summits in partnership with Department of Foreign Affairs and International Trade and Canadian Heritage.

Partners are the departments and agencies which are included in Schedule I of the *Public Service Staff Relations Act*.

Both the Agency and client departments benefited from efficient planning of service needs and the reporting back on accomplishments.

Service Line F: Emergency Services

Financial Information

(millions of dollars)

	1999-2000 Planned Spending	1999-2000 Total Authorities	1999-2000 Actual Spending
Gross expenditures	$1.6	$1.8	$1.9
Expected revenue	($0.1)	($0.1)	($0.1)
Net expenditures	$1.5	$1.7	$1.8*

* This represents 0.7 percent of the Management of Risks to Health actual spending.

Web site: < http://www.hc-sc.gc.ca./msb/emergency/index_e.htm >

Objective

To support health care and social service systems when disasters occur.

Key Results Commitment (KRC) and Accomplishments

KRC 1.7 Effective response to natural and man-made disasters

Accomplishments

- Maintained the national emergency services stockpile, a supply of medical equipment, supplies and pharmaceuticals to support the delivery of emergency health and social services in times of disaster.
- Held a two-day exercise in April 1999, to test the Federal Nuclear Emergency Plan. Following the exercise, a review was conducted and a report prepared in cooperation with Radiation Protection Bureau. Lessons learned from the exercise will be incorporated into the Plan in order to have an improved response to such an event and better protect the health of Canadians.
- Delivered, with the cooperation of the provinces, training and seminars for emergency and social planners as well as responders from hospitals and social service agencies, on emergency health and social services preparedness.
- Produced guidelines related to emergency programs such as food services, lodging, registration of evacuees and response to enquiries about missing persons for provincial and municipal emergency and social planners as well as for non-governmental organizations.

Service Line G: Pest Management Regulation

Financial Information

(millions of dollars)

	1999-2000 Planned Spending	1999-2000 Total Authorities	1999-2000 Actual Spending
Gross expenditures	$16.1	$25.8	$26.6
Expected revenue	($0.2)	($6.5)	($7.3)
Net expenditures	$15.9	$19.3	$19.3*

* This represents 7.3 percent of the Management of Risks to Health actual spending.

Web site: < http://www.hc-sc.gc.ca/pmra-arla/english/MenuPages/MainMenu_NC2.htm >

Objective

To protect human health and the environment by minimizing the risks associated with pest control products, while enabling access to pest management tools, namely, these products and sustainable pest management strategies.

Key Results Commitment (KRC), Strategies and Accomplishments

KRC 1.8 Safe and effective pest control products

Strategy 1

Sound, progressive science, including innovative approaches to sustainable pest management

Accomplishments

- Conducted broad consultation on an enhanced reevaluation program - the goal is to reevaluate all pesticides registered up to December 31, 1994 by 2005-2006 in order to ensure that they meet current safety standards (See Web site above under Publications/Guidelines/Regulatory Proposals/1993-1999/Pro99-01).

- Negotiated an agreement with Canola Council of Canada for voluntary phase out of canola seed treatment with lindane in light of national and international concerns about its persistence, long-range transport and widespread occurrence in the environment.
- Established a partnership arrangement with Standards Council of Canada to establish and maintain a Good Laboratory Practices (GLP) Compliance Monitoring Program (GLP promotes the quality and validity of test data supporting pesticide registrations) - 11 test facilities/field sites recognized as in compliance.

Conducted approximately 2,500 investigations, inspections and consultations, supported by approximately 1,300 laboratory analyses, to promote and verify compliance with the *Pest Control Products Act (PCPA)*

- Continued participation on the Organization for Economic Co-operation and Development (OECD) Pesticide Risk Reduction Steering Committee which developed plans for pesticide risk indicator pilot projects by member countries in 2000.
- Tested systems for collection and processing of sales data and reached agreement for member companies of Crop Protection Institute and Canadian Manufacturers of Chemical Specialities to voluntarily submit sales data beginning April 2000, while development of a proposed regulation to require all registrants to submit sales data annually continues.

Strategy 2

Open, transparent, participatory regulatory processes, and timely access to new, safer pest control products

Accomplishments

- Met the 18 month review performance standard for 34 complex submissions to register new active ingredients or major new uses of registered pesticides, according to the old system (transition to new system caused delays of 2-16 days for eight submissions).
- Met the 12 month performance standard for joint Canada/US reviews, resulting in simultaneous registration of a reduced risk fungicide for use on grapes, strawberries and ornamentals.
- Refined proposals for new pesticide legislation.
- Held two meetings of Pest Management Advisory Council, resulting in advice to Minister on legislation and on integrated pest management, continued collaboration with provinces/territories through Federal-Provincial-Territorial Committee on Pest Management and Pesticides and considered strategic advice on streamlining operations and reducing costs provided by Economic Management Advisory Committee.

- Published five Proposed Regulatory Decision Documents to consult on proposed full registration of new active ingredients and one Regulatory Decision Document to report final registration decision following consideration of comments received.

Strategy 3

Effective management of human and financial resources

Accomplishments

- Stayed on track to achieve a 40 percent efficiency gain in the review of submissions for new products by the end of 2004, having increased efficiency by 23 percent in the two years since 1997 - further gains are dependent on industry filing submissions that meet screening standards, filing electronic submissions and/or filing submissions for joint review by Canada and the US.
- Held the first meeting of "North American Market for Pesticides", including senior officials from Pest Management Regulatory Agency (PMRA), Agriculture and Agri-Food Canada, US Environmental Protection Agency, US Department of Agriculture and representatives of grower organizations and pesticide industry, to promote harmonization, minimize potential for trade irritants and improve communication and collaboration among growers, pesticide industry, regulators and departments of agriculture.
- Conducted a joint industry-PMRA pilot to compare review processes using three formats: Web browser-based (first ever for a pesticide submission), computer-aided dossier and data supply (CADDY) and traditional hard copy - results indicated that electronic capacity will result in efficiency gains for the review of complex submissions.
- Conducted extensive staff training on electronic review templates and standardized review processes for major categories of pesticide submissions as part of Government of Canada On-Line preparedness.

Service Line H: Canadian Blood Secretariat

Financial Information

(millions of dollars)

	1999-2000 Planned Spending	1999-2000 Total Authorities	1999-2000 Actual Spending
Net expenditures	$41.7	$43.9	$42.1*

* This represents 15.9 percent of the Management of Risks to Health actual spending.

Web site: < http://www.hc-sc.gc.ca >

Objective

To provide Health Canada with a blood system policy, planning and coordination capacity to ensure the Department's regulatory, surveillance, and blood governance program functions are coordinated in the best interests of all key players in the blood system.

Key Results Commitment (KRC) and Accomplishments

KRC 1.2 Safe and effective blood and blood products

Accomplishments

- Assisted the Laboratory Centre for Disease Control in the development of a comprehensive surveillance and investigation capability, as well as a research and development agenda for dealing with blood-borne viruses. Projects included Creutzfeldt-Jakob Disease (CJD) and other Prion Surveillance; Blood-borne Pathogens; Public Health Investigations of Emerging Blood-borne Pathogens; hospital-based surveillance and clinical epidemiological studies.
- Participated in the planning of Transfusion Transmitted Injuries Surveillance System (TTISS). The system will provide a central transfusion registry in each of the pilot sites (B.C., Quebec, Nova Scotia, P.E.I) to collect data on moderate and severe adverse events among recipients of blood and blood products.

- Assisted in developing regulatory and operational policies on blood, tissues, organs and xenographs (BTOX). The policies are designed to mitigate the risk of transmission of diseases, such as HIV/AIDS and Hepatitis C, thereby contributing to the health and safety of all Canadians who rely on blood, tissues and organs for therapeutic purposes.
- Provided records management, policy, administrative and litigation support to the Department of Justice in negotiations and litigation relating to blood-borne diseases such as Hepatitis C, HIV.
- Assisted and facilitated the ongoing RCMP investigation by developing and maintaining an extensive repository of departmental documents which were turned over to the RCMP under warrant.
- Supported the National Blood Safety Council in hosting three national open forums on blood related topics: Krever's Recommendations: Status and Questions, CJD and Issues for the Blood System and Shortages of Intravenous Immune Globulins and other Plasma Products.

Business Line 2: Promotion of Population Health

Financial Information

(millions of dollars)

	1999-2000 Planned Spending	1999-2000 Total Authorities	1999-2000 Actual Spending
Net expenditures	$215.1	$238.7	$238.7*
Statutory payment	-	$855.3	$855.3

* This represents 11.7 percent of the Department's actual spending. This percentage excludes the one-time court ordered Hepatitis C payment of $855.3M to allow for comparability with previous year.

Web site: < http://www.hc-sc.gc.ca/hppb >

Objective

To promote population health through action on the social and behavioural determinants of health.

Commitment, Key Results Commitments (KRC) and Accomplishments

Commitment

To provide Canadians with an approach to improving health that acts on the determinants of health to promote healthy behaviours and attitudes and prevent disease and injury.

KRC 2.1 **Public awareness and understanding of the factors that determine individual and collective health and the actions to take to maintain and/or improve health**

Accomplishments

- Released *Nutrition for a Healthy Pregnancy: National Guidelines for the Childbearing Years*, which uses the population health approach to address maternal nutritional well-being, pregnancy outcome, and related women's health issues throughout the childbearing years. The Guidelines, intended for use by health professionals, are endorsed by: the Dietitians of Canada, Society of Obstetricians and

Gynaecologists of Canada, the College of Family Physicians of Canada and the F/P/T Group on Nutrition. For further information visit:

< http://www.hc-sc.gc.ca/hppb/nutrition >

- Continued implementation of the Postpartum Parent Support Program in over 600 hospital and community health sites across Canada to provide educational support to families of newborn infants during the postpartum period.

  < http://www.hc-sc.gc.ca/hppb/childhood-youth/guide/health_prenatal/postpartum.htm >

- Released *Because Life Goes On...Helping Children and Youth Live with Separation and Divorce* (3rd edition), in partnership with Justice Canada. Intended for families as well as health, social service, justice and education professionals, the revised edition provides Canadians with more up-to-date information on family mediation and on the ways in which mental health promotion relates to separation and divorce as they affect the family.

  < http://www.mentalhealthpromotion.com >

- Released *Canada's Physical Activity Guide for Healthy Active Living for Older Adults*, a practical tool for older adults to become more physically active. The Guide was developed in partnership with the Canadian Society for Exercise Physiology and the Active Living Coalition for Older Adults. The Guide is available at < http://www.paguide.com/older-aines/english/index.html > or by phone at 1-888-334-9769.

- Launched the National Advisory Council on Aging (NACA) report entitled *1999 and Beyond: Challenges of an Aging Canadian Society*. This document outlines the key issues, challenges and opportunities facing public policy makers and all those interested in issues raised by the aging population.

  < http://www.hc-sc.gc.ca/seniors-aines >

- Funded through the **Hepatitis C Prevention, Support and Research Program** over 40 community-based initiatives, 12 national projects and 18 research projects. These projects have assisted those who are infected with, affected by, or at risk of the Hepatitis C virus (HCV), helped strengthen national capacity to address HCV, and provided further knowledge on HCV and potential ways to prevent the spread of the virus.

International Year of Older Persons (IYOP)

Health Canada's **Population Health Fund**, provided funding and expertise to 51 later life projects pertaining to IYOP. The projects addressed a number of seniors' health issues while being consistent with the Canadian objectives for the IYOP. More information is available at:
< http://iyop-aipa.ic.gc.ca/ >

- Developed the new Canadian Diabetes Strategy composed of four major components: an epidemiological surveillance system, the Aboriginal Diabetes Initiative, a prevention and promotion component and a national coordination system. Key partners include: provincial and territorial governments, Aboriginal organizations, non-governmental organizations involved in diabetes prevention and control, academic organizations, professional organizations, and private sector organizations.

- Improved the Canadian Breast Cancer Initiative through renewed funding, and a collaborative effort of all levels of government, professional associations, non-governmental organizations, academics, and women with cancer. The program builds on the existing Initiative with improved access and participation in quality early detection and screening programs, client-centred approaches to early detection and screening including a focus on post-screen professional practices, primary prevention, and community capacity building for breast cancer information and support.
- Launched Supporting Self Care: A Shared Initiative which assists health care professionals to support self care in their practice and education. The program solicits, selects, funds and monitors interdisciplinary projects that can take place in clinical practice settings or in educational settings.
- Launched the Canadian Health Network (CHN), an Internet-based service that ensures Canadians have access to trustworthy information on healthier lifestyles, the prevention of disease, self care and the performance of the health system.

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

- Released *Report from Consultations on a Framework for Sexual and Reproductive Health* which outlines a comprehensive assessment of sexual and reproductive health issues in Canada. Developed with input from F/P/T governments, and non-governmental organizations, the Report represents a national discussion on sexual and reproductive health, providing a basis for future policy, program planning, related decision-making and collaborative actions. The Report can be found at:

  < http://www.hc-sc.gc.ca/hppb/srh >

Web-based sexuality education workshops have been developed for health educators working with teenage students, and are available at:

< http://hc-sc.gc.ca/hppb/srh >

- Designed a rural health funding program, in collaboration with the provinces and territories, as part of Innovations in Rural and Community Health. The objectives of the funding program are at: < http://www.hc-sc.gc.ca/ruralhealth/ >
- Negotiated new contribution agreements for the **Alcohol and Drug Treatment and Rehabilitation (ADTR) Program** between federal and provincial/territorial governments. This will ensure improved access to effective treatment and

rehabilitation programs and services by Canadians with alcohol and drug problems. Youth are the prime target group for services funded under ADTR although the special needs of other populations at risk are also targeted.

- Engaged all partners of the **Canadian Strategy on HIV/AIDS** in developing a priority setting and work planning model for the strategy. Agreement on the model is the first step in ensuring sustained national action on HIV/AIDS.

KRC 2.2 A reduction in health inequalities for specific population groups and improvements in their health status

Accomplishments

There are 110 **Aboriginal Head Start** projects serving about 3,500 Aboriginal children and their families in urban centres and large northern communities across Canada. Distinguishing features of this program include local Aboriginal control and a strong culture and language component. Further information can be found at: < http://www.hc-sc.gc.ca/hppb/childhood-youth/acy/ahs.htm >

- Completed the 1999-2000 **Community Action Program for Children (CAPC)** and the **Canada Prenatal Nutrition Program (CPNP)** Project Renewal exercise to ensure that community based projects, serving more than 17,000 pregnant women living in conditions of risk are well managed, financially accountable, reflect the CAPC/CPNP guiding principles and are continuing to meet objectives.

  < http://www.hc-sc.gc.ca/hppb/childhood-youth/cbp.html >

- Ongoing development of up to five Centres of Excellence for Children's Well-Being. The Centres will advance knowledge, disseminate information and influence future policy and program decisions to meet health needs of children. < http://www.hc-sc.gc.ca/hppb/childhood-youth/centres/index2.html >

- Developed and implemented the 1999 *General Social Survey Victimization Report*, in partnership with Statistics Canada and other federal departments. The information will be used in the development of policies and programs addressing the prevention of family violence.

- Hosted, under the **Canadian Strategy on HIV/AIDS**, Dialogue on HIV/AIDS: Policy Dilemmas Facing Governments, the first international policy dialogue on HIV/AIDS. The conference agenda focussed on at-risk populations.

Back to Sleep Program

Health Canada has partnered with The Canadian Foundation for Study of Infant Deaths, Canadian Paediatric Society, Canadian Institute of Child Health, and corporate partner Proctor & Gamble to inform parents, caregivers and health professionals of the risk factors related to Sudden Infant Death Syndrome.

The National Clearinghouse on Family Violence, promotes family violence prevention and supports the federal government in helping Canadians reduce the occurrence of violence in their communities.

< http://www.hc-sc.gc.ca/nc-cn >

- Organized and helped plan, in consultation with the Aboriginal community, the Aboriginal HIV/AIDS Summit, which brought together key stakeholders within Aboriginal communities and organizations across Canada, and government officials. The Summit resulted in agreement on a process to better coordinate Aboriginal HIV/AIDS activities under the **Canadian Strategy on HIV/AIDS**.

KRC 2.3 The impacts on health of existing or new policies, practices, programs and services are assessed and taken into account by the private, public and voluntary sectors

Accomplishments

- Supported national voluntary health organizations in the areas of training, skill development or policy, further strengthening the capacity of the volunteer sector in its ability to provide better programs/services to Canadians.
- Established the Canadian Population Health Initiative (CPHI) and its first governing Council in partnership with Statistics Canada, the Canadian Institute for Health Information, the F/P/T Advisory Committee on Population Health and a pan-Canadian network of population health researchers. The CPHI provides leadership in Canada by bringing together researchers and decision makers from across the country to define priorities for research on the broad factors that influence health.

  < http://www.cihi.ca/Roadmap/CPHI/start.htm >

KRC 2.4 A reduction in tobacco caused illness and death

Accomplishments

- Launched two new advertising campaigns aimed at educating the public on the toxic constituents of tobacco smoke and the addictiveness of tobacco products. More information is available at:

  < http://www.hc-sc.gc.ca/hppb/tobacco >
- Created the Youth Advisory Committee (YAC) on tobacco, which provides advice on issues and activities regarding tobacco and young Canadians. The YAC is comprised of 17 members (aged 13 to 19) from across Canada who reflect the diversity of Canadian society. More information on the YAC is available at:

  < http://www.hc-sc.gc.ca/hppb/tobacco/yac/yac/index.html >
- Released the *Guildford documents* which profile the marketing and promotional strategies used by tobacco companies and increase understanding of the tobacco industry's knowledge of the health consequences and addictive nature of cigarettes.

- Announced proposed changes to warning labels for tobacco products. The proposed labelling regulations require that the packaging of tobacco products include smoking cessation information, information on tobacco related diseases, increased disclosure of toxins contained in tobacco products, and graphics which display the effects of tobacco use on the human body.

Grants and Contributions Programs over $5M:
(indicated in bold throughout text)

Grants:

Canadian Strategy on HIV/AIDS
Hepatitis C Prevention, Support and Research Program
Population Health Fund

Contributions:

Alcohol and Drug Treatment and Rehabilitation Program
Canada Prenatal Nutrition Program
Canadian Strategy on HIV/AIDS
Community Action Program for Children
Hepatitis C Prevention, Support and Research Program
Population Health Fund

Business Line 3: Aboriginal Health

Financial Information

(millions of dollars)

	1999-2000 Planned Spending	1999-2000 Total Authorities	1999-2000 Actual Spending
Gross expenditures	$1,158.5	$1,157.4	$1,155.1
Expected revenue	($9.1)	($9.1)	($8.8)
Net expenditures	$1,149.4	$1,148.3	$1,148.3*

* This represents 56.3 percent of the Department's actual spending.This percentage is based on total departmental spending excluding the one-time court ordered Hepatitis C payment of $855.3M in Promotion of Population Health to allow for comparability with previous year.

Web site: < http://www.hc-sc.gc.ca/msb/msb_e.htm >

Objective

To assist Aboriginal communities and people in addressing health inequalities and disease threats and in attaining a level of health comparable to that of other Canadians, and to ensure the availability of, or access to, health services for registered First Nations people and Inuit.

Commitment, Key Results Commitments (KRC) and Accomplishments

Commitment

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

The services provided under the Aboriginal Health Business Line are targeted towards First Nations living on-reserve and Inuit populations. This Business Line works closely with both the Assembly of First Nations and the Inuit Tapirisat of Canada. Other national partners include the Métis National Council, the Congress of Aboriginal People and the Native Women's Association of Canada. Stakeholders are also found at the provincial and community level, including the First Nations and Inuit people themselves.

KRC 3.1 **Improvements in First Nations and Inuit people's health and a reduction in health inequalities between them and other Canadians**

KRC 3.2 **A First Nations and Inuit population that is informed and aware of the factors that affect health and what actions can be taken to improve health**

Health Canada provides on-reserve community-based disease prevention and health promotion programs.

Accomplishments

- Distributed a *Planning Resource Kit* to First Nations and Inuit communities which assisted 400 communities with the implementation planning process of the Home and Community Care Program (HCC). The HCC pilot projects were evaluated and the program and accountability framework and funding formula were developed and implemented.
- Approved 203 projects under the **Aboriginal Head Start (AHS)** On-Reserve Program; a National Evaluation Framework was developed; a *National Annual Report* was produced and a National Training Workshop was held focussing on best practices in Head Start programs. Approximately 6,500 children on-reserve have received **AHS** services nationally.
- Drafted an Aboriginal Diabetes Framework in consultation with communities, which led to the establishment of a working group of Aboriginal experts. Twelve First Nations diabetes prevention programs were funded for one year.
- The proposed Aboriginal Health Institute has been incorporated as the Organization for the Advancement of Aboriginal Peoples' Health (OAAPH) and has received funding for five years. The OAAPH will provide improved analysis and dissemination of information and research on Aboriginal health and increase partnership, capacity and support for Aboriginal health.
- Completed an environmental scan to review existing **mental health** programs and a framework was drafted outlining means to address mental health issues in First Nations and Inuit communities and to develop practical solutions and policies.
- Established a National Steering Committee for the Canada Prenatal Nutrition Program (CPNP) including a fetal alcohol syndrome/effects component which will direct the evolution of the program to best meet community needs. As well, the program framework has been finalized and over 400 projects were funded. Communities are now beginning the planning process of program expansion.
- Established a First Nations/Inuit/Health Canada working group to determine the health indicators to be collected and to define the methodologies for data collection and the framework for annual collection of this health data.

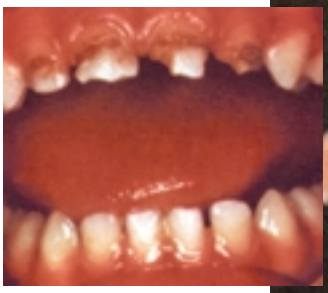
KRC 3.3 Effective health care services available and accessible to First Nations and Inuit people

Building partnerships has, for some time, been a key focus of joint work between the Assembly of First Nations (AFN) and Health Canada's First Nations and Inuit Health Branch (FNIHB). There are many different regional and national partnership agreements between FNIHB and AFN which will be the foundation upon which to develop a renewed First Nations and Inuit health system. The renewal process will, in turn, determine mechanisms for future relationships.

Accomplishments

- Through the **Non-Insured Health Benefits Program (NIHB)** provided a range of medically necessary goods and services which supplement benefits provided through other private, federal or provincial programs, to more than 650,000 First Nations and Inuit clients regardless of residence in Canada. **NIHB** benefits include drugs, dental care, vision care, medical supplies and equipment, as well as transportation to medical services and crisis mental health counselling.

First Nations and Inuit children experience a higher level of tooth decay than non-native children. The oral health program delivered under **NIHB** provides treatment while encouraging a focus on modern oral health prevention methods such as oral hygiene instruction, diet/lifestyle, and communal water fluoridation to avoid the suffering related to extensive dental disease.



- Implemented an enhanced provider audit program and provider profiling tools to improve the detection of unusual patterns of billing. This will prevent inappropriate billings and ensure that services and items for **NIHB** clients are paid in a proper manner.
- Connected almost all pharmacy providers that bill the **NIHB** Program to the Point of Service system which provides on-line drug utilization messages to support optimal drug therapy.

- Distributed the First Nations and Inuit Health Information System (FNIHIS) which is one of the Canadian Health Infostructure initiatives (see page 73), to 114 health facilities for an overall total of 260 in First Nations communities. The system provides communities with the tools and training to effectively use health data in a standardized and timely fashion. A data integration pilot was launched with British Columbia to allow health professionals to view client immunization profiles.
- Funded through the Health Transition Fund, five telehealth projects which have been implemented and community health workers trained in usage. Support documents were developed to assist communities which wish to undertake telehealth initiatives.
- Established an accountability framework to ensure greater transparency; the framework will structure reporting requirements resulting in better community health planning and evaluation.

KRC 3.4 Increased First Nations and Inuit management of and accountability for health care services and the Non-Insured Health Benefits Program

Health Canada is taking steps to facilitate the takeover of its health services by First Nations and Inuit.

Accomplishments

- Established a National Joint Steering Committee in partnership with First Nations and Inuit groups to oversee the policy framework for the transfer of **NIHB** and evaluation of the six **NIHB pilot projects**.
- Completed Canada/First Nations Funding Agreements (CFNFA) with seven First Nations Bands; this joint multi-departmental funding mechanism will reduce the number of agreements needed and be less burdensome administratively for Bands.
- Signed 248 **transfer** and **integrated** agreements with 403 of 614 First Nations and Inuit communities. In addition, 10 self-government final agreements which include health services and related resources have been signed. Overall, 81 percent of First Nations communities are involved in the **transfer** process. For more information: < http://www.hc-sc.gc.ca/msb/pptsp/hfa_e.htm >
- Introduced improved processes and tools to enhance accountability mechanisms with **transferred** First Nations and Inuit communities. On a national basis, 86 percent of audit reports, 70 percent of annual reports, and 58 percent of evaluation reports have been received from transferred First Nations and Inuit communities.
- Continued to work towards the transfer of remaining departmental hospitals to First Nations and Inuit control.
- Continued to support Nunavut as it implements and manages FNIHB programs and services.

Contributions Programs over $5M:
(indicated in bold throughout text)

Contributions:

Aboriginal Head Start
Brighter Futures
Community Health Services
Health Program Transfer
Home Nursing
Integrated Community Service
Mental Health
National Native Alcohol Drug Abuse Program
Non Departmental Health Care Facilities
Non-Insured Health Benefits
Non-Insured Health Services - Pilot Projects
Solvent Abuse

Business Line 4: Health System Support and Renewal

Financial Information

(millions of dollars)

	1999-2000 Planned Spending	1999-2000 Total Authorities	1999-2000 Actual Spending
Net expenditures	$82.5	$49.1	$49.1*

* This represents 2.4 percent of the Department's actual spending. This percentage is based on total departmental spending excluding the one-time court ordered Hepatitis C payment of $855.3M in Promotion of Population Health to allow for comparability with previous year.

Web site: < http://www.hc-sc.gc.ca/english/about.htm >

Objective

To ensure the long-term sustainability of a health system having significant national character.

Commitment, Key Results Commitments (KRC), Strategies and Accomplishments

Commitment

To provide Canadians with leadership that contributes to the long-term sustainability of a health system that has significant national character.

KRC 4.1 **Publicly-funded hospital and physician services consistent with the principles of the *Canada Health Act (CHA)***

KRC 4.2 **An integrated health system embodying efficient health services**

KRC 4.3 **Innovative national and international initiatives that strengthen the health system**

KRC 4.4 **A better understanding of the fundamental issues relating to health care, and better tools and mechanisms for improving access to a range of high quality, equitable services**

KRC 4.5 **Strengthened partnerships among federal, provincial and territorial governments, key stakeholders, Canadians and international partners**

Strategy 1

Strengthen health care services in Canada to deal immediately with existing problems in the health care system and, over the longer term, provide a full range of high quality, integrated, patient-centred services.

Accomplishments

- Co-chaired the Federal/Provincial/Territorial (F/P/T) Conference of Ministers of Health and the Conference of Deputy Ministers of Health. F/P/T governments have worked together to ensure that Canadians have continuing access to quality health care services through Canada's publicly-funded health system. In September 1999, F/P/T Health Ministers noted concrete progress on several fronts, including: maintenance of a financially sustainable health care system; collaboration on health human resource planning; joint work on population health approaches; and the development and effective use of information technologies.
- Funded 141 projects through the **Health Transition Fund** to test ways to improve health care in four priority areas: home care, pharmacare, primary care and integrated service delivery. Results of these projects will help inform future policy and service delivery decisions to improve the quality and accessibility of health care.
- Established with partners an interdisciplinary network of health care professionals and service users to promote the integration of self care support into the education and practice of health care professionals, especially physicians and nurses.
- The Centres of Excellence for Women's Health scanned Canadian research information regarding health care privatization and found very little that captures the differential impacts on women and men. Initial findings were that health care privatization is having more profound negative effects on women (as workers, care providers, and patients). The work has been brought to the attention of provincial health ministries and federal officials.

Strategy 2

Improve knowledge, practices and the development of standards for integrated quality care in key sectors.

Accomplishments

Home and Community Care

- Made progress in developing consensus, among governments and with national health organizations, on key principles, objectives and outcomes that should be achieved through publicly-funded home and community care.
- Completed analytical work to achieve a better understanding of: 1) the impacts of an aging population on the need for home, community and long-term care, and also cost and service utilization implications of different service mix policy

scenarios; 2) the impacts of current funding approaches on effective transitions from hospital to home or community, decision-making under restraint, and mixes of public and private funding.

Access to Pharmaceuticals

- Completed a major study that examined Canadians' access to insurance coverage for prescription medicines. Pursuant to an agreement with Health Canada, the Patented Medicines Prices Review Board (PMPRB) completed its first year of a study of costs in regard to public drug benefit plans - see the PMPRB *Departmental Performance Report* for more detail.

Rural Health

- Funded seven innovative telehealth projects through the Health Infostructure Support Program to improve health care delivery in rural and remote areas across Canada. An example is the tele-ultrasound project in the Keeweetinok Health Authority in northern Alberta. For people living in remote and rural areas, these projects improved access to health services through the integration of information technologies.
- Supported eight tele-homecare projects to demonstrate technology innovations in the delivery of home care and to examine their potential and implications. An example is the tele-hospice project in West Prince, Prince Edward Island where nursing staff have an increased capacity to monitor terminally ill patients in their rural homes.

Integrated Service Delivery

- Established the Office of Nursing Policy through the Innovations in Rural and Community Health Program. The Office provided expert advice to the health community on issues relating to health human resources and health systems from a nursing perspective.
- Facilitated a roundtable of nurse leaders and researchers, health care executives, and government representatives on improving the health and workplace setting of nurses.
- Established a steering committee, comprised of representatives of medical schools and governments to raise awareness of the role and accountability of medical schools in ensuring an appropriate supply and mix of physicians relative to Canadians' health needs. Background papers prepared for the committee by Health Canada were subsequently delivered to Ministers of Health. They assessed efforts within Canada and internationally to improve access to medical care in rural and remote areas, and to look at issues related to the geographic distribution of physicians in Canada. These efforts will help to ensure that Canada continues to have an adequate supply and appropriate mix of health professionals to meet the health care needs of Canadians. Reports are available at:

  < http://www.hc-sc.gc.ca/english/archives/releases/99_pice.htm >

Contributions Program over $5M:

(indicated in bold in text)

Health Transition Fund

Business Line 5: Health Policy, Planning and Information

Financial Information

(millions of dollars)

	1999-2000 Planned Spending	1999-2000 Total Authorities	1999-2000 Actual Spending
Net expenditures	$139.8	$178.5	$178.3*

* This represents 8.7 percent of the Department's actual spending. This percentage is based on total departmental spending excluding the one-time court ordered Hepatitis C payment of $855.3M in Promotion of Population Health to allow for comparability with previous year.

Web site: < http://www.hc-sc.gc.ca/iacb-dgiac/english/main_e.html >

Objective

To foster strategic and evidence-based decision-making within Health Canada and to promote evidence-based decision-making in the Canadian health system and by Canadians themselves.

Commitment, Key Results Commitments (KRC), Strategies and Accomplishments

Commitment

To provide Canadians with effective national health policies and plans, and current, reliable health information to support strategic and evidenced-based decision-making in Health Canada, throughout the health system and by Canadians.

KRC 5.1 **National policies and plans that effectively address emerging health challenges and/or changes to existing health priorities**

Strategy 1

Improve the effectiveness of Canada's health research.

Accomplishments

- Played a key role in partnership with the Medical Research Council, the provinces, health non-governmental organizations and the research community in creating the Canadian Institutes of Health Research (CIHR), through financial, secretariat and policy support. < http://www.cihr.ca/ >

- Launched Culture and Health of Canadians II in collaboration with the Social Sciences and Humanities Research Council (SSHRC), an initiative designed to support CIHR objectives and establish new and innovative partnerships.
- Launched through the **National Health Research and Development Program**, the Health Career Awards, in partnership with the CIHR and SSHRC, to build a critical mass of health-related research and research training in the social sciences and humanities, needed to better understand the broader social and cultural determinants of health.
- Provided funding to the Canadian Health Services Research Foundation (CHSRF) through the **Canadian Health Services Research Fund** to promote applied health systems research, enhance research quality and relevance, and facilitate the use in evidence-based decision making by policy makers and health systems managers. For more information on the CHSRF refer to its 1999 annual report at:

  < http://www.chsrf.ca/english/document-library/99-anreport.pdf >

Strategy 2

Expand the policy research capacity of the Department.

Accomplishments

- Established a major research program to foster better understanding of health issues such as aging and health care reform, in particular, health human resources issues and cost drivers; collaborated in developing a database on economic burden of illness in Canada; and provided desktop access to core data, analytical tools, key research reports and analysis for departmental policy and program analysts.
- Reoriented extramural research funding through the **National Health Research and Development Program** to meet Health Canada's needs in targeted areas such as: home care, children and youth, aging, and financing of the health care system.
- Co-funded, with Statistics Canada and the Policy Research Initiative, the Population Health Perspective Conference to showcase promising research in the population health field and to explore linkages with policy development.

Strategy 3

Improve the integrity of the policy process and expand the evidence base of policy-making.

- Consulted provincial/territorial partners and key stakeholders on a proposed federal approach to Reproductive and Genetic Technologies, resulting in a Feedback Report to all participants. This input will help inform the government on the next steps to be taken on this issue.

- Created a Departmental Executive Subcommittee on Policy and Analysis comprised of senior representatives of all branches and regions to ensure that key health policies are adequately challenged and integrated into the full scope of the Department's activities.
- Developed preliminary tools and frameworks to support comprehensive policy analyses in the areas of family, early childhood development, migration health and genomics. These tools will enhance the quality of the policy decision-making process.
- Launched a Working Group on Genetic Testing for Late Onset Diseases, to identify and analyze the key policy issues that are likely to arise and to develop policy options.
- Created a Horizontal Policy Division, to ensure that health policies are cohesive and integrated with the overall government agenda and the priorities of other federal departments.
- Developed preliminary tools for conducting gender-based analyses of health policies and programs. This will help ensure that health policies and programs are sensitive to gender differences.

KRC 5.2 A health system that is more effective, efficient and accountable and which includes a well functioning national health information and health research infrastructure

Strategy 4

Develop, in collaboration with provinces, territories and stakeholders, an integrated approach to organizing and disseminating health information and knowledge.

Accomplishments

- Provided financial support through some 36 projects in telehealth, electronic patient records, and electronic health information to foster innovative applications of information and communications technologies in health and health care. For example, a tele-homecare project from The Hospital for Sick Children in Toronto has created a specialized telecommunications network, designed specifically for children with intermediate care needs. Parents assist intermittently monitoring their child's heart rate, respiration rate and blood oxygen levels at home. This information is regularly and automatically transmitted to a nurse at a 24-hour monitoring centre in the hospital.
- Provided leadership in the launch and management of major projects that contribute to the Canadian Health Infostructure (CHI) — the National Health Surveillance Infostructure (NHSI) network, the First Nations and Inuit Health Information System (FNIHIS) and the Canadian Health Network (CHN).
  - Established the tools and the Internet-based infrastructure to support the NHSI for a variety of health concerns with the support of FPT, regional and municipal governments, First Nations, and non-governmental organizations.

Accountability frameworks have been established for key areas that have recently assumed expanded responsibilities. These areas include: enteric (food-borne) disease surveillance, perinatal health surveillance, national diabetes surveillance system, and surveillance for blood and blood-borne pathogens. The NHSI network will provide public health officials Internet access to the information they need to prevent disease, develop policies to reduce health hazards, and allow for faster reaction to public health issues. This will save lives and prevent disease and disability.

- Funded the implementation of the First Nations and Inuit Health Information System (FNIHIS) to provide First Nations and Inuit communities with the information and tools required to more effectively use health data to maintain and improve their health (See page 65 for details).
- Launched the CHN (http://www.canadian-health-network.ca/), a national Internet-based service that provides Canadians access to trusted information on health promotion and disease prevention.

- Developed a new incentive program, the Canada Health Infostructure Partnerships Program, aimed at supporting large-scale implementation of innovative model projects using information and communications technologies to improve the accessibility and quality of health care delivery.
- Created the F/P/T Advisory Committee on Health Infostructure (ACHI) to enable collaborative and coordinated approaches to telehealth, electronic health records, privacy and confidentiality, health surveillance and overall strategic integration of emerging health infostructure applications.
- Prepared a white paper, Toward Electronic Health Records, which describes a pan-Canadian approach to electronic health records.
- Conducted vision workshops aimed at raising awareness of health infostructure among key health stakeholders such as physicians, nurses, administrators, and children's health care professionals.
- Published the results of a consultation on women's health surveillance. The report identified gaps and proposed six areas where surveillance data should be collected. < http://www.hc-sc.gc.ca/hpb/lcdc/publicat/whs-ssf/index.html >
- Initiated development of indicators to measure the health status of women and their utilization of health services. These indicators will serve as benchmarks for monitoring the health of Canadian women over time.

KRC 5.4 International health policies, programs and strategies which contribute to the Department's ability to fulfil its national and international objectives

Strategy 5

Strengthen cooperation and partnership at the international level among governments, non-governmental organizations and other stakeholders.

Accomplishments

- Co-sponsored with UNAIDS, the First Policy Dialogue on HIV/AIDS, where participants made significant contributions to HIV/AIDS policy at the national and international levels.
- Published *The Case for Canadians to Act Globally Against HIV/AIDS*, to help promote action against HIV/AIDS; and the guide *Beyond our Borders: A Guide to Twinning for HIV/AIDS Organizations*, to help voluntary organizations team up with organizations in other countries to combat HIV/AIDS. For a copy of these reports, go to:

  < http://www.hc-sc.gc.ca/hppb/hiv_aids/can_strat/international/index.html >
- Increased awareness of Canada's health system and gathered information on the experience of other countries by receiving more then 100 foreign delegations which included 13 Ministers of Health.
- Organized a major presentation on Canadian telehealth to the Conference of Spouses of Heads of State and Governments of the Americas held in October 1999.

Accountability

Responsibility and funding for improving the quality and use of performance information within the Department and for improving reporting to Canadians on the performance of Health Canada policies and programs lies primarily with the Health Policy, Planning and Information Business Line. Please see the special section on Accountability on page 30 for information on major commitments and accomplishments such as the launch of the Federal Accountability Initiative Focussing on Health Canada's Policies and Programs.

Grants and Contributions Programs over $5M:

(indicated in bold throughout text)

Contributions:

National Health Research and Development Program

Grants:

Canadian Health Services Research Fund

Business Line 6: Corporate Services

Financial Information

(millions of dollars)

	1999-2000 Planned Spending	1999-2000 Total Authorities	1999-2000 Actual Spending
Gross expenditures	$137.4	$166.0	$161.3
Expected revenue	($1.2)	($1.2)	($0.4)
Net expenditures	$136.2	$164.8	$160.9*

* This represents 7.9 percent of the Department's actual spending. This percentage is based on total departmental spending excluding the one-time court ordered Hepatitis C payment of $855.3M in Promotion of Population Health to allow for comparability with previous year.

The actual spending is $3.9M lower than the total authorities mainly resulting from Y2K contingency planning activities which did not require as many resources as planned. Lapsed resources will be applied towards the repayment of the Y2K loan.

Web site: < http://www.hc-sc.gc.ca/csb-dgsg/english/ov_ap1_e.htm >

Objective

To support the delivery of Health Canada's programs through the provision of administrative services and advice and direction to senior management regarding the effective and efficient use of resources.

Commitment, Key Results Commitments (KRC), Strategies and Accomplishments

Commitment

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

KRC 6.1 Continuous improvement in the provision of corporate administrative services

Strategy 1

Build and sustain a highly qualified work force.

Accomplishments

- Established partnerships with selected departments to develop the Compensation Advisor Bridging Program to ensure sound compensation advice and the Aboriginal Career Development Initiative that facilitates interdepartmental assignments for federal Aboriginal employees.
- Implemented, to meet the needs of a growing and diverse work force, a Departmental Orientation Program and introduced a new series of learning programs.

KRC 6.2 Continuous improvement in the promotion of sound management practices

Strategy 2

Enhance the Department's capabilities for utilizing modern comptrollership practices and managing its programs, expenditures and assets effectively.

Accomplishments

- Expanded and upgraded the Department's financial system that now provides managers a single, common system with desktop access to financial, procurement and assets information.
- Established a Client Services Renewal Secretariat that oversees a series of client services improvement initiatives in collaboration with Program Branches.

Strategy 3

Rejuvenate the Department's assets, strengthen its assets management capabilities, and reduce the adverse impacts of its physical operations on the environment.

Accomplishments

- Developed a partnership with Public Works and Government Services Canada (PWGSC) for the provision of day-to-day facilities services and developed an Annual Departmental Accommodation Strategy which have resulted in improved space utilization and a more strategic approach to space acquisition.

- Identified actions that are intended to reduce the impact of vehicle emissions, implemented a zero waste program and developed a remediation plan related to contaminated fuel tank sites.
- Completed the construction and renovation of over 40 health facilities through the **Capital Construction for First Nations and Inuit Communities Contribution Program** to allow for improved availability and accessibility of health care services for the First Nations and Inuit people.

Strategy 4

Develop effective ways to manage corporate information and support knowledge management in the Department, utilizing information technologies.

Accomplishments

- Implemented a Knowledge Sharing Database and developed a *Record Keeping Procedures Manual* to provide better organization for, and more efficient access to departmental corporate memory information.
- Ensured the Year 2000 readiness of the Department's mission-critical systems and established an effective working partnership with provincial, territorial Ministries of Health, other health care partners and stakeholders for the successful transition of the health care sector to the Year 2000.
- Introduced a number of Internet accessible library databases to improve access to research information and to improve search capabilities from remote locations.
- Improved the capacity to exchange and store information in a secure and confidential manner through the application of the Applied Secure Electronic Service Delivery, which has lead to increased capacity to form partnerships, and the Public Key Infrastructure, an encryption technology, which has increased user confidence in the electronic exchange of information and business transactions.

Contributions Program over $5M:

(indicated in bold in text)

Capital Construction for First Nations and Inuit Communities

SECTION IV: CONSOLIDATED REPORTING

Modernizing Comptrollership

Health Canada, over the past couple of years, has adopted a new management vision that will better align departmental management practices with the concepts, principles and requirements of the government's Modern Comptrollership Initiative < http://www.tbs-sct.gc.ca/cmo_mfc/contents.htm > and the Financial Information Strategy. To this end, a number of initiatives have been and are being implemented.

- Implemented a new system called Framework for Integrated Resource Management (FIRM)/SAP R/3, a state-of-the-art, on-line, integrated enterprise system for effective management of departmental financial and non-financial resources.
- Established a Departmental Financial Council (DFC) to ensure the Department's financial community remains informed and prepared to meet the challenges associated with departmental resource management.
- Developed a Risk Management Evaluation Framework with respect to health protection of Canadians entitled Health Canada's Decision-Making Framework for Identifying, Assessing, and Managing Health Risks.
- Implemented a Federal Accountability Initiative; projects included the development of performance measurement frameworks and core indicators related to key issues and programs, management training and improvements to departmental reporting.
- Developed action plans to address common issues raised by employees in the Public Service Employee Survey. A senior level Steering Committee and Branch Working Committees have been established to guide the ongoing work.
- Launched a corporate services Client Services Renewal Initiative aimed at improving the delivery and quality of corporate services.
- Developed a Conflict of Interest Accountability Framework, guidelines and an employee training tool to address conflict of interest situations.

- Ensured better management of horizontal program and management issues through Departmental Executive Sub-Committees in the areas of policy and analysis, communications, finance, human resources, assets management, information management/information technology, risk management and regulatory affairs.
- Conducted program impact assessments to determine whether current program activities are achieving the best outcomes in key areas such as Policy and Analysis, First Nations and Inuit Health, Joint Health Promotion/Disease Prevention and Control, Environmental Health Program and Communications. These projects provided an opportunity to analyze resource inputs against program outputs.

Matériel Management

The Department has made significant progress towards readiness for implementation of the Financial Information Systems (FIS) strategy for moveable goods and to address accrual accounting and life-cycle costing.

- Launched a new departmental Matériel Management System SAP/FIRMS on April 6, 1999. Responsibility Centre Managers (RCMs) are required to use SAP/FIRMS, which integrates matériel management processes into a single structure and includes financial, salary and matériel functions.
- Launched a comprehensive Department-wide inventory process as part of preparations for Health Canada's move to an accrual accounting environment, a move initiated by Treasury Board. Data was gathered on physical assets within the Department from RCMs nation-wide and recorded in the Framework for Integrated Resource Management Systems (SAP/FIRMS) database.
- Successfully launched orientation sessions in two Regions to provide Health Canada's RCMs with information on contracting policy and procedures: Atlantic (Halifax) and Central (Winnipeg, NCR and Toronto). Information provided to personnel included current Treasury Board and departmental contracting policy, trade agreements and departmental limits.

Sustainable Development

The concept of sustainable development has been evolving; ideas about what makes human populations healthy have also been changing. Over the last two decades, there has been a growing awareness of the interrelated determinants (or factors) that contribute to population health. These are now recognized to include income and social status, social support networks, education, employment and working conditions, social environments, physical environments, personal health practices and coping skills, healthy child development, biology and genetic endowment, health services, gender and culture.

Health Canada as a federal department has a direct influence on social/cultural, economic and environmental conditions in Canada through implementation of its policies, programs and regulatory responsibilities. To foster the creation of a healthier society where human and ecosystem well-being are enhanced, the Department is striving for fuller consideration and integration of the economic, social and environmental spheres in its decision-making process.

Sustainable development is a practical process with ethical and legal responsibilities that shape decision-making throughout the Department. Sustainable development is about our quality of life. Health Canada is currently implementing its 1997 Sustainable Development Strategy (SDS), prepared under the authority of the *Auditor General's Act* (revised 1995). In 1998, the Department revised its targets in response to the recommendation of the Commissioner of the Environment and Sustainable Development and made them more quantifiable. The targets, published on the departmental Web site < http://www.hc-sc.gc.ca/susdevdur/health_e.htm >, are arranged under four strategic themes:

- **Promoting and Supporting Population Health:** Opportunities to contribute to sustainable development through a population health approach and through our intention to more fully explore the linkages between population health and sustainable development, and to support healthy child and youth development;
- **Identifying and Reducing Health Risks from the Environment:** Opportunities to address health risks of environmental origin (toxic substances in the environment, bio-regional health effects, and environment-related diseases) and from the food supply;
- **Strengthening Partnerships on Health, Environment and Sustainable Development:** Opportunities for collaboration with other federal departments, provincial and territorial governments, First Nations and Inuit communities and organizations, as well as health professionals, health advocates, consumers and researchers;
- **Integrating Sustainable Development into Departmental Decision-making and Physical Operations:** Opportunities for the Department to become more responsive to sustainable development by clearly establishing responsibilities and accountability for sustainable development; and by "greening" operations in its laboratories, health care facilities, warehouses and offices.

The direction at Health Canada is to integrate sustainable development thinking into the development of all policies and programs, and into planning, staffing, training, risk assessments, regulatory evaluations, partnership activities, public

consultation and more. Integrating sustainable development thinking into all we do will require continuous examination of the processes and tools we have and the ones we need. The availability of the Lotus Notes Departmental Sustainable Development Database throughout the Department is improving the measurement of results and reporting on progress to date.

The following results which Health Canada has achieved are arranged by Business Lines and subsequently by Service Lines.

Management of Risks to Health Business Line

Food Safety, Quality and Nutrition Service Line

Completed more than 1200 projects relating to the assessment of risks associated with food allergens and chemical contaminant levels in food. These included approximately 20 comprehensive health risk assessments on priority contaminant issues such as dioxins in imported foods from Belgium, microcystins in blue-green algae products, etc.

Disease Prevention and Control Service Line

Developed community cancer surveillance procedures which were implemented in environmental hot spots in the Great Lakes Basin area (Port Hope, Windsor and Pickering/Ajax). Additionally, hot spots risk assessment reports were released to the public in November 1999.

Studied the impact of residential exposure to effluents and air-borne emissions from pulp and paper mills and completed the risk assessment on Non-Hodgkin's Lymphoma.

Enhanced environmental reproductive health surveillance and risk assessment through the study of the association between disinfection byproducts and adverse reproductive outcomes.

Acquired and analyzed data to develop control options for substances declared toxic under the *Canadian Environmental Protection Act (CEPA)*.

Reduced the public's exposure to St. Lawrence River drinking and recreational water that presents a risk of contamination.

Determined through the Great Lakes Health Effects Program, the human exposure and health effects associated with contaminants (chemical, microbiological and radiological) of all sources of pollution and communicated with agencies and the public to enhance decision-making on health and environmental issues.

Reported on health risks due to pollutants in the north, through a collaborative effort involving First Nations and Inuit communities as well as federal, provincial and territorial government departments.

Placed conditions and use restrictions, under Section 29 of *CEPA*, on the type of use and/or amount for two substances suspected to be toxic to human health.

Pest Management Regulation Service Line

Developed in partnership with Canola Council of Canada and Canadian Canola Growers Association, a *Pest Management [Information] Matrix for Canola* to aid canola producers in applying IPM practices. This matrix has been released in draft form for evaluation by producers and agronomists in Canada and the US. A similar matrix has been designed for apples and is being tested by apple producers.

Developed a user requested *Minor Use Registration Directive* to facilitate access to new technologies, including reduced risk chemicals and biopesticides. This resulted in granting a time-limited registration (until December 1999) to an innovative, IPM compatible tool to fight insect damage to cranberries, pending consultation on proposed full registration, and the approval of the first-ever biological pesticide for use in greenhouses on ornamentals, cucumbers, tomatoes and peppers.

> IPM is a sustainable approach, combining biological, cultural, physical, and chemical tools to manage pests resulting in the benefits of pest control being maximized and the health and environmental risks being minimized.

Published a voluntary *Pesticide Resistance Management Labelling Directive* introduced jointly by Canada, US and Mexico (DIR99-06) in order to ensure consistency in pesticide grouping and labelling, and to contribute to the management of the pesticide resistance problem.

Contributed to a uniform North American approach to help reduce development of pesticide resistance and support joint registration decisions.

Promotion of Population Health Business Line

The Community Animation Program established and expanded more than 20 relationships with federal, provincial, and territorial governments and non-governmental organizations, and provided support in the form of facilitation, training and resources to more than 350 community organizations to address a variety of issues affecting the health of Canadians.

Supported 474 Community Action Program for Children projects across Canada to establish and deliver services through community coalitions, addressing health and development needs of pre-school children and their families living in conditions of risk.

Held an annual workshop on Aboriginal Head Start (AHS) to strengthen the AHS program across Canada.

Administered 112 AHS sites to address the early childhood development needs of Aboriginal children living in urban centres and large northern communities.

The Canada Prenatal Nutrition Program (CPNP) successfully reached the population of women who are at risk of delivering unhealthy babies. The population included teenagers (38%), single women (49%), Aboriginals (23%), those with 11 or fewer years of education (58%), those living on household incomes of less than $1,300 per month (58%) and those experiencing abuse during their pregnancy (13%).

Developed new Tobacco Reporting Regulations which will increase the level of reporting required from the tobacco industry.

Aboriginal Health Business Line

Responded to the concept of sustainable development by addressing the health inequalities that First Nations and Inuit people face. Examples of this work included the Aboriginal Head Start On-Reserve Program, the Aboriginal Diabetes Strategy and the First Nations and Inuit Home and Community Care Program.

Assessed and updated fuel storage tank remediation action plans to address 12 fuel impacted sites and fuel storage tank systems.

Assessed 11 fuel/oil contaminated sites to determine the extent of soil contamination and de-contaminated three of the sites.

Initiated ground water remediation at one site to alleviate potential risk of contaminated ground water. Initiated upgrade/replacement of fuel tanks at eight sites and one tank was brought into compliance.

Developed an Environmental Management System for the Percy Moore, Norway House and Sioux Lookout hospitals to improve these hospitals' environmental performance.

Corporate Services Business Line

Improved the management of environmental aspects by completing the development of a Department-wide Environmental Management System (EMS). This included the creation of an award-winning 14001 EMS database serving as a management tool for facility managers.

Developed a departmental remediation action plan to facilitate the "greening"of Health Canada's physical operations which should result in a reduction in the number of departmental contaminated sites and in the upgrading of fuel storage tank systems.

In 1999-2000, two new vehicles were retrofitted to operate using alternative fuel and a review was conducted of the Ontario motor vehicle fleet.

Designed and distributed six editions of the electronic newsletter *Green Pages* to increase environmental awareness among all Health Canada employees.

Prepared action plans for the promotion of "green" procurement and environmentally responsible fleet management at Health Canada.

Additional information on the departmental environmental management achievements (such as implementation of Zero Waste program, decrease in energy consumption and regional ISO 14001 training to employees with direct environmental management responsibilities) can be found in *Annual Environmental Report 1999-2000,* available from Director, Environmental Management Systems Division, (613) 957-1924.

Regulatory Initiatives

Performance of Regulatory Initiatives

Purpose of Regulatory / Legislative Initiative	Expected Results	Performance Measurement Criteria	Outcome
Food and Drug Regulations (Nutrient Content Claims) Regulations have been drafted and a regulatory package is being prepared for publication in *Canada Gazette*, Part I.	New regulations will provide the consumer with nutrient content claims that - are consistent, accurate and non-misleading - are based on health criteria and support dietary guidance - are not in conflict with health and safety issues, but still take into account economic and trade considerations.	Reduced number of submissions on nutrition claims and reduced levels of compliance activity.	The outcomes of this initiative will not be seen until after these regulations have been published in *Canada Gazette*, Part II.
Food and Drug Regulations (Addition of Vitamins and Minerals to Foods) Broad stakeholder consultation on development of a more flexible policy for addition of vitamins and minerals to foods has been held. Widespread public consultation on the policy recommendations has been completed and the comments are being assessed.	An appropriate regulatory framework for the food industry will provide consumers with a wider variety of food products with added vitamins and minerals to meet public health needs and, at the same time, protect the population from excessive or imbalanced intakes.	Reduced number of submissions and reduced enforcement and compliance activity. Determination of whether Canadians are meeting their recommended intakes of vitamins and minerals would be assessed through dietary surveys.	Benefits to the consumer will begin to accrue after the implementation of the revised policy in late 1999 - 2000.

Performance of Regulatory Initiatives (continued)

Purpose of Regulatory / Legislative Initiative	Expected Results	Performance Measurement Criteria	Outcome
Food and Drug Regulations (Revision of Division 16 - Food Additive Tables) A draft Schedule of Amendments is in preparation and is expected to be published in *Canada Gazette*, Part I in 2001.	The new approach will give industry greater choice in the use of food additives, while continuing to ensure public safety.	Reduced food additive submission activity, reduced amendment of food standards, and a reduced number of compliance actions.	The contract to rectify deficiencies identified by Legal Services has been completed. Outcomes will begin to accrue one year following publication of Schedule of Amendments in *Canada Gazette*, Part II.
Food and Drug Regulations (Blood, Tissues, Organs and Xenografts) Awaiting finalization of CSA standards and consultation on regulatory frameworks.	Health Canada is proposing to introduce new regulations and update others to ensure the safety of blood and blood components as well as tissue and organ transplants, including xenotransplants.	Determination of the performance measurement criteria will be established once the final format and content of the regulations are known.	The outcomes of this initiative will not be seen until after these regulations have been completed and published.

Performance of Regulatory Initiatives (continued)

Purpose of Regulatory / Legislative Initiative	Expected Results	Performance Measurement Criteria	Outcome
Tobacco (Products Information) Regulations On January 22, 2000, a Notice of Intent to regulate was published in *Canada Gazette*, Part I. Regulations are expected to become law before the end of 2000.	New regulations will be proposed that all tobacco products carry health warning labels within one year, and those that have more than 2% of the market have to have them in place 180 days after the regulations are registered. The aim is to provide Canadians (especially young people) with information about health effects of tobacco use. A consultation paper, Options for Tobacco Promotion Regulations, was published and distributed to industry and interested parties in January 1999 to solicit their comments.	Determination of the performance measurement criteria will be established once the final format and content of the regulations are known.	The outcomes of this initiative will not be seen until after these regulations have been completed and published.
Tobacco (Reporting) Regulations On January 22, 2000, a Notice of Intent to regulate was published in *Canada Gazette*, Part I. Regulations are expected to become law before the end of 2000.	The proposal is intended to expand the list of reportable ingredients and emissions, and will apply to all classes of tobacco products. To this end, a Health Protection Branch *Information Letter* was published on June 10, 1998 soliciting comments on these regulatory proposals. Comments were analyzed and, as a result, the regulatory text is being drafted by Regulations Section (Justice).	Determination of the performance measurement criteria will be established once the final format and content of the regulations are known.	The outcomes of this initiative will not be seen until after these regulations have been completed and published.

Performance of Regulatory Initiatives (continued)

Purpose of Regulatory / Legislative Initiative	Expected Results	Performance Measurement Criteria	Outcome
Controlled Drugs and Substances Act New regulations for benzodiazepines enacted June 2000.	New regulations for benzodiazepines and precursors and consolidation of existing regulations will provide an updated regulatory framework to comply with international obligations.	Determination of the performance measurement criteria will be established once the final format and content of the Act is known.	The outcomes of this initiative will not be seen until after these regulations have been completed and published.

SECTION V: FINANCIAL PERFORMANCE

Financial Performance Overview

The following financial summary tables are presented to provide an overview of Health Canada's 1999-2000 resource utilization along with prior years' comparative information. Again this year, Health Canada has strived to utilize resources in the most effective and efficient way possible, in an effort to ensure Canadians receive value for resources expended.

Overall in 1999-2000, Health Canada did not have significant lapses. A surplus of $15.4M or one percent of the authorities in operating resources did occur. This was primarily attributable to delays encountered during the year in the start-up of new initiatives.

Financial Summary Tables

Table 1:
Summary of Voted Appropriations for 1999-2000

Financial Requirements by Authority (millions of dollars)

Vote		Planned Spending [1] 1999-2000	Total Authorities [2] 1999-2000	Actual Spending [2] 1999-2000
	Health Canada			
1	Operating expenditures	1,083.1	1,120.3	**1,104.9**
5	Grants and Contributions	850.5	864.5	**864.5**
(S)	Minister of Health - Salary and motor car allowance	-	0.1	**0.1**
(S)	Contributions to employee benefit plans	61.2	70.0	**70.0**
(S)	Spending of proceeds from the disposal of surplus Crown assets	-	0.6	**0.4**
(S)	Payments pursuant to section 30 of the *Crown Liability and Proceedings Act* in respect of the judgement in favour of individuals infected with Hepatitis C *	-	855.3	**855.3**
(S)	Refunds of amounts credited to revenues in previous years	-	0.1	**0.1**
	Total Department	**1,994.8**	**2,910.9**	**2,895.3**

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

Note (1): from the 1999-2000 Report on Plans and Priorities

Note (2): from the 1999-2000 Public Accounts

* A one-time court-ordered payment of $855.3M provided compensation to individuals infected with Hepatitis C through the blood supply between January 1, 1986 and July 1, 1990.

Table 2: Comparison of Total Planned to Actual Spending

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

Business Lines	Full-Time Equivalents	Operating	Capital	Grants & Contributions	Total Gross Expenditures	Less: Respendable Revenues	Total Net Expenditures
Management of Risks to Health	2,774	271.6	-	45.1	316.7	-44.9	271.8
(Total authorities)	*2,800*	*287.2*	-	*44.8*	*332.0*	*-55.8*	*276.2*
(Actuals)	**2,711**	**273.7**	-	**44.8**	**318.5**	**-53.8**	**264.7**
Promotion of Population Health	545	74.8	-	140.3	215.1	-	215.1
*(Total authorities)**	*676*	*945.7*	-	*148.3*	*1,094.0*	-	*1,094.0*
(Actuals)*	**721**	**945.7**	-	**148.3**	**1,094.0**	-	**1,094.0**
Aboriginal Health	1,403	619.5	-	539.0	1,158.5	-9.1	1,149.4
(Total authorities)	*1,336*	*591.8*	-	*565.6*	*1,157.4*	*-9.1*	*1,148.3*
(Actuals)	**1,336**	**589.5**	-	**565.6**	**1,155.1**	**-6.8**	**1,148.3**
Health System Support and Renewal	88	11.0	-	71.5	82.5	-	82.5
(Total authorities)	*63*	*5.3*	-	*43.8*	*49.1*	-	*49.1*
(Actuals)	**63**	**5.3**	-	**43.8**	**49.1**	-	**49.1**
Health Policy, Planning and Information	574	104.4	-	35.4	139.8	-	139.8
(Total authorities)	*865*	*148.7*	-	*29.8*	*178.5*	-	*178.5*
(Actuals)	**855**	**148.5**	-	**29.8**	**178.3**	-	**178.3**
Corporate Services	845	112.4	5.8	19.2	137.4	-1.2	136.2
(Total authorities)	*971*	*129.6*	*4.2*	*32.2*	*166.0*	*-1.2*	*164.8*
(Actuals)	**999**	**124.9**	**4.2**	**32.2**	**161.3**	**-0.4**	**160.9**
Total	6,229	1,193.7	5.8	850.5	2,050.0	-55.2	1,994.8
(Total authorities)	*6,711*	*2,108.3*	*4.2*	*864.5*	*2,977.0*	*-66.1*	*2,910.9*
(Actuals)	**6,685**	**2,087.6**	**4.2**	**864.5**	**2,956.3**	**-61.0**	**2,895.3**
Non-Respendable Revenues							-7.8
(Total authorities)							*-7.8*
(Actuals)							**-14.6**
Cost of services provided by other departments							40.0
(Total authorities)							*40.0*
(Actuals)							**49.5**
Net Cost of the Program							2,027.0
(Total authorities)							*2,943.1*
(Actuals)							**2,930.2**

Planned spending for 1999-2000 was updated to reflect the Budget 1999 resources by Business Line.

* A one-time court-ordered payment of $855.3M provided compensation to individuals infected with Hepatitis C through the blood supply between January 1, 1986 and July 1, 1990.

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

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

Business Lines	Actual Spending 1997-1998	Actual Spending 1998-1999	Planned * Spending 1999-2000	Total Authorities 1999-2000	Actual Spending 1999-2000
Management of Risks to Health	180.3	267.8	271.8	276.2	264.7
Promotion of Population Health **	175.1	201.6	215.1	1,094.0	1,093.9
Aboriginal Health	1,026.8	1,060.5	1,149.4	1,148.3	1,148.2
Health System Support and Renewal	14.6	30.7	82.5	49.1	49.2
Health Policy, Planning and Information	114.3	288.1	139.8	178.5	178.3
Corporate Services	131.7	146.1	136.2	164.8	161.0
Total	**1,642.8**	**1,994.8**	**1,994.8**	**2,910.9**	**2,895.3**

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

* Planned spending for 1999-2000 was updated to reflect the Budget 1999 resources by Business Line.

** A one-time court-ordered payment of $855.3M provided compensation to individuals infected with Hepatitis C through the blood supply between January 1, 1986 and July 1, 1990.

Table 4: Resource Requirements by Organization and Business Line

Comparison of 1999-2000 (RPP) Planned Spending and Total Authorities to Actual Expenditures by Organization and Business Line (millions of dollars)

Organization	Management of Risks to Health	Promotion of Population Health*	Aboriginal Health	Health System Support and Renewal	Health Policy, Planning and Information	Corporate Services	Total Net Expenditures
Health Protection	221.6	-	-	-	14.8	-	236.4
(Total authorities)	*228.6*	-	-	-	*25.9*	-	*254.5*
(Actuals)	**217.0**	**-**	**-**	**-**	**25.9**	**-**	**242.9**
Pest Management Regulatory Agency	15.9	-	-	-	-	-	15.9
(Total authorities)	*19.3*	-	-	-	-	-	*19.3*
(Actuals)	**19.3**	**-**	**-**	**-**	**-**	**-**	**19.3**
Health Promotion and Programs	9.9	215.1	22.1	2.6	14.1	-	263.8
(Total authorities)	*2.2*	*1,094.0*	*22.0*	*2.9*	*0.0*	-	*1,121.1*
(Actuals)	**2.2**	**1,094.0**	**22.0**	**2.9**	**0.0**	**-**	**1,121.1**
Medical Services	1.5	-	1,127.3	-	-	-	1,128.8
(Total authorities)	*1.7*	-	*1,126.3*	-	-	-	*1,128.0*
(Actuals)	**1.8**	**-**	**1,126.3**	**-**	**-**	**-**	**1,128.1**
Occupational Health and Safety Agency	22.9	-	-	-	-	-	22.9
(Total authorities)	*24.4*	-	-	-	-	-	*24.4*
(Actuals)	**24.4**	**-**	**-**	**-**	**-**	**-**	**24.4**
Policy and Consultation	-	-	-	79.9	68.0	-	147.9
(Total authorities)	-	-	-	*46.2*	*75.9*	-	*122.1*
(Actuals)	**-**	**-**	**-**	**46.2**	**75.9**	**-**	**122.1**
Corporate Services	-	-	-	-	14.5	133.3	147.8
(Total authorities)	-	-	-	-	*24.5*	*128.3*	*152.8*
(Actuals)	**-**	**-**	**-**	**-**	**24.3**	**124.4**	**148.7**
Information, Analysis & Connectivity	-	-	-	-	28.4	2.9	31.3
(Total authorities)	-	-	-	-	*52.2*	*36.5*	*88.7*
(Actuals)	**-**	**-**	**-**	**-**	**52.2**	**36.5**	**88.7**
Total							
(Planned spending)	271.8	215.1	1,149.4	82.5	139.8	136.2	1,994.8
(Total authorities)	*276.2*	*1,094.0*	*1,148.3*	*49.1*	*178.5*	*164.8*	*2,910.9*
(Actuals)	**264.7**	**1,094.0**	**1,148.3**	**49.1**	**178.3**	**160.9**	**2,895.3**
% of Total **	**13.0%**	**11.7%**	**56.3%**	**2.4%**	**8.7%**	**7.9%**	**100%**

Note: Numbers in italics denote Total Authorities for 1999-2000 (Main and Supplementary Estimates and other authorities).
Bolded numbers denote actual expenditures/revenues in 1999-2000.
Planned spending for 1999-2000 was updated to reflect the Budget 1999 resources by Business Line.

* A one-time court-ordered payment of $855.3M provided compensation to individuals infected with Hepatitis C through the blood supply between January 1, 1986 and July 1, 1990.

** A one-time court-ordered payment of $855.3M has been removed from the "% of Total" to allow for comparability with previous years.

Table 5:
Respendable Revenues

(millions of dollars)

Business Lines/ Service Lines	Actual 1997-1998	Actual 1998-1999	Planned Revenues 1999-2000	Total Authorities 1999-2000	Actual 1999-2000
Management of Risks to Health					
Food Safety, Quality and Nutrition	0.7	1.0	1.3	1.3	**1.1**
Therapeutic Product Regulation	35.5	31.8	34.7	39.3	**38.7**
Environmental Health	2.2	2.0	3.3	3.3	**2.1**
Occupational Health and Safety Agency	2.7	4.1	5.3	5.3	**4.5**
Pest Management Regulation	7.4	7.8	0.2	6.5	**7.3**
Emergency Services	0.1	0.1	0.1	0.1	**0.1**
Aboriginal Health					
Indian and Inuit Health	7.0	6.7	9.1	9.1	**6.8**
Corporate Services	1.3	1.2	1.2	1.2	**0.4**
Total Respendable Revenues	**56.9**	**54.7**	**55.2**	**66.1**	**61.0**

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

Respendable Revenues: These revenues were formerly called "Revenues Credited to the Vote" and are available for spending by the Department.

Table 6:
Non-Respendable Revenues

(millions of dollars)

Main Classification and Source	Actual 1997-1998	Actual 1998-1999	Planned * Revenues 1999-2000	Total Authorities 1999-2000	Actual 1999-2000
Tax revenues:					
Goods and services tax	-	0.2	-	-	**0.3**
Non-tax revenues:					
Food and drug analysis fees	-	-	0.2	0.2	-
Refunds of expenditures	10.4	6.3	-	-	**5.2**
Service fees	2.6	2.1	2.8	2.8	**1.9**
Pharmacy and dietary revenues	-	-	3.6	3.6	-
Proceeds from the disposal of surplus Crown assets	0.3	0.3	-	-	**0.6**
Miscellaneous non-tax revenues	7.4	7.0	1.2	1.2	**6.6**
Total Non-Respendable Revenues	20.7	15.9	7.8	7.8	**14.6**

Non-Respendable Revenues: These revenues were formerly called "Revenues Credited to the Consolidated Revenue Fund" They are not available to be spent by the Department but are available to the Government.

Table 7:
Statutory Payments

(millions of dollars)

Business Lines	Actual Spending 1997-1998	Actual Spending 1998-1999	Planned * Spending 1999-2000	Total Authorities 1999-2000	Actual Spending 1999-2000
Promotion of Population Health	-	-	-	855.3	**855.3**
Total Statutory Payments	**-**	**-**	**-**	**855.3**	**855.3**

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

* A one-time court-ordered payment of $855.3M provided compensation to individuals infected with Hepatitis C through the blood supply between January 1, 1986 and July 1, 1990.

Table 8:
Transfer Payments

(millions of dollars)

Business Lines	Actual Spending 1997-1998	Actual Spending 1998-1999	Planned * Spending 1999-2000	Total Authorities 1999-2000	Actual Spending 1999-2000
Grants					
Management of Risks to Health	0.1	30.1	37.1	37.1	**37.1**
Promotion of Population Health	10.4	15.8	17.0	17.8	**17.8**
Aboriginal Health	0.6	-	-	-	**-**
Health Policy, Planning and Information	23.0	167.1	11.9	11.9	**11.9**
Total Grants	**34.1**	**213.0**	**66.0**	**66.8**	**66.8**
Contributions					
Management of Risks to Health	8.5	12.6	8.0	7.7	**7.7**
Promotion of Population Health	110.4	118.8	123.3	130.5	**130.5**
Aboriginal Health	461.8	505.1	539.0	565.6	**565.6**
Health System Support and Renewal	10.4	24.2	71.5	43.8	**43.8**
Health Policy, Planning and Information	26.0	18.8	23.5	17.9	**17.9**
Corporate Services	33.2	30.8	19.2	32.2	**32.2**
Total Contributions	**650.3**	**710.3**	**784.5**	**797.7**	**797.7**
Total Transfer Payments	**684.4**	**923.3**	**850.5**	**864.5**	**864.5**

Table does not include Statutory Payments.

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

* Planned spending for 1999-2000 was updated to reflect the Budget 1999 resources by Business Line.

Table 9:
Capital Spending

(millions of dollars)

Business Lines	Actual Spending 1997-1998	Actual Spending 1998-1999	Planned Spending 1999-2000	Total Authorities 1999-2000	Actual Spending 1999-2000
Corporate Services	9.3	4.2	5.8	4.2	**4.2**
Total Capital Spending	**9.3**	**4.2**	**5.8**	**4.2**	**4.2**

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

Table 10:
Contingent Liabilities

There are a number of individual as well as class action suits against the Goverment with allegations of negligence, particularly related to Hepatitis C and the federal government's role in the regulation of medical devices. Because of the complexity involved in determining any federal obligation, a reliable estimate of potential costs cannot be made at this time with regard to the class action and individual suits.

The class action suits for Canadians infected with Hepatitis C through the Canadian blood system between January 1, 1986 and July 1, 1990 were resolved through the Settlement Agreement approved by the courts effective January 2000. Class action suit members are bound by the settlement unless they opt out in writing before January 31, 2001, at which point they may pursue individual actions against the Government. In January 2000, the federal government paid approximately $855.3 million to the settlement trustee appointed by the courts, fully discharging the federal government liability for the class action suits related to the 1986-1990 period under the settlement.

The remaining individual and class actions suits are being defended.

SECTION VI: OTHER INFORMATION

Departmental Contacts

General enquiries

Write to us:

Health Canada
0913A, 13th Floor, Brooke Claxton Building
Ottawa, Ontario K1A 0K9
CANADA

Web site: < http://www.hc-sc.gc.ca/ >

E-mail us: < http://www.hc-sc.gc.ca/english/feedback.htm#general >

Fax us: General enquiries (613) 941-5366

Telephone us: Headquarters (613) 957-2991

Deputy Minister
0915B Brooke Claxton Building
Ottawa, Ontario K1A 0K9
(613) 957-0212

Associate Deputy Minister
0915A Brooke Claxton Building
Ottawa, Ontario K1A 0K9
(613) 954-5904

Senior Assistant Deputy Minister
Corporate Services Branch
0905B Brooke Claxton Building
Ottawa, Ontario K1A 0K9
(613) 952-3984

Assistant Deputy Minister
Health Policy and
Communications Branch
0911B Brooke Claxton Building
Ottawa, Ontario K1A 0K9
(613) 957-3059

Assistant Deputy Minister
First Nations and Inuit Health Branch
1921A Jeanne Mance Building
Ottawa, Ontario K1A 0L3
(613) 957-7701

Assistant Deputy Minister
Health Products and Food Branch
0701A1 Health Protection Building
Ottawa, Ontario K1A 0L2
(613) 957-1804

Assistant Deputy Minister
Population and Public Health Branch
1916A Jeanne Mance Building
Ottawa, Ontario K1A 0K9
(613) 954-8524

Assistant Deputy Minister
Healthy Environments and Consumer Safety Branch
1600 Scott Street, Holland Cross Tower B, 5th floor 3105A
Ottawa, Ontario K1A 1B6
(613) 946-6701

Regional Director General
Quebec Region
Complexe Guy Favreau, East Tower
Suite 202
200 René Lévesque Blvd.
Montreal, Quebec H2Z 1X4
(514) 283-2856

Regional Director General
Manitoba and Saskatchewan Region
391 York Avenue, Suite 415
Winnipeg, Manitoba R3C 0P4
(204) 984-4359

Regional Director General
British Columbia and Yukon Region
2nd Floor, Room 235, Sinclair Centre - Federal Tower
757 West Hasting Street
Vancouver, British Columbia V6C 1A1
(604) 666-5251

Executive Director
Pest Management Regulatory Agency
6607D2, 2250 Riverside Drive
Ottawa, Ontario K1A 0K9
(613) 736-3708

Chief Executive Officer
Occupational Health and Safety Agency
1903A1 Jeanne Mance Building
Ottawa, Ontario K1A 0L3
(613) 957-7669

Assistant Deputy Minister
Information, Analysis and Connectivity Branch
0913D Brooke Claxton Building
Ottawa, Ontario K1A 0K9
(613) 946-3209

Regional Director General
Atlantic Region
Maritime Centre, Suite 1918
1505 Barrington Street
Halifax, Nova Scotia B3J 3Y6
(902) 426-4097

Regional Director General
Ontario and Nunavut Region
4th Floor
25 St. Clair Avenue East
Toronto, Ontario M4T 1M2
(416) 954-3592

Regional Director General
Alberta and Northwest Territories Region
Canada Place, Suite 710
9700 Jasper Avenue
Edmonton, Alberta T5J 4C3
(780) 495-6737

Senior General Counsel
Legal Services
0902D Brooke Claxton Building
Ottawa, Ontario K1A 0K9
(613) 957-3766

Director, Internal Audit
Corporate Services Branch
0914D Brooke Claxton Building
Ottawa, Ontario K1A 0K9
(613) 957-4362

References

Health Canada documents can be ordered from:

Publications
Health Canada
Ottawa, Ontario
K1A 0K9

Telephone:	(613) 954-5995
Fax:	(613) 941-5366
Telecommunication Device for the Deaf:	1-800-267-1245

The following are examples of documents available.

Reports:

A New Approach to Health Research for the 21st Century
A New Perspective on the Health of Canadians
Aboriginal Health in Canada
Canada Health Action: Building on the Legacy
Canada Health Infoway
Canada's Alcohol and Other Drugs Survey: Preview 1995
Family Centered Maternity and Newborn Care: National Guidelines
How Effective are Alcohol and Other Drug Treatment Programs
Nutrition for a Healthy Pregnancy
Toward a Healthy Future: Second Report on the Health of Canadians
Trends in the Health of Canadian Youth
Various reports on Mental Health

Books, brochures, kits and posters on the following subjects:

AIDS
Alcohol and Drug Abuse
Children
Family Violence
Fitness
Health and the Environment
Heart Health
Maternity and Newborn Care
Mental Health
Native Issues
Nutrition and Food Safety
Product Safety
Seniors
Tobacco

Listing of Statutes and Regulations

PART 1

STATUTES and/or REGULATIONS FOR WHICH THE MINISTER OF HEALTH IS RESPONSIBLE

Part 1 includes the Acts in whole or in part and/or specific regulations which are under the responsibility of the Minister of Health/

Canada Health Act, R.S.C. 1985, c. C-6

- Extra-billing and User Charges Information Regulations, SOR/86-259

Canadian Centre on Substance Abuse Act, R.S.C. 1985, c. 49 (4th Supp.)

Canadian Environmental Protection Act 1999, S.C. 1999, c. 33

Controlled Drugs and Substances Act, R.S.C. 1985, c. C-38.8

Department of Health Act, R.S.C. 1985, c. H-3.2

- Potable Water on Common Carriers, C.R.C. 1105
- Human Pathogens Importation Regulations, SOR/94-558

Financial Administration Act, R.S.C. 1985, c. F-11

- Dosimetry Services Fees Regulations, SOR/90-109, SOR/94-279
- Authority to Sell Drugs Fees Regulations, SOR/95-31
- Drug Evaluation Fees Regulations, SOR/95-424
- Medical Devices Fees Regulations, SOR/95-585
- Veterinary Drug Evaluation Fees Regulations, SOR/96-143
- Regulations Prescribing Fees to be Paid for a Pest Control Product, SOR/97-173
- Establishment Licensing Fees Regulations, SOR/98-4
- Licensed dealers for Controlled Drugs and Narcotics Fees Regulations, SOR/98-5

Fitness and Amateur Sport Act, R.S.C. 1985, c. F-25

Food and Drugs Act, R.S.C. 1985, c. F-27

Hazardous Materials Information Review Act, R.S.C. 1985, c. H-2.7

Hazardous Products Act, R.S.C. 1985, c. H-3

Medical Research Council Act, R.S.C. 1985, c. M-4 and the *Canadian Institutes of Health Research Act*, S.C. 2000 c. 6, except for the sections 40, 41, 43, 45, 47, 49 and 51 which are not into force yet

Patent Act, R.S.C. 1985, c. P-4

- Patented Medicines (Notice of Compliance) Regulations, SOR/93-133, SOR/98-166

- Patented Medicines Regulations, SOR/88-474, SOR/94-688, SOR/95-172, SOR/98-105

Pest Control Products Act, R.S.C. 1985, c. P-9

Pesticide Residue Compensation Act, R.S.C. 1985, c. P-10

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

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

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

Tobacco Act, R.S.C. 1985, c. T-11.5

- Tobacco (Access) Regulations, SOR/99-93
- Tobacco (Seizure and Restoration) Regulations, SOR/99-94
- Tobacco Products Information Regulations, SOR/2000-272
- Tobacco Reporting Regulations, SOR/2000-273

PART 2

STATUTES NOT ADMINISTERED BY THE MINISTER OF HEALTH

Part 2 includes the Acts which are administrated by other Ministers in which the Minister of Health Plays an Advisory or Consultative Role

Nuclear Safety and Control Act, R.S.C. 1985, N-28.3

- General Nuclear Safety and Control Regulations, SOR/2000-202

Broadcasting Act, R.S.C. 1985, c. B-9.01

Canada Labour Code, R.S.C. 1985, c. L-2

Canada Medical Act, R.S.C., 1952, c. 27

Canada Shipping Act, R.S.C., 1985, c. S-9

- Ships Crews Food and Catering Regulations, C.R.C., 1978, c. 1480

Canadian Food Inspection Agency Act, R.S.C., 1985, c. C-16.5

Emergency Preparedness Act, R.S.C., 1985, c. 6 (4th Supp.)

Energy Supplies Emergency Act, R.S.C., 1985, c.E-9

Excise Tax Act, R.S.C., 1985, c. E-15

Federal-Provincial Fiscal Arrangements Act, R.S.C. 1985, c.F-8

Feeds Act, R.S.C., 1985, c.F-9

Immigration Act, R.S.C. 1985, c.I-2

National Parks Act, R.S.C., 1985, c. N-14

Trade Marks Act, R.S.C., 1985, c.T-13

Index

Health Canada Santé Canada

Information, Analysis and Connectivity Branch
Applied Research and Analysis Directorate

Direction générale, de l'information, de l'analyse et de la connectivité
Direction de la recherche appliquée et de l'analyse

Departmental Performance Report

1999 – 2000

Annex A:

Measuring Health In Canada

The health of a population is determined by many factors, and only partly the result of government actions. Nevertheless, information on government programs affecting health can be better interpreted when placed in the context of the overall health status of Canadians.

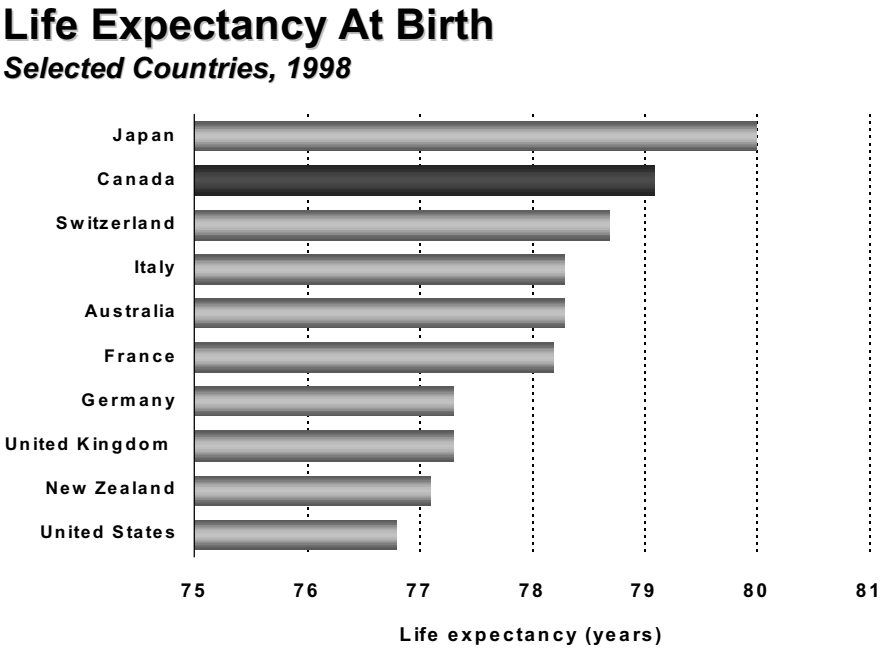
Measuring Health in Canada provides this context, including information on:

- General Indicators of Life Expectancy and Mortality:

- General Indicators of Health Status and Morbidity:

- Behaviours and Preventative Measures:

General Indicators of Life Expectancy and Mortality

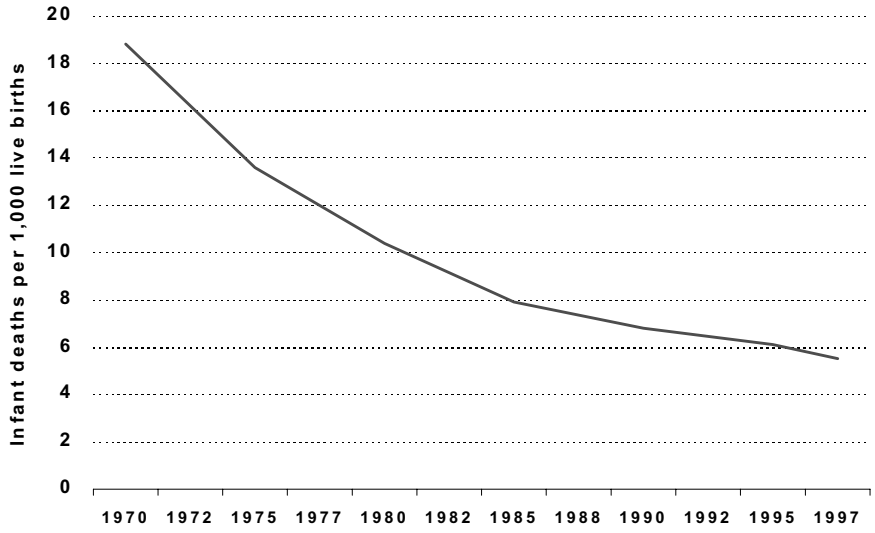


Source: 2000 Human Development Report, United Nations Development Programme

- Life expectancy at birth in Canada rose steadily from 59 years in the early 1920s to over 79 years by 1998.
- In 1998, life expectancy at birth in Canada was 79.1 years, second only to Japan and tied with Iceland in international rankings.

Infant Mortality Rate

Canada, 1970 to 1997

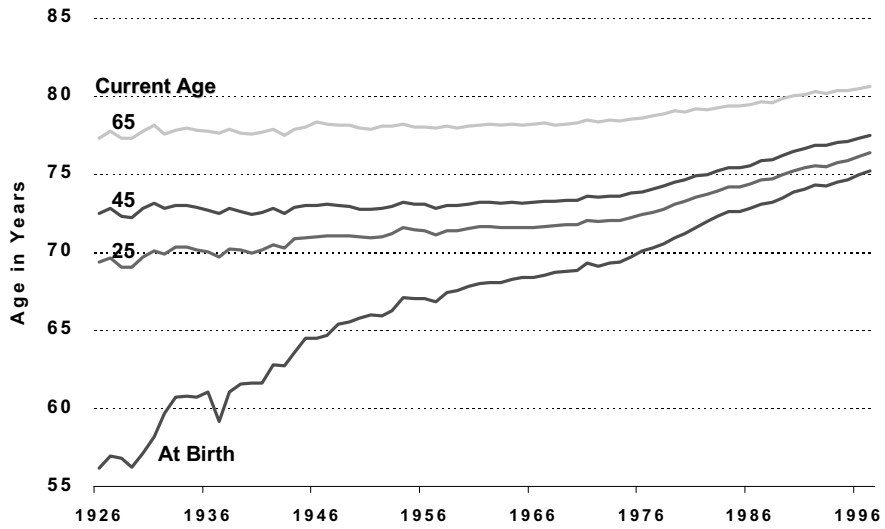


Source: Statistics Canada

- Canada's infant mortality rate declined from 18.8 infant deaths per 1000 live births in 1970 to 5.5 in 1997.
- Ongoing reductions, including a decline from 6.8 to 5.5 infant deaths per 1,000 live births from 1990 to 1997, have continued to contribute to increases in life expectancy.

Life Expectancy Given Selected Ages

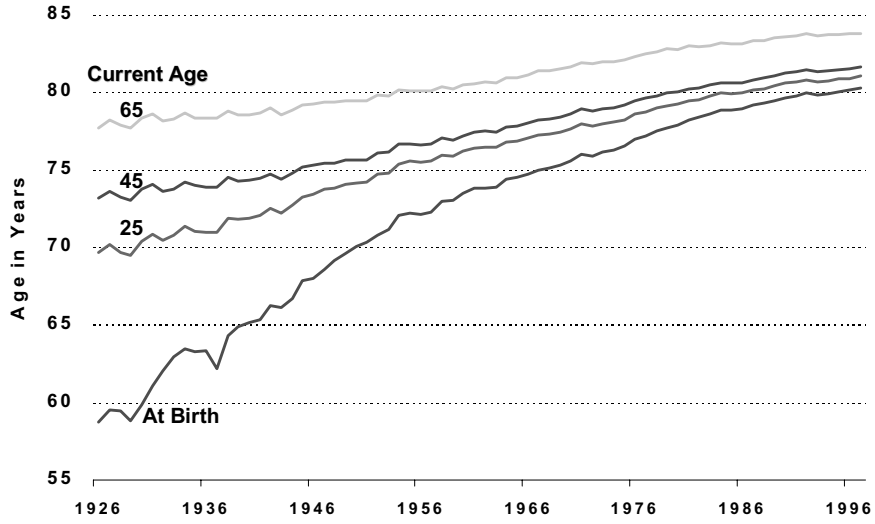
Males – Canada, 1926 to 1996



Source: Statistics Canada

Life Expectancy Given Selected Ages

Females – Canada, 1926 to 1996

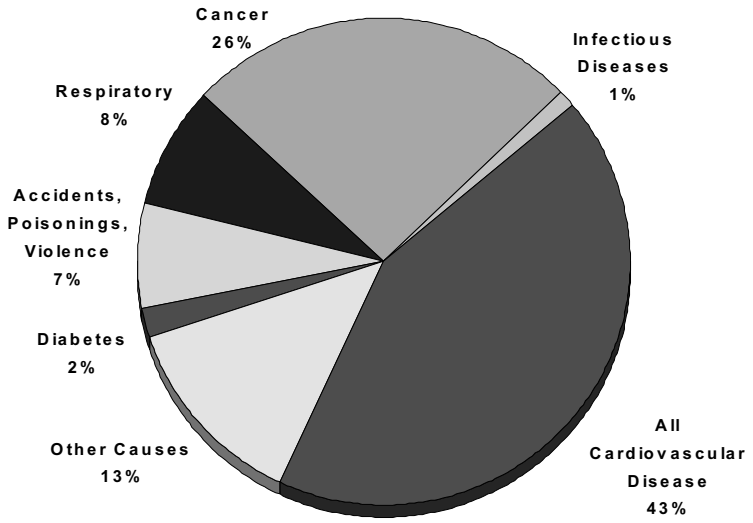


Source: Statistics Canada

- Life expectancy can be measured at birth or at any age.
- Life expectancies at all ages have increased in Canada over the past 60 years.
- The largest gains have been in life expectancy at birth, due to reductions in infant mortality. There have also been large gains in life expectancy at ages 25 and 45.
- From the 1960s on, life expectancy at age 65 for males increased from 78 to over 80, and for females from 80 to over 83.

Leading Causes of Deaths

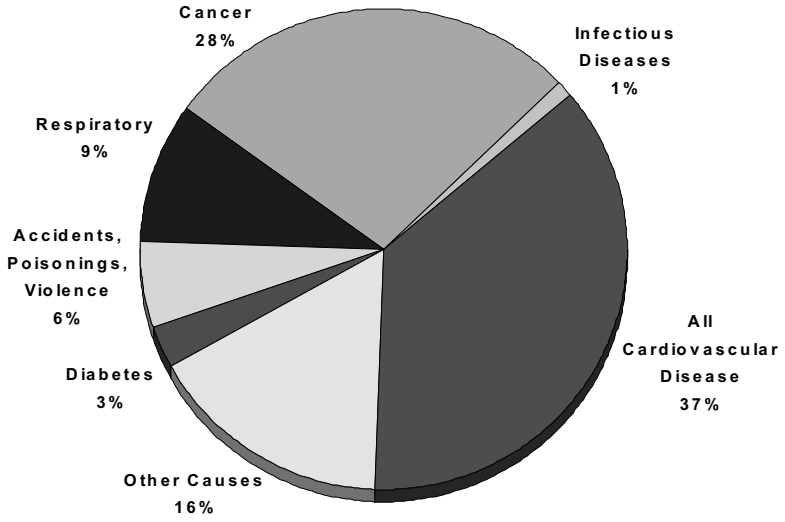
Percentage of all Deaths – Canada, 1985



Source: Laboratory Centre for Disease Control, Health Canada

Leading Causes of Deaths

Percentage of all Deaths – Canada, 1997

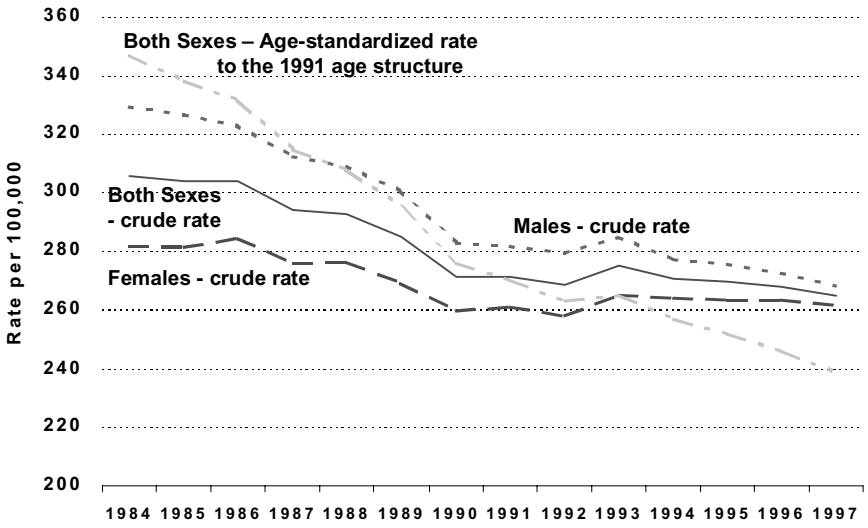


Source: Laboratory Centre for Disease Control, Health Canada

- The leading causes of death in Canada are cardiovascular diseases and cancer.
- Deaths due to cardiovascular diseases declined as a percentage of all deaths, from 43 per cent in 1985 to 37 per cent in 1997.
- Cancer deaths as a percentage of all deaths increased from 26 per cent to 28 per cent between 1985 and 1997.

Cardiovascular Disease Mortality Rates

Canada, 1984-1997



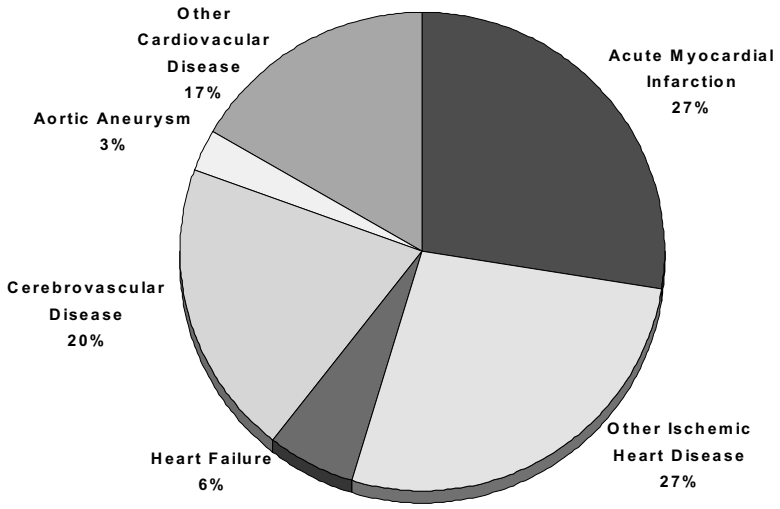
Source: Laboratory Centre for Disease Control, Health Canada

- Canada's age-standardized mortality rates for cardiovascular disease have declined since 1984.
- Between 1991 and 1997, crude mortality rates declined for males and increased slightly for females.

- For many diseases, including cardiovascular diseases, the number of new cases and deaths rise as the population ages. Age-standardization accounts for changes in the age distribution of the population and permits comparisons over time. Age standardized rates in this annex have been standardized to the 1991 Canadian age structure.

Cardiovascular Disease Deaths

Percentage of all Deaths – Canada, 1997



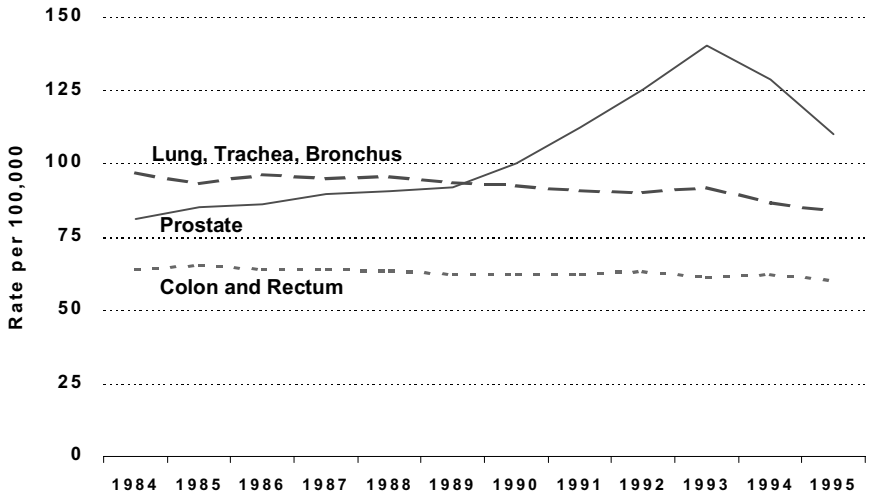
Source: Laboratory Centre for Disease Control, Health Canada

- Acute myocardial infarction (AMI), other ischemic heart disease, and cerebrovascular disease (including stroke) account for the greatest proportion of cardiovascular disease deaths in Canada.

Cancer Incidence Rates – Males

Canada, 1984-1995

Age-standardized rate to the 1991 age structure

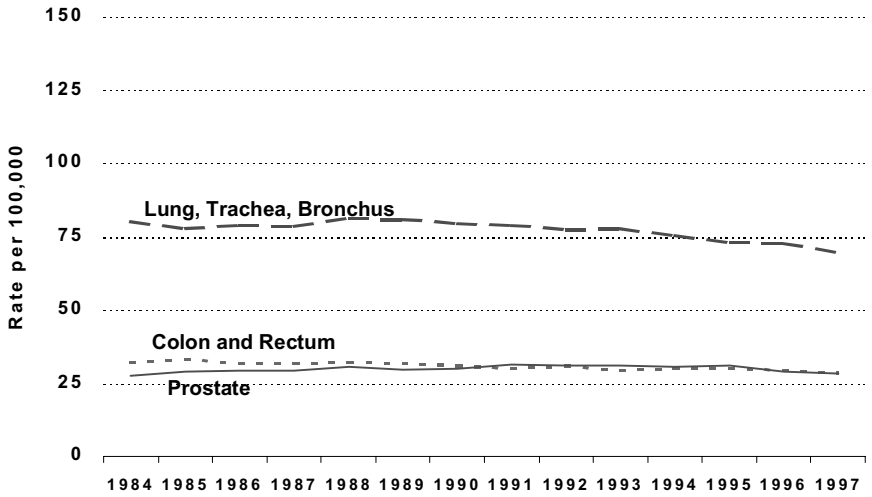


Source: Laboratory Centre for Disease Control, Health Canada

Cancer Mortality Rates – Males

Canada, 1984-1997

Age-standardized rate to the 1991 age structure



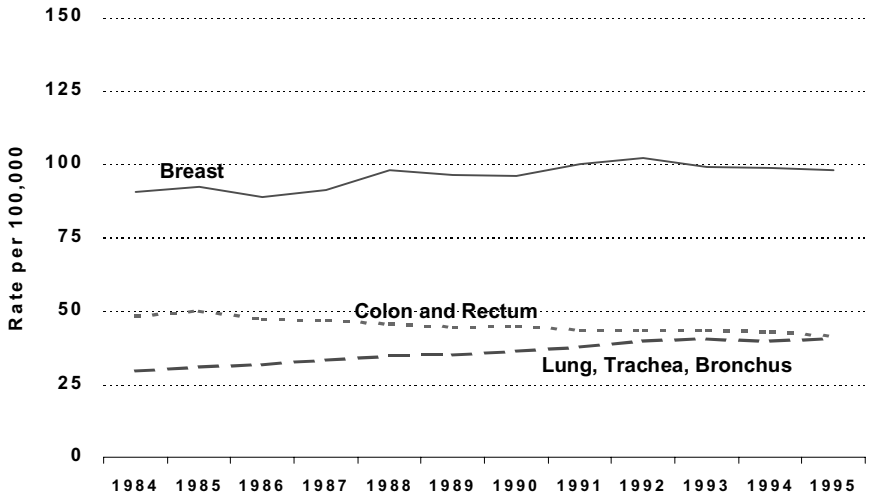
Source: Laboratory Centre for Disease Control, Health Canada

- Lung cancer continues to have the highest mortality rate among cancers for the Canadian male population, although the age-standardized rate has been declining since 1988.
- While the age-standardized mortality rate for prostate cancer has remained relatively constant, the age-standardized incidence rate has increased significantly and has been higher than that of lung cancer since 1989.
- In this annex, **incidence rates** are defined as the number of new cases per 100,000 people in a given year, and **mortality rates** as the number of deaths per 100,000 people in a given year. Differences between incidence and mortality rates over time reflect rates of survival.

Cancer Incidence Rates – Females

Canada, 1984-1995

Age-standardized rate to the 1991 age structure

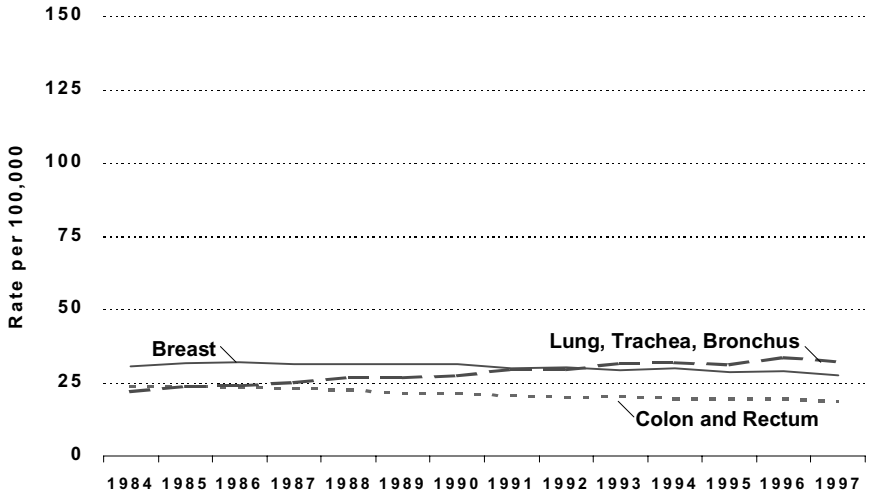


Source: Laboratory Centre for Disease Control, Health Canada

Cancer Mortality Rates – Females

Canada, 1984-1997

Age-standardized rate to the 1991 age structure



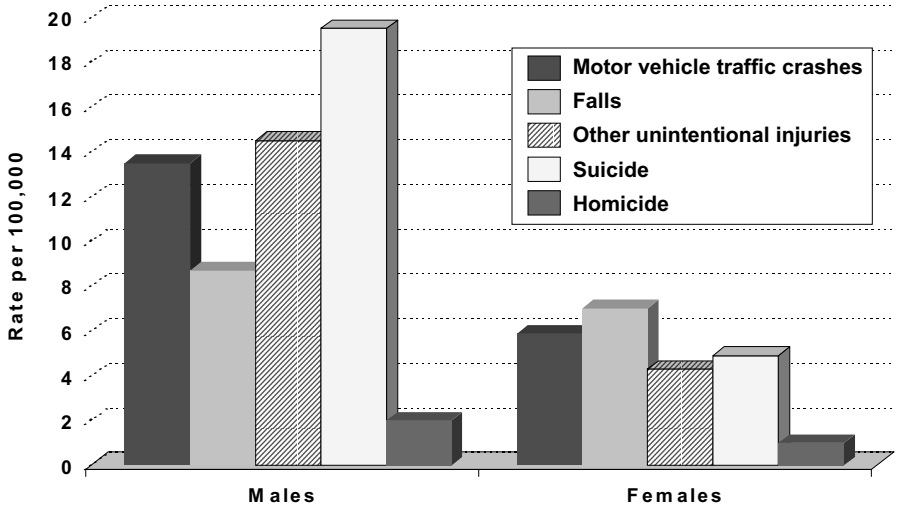
Source: Laboratory Centre for Disease Control, Health Canada

- The age-standardized incidence rate for lung cancer among Canadian women has increased relative to breast cancer, however breast cancer remains the most frequently contracted cancer among women.
- While the age-standardized mortality rate for breast cancer has declined since 1986, the rate for lung cancer has increased. Lung cancer surpassed breast cancer in 1993 as the leading cause of cancer mortality among women in Canada.

Injury Mortality Rates

by Cause of Death & Sex – Canada, 1997

Age-standardized rate to the 1991 age structure



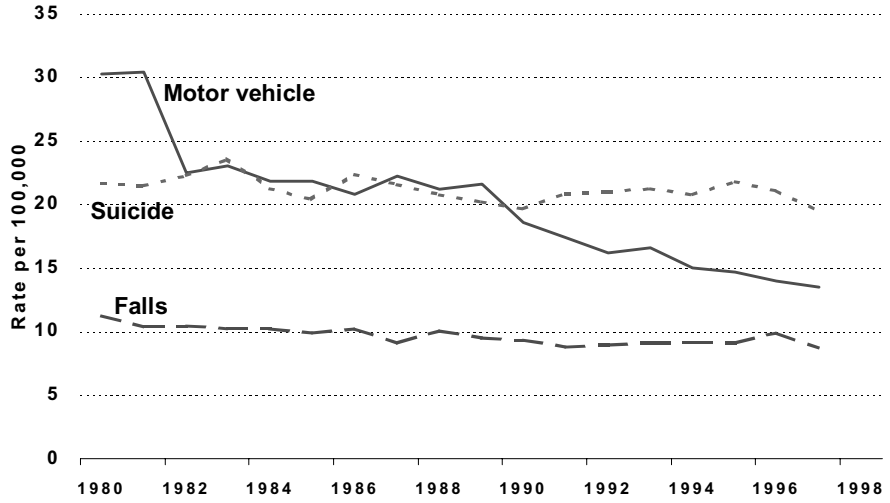
Source: Laboratory Centre for Disease Control, Health Canada

- Injury mortality rates in Canada are significantly higher for men than for women.
- Age-adjusted suicide rates are almost four times higher for males than females, and more than twice as many males as females die in motor vehicle accidents.
- Mortality rates for falls do not differ greatly between sexes, accounting for fewer than 9 deaths per 100,000 men and 7 deaths per 100,000 women.

Injury Mortality Rates – Males

by Cause of Death - Canada, 1980-1997

Age-standardized rate to the 1991 age structure

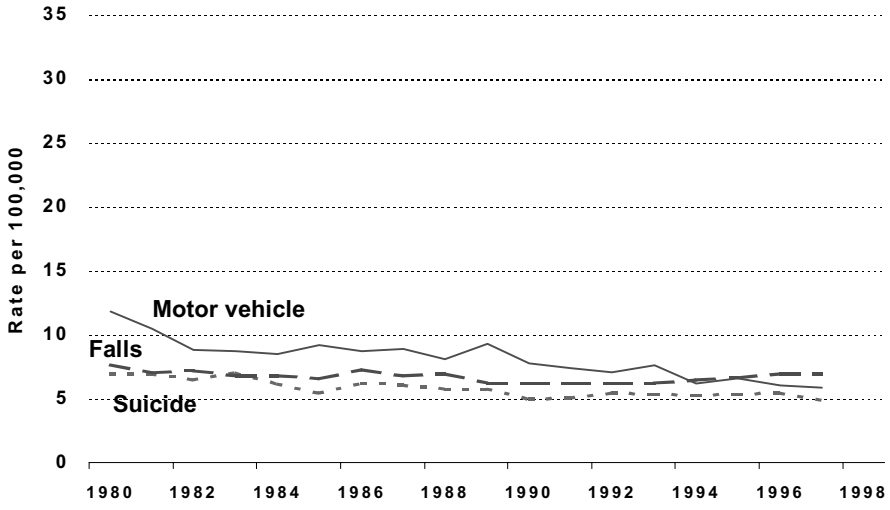


Source: Laboratory Centre for Disease Control, Health Canada

Injury Mortality Rates – Females

by Cause of Death - Canada, 1980-1997

Age-standardized rate to the 1991 age structure



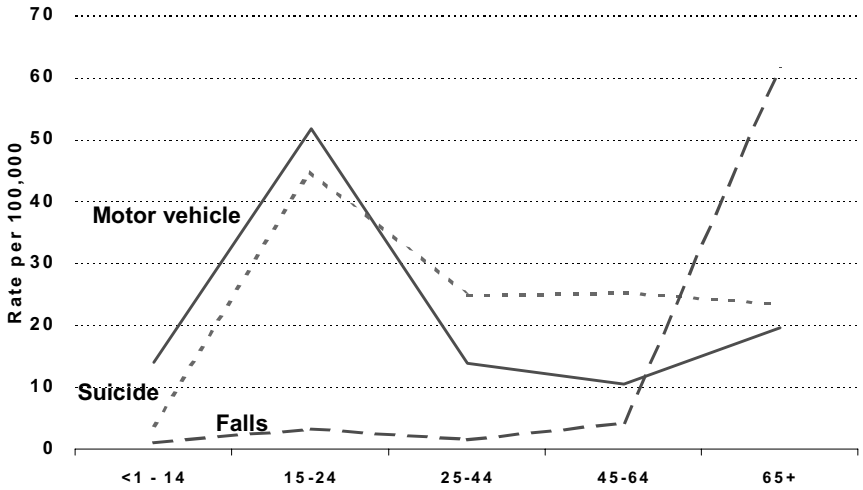
Source: Laboratory Centre for Disease Control, Health Canada

- Age-standardized motor vehicle mortality rates have declined for both males and females since 1980.
- Since 1990, suicide has been the leading cause of injury mortalities among men. The age-adjusted suicide rate has been relatively stable since 1980, at approximately 20 deaths per 100,000.
- For women, the age-standardized mortality rate for falls has remained relatively constant at around 7 deaths per 100,000, and falls have been the leading cause of injury mortalities since 1994.

Injury Mortality Rates – Males

by Cause of Death and Age - Canada, 1997

Age-standardized rate to the 1991 age structure

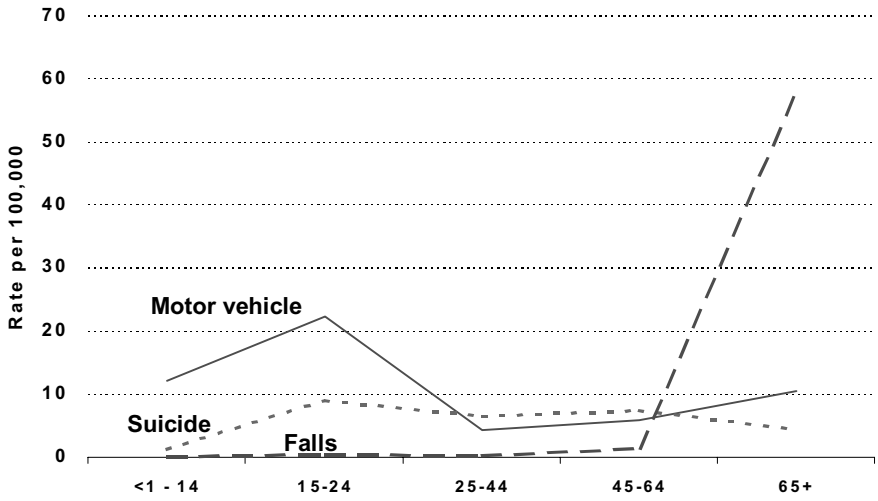


Source: Laboratory Centre for Disease Control, Health Canada

Injury Mortality Rates – Females

by Cause of Death and Age - Canada, 1997

Age-standardized rate to the 1991 age structure



Source: Laboratory Centre for Disease Control, Health Canada

- For both males and females, injury mortality rates for falls rise dramatically for the 65+ year age group.
- Motor vehicle mortality and suicide rates peak at the 15-24 year age group.

General Indicators of Health Status and Morbidity

Self-Rated Health

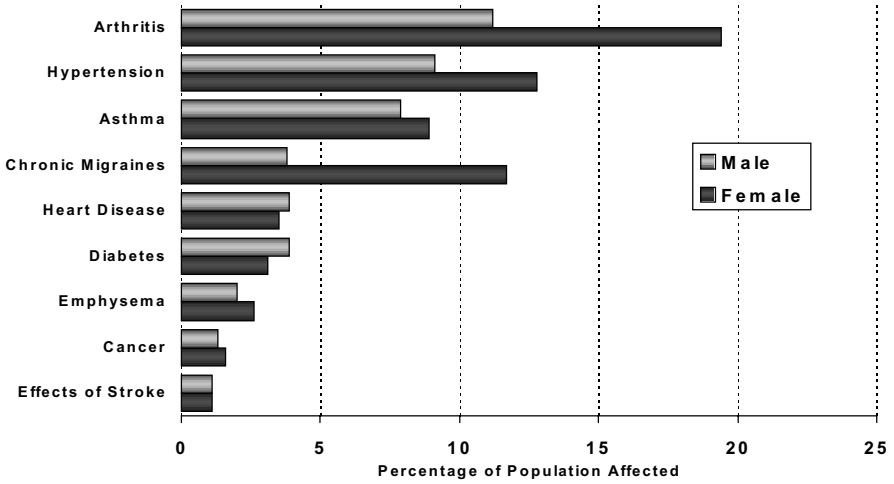
Canadians aged 12+, 1994/95, 1998/99

Source: National Population Health Survey (1994/95, 1998/99), Statistics Canada

- The percentage of Canadians rating their health highly increased between 1994/95 and 1998/99. In 1998/99, approximately 92 per cent of Canadians rated their health as good, very good or excellent.

Prevalence of Selected Chronic Conditions

by Sex - Canada, 1998/99

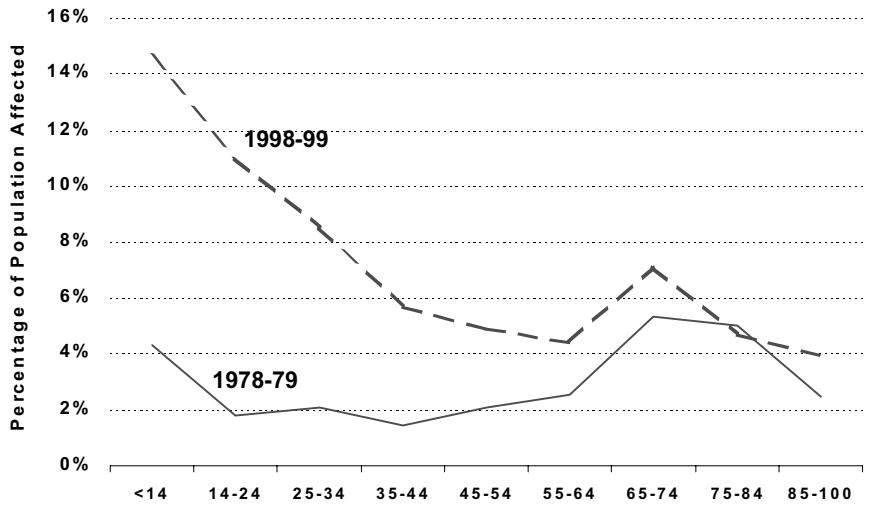


Source: National Population Health Survey (1998/99), Statistics Canada

- Arthritis and hypertension are the most prevalent chronic conditions in Canadians. Prevalence, defined as the percentage of the population affected, increases substantially for both men and women over the age of 54 years.
- In 1998/99, almost twice as many women as men were likely to suffer from arthritis, and women were three times as likely to suffer from chronic migraines. Chronic migraines were most prevalent among women in the 35-44 year age group.

Canadians with Asthma – Males

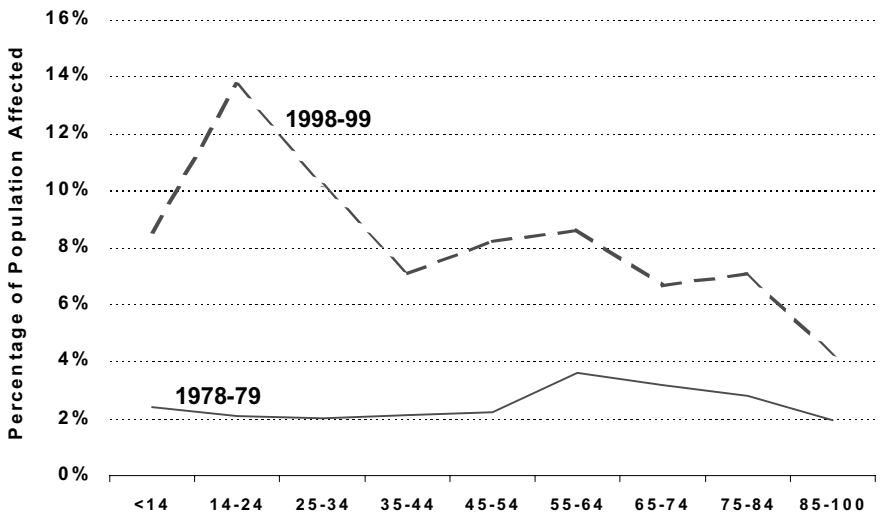
by Age Group - Canada, 1978/79, 1998/99



Source: Canada Health Survey (1978/79), National Population Health Survey (1998/99), Statistics Canada

Canadians with Asthma – Females

by Age Group - Canada, 1978/79, 1998/99

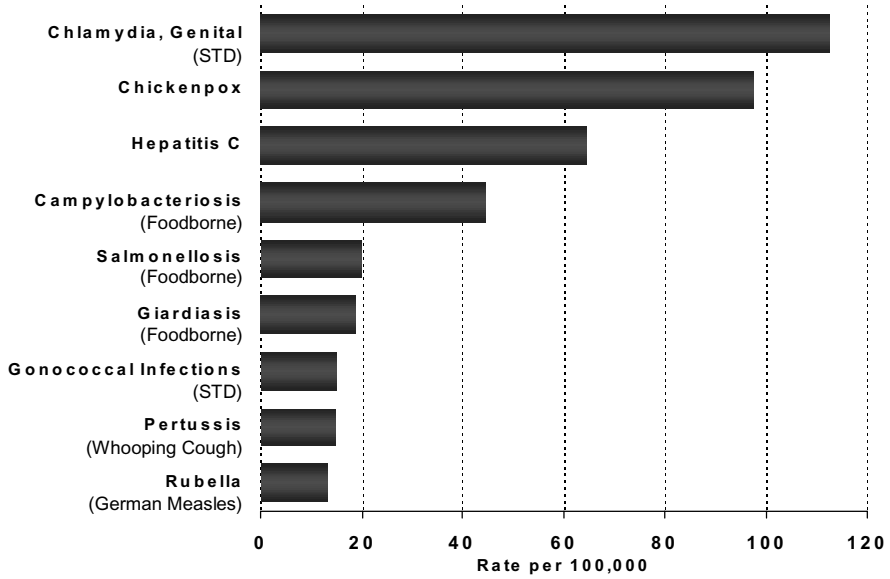


Source: Canada Health Survey (1978/79), National Population Health Survey (1998/99), Statistics Canada

- Asthma is a chronic condition affecting Canadians of all ages.
- Prevalence rates have risen considerably over the past twenty years, particularly in the under 35 year age groups.
- The increase in prevalence could be due, in part, to changes in diagnostic criteria.

Leading Notifiable Diseases Incidence Rates

Canada, 1997

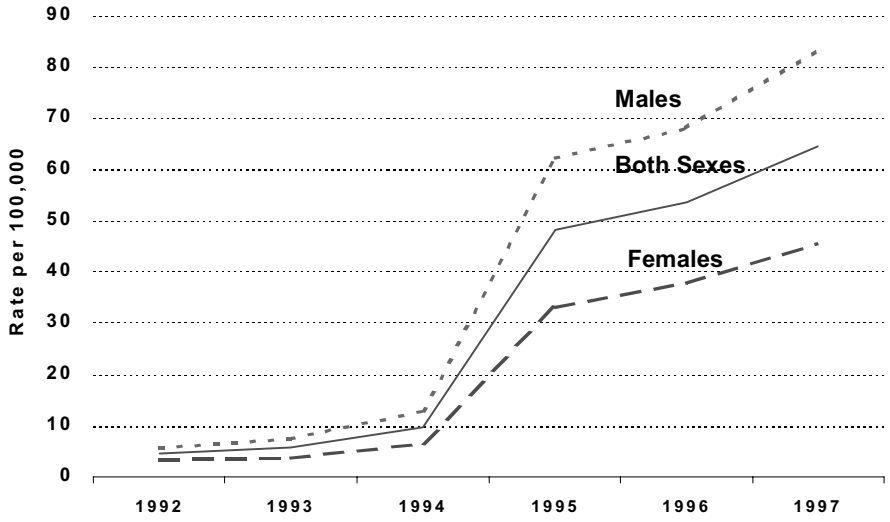


Source: Laboratory Centre for Disease Control, Health Canada

- Leading notifiable diseases include sexually transmitted diseases, foodborne illnesses, childhood diseases, and hepatitis C.

Hepatitis C Incidence Rates

by Sex - Canada, 1992-1997

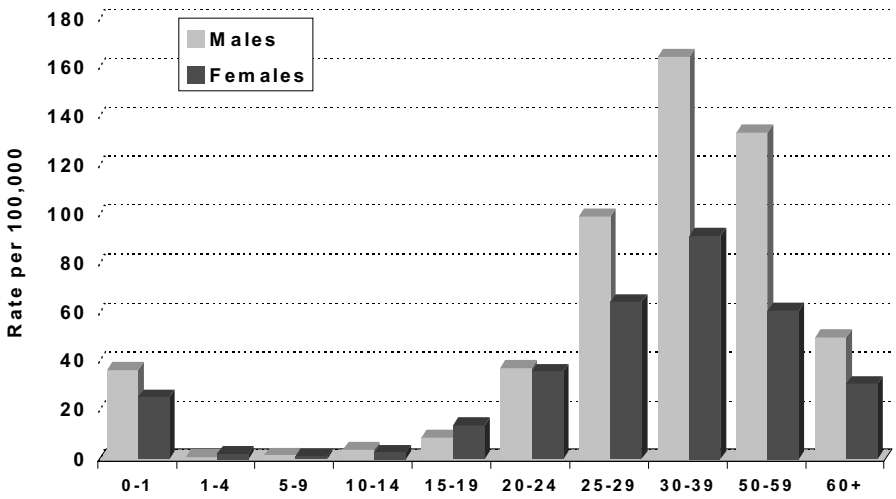


Source: Laboratory Centre for Disease Control, Health Canada

- There was a significant increase in the incidence rate of hepatitis C between 1992 and 1997. The greatest increase was among males.

Hepatitis C Incidence Rates

by Age and Sex - Canada, 1997

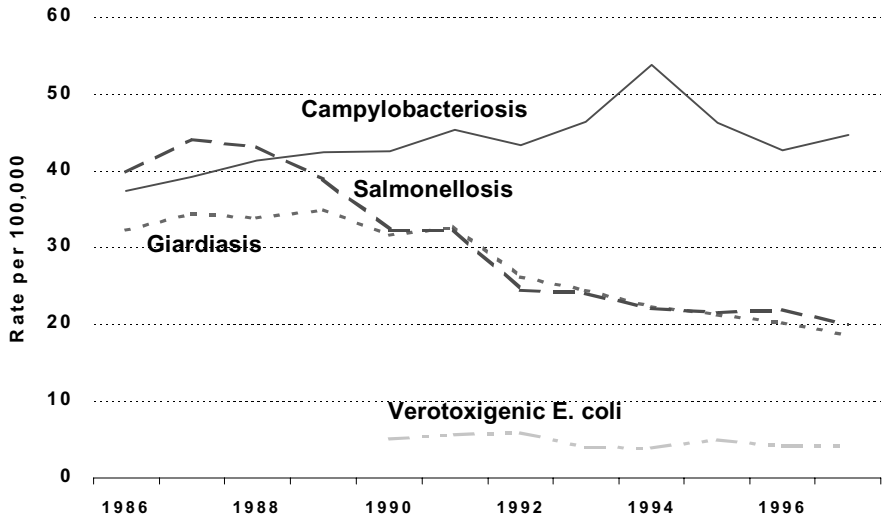


Source: Laboratory Centre for Disease Control, Health Canada

- In 1997, Canadians most likely to contract hepatitis C were between the ages of 25 and 59.
- The incidence rate of hepatitis C is much higher for men than for women.

Foodborne Illnesses Incidence Rates

Canada, 1986-1997



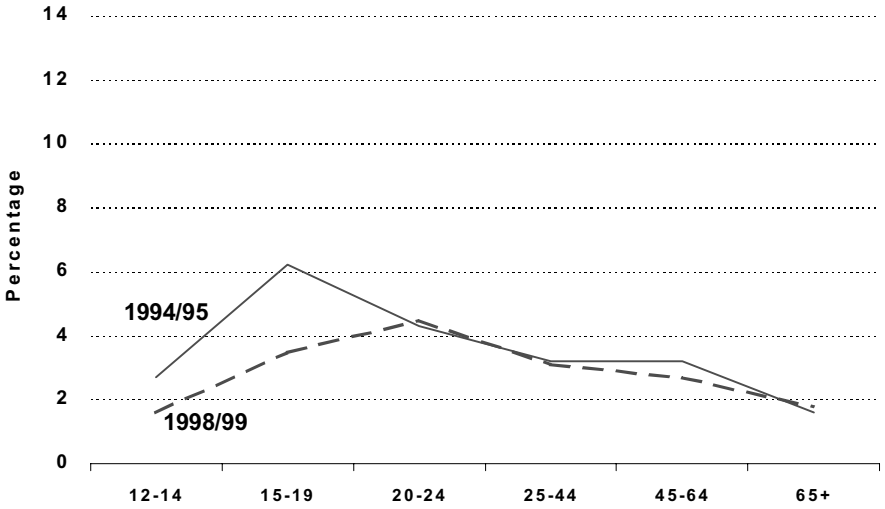
Source: Laboratory Centre for Disease Control, Health Canada

- The incidence rates for giardiasis and salmonellosis have declined since 1987, while there has been an increase in the incidence rate of campylobaceteriosis.
- The incidence rate of verotoxigenic E. coli has remained relatively stable since 1990.
- Foodborne illnesses are far more common than the reported numbers suggest and as few as 10 per cent of cases may be recorded.

- **Campylobacteriosis** is a bacterial disease transmitted through undercooked chicken or pork, contaminated water or raw milk, or through contact with infected infants or animals.
- **Giardiasis** is a parasitic infection transmitted through contaminated food, unfiltered water or through person-to-person contact where personal hygiene may be poor.
- **Salmonellosis** is a bacterial illness transmitted through contaminated food or beverages.
- **Verotoxigenic E. coli** is usually transmitted through undercooked, contaminated ground beef. Infection may also be transmitted through raw milk or sewage-contaminated water.

Prevalence of Depression – Males

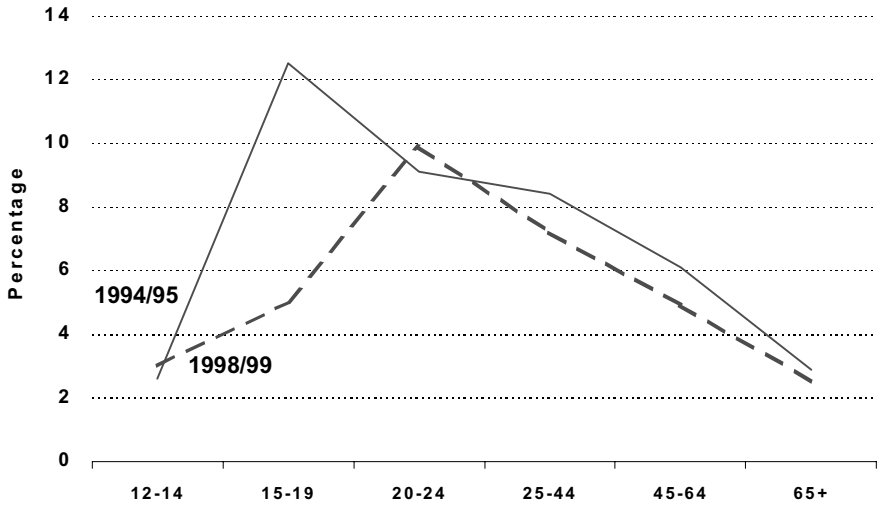
Percentage with depressive episode in previous 12 months by Age - Canada (excluding Territories), 1994/95, 1998/99



Source: Health Reports (Vol. 11, No. 3, 1999), Statistics Canada

Prevalence of Depression – Females

Percentage with depressive episode in previous 12 months by Age - Canada (excluding Territories), 1994/95, 1998/99



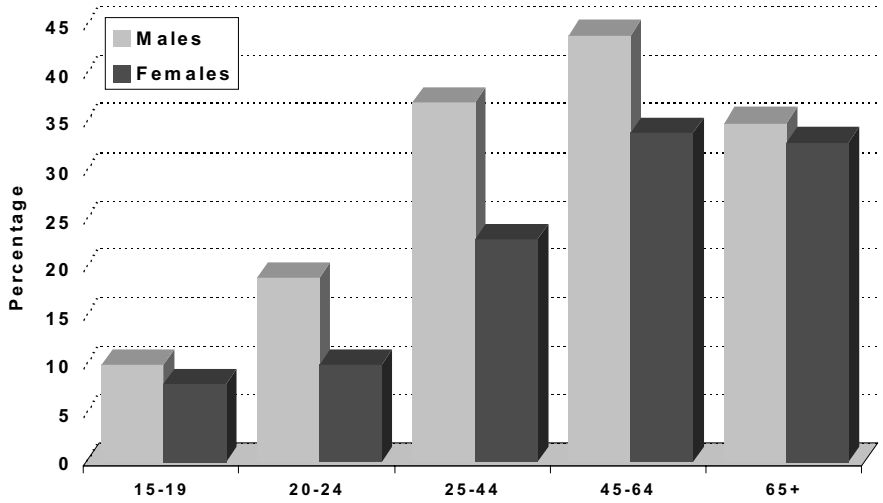
Source: Health Reports (Vol. 11, No. 3, 1999), Statistics Canada

- According to the National Population Health Survey, depression is more prevalent among women than men. The prevalence of depression peaks among those aged 15 to 24 years, declines in mid-life and is lowest among those aged 65 or older.
- The percentage of the population reporting a depressive episode in the previous 12 months was lower in 1998/99 than in 1994/95.

- The National Population Health Survey includes a set of questions designed to determine whether respondents experienced a major depressive episode during the preceding year. It should be noted that prevalence estimates are based on responses of household residents and do not include residents of institutions.

Overweight Prevalence

Percentage with Body Mass Index (BMI) ≥ 27 by Age and Sex
Canada (excluding Territories), 1998/99



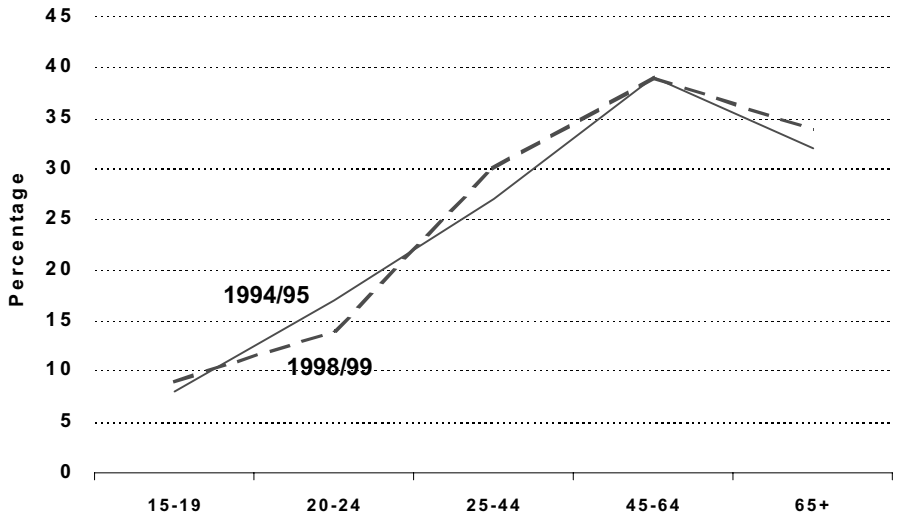
Source: National Population Health Survey (1998/99), Statistics Canada

- Based on a Body Mass Index measurement greater than or equal to 27, in 1998/99 the percentage of overweight men was greater than the percentage of overweight women for all age groups.
- The proportion of the population that was overweight was greatest for the 45-64 year age group.

- Body Mass Index (BMI) is a measure of human body size and proportion. It is defined as the weight in kilograms, divided by the square of height in meters.

Overweight Prevalence

Percentage with Body Mass Index (BMI) ≥ 27 by Age
Canada (excluding Territories), 1994/95, 1998/99



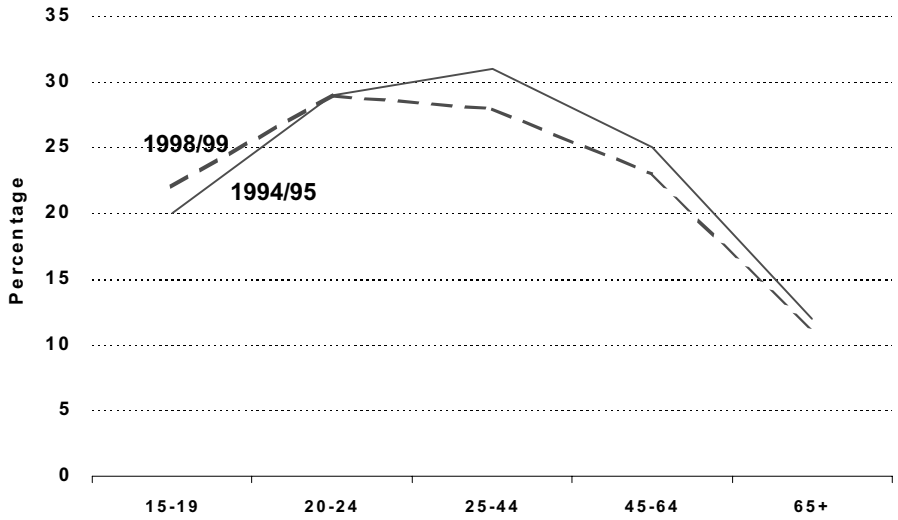
Source: National Population Health Survey (1994/95, 1998/99), Statistics Canada

- The proportion of the population that is overweight has been relatively stable over the past five years.

Behaviours and Preventative Measures

Daily Smoking

Percentage by Age
Canada (excluding Territories), 1994/95, 1998/99

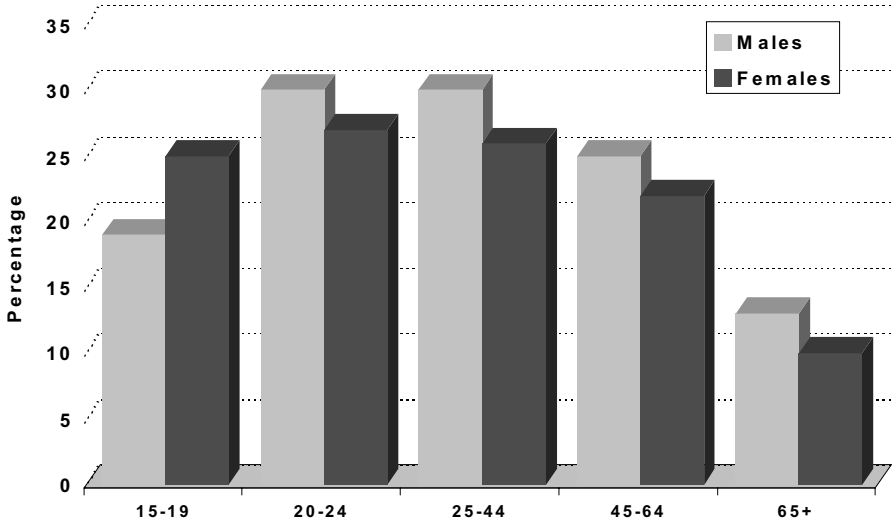


Source: National Population Health Survey (1994/95, 1998/99), Statistics Canada

- In 1996/97, 96 per cent of Canadians aged 12 and over felt that there were smoking-related health risks for those who smoke. Nevertheless, 24 per cent of Canadians were daily smokers in 1998/99.
- Between 1994/95 and 1998/99 there was an increase in the percentage of Canadians aged 15 to 19 who were daily smokers, due to an increase in the percentage of females who smoked.
- The percentage of those in the 20-24 year age group who smoked on a daily basis remained constant, although the percentage of males who smoked increased and the percentage of females who smoked decreased.
- The greatest reduction in daily smoking was in the 25-44 year age group for both males and females.

Daily Smoking

Percentage by Age & Sex
Canada (excluding Territories), 1998/99

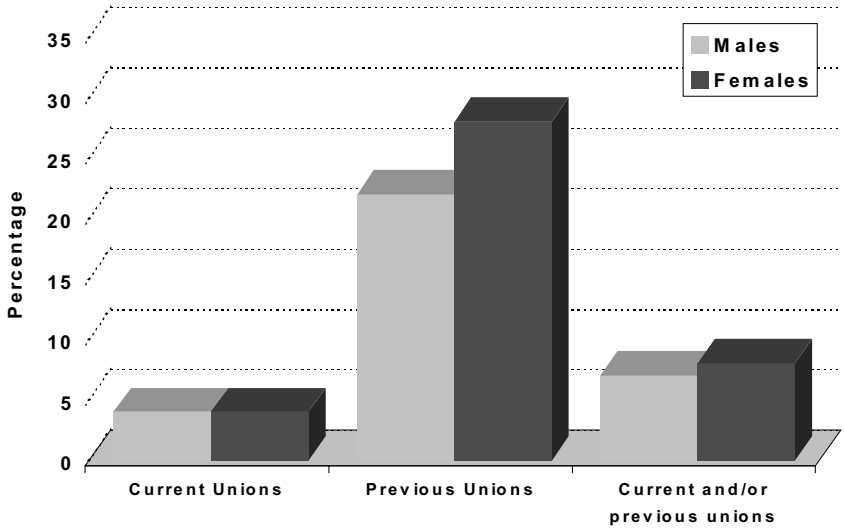


Source: National Population Health Survey (1998/99), Statistics Canada

- In 1998/99 females aged 15 to 19 were more likely to smoke than their male counterparts. For all other age groups, a greater proportion of males than females smoke daily.

Family Violence - Spousal

Rates of spousal violence by sex, past 5 years
Canada (non-institutionalized population), 1999

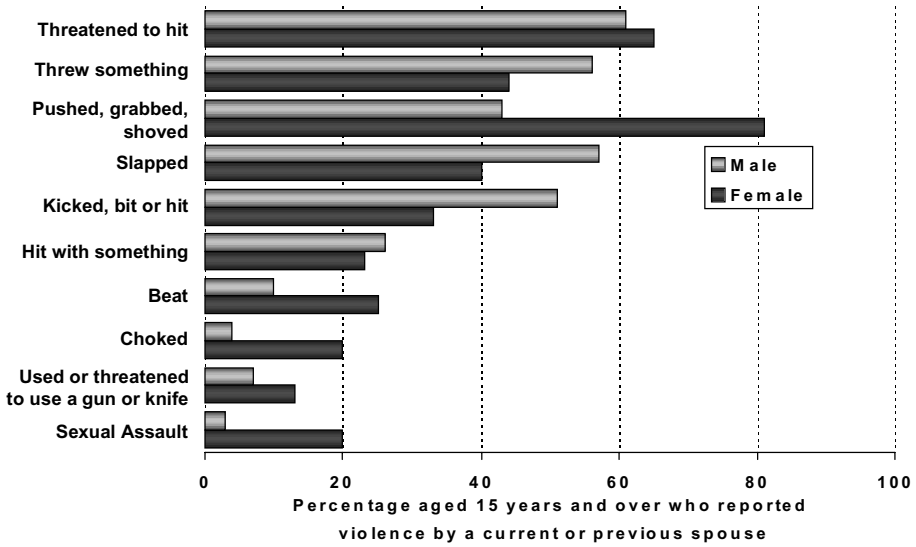


Source: General Social Survey, 1999, Statistics Canada

- Based on the results of the 1999 General Social Survey, approximately 7 per cent of people who were married or living in a common-law relationship during the past 5 years experienced some type of violence by their intimate partners.
- The 5 year rate of violence was similar for men and women (7 and 8 per cent respectively), affecting approximately 549,000 men and 690,000 women.
- People who ended relationships in this period were more likely to report some type of spousal violence in that previous union – 28 per cent of women and 22 per cent of men. Whereas only 4 per cent of those who were in the same relationship throughout this period reported some type of violence.

Family Violence – Spousal

Reported violence, past 5 years
by sex and type of violence, Canada, 1999

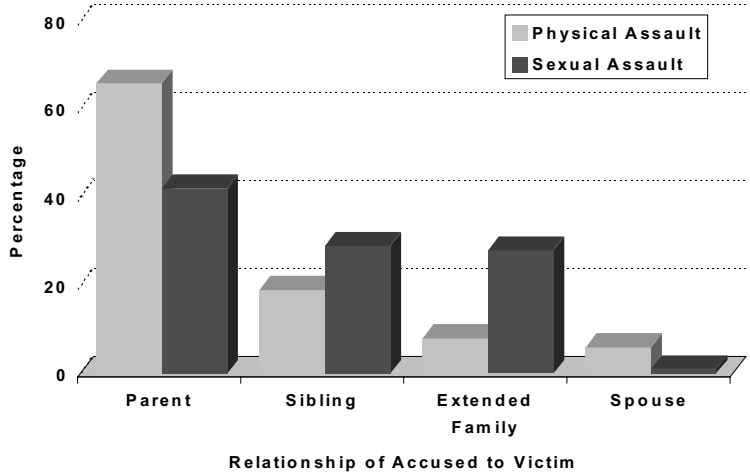


Source: General Social Survey, 1999, Statistics Canada

- In the 1999 General Social Survey, women and men reported experiencing somewhat different forms of violence. Women were more likely than men to report more severe forms of violence.
- Women were more than twice as likely as men to report being beaten (25 versus 10 per cent), five times more likely to report being choked (20 versus 4 per cent), and almost twice as likely to report being threatened by, or having a gun or knife used against them (13 versus 7 per cent).
- Men were more likely than women to report being slapped (57 versus 40 per cent) having something thrown at them (56 versus 44 per cent), and being kicked, bit or hit (51 versus 33 per cent).

Family Violence - Violence Against Children and Youth by Family Members

Child and youth victims of assault reported to police by accused – victim relationship, 1999

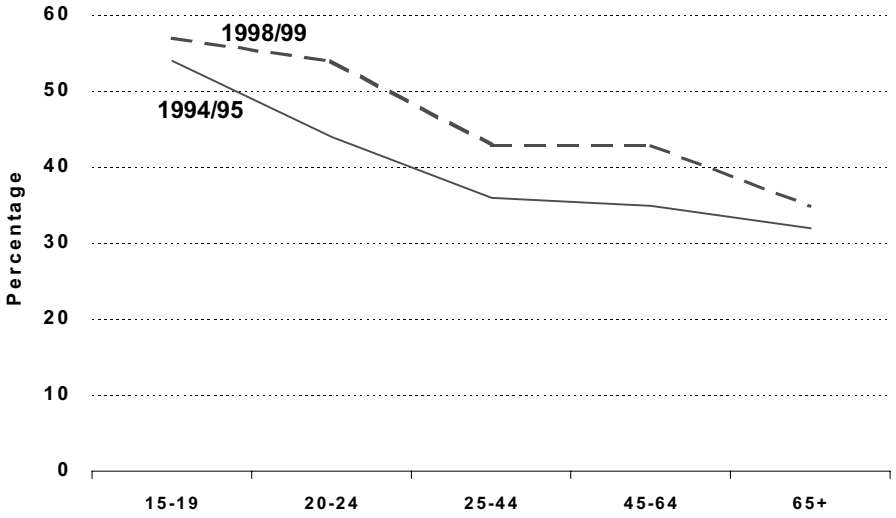


Source: Canadian Centre for Justice Statistics, Incident-based Uniform Crime Reporting (UCR2) Survey, Statistics Canada

- In 1999, children and youth under 18 years of age made up 23 per cent of the Canadian population and were the victims in 24 per cent of assaults reported to a sample of police departments.
- Within families, children and youth were most often assaulted by parents. Sixty-six per cent of victims of physical assault and 42 per cent of victims of sexual assault were victimized by their parents.

Moderate Leisure-Time Physical Activity

Percentage Reporting Regular Moderate Physical Activity by Age - Canada (excluding Territories), 1994/95, 1998/99

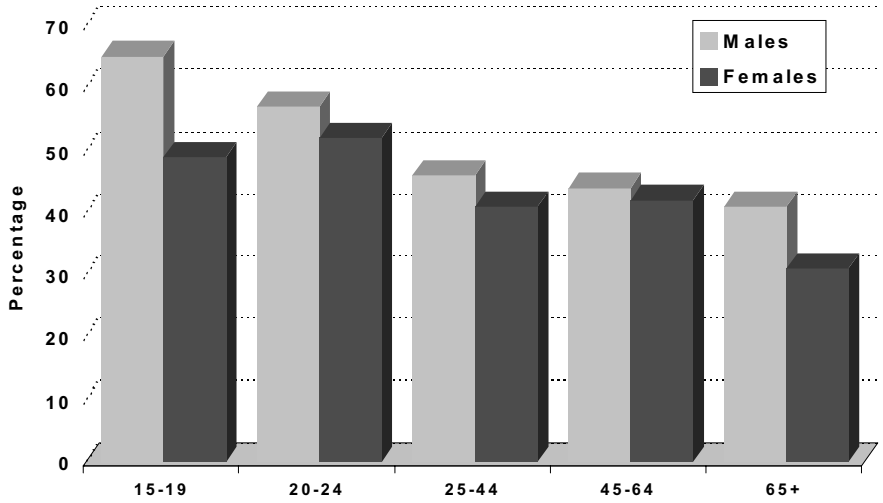


Source: National Population Health Survey (1994/95, 1998/99), Statistics Canada

- Between 1994/95 and 1998/99, there was an increase in the proportion of the population regularly participating in leisure-time activities requiring moderate or higher levels of energy expenditure.
- The greatest increase in these activities was in the 20-24 year age group.

Regular Moderate Physical Activity

by Age and Sex
Canada (excluding Territories), 1998/99

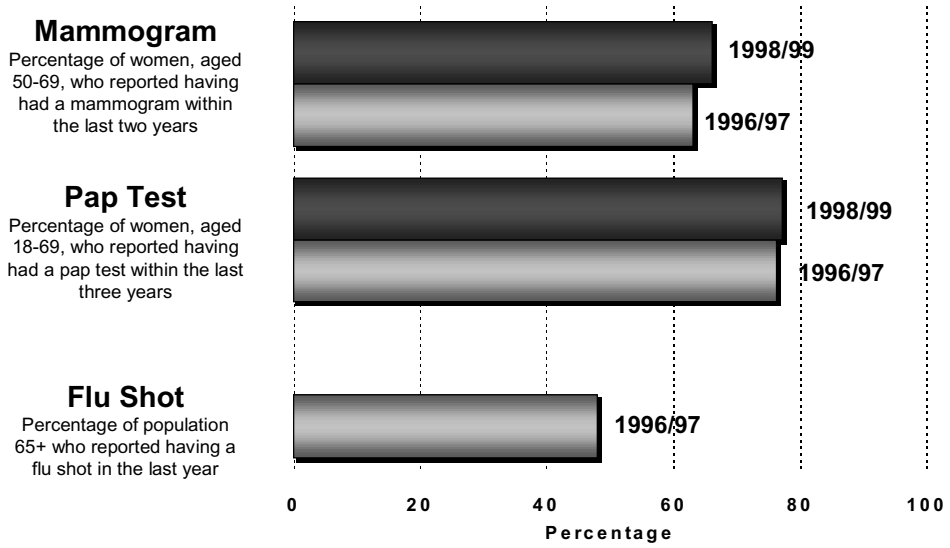


Source: National Population Health Survey (1998/99), Statistics Canada

- In 1998/99 males were more likely to be physically active than females, particularly for the 15-19 and 65+ age groups.

Preventative Measures

Canada, 1996/97, 1998/99



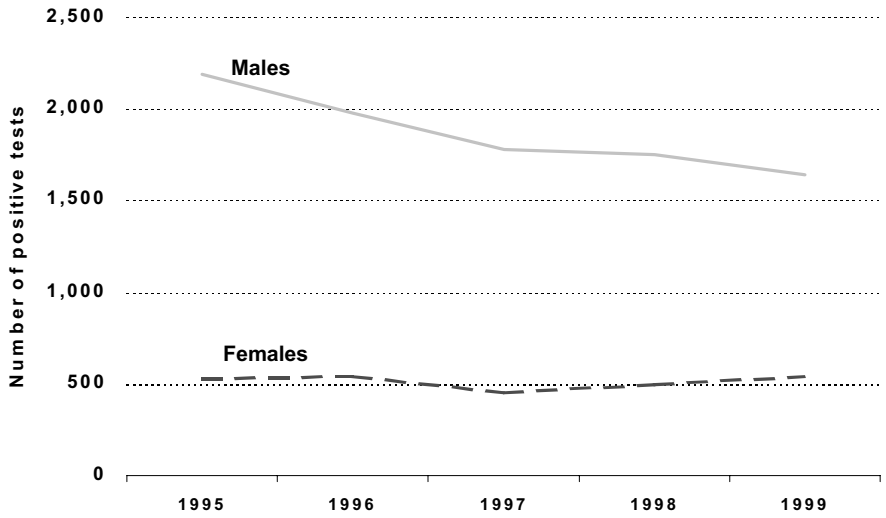
Source: Health Indicators 2000, Canadian Institute for Health Information

- Between 1996/97 and 1998/99 there was a modest percentage increase in the number of women who reported having mammograms within the preceding two years and pap tests within the preceding three years.
- In 1996/97, about 48 per cent of the population 65+ reported having a flu shot in the preceding year.

HIV/AIDS

Positive HIV Test Results

by Sex - Canada, 1995-1999

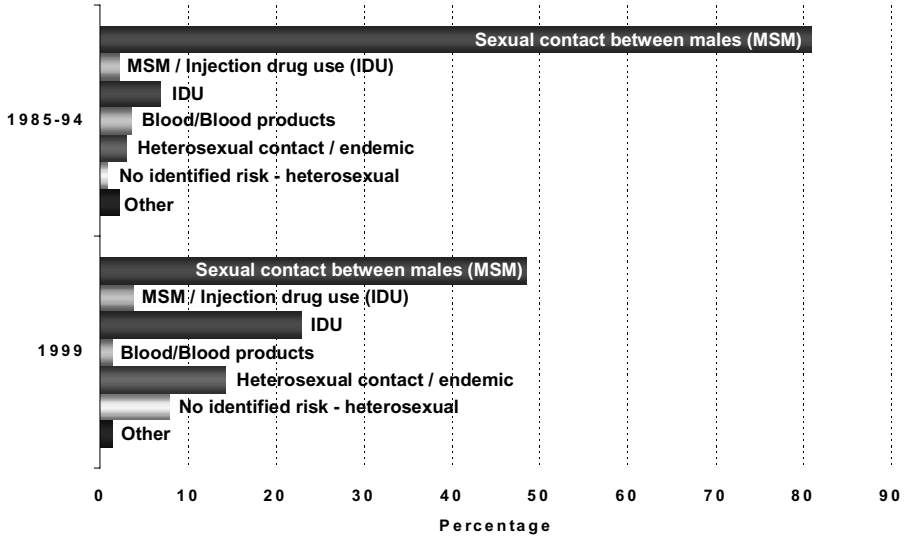


Source: Laboratory Centre for Disease Control, Health Canada

- The number of positive HIV test reports declined for males in Canada between 1995 and 1999, but remained relatively constant for females.
- Females accounted for about 25 per cent of all positive test results in 1999.

Positive HIV Test Results – Adult Males

by Exposure Category and Year of Test
Canada, 1985-94, 1999



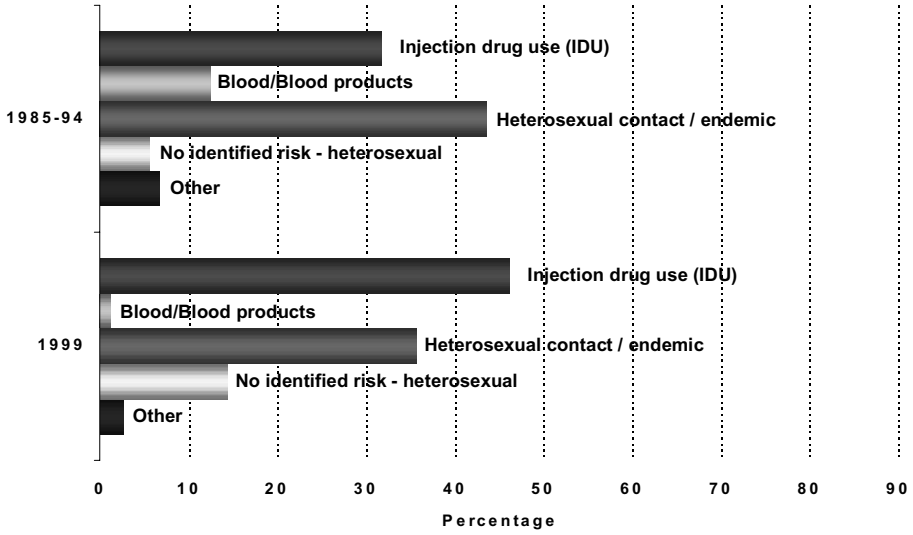
Source: Laboratory Centre for Disease Control, Health Canada

- For males, there has been a significant decrease in the percentage of positive HIV tests reporting sexual contact between males as the exposure category. This remains the primary exposure to HIV among males.
- There has been a significant increase in HIV transmission by injection drug use, accounting for almost 23 per cent of positive test results in 1999.

- *__Heterosexual contact/endemic__ includes persons who were born in a country in which the predominant means of HIV transmission is heterosexual contact and persons who report heterosexual contact with a person who is either HIV-infected or who is at increased risk for HIV infection.

Positive HIV Test Results – Adult Females

by Exposure Category and Year of Test
Canada, 1985-94, 1999

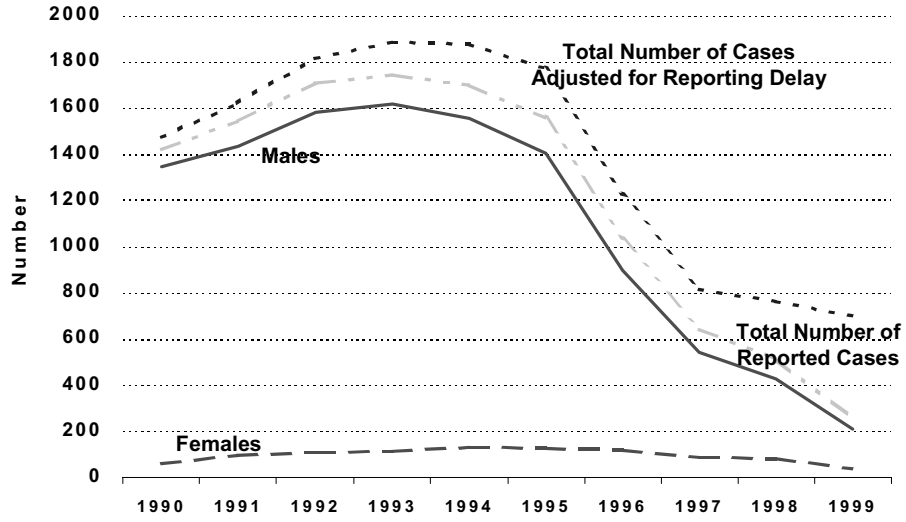


Source: Laboratory Centre for Disease Control, Health Canada

- For females, injection drug use has become the primary mode of transmission for HIV infection, accounting for 46 per cent of positive test results in 1999.

Acquired Immune Deficiency Syndrome

Reported Cases, Canada, 1990-1999



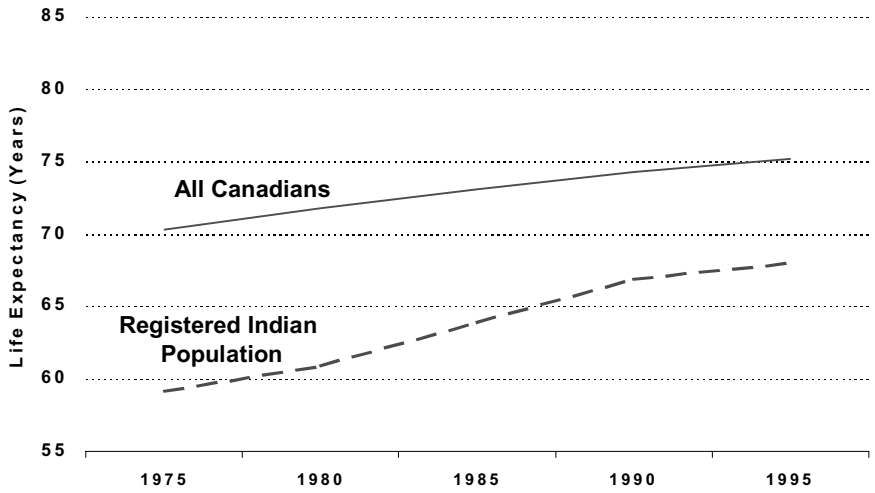
Source: Laboratory Centre for Disease Control, Health Canada

- Cases adjusted for reporting delays are estimates of the number of AIDS cases diagnosed in each year that will eventually be reported.
- Since 1993, the annual number of reported AIDS cases has steadily declined.
- Since 1997, however, the rate of decline in the number of delay-adjusted AIDS cases has slowed and the curve is now levelling off.

First Nations and Inuit Health

Life Expectancy at Birth – Males

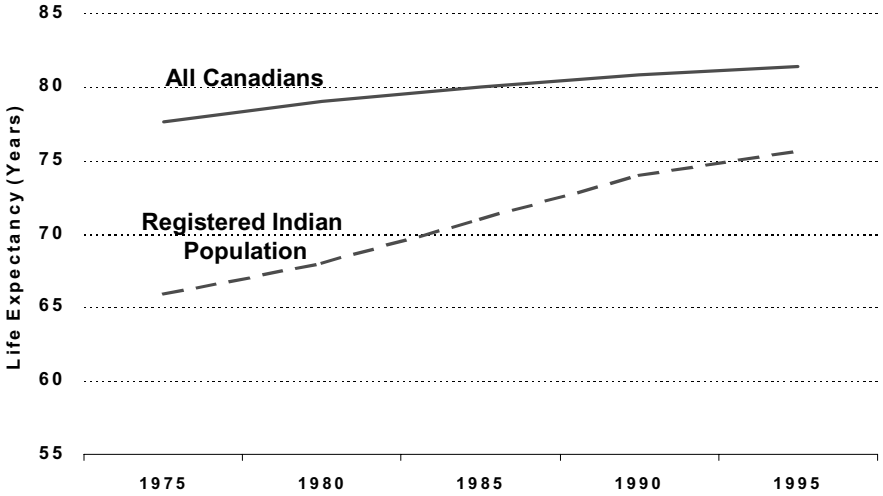
Registered Indian Population and Canadian Population
Canada, 1975-1995



Source: DIAND; Health Canada

Life Expectancy at Birth – Females

Registered Indian Population and Canadian Population
Canada, 1975-1995

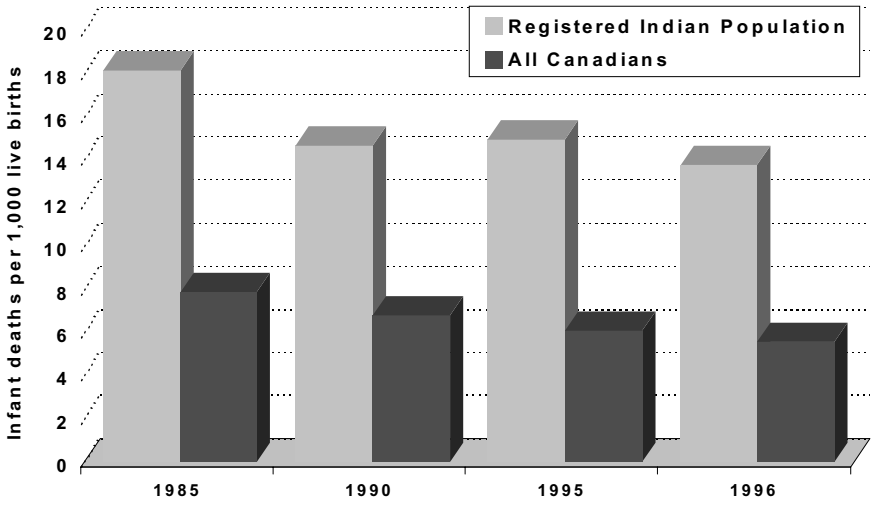


Source: DIAND; Health Canada

- Life expectancy at birth for the registered Indian population is much lower than for the overall Canadian population. It is, however, increasing relative to the overall Canadian population.
- From 1975 to 1995 the gap in life expectancy for males in the registered Indian population compared to that of the overall Canadian population decreased from approximately 9 to 5 years. The gap for females decreased from approximately 12 to 6 years.

Infant Mortality Rates

Registered Indian Population and Canadian Population
Canada, 1985-1996

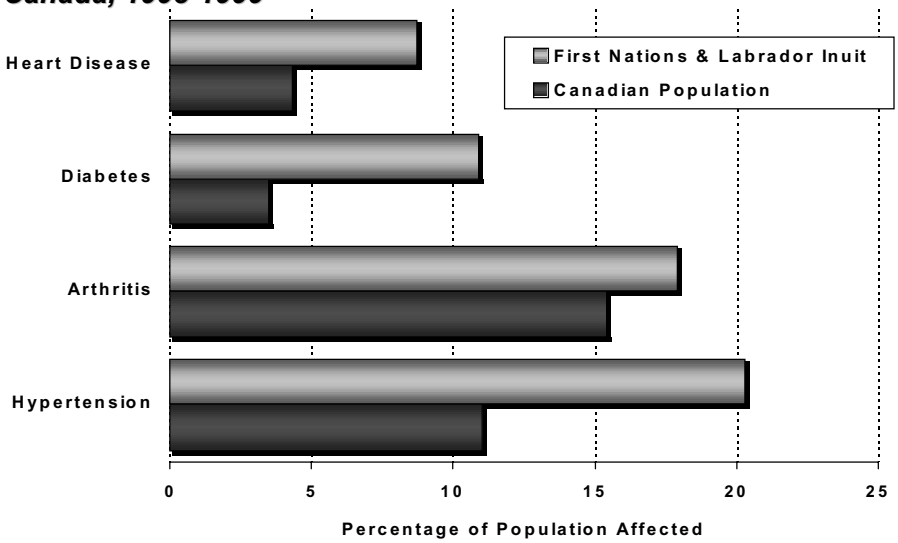


Source: Statistics Canada; Health Canada

- The infant mortality rate of the registered Indian population decreased relative to that of the overall Canadian population between 1985 and 1996, but continues to be more than twice as high.

Prevalence of Chronic Conditions

First Nations and Labrador Inuit and Canadian Population
Canada, 1998-1999



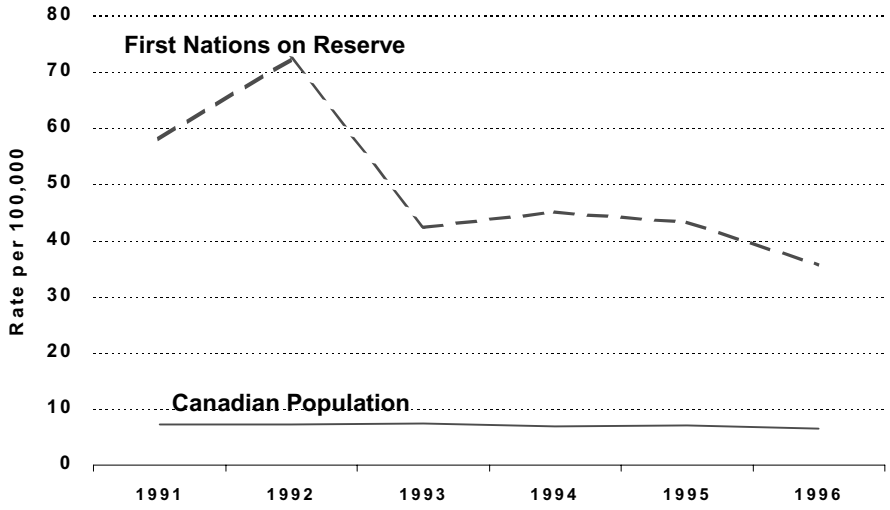
Source: National Population Health Survey (1998/99), Statistics Canada;
First Nations and Inuit Regional Health Survey (1999), Assembly of First Nations

- All of these chronic conditions are more prevalent among the First Nations and Labrador Inuit people than in the overall Canadian population.
- In relative terms, the greatest difference is in the prevalence of diabetes, which is more than three times as prevalent among First Nations and Labrador Inuit than in the overall Canadian population.

Tuberculosis Incidence Rates

First Nations on Reserve and Canadian Population
Canada, 1991-1996

Age-standardized rate to the 1991 age structure

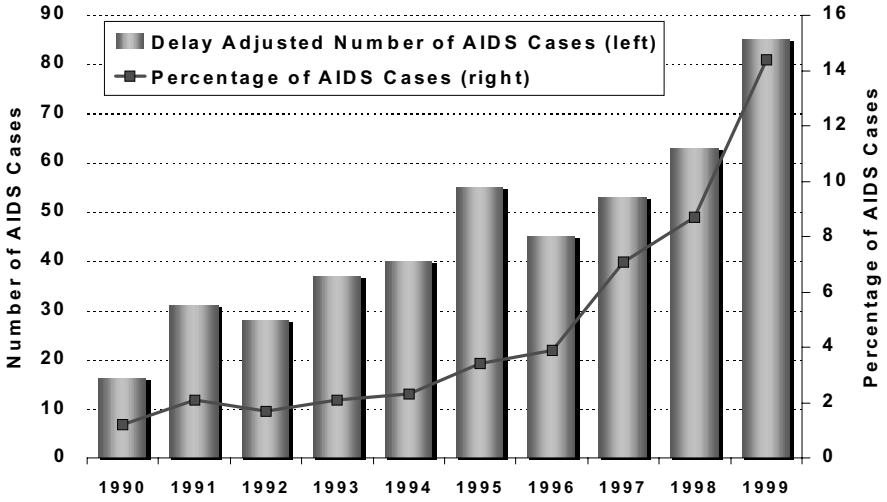


Source: Laboratory Centre for Disease Control, Health Canada

- The incidence rate for tuberculosis among the First Nations on reserve declined between 1991 and 1996, but remains more than five times greater than that of the overall Canadian population.

Aboriginal AIDS Cases

Delay Adjusted Number of Aboriginal AIDS Cases, and As a Percentage of Reported AIDS Cases in Canada Canada, 1990-1999

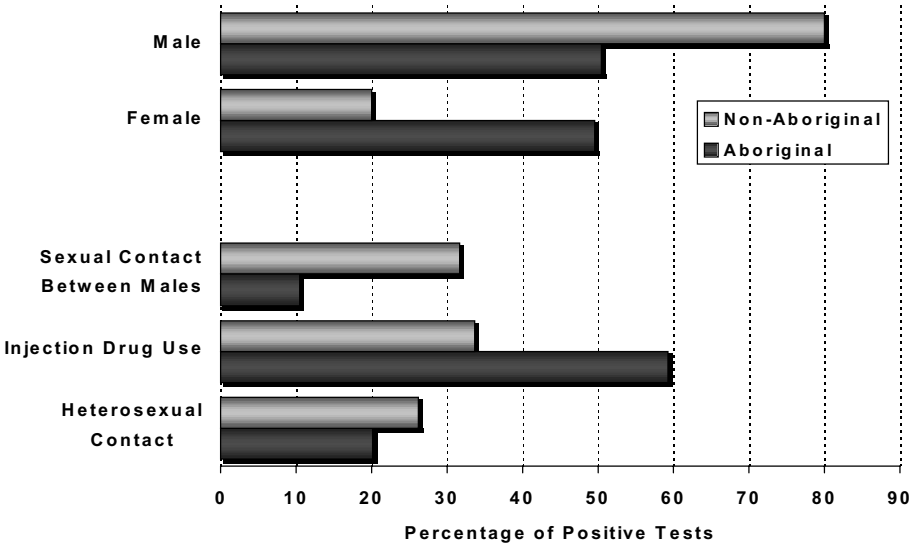


Source: Laboratory Centre for Disease Control, Health Canada

- The annual number of AIDS cases reported in the Aboriginal population grew between 1990 and 1999, whereas the number in the overall Canadian population declined significantly.
- The Aboriginal population represents about 3 per cent of the Canadian population. However, in 1999, reported Aboriginal AIDS cases represented over 14 per cent of all reported AIDS cases in Canada.

Positive HIV Tests

Aboriginal and Non-Aboriginal Persons in Canada, 1998-1999 by Sex and Exposure Category



Source: Laboratory Centre for Disease Control, Health Canada

- Evidence suggests that injection drug use is the most important mode of HIV transmission among the Aboriginal people, compared to male sexual contact with other males for the non-Aboriginal population.
- The number of males and females with positive HIV test reports is about equal for the Aboriginal population, whereas 80% of the non-Aboriginal positive HIV test reports are for males.
- There are limitations to the Aboriginal HIV data. Studies have been done among high-risk populations and results may not be generalizable to the Aboriginal population. Data are available only for those who came forward for testing and/or treatments, and may not represent the total number of Aboriginal people infected.