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Health Canada

2016–17

Departmental Results Report

The Honourable Ginette Petitpas Taylor, P.C., M.P.
Minister of Health

YOUR HEALTH AND SAFETY... OUR PRIORITY.

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Minister's message

As the Minister of Health, I am pleased to present the 2016-17 Departmental Results Report for Health Canada. This report sets out the results that the Department achieved for Canadians over the past year in support of maintaining and improving their health.

A key focus of our work was the strengthening of our publicly-funded universal health care system. I am pleased that the federal, provincial and territorial governments have reached an agreement on the Common Statement of Principles on Shared Health Priorities, which outlines key priorities for federal investments in mental health and addictions, and home and community care, and outlines a commitment for governments to report on results to Canadians through common metrics. This Common Statement of Principles is supported by historic federal investments of $11 billion over 10 years, including $6 billion to support home and palliative care and $5 billion to improve mental health and addiction services, the foundation of a healthy population. I am convinced that by working together, we can make a real difference in the lives of Canadian families and adapt our health systems to better meet today's needs and those of the future.

Health Canada also continued to support the Government's commitment to a renewed relationship with Indigenous peoples. The Department collaborated with Indigenous and government stakeholders to design an engagement strategy for the development of a national reconciliation framework informed by the Truth and Reconciliation Commission's recommendations. Our Government also implemented Jordan's Principle – A Child-First Initiative through enhanced collaboration with partners and stakeholders to ensure that all First Nations children have access to the services and supports that they need. In addition, Health Canada strengthened programs and services in remote and isolated First Nations communities. For example, the Department enhanced the suite of mental wellness services available to First Nations and Inuit peoples, including the creation of a toll-free 24/7 culturally safe Hope for Wellness phone line, and increased the number of mental wellness teams.

Our Government took a number of concrete actions designed to address the ongoing opioid crisis and continued to work towards decreasing the prevalence and harms of problematic substance use among Canadians. In November 2016, our Government co-hosted an Opioid Conference and Summit in November 2016 to bring together partners from across the country to identify short- and long-term actions to address the current opioid crisis. In December 2016, the Department announced the new Controlled Drugs and Substances Strategy, which restores harm reduction as a core pillar of Canada's drug policy. Furthermore, our Government introduced legislation to streamline and simplify the application process for supervised consumption sites as well as prohibit unregistered importation of designated devices such as pill presses.

Helping Canadians lead healthier lives continued to be a priority for Health Canada in 2016-17. In October 2016, our Government launched the Healthy Eating Strategy, which includes a process to revise Canada's Food Guide to reflect the latest scientific evidence on diet and health, and to better support Canadians in making healthy food choices. The Department finalized regulations on nutrition labelling and food colors to make the Nutrition Facts Table on packaged foods easier for Canadians to use and understand.

Health Canada worked with Justice Canada and the Department of Public Safety Canada towards the introduction of legislation to legalize, regulate and restrict access to cannabis to keep it out of the hands of youth, and to keep profits out of the hands of criminals. An Expert Task Force was launched on June 30, 2016 to develop recommendations to inform the development of legislation. The Department also finalized regulations for plain packaging requirements for tobacco products and supported legislation to address the potential benefits and harms of vaping products.

I look forward to continuing to advance my key mandate priorities through collaboration and evidence-based decision-making that will improve the health and safety of all Canadians.

The Honourable Ginette Petitpas Taylor, P.C., M.P.

Minister of Health

Results at a glance

Resources used to achieve results for Canadians

Health Canada's total actual spending for 2016–17: **$4,153,217,124**

Health Canada's total actual full-time equivalents for 2016–17: **8,852**

Priority I: Support health system innovation.

Description

A highly functioning health care system is vital to addressing the health needs of Canadians. Although health care delivery is primarily under provincial and territorial jurisdiction, the federal government has an ongoing role in providing financial support through fiscal transfers to the provinces and territories, maintaining the core principles of the Canada Health Act, and supporting health care innovation and collaboration across the country. Health Canada contributes to improving the quality and sustainability of health care as the system continues to evolve in a context of technological and social changes, demographic shifts and fiscal pressures. Based on a Common Statement of Principles for Shared Health Priorities endorsed by provinces and territories, the Government is negotiating multi-year, bilateral agreements with provinces and territories to flow targeted funding for home care and mental health services as part of its commitment to ensure the health care system continues to evolve and innovate.

Key Results

- In 2016-17, Health Canada delivered on the federal commitment to engage with provincial and territorial governments to strengthen health care, with a focus on the shared priorities identified by Federal-Provincial-Territorial (FPT) Ministers of Health in January 2016: home and community care, mental health, affordability, accessibility and appropriate use of prescription drugs, and health innovation. In December 2016, the Government of Canada tabled a 10-year offer of additional support, for a total of $11.5B, for these four priority areas. Funding was confirmed in Budget 2017 and all provinces and territories have now accepted the federal funding offer.
- With regard to health innovation, FPT Ministers of Health agreed to examine how existing pan-Canadian health organizations and provincial counterpart organizations could better support system transformation, and to explore the role of critical enablers such as health information and data analytics, digital health and technology management.
- Key pan-Canadian health organizations continued to advance projects to support more widespread use of digital health technologies and greater adoption of service delivery innovations to improve the quality and responsiveness of patient care. Budget 2017 provided additional funding to key pan-Canadian health organizations to deliver on the Government of Canada's commitment to support health innovation, specifically to improve digital health infrastructure, accelerate the spread and scale of innovative practices and promote better health system information.

Priority II: Strengthen openness and transparency as modernization of health protection legislation, regulation and delivery continues.

Description

Health Canada's operating environment is constantly evolving. For example, the integrity of the global supply chain is changing; the speed of innovation continues to accelerate; and there is increased demand for greater openness and transparency. To address these challenges in the environment, and to help Canadians live healthier lives and protect them from unsafe food, products, and threats, Health Canada will continue its efforts with its partners at home and abroad to modernize regulatory frameworks and service delivery models and to strengthen openness and transparency. The Department will provide credible and timely information to empower Canadians to make informed health decisions and support businesses' responsibility for the safety of their products.

Key Results

- Health Canada worked with the Department of Justice and the Department of Public Safety towards the introduction of legislation to legalize, regulate and restrict access to cannabis. An Expert Task Force, launched on June 30, 2016, held consultations with experts in public health, law enforcement, economics and industry, provincial, territorial and municipal officials, representatives from Indigenous governments and organizations, and, young Canadians. Informed by the recommendations of the Task Force, the proposed Cannabis Act (Bill C-45) was introduced in the House of Commons on April 13, 2017. The Act sets out the framework to legalize, strictly regulate and restrict access to cannabis, in order to help keep it out of the hands of youth and keep profits out of the hands of criminals and organized crime.
- The Department made progress on another ministerial priority pertaining to the introduction of plain packaging requirements for tobacco products. The development of plain packaging regulations began on May 31, 2016 (on World No Tobacco Day), with the launch of a three-month public consultation. The Department published a summary of comments received as part of the consultation in January 2017 (during National Non-Smoking Week). Having considered all comments, the Department is finalizing draft regulations for plain and standardized packaging. Bill S-5 (An Act to Amend the Tobacco Act and the Non-Smokers' Health Act and to make Consequential Amendments to Other Acts) was introduced in the Senate in November 2016 and, provided it receives Royal Assent, the proposed regulations will be in a position to advance through the regulatory process (i.e. posting in Canada Gazette).
- The Department consulted on a proposal to introduce a mandatory front-of-package labelling approach for foods high in nutrients of public health concern (i.e., sodium, sugars and saturated fat); and, finalized amendments to the Food and Drug Regulations on "Nutrition Labelling, Other Labelling Provisions, and Food Colours" in Canada Gazette, Part II to improve food labels, making the information more useful and easier to understand.

- Health Canada identified 50 planned Regulatory Transparency and Openness Framework activities to advance transparency and openness, a ministerial priority. Health Canada completed 31 of 50 (62%) activities such as including information for natural health products, medical devices and a subset of over-the-counter medications in the Drug Health Products Register. The remaining activities will be completed in 2017-18.
- Health Canada published updates to the Pest Control Product Fees and Charges Regulations (including the fee schedules) in Canada Gazette, Part II on February 22, 2017. With the new Cost Recovery Regime coming into force on April 1, 2017, the Department completed the review of the Pesticide program business processes and implemented the required changes to ensure a smooth transition to the new regime. The Department also began posting pesticide registrant inspection reports online in 2016, furthering Health Canada's commitment to openness and transparency.

Priority III: Strengthen First Nations and Inuit health programming.

Description

First Nations and Inuit Peoples continue to experience serious health challenges compared to other Canadians. In an effort to close the Indigenous health gap, Health Canada plays an important role in supporting the delivery of health programs and services for First Nations and Inuit. The Department works with partners on innovative approaches to strengthen access to health services, ensure better integration of those services and to encourage greater control and management of health care delivery by First Nations and Inuit to better respond to their own needs. In addition, Health Canada continues to work with partners to further the implementation of a First Nations and Inuit Health Strategic Plan which provides stronger coherence and direction for the Department's activities in this area, and demonstrates how the Department collectively contributes to improving health outcomes for First Nations and Inuit Peoples.

Key Results

- Health Canada continued to support a renewed relationship with Indigenous Peoples by working collaboratively with Indigenous and government stakeholders. As part of these efforts, Health Canada worked with the Assembly of First Nations, Inuit Tapiriit Kanatami and Métis National Council to undertake engagement activities with their membership in order to identify their health priorities and support federal-provincial-territorial discussions related to health care.
- Health Canada implemented Jordan's Principle – A Child-First Initiative through collaboration with partners and stakeholders to ensure all First Nations children have access to the health, social and educational services and supports that they need.
- Capital investments were made in First Nations health facilities, including 135 maintenance and minor repair projects; the design and construction of 42 major renovations to and/or expansions of major health facility capital projects; and, the repair and/or replacement of 29 facilities used by First Nations for the delivery of their Aboriginal Head Start on-Reserve program.

Priority IV: Recruit, maintain and foster an engaged, high performing and diverse workforce within a healthy workplace.

Description

Health Canada's greatest strength is an engaged, empowered and well-equipped workforce with employees that have the competencies, tools and opportunities to succeed in the pursuit of excellence in program and service delivery. Two of the key priorities for the Government of Canada, as referenced in the Clerk's 23rd Annual Report to the Prime Minister on the Public Service of Canada, are respectful workplaces with a focus on mental health, and recruitment. Health Canada is achieving this by building a healthy, respectful and supportive work environment and by developing an engaged, high-performing and diverse workforce across Canada, which includes recruiting for the future.

Key Results

- The Department continued to work in support of the Multi-Year Strategy for Mental Health and Wellness in the Workplace, which included the implementation of National Standard for Psychological Health and Safety in the Workplace action plans and the delivery of Mental Health First Aid sessions.
- Recruitment continued through various initiatives, including the post-secondary recruitment (PSR) program, which saw Health Canada exceed its 2016-17 PSR hiring target by 136%.
- The Department's Blueprint group hosted three Dialogue Santé armchair discussions that explored topics such as mental wellness, innovation and key program priorities. The group also hosted a second Innovation Showcase, which put the spotlight on dozens of employee innovations.

For more information on the Department's plans, priorities and results achieved, see the "Results: what we achieved" section of this report.

Raison d'être, mandate and role: who we are and what we do

Raison d'être

Health Canada regulates specific products and controlled substances, works with partners to support improved health outcomes for First Nations and Inuit, and supports innovation and information sharing in Canada's health system to help Canadians maintain and improve their health.

The Minister of Health is responsible for this organization.

Mandate and role

At Health Canada, our role is to help Canadians maintain and improve their health. While the provinces and territories are responsible for delivering health care to the majority of Canadians, the federal government also has a number of key roles and responsibilities in areas that affect health and health care. In addition to working closely with provincial and territorial governments, we also work with partners in the Health Portfolio, other federal departments and agencies, non-governmental organizations, other countries, Indigenous partners and the private sector to help achieve our goal of Canada being one of the healthiest countries in the world.

As a partner in health, Health Canada:

- **protects Canadians** from unsafe food, health and consumer products;
- **supports the delivery** of health care to First Nations and Inuit;
- **promotes innovation** in health care; and,
- **informs Canadians** to make healthy choices.

The meals we serve our families, the pesticides farmers put on crops, the herbal remedies, vitamins and drugs in our medicine cabinets, the toys we buy our children - they are all products regulated by Health Canada for safety. Hundreds of new products, with new ingredients and new purposes, are introduced by industry every year in Canada. Health Canada's decisions are made with the best interest of Canadians in mind, whether to approve the safety and quality of new products or to provide advice after they are on the market. Our actions are supported by scientific evidence.

We support the delivery of front-line health services to First Nations and Inuit communities, often in remote and isolated parts of our country. We recognize that partnering with First Nations and Inuit in the management of their health services is key to improving their health.

Our Department is committed to upholding the Canada Health Act and protecting our publicly funded health care system, which helps to ensure Canadians have access to quality, universal health care based strictly on their medical needs, not their ability and willingness to pay. We also promote innovation and the use of best practices across Canada.

Health Canada's vision is to help make Canada's population among the healthiest in the world. From coast to coast to coast, we have almost 9,000 employees - scientists and researchers, inspectors, doctors and nurses, policy analysts and administrative professionals, and many others - working to help Canadians maintain and improve their health.

As a regulator, service provider, promoter of innovation, and trusted source of information, we are a partner in health for all Canadians.

For more general information about the Department, see the "Supplementary information" section of this report. For more information on the Department's organizational mandate letter commitments, see the Minister's mandate letter.[ii]

Operating context and key risks

Operating context

As in previous years, Health Canada continued to operate in a complex and dynamic environment, facing several challenges as it worked to deliver results for Canadians. Many of these challenges were beyond the sole control of the Department and involved working collaboratively with a range of partners, including Indigenous Peoples, stakeholders and governments, both national and international.

Health care across Canada continued to change at a rapid pace in order to keep up with demographic shifts, social changes, technological evolution and fiscal pressures. As a partner in the national health system, in 2016-17, the Department worked with provinces and territories to develop a common framework to strengthen Canadian health care systems to make home care more available, prescription drugs more affordable, and mental health care more accessible.

The acceleration of scientific and technological innovation, globalization, and the complexity of the global supply chain also challenged the Department's ability to effectively regulate new, innovative and complex products, substances, food and emerging product categories. Many of these products and foods come from emerging economies, with varying degrees of regulatory oversight. Increasingly, the health and safety of Canadians is being influenced by issues beyond Canada's borders.

Public health issues including the problematic use of substances, such as the opioid crisis, and mental health concerns in some First Nations communities also presented significant challenges to the Department, requiring it to respond in a timely and responsible manner while continuing to deliver on its day-to-day operations.

Canadians continued to expect their Government to be more open and transparent and to effectively engage them in decision-making. The provision of credible and timely information is critical to helping Canadians make informed health decisions for themselves and their families. However, the Department is one of many sources of health information for Canadians. The varying scientific quality and accuracy of information available to the general public can hinder the Department's efforts to reach Canadians, but also provides an opportunity for leadership in the provision of high quality, evidence-based health information.

Another challenge for the Department during 2016-17 pertained to managing the implementation of the Minister's mandate commitments within existing resources. Health Canada took steps to reassign resources to the policy and program areas required to respond to the above-referenced challenges. For example, the Department realigned resources for the legalization and regulation of cannabis including the creation of the Cannabis Legalization and Regulation Branch to spearhead the work in collaboration with the Department of Justice and the Department of Public Safety.

The past year also saw an internal transformation of Health Canada with respect to performance measurement, evaluation and results functions and governance structures. The Department began to implement the Treasury Board Secretariat's Policy on Results which came into effect on July 1, 2016. The Policy aims to improve the achievement of results across government and to

enhance the understanding of the results the Government seeks to achieve, does achieve, and the resources used to achieve them. While performance measurement is not new in the Department, the new Policy brings a renewed attention to it, and embeds a structure and processes to ensure that it is happening in a more systematic way with a sharper focus on achieving results. The Policy also offers a more flexible and focused evaluation function that can provide strong evidence to support continuous improvement and resource allocation.

Key risks

Health Canada has established risk management practices to respond proactively to change and uncertainty. A well-defined governance structure is in place to implement and sustain effective risk-management practices throughout the organization and is set out in detail in the Departmental Integrated Risk Management Framework.

The key risks are identified by the organization through the development of the annual Corporate Risk Profile (CRP), which is aligned with the Departmental Plan. The CRP sets out the key threats and opportunities that have the potential to affect the achievement of the Department's mandate and commitments, and outlines in detail the management strategies to address these risks.

The risks identified in the table below represent the top four risks that could potentially be disruptive to the Department's ability to achieve its objectives. Each risk was monitored to ensure that the associated response strategies helped to reduce their potential impact.

Key risks

Risks	Mitigating strategy and effectiveness	Link to the Department's Programs	Link to mandate letter commitments or to government-wide and departmental priorities
Risk 1: Existing Canadian confidence in the safety of health and consumer products. There is a risk that Canadians will lose confidence in the safety of health and consumer products, if Health Canada is not regarded as a trusted regulator and used as a credible source of information.	Risk mitigation strategies were successfully executed as planned, and targets were met or exceeded. To ensure that Health Canada continued to be seen as a trusted regulator and credible source of information, the following risk mitigation strategies were executed: 1. Health Canada expanded the amount of regulatory health and safety information made available to Canadians in a simple and accessible way through the implementation of Health Canada's Regulatory Transparency and Openness Framework. This included: • Provided timely regulatory information through a "digital first" approach to inform, communicate	• Program 2.1: Health Products • Program 2.2: Food Safety and Nutrition • Program 2.3: Environmental Risks to Health • Program 2.4: Consumer Product and Workplace Hazardous Materials • Program 2.5:	**Government Priority:** Open and Transparent Government. **Organizational Priority II:** Strengthen openness and transparency as modernization of health protection legislation, regulation and delivery continues.

Risks	Mitigating strategy and effectiveness	Link to the Department's Programs	Link to mandate letter commitments or to government-wide and departmental priorities
	with, and engage Canadians on Canada.ca and on Health Canada social media channels. Additional methods included news releases, proactive media outreach, interviews, and letters to the editor. • Developed and posting 10 "storylines" to better explain some of Health Canada's key regulatory activities and processes. 2. Opportunities were increased for Canadians to provide input on regulatory decision-making: • Health Canada exceeded its established target (i.e. 2,000) by 900, with 2,900 stakeholders and Canadians receiving information on consultations through the Consultation and Stakeholder Information Management System (CSIMS). Altogether, citizens and stakeholders registered in CSIMS received multiple notices for a total of 71,000 notifications, the majority of which were related to regulatory decision-making. • Health Canada successfully migrated its web content to Canada.ca, making it easier for Canadians to access Government of Canada health and safety information.	Problematic Substance Use[1] • Program 2.6: Radiation Protection • Program 2.7 Pesticides	
Risk 2: Existing Protect Canadians from product risks. Health Canada's ability to protect Canadians from the risks of products may be weakened	Risk mitigation strategies were successfully executed as planned, new strategies were developed as required, and targets were met or exceeded. To ensure that Health Canada is able to protect Canadians from the risks associated with the use of products, the following risk mitigation strategies were executed: 1. Health Canada collaborated with	• Program 2.1: Health Products • Program 2.2: Food Safety and Nutrition • Program 2.3: Environmental Risks to Health	**Organizational Priority II:** Strengthen openness and transparency as modernization of health protection legislation, regulation and

[1] Formerly Substance Use and Abuse.

Risks	Mitigating strategy and effectiveness	Link to the Department's Programs	Link to mandate letter commitments or to government-wide and departmental priorities
due to the increasing complexity of the global supply chain and pace of innovation.	international regulatory organizations and aligned with foreign regulators. Specifically, 84% of planned Canada-United States Regulatory Cooperation Council activities for 2016-17 were completed. Achievements include: • A guidance document on Good Regulatory Review Practices for medical devices was developed. • A workplace chemicals work plan was finalized and is posted on both Canadian and US websites. • Health Canada worked closely with the US Environmental Protection Agency on Pollinator Protection and the Neonicotinoid Pesticides, Pesticide Re-evaluation, Integrated Approach to Testing and Assessment, and Alignment of Pesticide Residue Trial Requirements. 2. Health Canada ensured that modern e-tools were made available to support regulatory functions. • The Department took steps to implement an "Application Portfolio Management" framework for the sustainability and lifecycle management of modern e-tools. 3. Health Canada increased the use of regulatory and non-regulatory activities that address changing business models in the supply chain, specifically those involving foreign sites, specifically: • Health Canada completed 96% of all planned foreign inspections (on-site and virtual). Inspection ratings and initial findings are posted in the Drug and Health Product Inspection Database. • Health Canada continued its work with global partners including the US Consumer Product Safety Commission, Mexico, China's Administration of Quality Supervision, Inspection and Quarantine, and the Australian	• Program 2.4: Consumer Product and Workplace Hazardous Materials • Program 2.6: Radiation Protection • Program 2.7: Pesticides	delivery continues.

Risks	Mitigating strategy and effectiveness	Link to the Department's Programs	Link to mandate letter commitments or to government-wide and departmental priorities
	Competition and Consumer Commission to further strengthen international coordination and cooperation in support of consumer product safety. 4. Health Canada developed oversight strategies and tools to strengthen market surveillance and oversight of emerging products. • Health Canada continued ongoing collaborative work related to market surveillance, media and journal monitoring and watch list materials/products. The Department explored social media analytics as a new source of information on health and safety incidents. Health Canada's ongoing use of industry and consumer reported incidents led to action on products, such as lithium-ion batteries, and provided data to inform activities on known risks to children, such as corded window coverings, furniture tip-overs, and laundry detergent pods.		
Risk 3: Existing Quality health services (First Nations and Inuit health facilities). Health Canada's ability to ensure continuous delivery of health services may be at risk due to a lack of quality maintenance and timely repairs of health facilities.	Risk mitigation strategies were successfully executed as planned, new strategies were developed as required, and targets were met or exceeded. To ensure that Health Canada is able to ensure continuous delivery of health services for First Nations and Inuit, the following risk mitigation strategies were executed: 1. Health Canada reallocated funding to address priority facility repairs and renovations. • All funded projects were prioritized on the basis of building condition reports or urgent and/or unexpected events. 100% of the $18.8M available funding in 2016-17 has been spent. 2. Health Canada renovated and updated facilities according to the Capital Management Framework. • 37 of the 42 health facilities projects	• Program 3.3: Health Infrastructure Support for First Nations and Inuit.	**Organizational Priority III:** Strengthen First Nations and Inuit health programming.

Risks	Mitigating strategy and effectiveness	Link to the Department's Programs	Link to mandate letter commitments or to government-wide and departmental priorities
	continue to be on or ahead of schedule; 100% of the $12.8M contribution funding for facility maintenance was spent. 3. Health Canada facilitated the use of alternative capital funding approaches on-reserve. • Health Canada continues work to develop a demonstration project to cluster community health facility capital projects. 4. Health Canada refined capital program practices to increase engagement of First Nations communities in the follow-up to facility inspections. • A total of 126 inspections were completed by Health Canada or one of its partners. The results of at least 101 have been shared with the First Nations partners.		
Risk 4: Existing Quality health services (First Nations and Inuit nursing capacity). Health Canada's ability to ensure continuous quality health services may be at risk due to limited availability of nursing capacity.	Risk mitigation strategies were successfully executed as planned, new strategies were developed as required, and targets were mostly met or exceeded. Where strategies were delayed or postponed, work will continue to ensure these targets are met. To ensure that Health Canada is able to ensure continuous quality health services, the following risk mitigation strategies were executed: 1. Continued to implement the Nursing Recruitment and Retention Strategy and mandatory training requirements for nurses. • A qualified pool of 285 nurses was created, and 55 nursing staff were hired between April 1, 2016 and March 31, 2017. 2. Worked with provinces and Regional Health Authorities to increase local access to physicians for First Nations living in remote and isolated communities. • Formal and informal arrangements to ensure access were established in 100% of communities where Health	• Program 3.1: First Nations and Inuit Primary Health Care • Program 3.2: Supplementary Health Benefits for First Nations and Inuit. • Program 3.3: Health Infrastructure Support for First Nations and Inuit.	**Organizational Priority III:** Strengthen First Nations and Inuit health programming.

Risks	Mitigating strategy and effectiveness	Link to the Department's Programs	Link to mandate letter commitments or to government-wide and departmental priorities
	Canada delivers services. The target of 80% was surpassed. 3. Pursued accreditation of nursing stations and health centers to maintain a standardized level of quality in health program planning, management and delivery of health services. • As of March 31, 2017, a total of 81 community health centres and four nursing stations (serving a total of 152 communities) are in the accreditation process. This represents the accreditation of 17.9% of nursing stations and health centres. 4. Developed Primary Health Care Information Systems for collection of critical operational data for analysis and planning. 5. Developed Business Requirements and analysis of options developed. Continue the modernization of clinical practice guidelines to support remote nursing services. • The Communicable Diseases Clinical Practice Guidelines (CPGs) were finalized. 6. Continued to implement primary care reform in remote and isolated First Nations communities. • Collaborative service delivery arrangements with external providers in 100% of remote and isolated communities. • Mapping of current models of care was completed for each nursing station in Alberta, Manitoba, Ontario, and Quebec. Nursing Station profiles were updated with current models as of June 2016. • Mapping of future delivery models was completed as part of the Assessment of Essential Services in each of the 46 nursing stations.		

Results: what we achieved

Programs

Strategic Outcome 1: A health system responsive to the needs of Canadians

Program 1.1: Canadian Health System Policy

Description

The Canadian Health System Policy program provides strategic policy advice, research, and analysis to support decision-making on health care system issues, as well as program support to provinces and territories, partners, and stakeholders on health care system priorities. Mindful of equity, sustainability and affordability, Health Canada collaborates and targets its efforts in order to support improvements to the health care system such as improved access, quality, and integration of health care services. Through the management of grants and contributions agreements with key pan-Canadian health partners, the Canadian Health System Policy program contributes to priority health issues requiring national leadership and strong partnership. The program objective is to support improvement in the health care system to help Canadians maintain and improve their health.

Results

Health Canada managed initiatives and new and existing funding agreements that advanced priority health issues, including the following:

- Worked with provinces and territories to negotiate shared priorities for action in home care, mental health, pharmaceuticals and innovation. Budget 2017 confirmed $11B over 10 years for provinces and territories to improve home care and mental health services, as well as $544M over five years to federal and pan-Canadian health organizations to support innovation and pharmaceutical initiatives.
- In partnership with Justice Canada, supported the development of federal legislation on medical assistance in dying which received Royal Assent in June 2016. Health Canada has since been working closely with provinces and territories to support implementation of the new legislation. This includes activities to meet the following federal commitments under the law: developing regulations for a monitoring and reporting system; initiation of independent reviews on areas requiring further examination; and supporting access by Canadians to care coordination resources related to medical assistance in dying, as well as a range of end-of-life care services.
- Conducted research, analysis and policy work on health care system issues to support departmental priorities, including work on home care, mental health, prescription drugs, innovation, the Federal Action on Opioids and implementation of the new Policy on Results.

- Contributed $21.3M to support the Canadian Brain Research Foundation, which is managed by Brain Canada.
- Provided $14.25M to the Mental Health Commission of Canada in support of public education and awareness on mental health issues, dissemination of mental health data and research, and collaboration with provinces and territories and mental health stakeholders.
- Provided $47.5M to support the Canadian Partnership Against Cancer which has, through collaboration with key stakeholders including the provinces and territories, accelerated uptake of new knowledge and coordinated approaches to advance cancer control in Canada.
- Provided $16.1M for the Canadian Agency for Drugs and Technologies in Health in support of health system effectiveness and sustainability by promoting, through the development of evidence, the cost-effective and optimal use of drugs and other health technologies.
- Completed a review of the Canadian Institute for Health Information strategic direction in preparation for a renewed five-year strategic plan.
- Provided $9.5M in funding for 14 contribution agreements under the Health Care Policy Contribution Program and advanced health care innovation and health system renewal through collaborative working arrangements with provinces, territories, academic institutions, and non-governmental organizations.
- Provided $7.6M to the Canadian Patient Safety Institute to support efforts to improve the safety of health care, including the delivery of an Integrated Patient Safety Action Plan.
- Provided $17M to the Canadian Foundation for Health Care Improvement to identify and support adoption of innovations that improve health care delivery.
- Provided $3M (2013-2017) to the Pallium Foundation of Canada to support training in palliative care to front-line health care providers. This initiative has developed a range of educational materials, trained trainers, and facilitated sessions to increase the palliative care capacity of front-line health care providers.
- Provided $21M to Canada Health Infoway to support short-term digital health activities in e-prescribing and tele-homecare.
- Continued to monitor and analyse emerging trends and drivers in health technology policy and worked with Canadian and international partners to explore health technology management approaches to advance this area in Canada.

Results achieved

Expected Results	Performance Indicators	Target	Date to achieve target	Actual Results		
				2016-17	2015-16	2014-15
Recipients contribute to improvements in the health care system.	% of recipients demonstrating a contribution to health care system improvements	100	March 31, 2017	100	N/A*	N/A*

*Actual results from previous years are not available as this is a new performance indicator developed to enhance reporting on program results. The Department will continue to strengthen reporting to Canadians on results achieved as it implements the Treasury Board Policy on Results.

Budgetary financial resources (dollars)

2016–17 Main Estimates	2016–17 Planned Spending	2016-17 Total Authorities Available for Use	2016-17 Actual Spending (authorities used)	2016-17 Difference (actual minus planned)
260,866,701	260,866,701	331,314,881	329,454,933	68,588,232

Note: The variance of $68.6M between actual and planned spending is mainly due to increased statutory grant funding provided to the Canadian Institute for Health Information for electronic health information communication technologies, as well as increased contribution funding to Canada Brain Research Fund, and the Canadian Foundation for Health Improvement.

The variance of $70.4M between planned spending and total authorities is mainly due to statutory grant funding provided to the Canadian Institute for Health Information for electronic health information communication technologies and in-year resources received for Canada Health Infoway, Canadian Foundation for Health Care Improvement, and Canada Brain Research Fund.

The variance of $1.9M between total authorities and actual spending is mainly due to funding that was underspent in the Health Care Policy Contribution Program.

Human resources (full-time equivalents [FTEs])

2016–17 Planned	2016-17 Actual	2016-17 Difference (actual minus planned)
238	177	-61

Note: The variance of 61 in FTE utilization is mainly the result of management's efforts to stabilize and control salary requirements through personnel departures and delays in staffing vacant positions.

Program 1.2: Specialized Health Services

Description

The Specialized Health Services program supports the Government of Canada's obligation to protect the health and safety of its employees and the health of visiting dignitaries. Health Canada delivers counselling, organizational development and critical incident support services to federal government departments through a network of contracted mental health professionals, and also provides immediate response to employees following traumatic incidents in the workplace. Health Canada delivers occupational health and occupational hygiene consultative services to ensure that public servants meet medical requirements to safely and effectively perform their duties and to prevent work-related illness and injury. Health Canada proactively contributes to reducing the number of work days lost to illness across the federal government through the provision of occupational and psycho-social health services to federal public servants. Health Canada also arranges for the provision of health services for Internationally Protected Persons (IPP) who have come to Canada for international events, such as meetings or official visits. An IPP is a representative of a State, usually Heads of State and/or Government, members of the Royal Family, or officials of an international organization of an intergovernmental character. The program objective is to ensure continuity of services and the occupational health of federal public servants who can deliver results to Canadians in all circumstances and to arrange health services for IPPs.

> Employee Assistance Services
>
> The specialized health services provided under the auspices of the Employee Assistance Services, via a network of 950 certified service providers across Canada, continue to assist federal employees and their families in achieving problem resolution in a majority of cases (97%), thereby contributing to reduced workplace absenteeism and better quality of health and well-being overall.

Results

Employee Assistance Services (EAS) offer high quality specialized health services to federal public servants and their families, under the auspices of Health Canada's fully-accredited Employee Assistance Program (EAP), on behalf of the Government of Canada.

According to 2016-17 EAS survey data on client satisfaction [how satisfied are you with how the EAP has met your needs], the EAP continues to achieve positive outcomes for federal employees. Specifically, in 2016-17, 97% of both male and female EAS clients reported achieving problem resolution within the EAS short-term counselling model and 74% of clients reported that the EAP services had a positive impact on life status. In addition, 80% of female clients and 72% of male clients reported improved coping skills. Furthermore, 60% of male clients and 56% of female clients reported improved resiliency.

For "reduced absenteeism", the target of 25% outlined in the table below refers to absences of 10 days or less, which is in line with industry standards. The drivers of short-term absenteeism fall more often within the domain of EAP's sphere of influence to address, in comparison to the drivers of longer-term absenteeism (more than 10 days). Self-reported short-term absenteeism among both females and males was reduced following usage of EAP services:

- 75 fewer person days were lost in 2016-17, as reported by 494 female respondents, and
- 45 fewer person days were lost in 2016-17, as reported by 306 male respondents.

From the perspective of challenges and lessons learned, ensuring good quality and timely reporting on the impact and outcomes of EAP services for federal employees and their families will require ongoing attention to quality improvement investments (i.e. systems, tools, etc.), in order to ensure compliance with the Treasury Board Secretariat Policy on Results requirements.

The IPP Program successfully delivered its mandate for Regular Visits. It also developed health plans with dedicated services, on relatively short notice, for the 2016 North American Leaders Summit in Ottawa in June 2016, as well as for the Fifth Replenishment Conference of the Global Fund to Fight AIDS, Malaria and Tuberculosis in Montreal in September.

Results achieved

Expected Results	Performance Indicators	Target	Date to achieve target	Actual Results		
				2016-17	2015-16	2014-15
Federal employees are able to manage their psycho-social issues during and immediately following, stressful or traumatic events.	% of clients that achieve problem resolution within the EAS short term counselling model.	75*	March 31, 2017	97	98	95
Reduced absenteeism in the workplace for employees who access employee assistance services.	% reduction in absenteeism in the 30 days that follow an employee's last Employee Assistance Program session versus the 30 days prior.	25*	March 31, 2017	50	41	43.8
Internationally Protected Persons (IPPs) have timely Health Plans available for emergency medical	% of Health Plans delivered to client departments at least 24 hours prior to the visit.	95	March 31, 2017	96	94	99

Expected Results	Performance Indicators	Target	Date to achieve target	Actual Results		
				2016-17	2015-16	2014-15
services and appropriate food surveillance services when they are in Canada.						

*This target will be revisited moving forward given that past performance has consistently exceeded the established target.

Budgetary financial resources (dollars)

2016–17 Main Estimates	2016–17 Planned Spending	2016-17 Total Authorities Available for Use	2016-17 Actual Spending (authorities used)	2016-17 Difference (actual minus planned)
18,685,517	18,685,517	14,921,829	13,588,652	-5,096,865

Note: The variance of $5.1M between actual and planned spending is mainly due to revenues collected below authorities which can vary year-to-year based on the needs of client departments.

Human resources (FTEs)

2016–17 Planned	2016-17 Actual	2016-17 Difference (actual minus planned)
260	178	-82

Note: The variance of 82 in FTE utilization is mainly due to the calculation of planned FTE figures being based on the Employee Assistance Services program using its full revenue authority. FTE utilization is a reflection of workforce requirements based on actual workload.

Program 1.3: Official Language Minority Community Development

Description

The Official Language Minority Community Development program involves the administration of Health Canada's responsibilities under Section 41 of the Official Languages Act[iii]. This Act commits the federal Government to enhance the vitality of official language minority communities and foster the full recognition and use of English and French in Canadian society. This program includes: consulting with Canada's official language minority communities on a regular basis; supporting and enabling the delivery of contribution programs and services for official language minority communities; reporting to Parliament and Canadians on Health Canada's achievements under Section 41; and, coordinating Health Canada's activities and awareness in engaging and responding to the health needs of official language minority communities. The program objectives are to improve access to health services in official language minority communities and to increase the use of both official languages in the provision of health care services. This program uses funding from the following transfer payment: Official Languages Health Contribution Program.

Results

In 2016-17, Health Canada continued to provide support to improve access to health services in the minority official language communities through the Official Languages Health Contribution Program (OLHCP). In particular, the Department:

- Supported a range of initiatives under the OLHCP in the areas of: (1) training of bilingual health personnel; (2) knowledge development and dissemination; and, (3) increased access to health services. The impacts of these initiatives include an increase in the availability of health service providers to meet the needs of official language minority communities, enhanced mechanisms for recognizing and dispensing effective health services for these communities, and improved understanding and measurement of health circumstances and challenges.
- Supported initiatives and the development of bilingual resources under other program areas, including the Substance Use and Addictions Program, the Canadian Patient Safety Institute, the Canadian Foundation for Health Care Improvement, and the Mental Health Commission of Canada.
- Held its "Health Canada Science Colloquium on the Health of Canada's Official Language Minority Communities" which succeeded in bringing researchers together to foster an exchange of knowledge about language barriers and the realities experienced by official language minority communities, as well as sharing tools and best practices to improve access to health care in both official languages of Canada.
- Undertook consultations with the general public, official language minority communities, and relevant stakeholder organizations with the view of informing the renewal of Health Canada's OLHCP. The process included an online consultation which was open to all and posted on the Government of Canada website from September 13 to November 4, 2016.

- Ensured that all its proposals, memoranda and decision documents submitted to the Treasury Board and to other committees of the Cabinet respected the Official Languages Act requirements.

Results achieved

Expected Results	Performance Indicators	Target	Date to achieve target	Actual Results		
				2016-17	2015-16	2014-15
Official Language Minority Communities have access to health care services in the official language of their choice.	% of health care professionals who successfully complete Health Canada funded training programs.*	70	March 31, 2017	72	73	N/A**
	% of program trained health professionals who are retained.***	86	March 31, 2017	71****	75****	87

*Refers to health professionals enrolled in language training programs in Quebec who successfully complete their training programs.

**Actual results are not available given that expected results and/or performance indicator methodology have changed over the specified fiscal years in support of continuous improvements to reporting on program results. The Department will continue to strengthen reporting to Canadians on results achieved as it implements the Treasury Board Policy on Results.

***Refers to students in French-language health programs (outside Quebec) who successfully complete their training programs and are retained in official language minority communities.

****The variance since 2014-15 is due to a change in methodology starting in 2015-16 whereby only the retention of graduates from French-language postsecondary training programs outside Quebec are included (and not graduates from language training programs in Quebec who are already included under the first indicator).

Budgetary financial resources (dollars)

2016–17 Main Estimates	2016–17 Planned Spending	2016-17 Total Authorities Available for Use	2016-17 Actual Spending (authorities used)	2016-17 Difference (actual minus planned)
38,093,638	38,093,638	38,085,206	37,435,684	-657,954

Note: The variance of $0.7M between actual and planned spending is mainly due to a change in anticipated staffing levels from plans due to personnel departures and delays in staffing vacant positions.

Human resources (FTEs)

2016–17 Planned	2016-17 Actual	2016-17 Difference (actual minus planned)
10	8	-2

Note: The variance of 2 in FTE utilization is mainly the result of management's efforts to stabilize and control salary requirements through personnel departures and delays in staffing vacant positions.

Strategic Outcome 2: Health risks and benefits associated with food products, substances, and environmental factors are appropriately managed and communicated to Canadians

Program 2.1: Health Products

Description

The Department of Health Act, and the Food and Drugs Act and Regulations provide the authority for Health Canada to develop, maintain, and implement a regulatory framework associated with a broad range of health products that affect the everyday lives of Canadians, including pharmaceutical drugs, biologics and radiopharmaceuticals, medical devices, and natural health products. Health Canada verifies that the regulatory requirements for the safety, quality, and efficacy of health products are met through risk assessments, including monitoring and surveillance, compliance, and enforcement activities. In addition, Health Canada provides evidence-based, authoritative information to Canadians and key stakeholders, including health professionals such as physicians, pharmacists and natural health practitioners, to enable them to make informed decisions. The program objective is to ensure that health products are safe, effective, and of high quality for Canadians.

> Did you know...
>
> Regulations came into force in March 2017 requiring drug companies experiencing shortages and discontinuances to publicly report them at DrugShortagesCanada.ca.

Results

In June 2016, Health Canada published a Notice of Intent to amend the Food and Drug Regulations and the Medical Devices Regulations in Canada Gazette announcing our intention to implement key authorities under the Protecting Canadians from Unsafe Drugs Act (Vanessa's Law). The proposed regulations are to be developed in phases and will be pre-published in Canada Gazette, Part I for consultation.

As part of the Regulatory Transparency and Openness Framework, Regulatory Decision Summaries, Summary Basis of Decision and Summary Safety Reviews have been made available in a searchable format in the Drug Health Products Register. The Licensed Natural Health Product Database and Medical Device Active Licenses Listing were also added to the register.

Also of note in 2016-17, Health Canada:

- Published a proposal seeking to amend the Food and Drug Regulations to improve the regulatory oversight of antimicrobials for veterinary use in Canada Gazette, Part I in July 2016;
- Engaged with government and non-government stakeholders through several workshops and meetings to identify and prioritize cell therapy issues;
- Published a Guidance Document that describes how Health Canada applies the authority to disclose confidential business information to eligible persons under the Food and Drug Act; and,
- Published a report of an online consultation on modernizing the regulation of self-care products in Canada in March 2017. This consultation builds on themes identified in the recommendations from the Evaluation of the Natural Health Products Program 2010-11 to 2014-15.

Results achieved

Expected Results	Performance Indicators	Target	Date to achieve target	Actual Results		
				2016-17	2015-16	2014-15
Health products available to Canadians on the Canadian market are safe, effective, and of high quality.	% of regulated parties who are deemed to be in compliance with the Food and Drugs Act and its associated Regulations. (Baseline 97)	95*	March 31, 2017	97	96	97

*The program will continue to monitor this target to ensure it remains appropriate.

Budgetary financial resources (dollars)

2016–17 Main Estimates	2016–17 Planned Spending	2016-17 Total Authorities Available for Use	2016-17 Actual Spending (authorities used)	2016-17 Difference (actual minus planned)
146,005,296	146,005,296	149,533,205	149,469,788	3,464,492

Note: The variance of $3.5M between actual and planned spending and between planned spending and total authorities is mainly due to revenues collected below authorities and pay list requirements.

Human resources (FTEs)

2016–17 Planned	2016-17 Actual	2016-17 Difference (actual minus planned)
1,922	1,733	-189

Note: The variance of 189 in FTE utilization is mainly due to the calculation of planned FTE figures being based on the Drugs and Medical Devices program using its full revenue authority. FTE utilization is a reflection of workforce requirements based on actual workload.

Program 2.2: Food Safety and Nutrition

Description

The Department of Health Act and the Food and Drugs Act provide the authority for Health Canada to develop, maintain, and implement a regulatory framework associated with the safety and nutritional quality of food. Food safety standards are enforced by the Canadian Food Inspection Agency. Health Canada develops and promotes evidence-based, national healthy eating policies and standards for Canadians and key stakeholders, including non-governmental organizations, health professionals, and industry associations, to enable all stakeholders to make informed decisions about food and nutrition safety as well as healthy eating. The program objectives are to manage risks to the health and safety of Canadians associated with food and its consumption, and to enable Canadians to make informed decisions about healthy eating.

> Did you know...
>
> Health Canada received almost 20,000 responses on its first consultation for Canada's Food Guide.

Results

As part of the Healthy Eating Strategy, Health Canada developed and consulted on a policy proposal to introduce a mandatory front-of-package labelling approach for foods high in nutrients of public health concern (i.e., sodium, sugars and saturated fat). The Department also published the final amendments to the Food and Drug Regulations on "Nutrition Labelling, Other Labelling Provisions, and Food Colours (formerly synthetic colours)" in the Canada Gazette, Part II in December 2016. These new requirements will make the labelling information on prepackaged food products more useful and easier to read for Canadians.

To address the ministerial priority regarding restricting the commercial marketing of unhealthy food and beverages to children, Health Canada hosted a roundtable with Canadian and international experts, and held several webinars with stakeholders to outline the policy considerations and the policy development considerations process.

Also of note in 2016-17, Health Canada:

- Collected information from the food industry on the use of partially hydrogenated oils (PHOs) in the food supply to inform a policy proposal to prohibit the use of PHOs in food;

- Conducted a targeted survey on sodium levels in select key food categories, held a symposium on sodium reduction in October 2016 and published a meeting report in February 2017; and,
- Held open stakeholder and public consultations on the revisions to Canada's Food Guide between October and December 2016.

In keeping with Canada's commitment of open government, the Department implemented a policy on transparency of stakeholder communications for the Healthy Eating Strategy initiatives. As part of this commitment, more information is being made available to the public such as a summary of comments received from consultations and What We Heard reports. Of note for this year, to enhance communication to Canadians, Health Canada published the "Evidence Review for Dietary Guidance: Summary of Results and Implications for Canada's Food Guide" report in June 2016, as recommended in the Evaluation of the Nutrition Policy and Promotion Program 2009-10 to 2014-15.

Results achieved

Expected Results	Performance Indicators	Target	Date to achieve target	Actual Results		
				2016-17	2015-16	2014-15
Policies, standards and guidelines exist that protect Canadians from identified risks in the Canadian food supply.	% of current and emerging high risk food safety issues which generate the development of either a regulatory or a non-regulatory response. (Baseline 100)	100	March 31, 2017	100	N/A*	N/A*

*Actual results from previous years are not available as this is a new performance indicator developed to enhance reporting on program results. The Department will continue to strengthen reporting to Canadians on results achieved as it implements the Treasury Board Policy on Results.

Budgetary financial resources (dollars)

2016–17 Main Estimates	2016–17 Planned Spending	2016-17 Total Authorities Available for Use	2016-17 Actual Spending (authorities used)	2016-17 Difference (actual minus planned)
68,562,778	68,562,778	71,165,659	69,079,818	517,040

Note: The variance of $0.5M between actual and planned spending is mainly due to an increase in requirements in the Healthy Eating Campaign and paylist requirements.

Human resources (FTEs)

2016–17 Planned	2016-17 Actual	2016-17 Difference (actual minus planned)
592	500	-92

Note: The variance of 92 in FTE utilization is mainly the result of management's efforts to stabilize and control salary requirements through personnel departures and delays in staffing vacant positions.

Program 2.3: Environmental Risks to Health

Description

The Canadian Environmental Protection Act (CEPA), 1999[iv], and the Department of Health Act provide the authorities for the Environmental Risks to Health program to assess and manage the health risks associated with climate change, air quality, drinking water quality, and new and existing substances. This program activity links closely with Health Canada's Health Products, Food Safety and Nutrition, Consumer Product Safety and Pesticides program activities, as the Food and Drugs Act, the Pest Control Products Act, and the Canada Consumer Product Safety Act provide the authority to manage the health risks associated with substances in products under the purview of these program activities. Key activities include: risk assessment and management, as well as research and bio monitoring of substances; provision of technical support for chemical emergencies that require a coordinated federal response; development of guidelines on indoor and outdoor air quality; development and dissemination of water quality guidelines; and provision of expert support related to environmental assessments and contaminated sites. The program objective is to protect the health of Canadians through the assessment and management of health risks associated with environmental contaminants, particularly substances, and to provide expert advice and guidelines to Canadians and Government partners on the health impacts of environmental factors such as air and water contaminants and a changing climate.

Results

Did you know…

In May 2016, Canada led the development and adoption of a World Health Assembly resolution calling on Ministries of Health worldwide to protect human health and the environment by strengthening their engagement in chemicals management. The resolution requested that the World Health Organization develop a roadmap outlining concrete actions to enhance health sector engagement to support the 2030 Sustainable Development Agenda. The roadmap was presented and adopted in May 2017.

Health Canada met its program objective of protecting the health of Canadians through the assessment and management of health risks associated with chemical substances and by providing expert advice and guidelines to partners on the health impacts of environmental factors such as air and water contaminants and a changing climate.

In 2016-17, Health Canada continued to implement the Chemicals Management Plan (CMP). The CMP's overall objective for existing substances is to assess the potential health and ecological risks associated with 4,363 substances that were identified through the risk prioritization of substances on the Domestic Substances List in the early 2000's by March 31, 2021. The third and final phase of the CMP, which

began in 2016-17 and runs until 2020-21, is intended to assess the approximately 1,550 substances remaining from the 2021 commitment. In 2016-17, Health Canada assessed 314 (or 20%) of these 1,550 targeted existing substances at the draft assessment stage. As of March 31, 2017, Health Canada has published final screening assessment reports for 2,653 substances (61% of 4,363); therefore, the cumulative total of substances assessed in either draft or final assessments is 3,073 (out of the 4,363 from all CMP phases), or 70%. In addition, four Science Approach Documents were published in 2016-17 covering 749 low concern CMP substances. Conclusions for these substances will be included in screening assessment reports at a later date. Health Canada is, therefore, well on its way to meeting its 2021 target for the assessment of existing substances.

In 2016-17, 100% of 37 existing substances which were assessed to be potentially harmful to human health and/or the environment had at least one risk management action taken under CEPA (1999) or another Act. As well, 100% (473) of new substances for which a notification of their manufacture or import had been received from industry were assessed within targeted timelines in 2016-17. As well, 100% (10) of new substances assessed to be harmful to human health also had control measures developed within mandated timeframes. The 10 substances that were risk managed represent 2% of new substances received from industry and assessed in 2016-17, which is consistent with historical levels. As well, following recommendations from the 2015-16 Evaluation of Phase 2 of the Chemicals Management Plan, in 2016-17, the program undertook actions to improve its performance tracking and its risk communications, including the development and implementation of a five-year planned outreach strategy.

Did you know…

The National Bio Monitoring program conducted under the Canadian Health Measures Survey is celebrating its 10th anniversary in 2017. Over the past decade, over 250 chemicals have been measured in 29,000 Canadians from three to 79 years of age, at 81 sites across Canada. The data are an important resource for assessing Canadians' exposure and informing risk assessment decisions and risk management actions under the Chemicals Management Plan.

In 2016-17, the Department continued to provide health science and guidance to support actions to address air quality and improve health. This included continued support for the development of Canadian Ambient Air Quality Standards, in collaboration with Environment and Climate Change Canada and the provinces and territories. New standards for sulphur dioxide were endorsed by the Canadian Council of Ministers of the Environment in October 2016, while the multi-stakeholder process to establish standards for nitrogen dioxide saw significant progress and is anticipated to conclude in 2017. Health Canada also completed significant health risk assessments on gasoline exhaust and on industrial emissions, and an assessment of the air quality impacts of shale gas. On indoor air, Health Canada proposed a new Residential Indoor Air Quality Guideline for acetaldehyde and contributed to two new product standards to address indoor air pollutants. Health Canada continued to conduct and publish leading research, including studies on the health impacts of wood smoke and how exposure to air pollution while pregnant may result in health impacts for the child.

Health Canada also protected the health of Canadians in 2016-17 by finalizing three health-based drinking water guidelines/guidance documents, which were approved by provinces/territories, and are used as the basis for drinking water quality requirements across Canada.

The Department continued to support the implementation of Heat Alert and Response Systems with partners across the country, including supporting a harmonized provincial system in Ontario. Several best practice and guidance documents were published in collaboration with partners, including community case studies on adapting to extreme heat and on identifying evidenced-based triggers for heat alerts. In addition, Health Canada provided support to the Pan-Canadian Framework on Clean Growth and Climate Change process to support integration of climate change-related health considerations.

Through its Environmental Assessment Program, Health Canada continued to provide its expert human health advice in the areas of noise, air/water quality, radiation and country/traditional foods and on reducing the potential risks from proposed major energy development projects (such as pipelines, mines, windfarms, electrical generation, etc.). Health Canada's Contaminated Sites Program also continued to provide expert support, scientific advice, training and tools to support the objectives and commitments of the Federal Contaminated Sites Action Plan, which aims to reduce human health risks and federal liabilities by assessing and mitigating legacy contaminated sites located across Canada.

17 air quality research projects were funded in 2016-17 to conduct research on the human health impacts of air pollution, the air quality health index program and indoor air quality management. These will contribute to the Addressing Air Pollution of the Government of Canada. For example, results from a study funded by Health Canada include a population-based cohort study which examined the incidence of dementia, Parkinson’s disease, and multiple sclerosis in relation to living near major roads. This new evidence suggests that the outdoor environment may be linked to certain neurological diseases in the Canadian population.

29 CMP health research, monitoring and surveillance projects were funded in 2016-17. For example, extensions of the Maternal-Infant Research on Environmental Chemicals (MIREC) Research Platform were approved to investigate potential associations between prenatal exposures and onset and progression of puberty and child metabolic health and obesity (MIREC-ENDO) and to measure additional chemicals in bio-banked maternal samples. In 2016-17, Health Canada continued analysis and publication of data resulting in six journal articles of bio monitoring results and 10 journal articles on the potential health effects of prenatal exposure to environmental chemicals.

Results achieved

Expected Results	Performance Indicators	Target	Date to achieve target	Actual Results		
				2016-17	2015-16	2014-15
Canadians and government partners have the guidance they need to respond to potential and actual environmental health risks.	% of planned guidance materials made available. (Baseline 93)	100	March 31, 2017	100	83	90
Substances deemed to be harmful to human health are risk managed according to the Canadian Environ-mental Protection Act (CEPA) (1999) and other "Best Placed Acts"*.	% of planned risk management actions taken under CEPA (1999) for new substances. (Baseline 96)	100	March 31, 2017	100	100	100
	% of planned risk management actions taken under CEPA (1999) or another Act for existing substances. (Baseline 96)	100	March 31, 2017	100	100	67

*"Best Placed Acts" refers to an approach that allows for the management of toxic substances under whichever Act is "best suited" to manage a substance, given its uses and exposures of concern.

Budgetary financial resources (dollars)

2016–17 Main Estimates	2016–17 Planned Spending	2016-17 Total Authorities Available for Use	2016-17 Actual Spending (authorities used)	2016-17 Difference (actual minus planned)
72,844,578	72,844,578	92,644,414	84,862,213	12,017,635

Note: The variance of $12M between actual and planned spending is mainly due to in-year resources received for Addressing Air Pollution and Clean Growth and Climate Change.

The variance of $19.8M between planned spending and total authorities is mainly due to in-year resources received for above-mentioned programs.

The variance of $7.8M between actual spending and total authorities is mainly due to a reallocation of resources within the Department to meet program needs and priorities, as well as the result of management's efforts to stabilize and control salary requirements through personnel departures and delays in staffing vacant positions.

Human resources (FTEs)

2016–17 Planned	2016-17 Actual	2016-17 Difference (actual minus planned)
597	553	-44

Note: The variance of 44 in FTE utilization is mainly due to a reallocation of resources within the Department to meet program needs and priorities, as well as the result of management's efforts to stabilize and control salary requirements through personnel departures and delays in staffing vacant positions.

Program 2.4: Consumer Product and Workplace Hazardous Materials

Description

The Consumer Product Safety and Workplace Hazardous Materials programs support efforts to protect Canadians from unsafe products and chemicals. The Consumer Product Safety program supports industry's responsibility for the safety of their products under the authorities of the Canada Consumer Product Safety Act and the Food and Drugs Act and its Cosmetic Regulations[v]. In addition, the program supports consumers' responsibility to make informed decisions about product purchase and use. Health Canada's efforts are focussed in three areas**:** active prevention; targeted oversight; and, rapid response. The Hazardous Products Act and the Hazardous Materials Information Review Act provide the authorities for the Workplace Hazardous Materials program to maintain a national hazard communication standard of cautionary labelling and safety data sheets for hazardous chemicals supplied for use in Canadian workplaces and to protect related confidential business information. The objectives of the programs are to identify, assess, manage and communicate health or safety risks to Canadians associated with consumer products and cosmetics, as well as to communicate the hazards of workplace chemicals.

Results

In 2016-17, Health Canada continued to implement the Food and Consumer Safety Action Plan, in part through the robust set of tools provided by the Canada Consumer Product Safety Act. Health Canada continued to monitor the efficiency of its risk management operational procedures, as recommended in the 2013-14 Evaluation of the Consumer Product Activities, to ensure prompt action is taken to reduce the risks posed by dangerous consumer products and cosmetics in the Canadian marketplace, which included working with industry to communicate 298 consumer product recalls to Canadians. Approximately one third of these recalls were released in coordination with regulatory partners such as the United States Consumer Product Safety Commission. In support of the Minister's priority of increased regulatory openness and transparency, Health Canada also continued posting the results of its cyclical enforcement activities and quarterly incident reporting on the Internet to make information readily available to Canadians.

Health Canada provided protection of industry confidential business information in accordance with the requirements of the Hazardous Materials Information Review Act, while also ensuring critical health and safety information was available to workers. Health Canada also published technical guidance to support the implementation of the Globally Harmonized System of classification and labelling of chemicals, and delivered on its commitments under the Regulatory Cooperation Council (RCC) work plan for workplace chemicals.

Health Canada triaged mandatory and voluntary incident reports to detect potentially unsafe consumer products and cosmetics at the earliest stage possible. In 2016-17, Health Canada received and processed 2779 reports (57% from industry, 43% from consumers).

One of the Consumer Product Safety Program's expected results is to ensure that targeted Canadian industries are aware of regulatory requirements related to consumer products and cosmetics. In 2016-17, the program found that 46% of targeted industry was reportedly aware, which was lower than the performance target of 95%; this decrease in performance is due to a change in data collection methodology, which now targets establishments that have not previously had any prior contact or interaction with the Consumer Product Safety Program. It is anticipated that this new targeted methodology will identify industries that may be unaware of the Canada Consumer Product Safety Act, allowing Health Canada additional opportunities to promote compliance to help industry meet its product safety requirements.

In June 2016, Health Canada introduced new regulations to improve the safety of cribs, cradles and bassinets for infants and young children. In December 2016, two amendments to existing regulations were proposed for public consultation, which included a new total content limit for cadmium, a reduced total limit for lead in children's jewellery, and a proposal to apply the total lead limits for a broadened scope of consumer products that children are likely to be in contact with during foreseeable use.

Did you know…

Following Health Canada's mandatory recall action to remove dangerous toys and novelty sets containing small, powerful magnets from the market, a peer reviewed study published in the March 2017 Journal of Pediatrics reported a significant reduction in the number of emergency room visits related to children who had ingested magnets.

To advance joint activities, inform decision-making and support product safety activities, Health Canada continued to work with its international counterparts, through participation in the International Consumer Product Health and Safety Organization Symposium, the Organisation for Economic Cooperation and Development, and the United Nations Sub-Committee on Classification and Labelling of Chemicals, as well as the RCC with respect to the work plan for workplace chemicals. Health Canada also recently renewed its action plan with China's Administration of Quality Supervision, Inspection and Quarantine, which was part of a renewed Memorandum of Understanding.

Results achieved

Expected Results	Performance Indicators	Target	Date to achieve target	Actual Results		
				2016-17	2015-16	2014-15
Risks associated with consumer products and cosmetics in the Canadian marketplace are managed.	% of non-compliant products identified through the Cyclical Enforcement Plan and incident reporting, for which risk management actions are completed within service standards. (Baseline 97)	85*	March 31, 2017	92	85	96
Suppliers are compliant with Canadian Workplace Hazardous Materials Information System 2015 requirements.	% of Safety Data Sheets (SDS) that are compliant as reviewed by Health Canada. (Baseline year 2017-18)	Baseline year 2017-18	Baseline year 2017-18	N/A**	N/A**	N/A**

*The target for 2016-17 was 85%, which reflected previous results. This target will be revisited moving forward given that past performance has consistently exceeded or met the established target.

**Actual results are not available as this is a new performance indicator developed to enhance reporting on program results. The Department will continue to strengthen reporting to Canadians on results achieved as it implements the Treasury Board Policy on Results.

Budgetary financial resources (dollars)

2016–17 Main Estimates	2016–17 Planned Spending	2016-17 Total Authorities Available for Use	2016-17 Actual Spending (authorities used)	2016-17 Difference (actual minus planned)
37,562,015	37,562,015	36,131,274	34,148,234	-3,413,781

Note: The variance of $3.4M between actual and planned spending is mainly due to a reallocation of resources within the Department to meet program needs and priorities.

Human resources (FTEs)

2016–17 Planned	2016-17 Actual	2016-17 Difference (actual minus planned)
295	289	-6

Note: The variance of 6 in FTE utilization is mainly the result of management's efforts to stabilize and control salary requirements through personnel departures and delays in staffing vacant positions.

Program 2.5: Problematic Substance Use[2]

Description

Under the authority of several Acts, the Problematic Substance Use program regulates tobacco products and controlled substances. Through the Tobacco Act and its regulations the program regulates the manufacture, sale, labelling and promotion of tobacco products. The program leads the Federal Tobacco Control Strategy, the goal of which is to further reduce the prevalence of smoking through regulatory, programming, educational and enforcement activities. Through the Controlled Drugs and Substances Act and its regulations, the program regulates access to controlled substances and precursor chemicals to support their legitimate use and minimize the risk of diversion for illicit use. As a partner department under the Canadian Drugs and Substances Strategy (CDSS)[3], the program supports prevention, health promotion, treatment initiatives, and enforcement with the goal of reducing problematic substance use, including problematic prescription drug use. In addition, the program provides timely, evidence-based information to key stakeholders including, but not limited to, law enforcement agencies, health professionals, provincial and territorial governments and Canadians. The program objective is to manage risks to the health of Canadians associated with the use of tobacco products, and the illicit use of controlled substances and precursor chemicals.

[2] Formerly Substance Use and Abuse.

[3] Replaced the National Anti-Drug Strategy.

Results

There are few other countries that have been as successful as Canada in lowering smoking rates and shifting public attitudes regarding tobacco. The 2015 results from the Canadian Tobacco, Alcohol and Drugs Survey found that 13% of Canadians were current cigarette smokers, a decrease from 15% in 2013 and down from 22% in 2001. The 2012-17 Federal Tobacco Control Strategy (FTCS) continues to make strides in moving forward with an aggressive policy and legislative agenda, aimed at strengthening the tobacco control framework in Canada.

> Did you know…
>
> In November 2016, a bill was introduced to create a new legislative regime to address the benefits and harms of vaping products. The bill contains provisions to protect youth from nicotine addiction and tobacco use, while allowing adult smokers legal access to a less harmful alternative to tobacco. The bill also supports the Government of Canada in delivering on its commitment to implement plain and standardized packaging for tobacco products. To ensure youth are protected from inducements to start smoking, Health Canada also developed new regulations that will ban menthol in 95% of tobacco products.

In November 2016, a bill was introduced to create a new legislative regime to address the potential benefits and harms of vaping products. The bill contains provisions to protect youth from nicotine addiction and tobacco use, while allowing adult smokers legal access to a less harmful alternative to tobacco. The bill also supports the Government of Canada in delivering on its commitment to implement plain and standardized packaging for tobacco products, and is consistent with the recommendation in the 2016-17 Evaluation of the Federal Tobacco Control Strategy 2012-13 to 2015-16.

Continuing Health Canada's efforts to limit the availability of flavoured tobacco products that are attractive to youth, Health Canada has also developed and consulted on new regulations to ban menthol in 95% of tobacco products. Since that time, regulations have come into force, effective October 2, 2017. Finally, to deliver on the ministerial priority to modernize the FTCS, Health Canada convened a National Forum in March 2017 attended by over 150 stakeholders to consult on an innovative long-term strategy. The involvement of Canadians, tobacco control stakeholders, and provinces and territories is a critical component in developing a bold new federal approach to tobacco control. Despite this success, there are over 3.9 million cigarette smokers in Canada. Current cigarette smoking is more prevalent among men (15.6%) than women (10.4%). Furthermore, the decline in the rate of cigarette smoking among youth has slowed down; in 2015, 10% of youth aged 15-19 were current cigarette smokers, a rate that is unchanged from 2013. Given the significant health, economic and social costs, Health Canada will continue to take decisive action to help protect young people and others from inducements to use tobacco products and to help Canadians who use tobacco to quit.

> What's new…
>
> The proposed Cannabis Act, Bill C-45, was introduced in the House of Commons on April 13, 2017. The Act sets out the framework to legalize, strictly regulate and restrict access to cannabis, in order to help keep it out of the hands of youth and keep profits out of the hands of criminals and organized crime.

Health Canada also conducted ongoing surveillance and monitoring through the Canadian Tobacco Alcohol and Drug Survey (CTADS) and Canadian Student Tobacco Alcohol and Drug Survey (CSTADS). The rate of use for some of the individual drugs included in the CTADS

increased for Canadians aged 15+, as compared to the previous reporting results. The prevalence of use of at least one of six illicit drugs (cannabis, cocaine or crack, speed, ecstasy, hallucinogens or heroin) in the past 12 months changed from 10.9% in 2013 to 12.6% in 2015, and was more prevalent among males than females (15.2% versus 10.0% in 2015). For school students (Grades 7 - 12), however, the rate of use of at least one of six illicit drugs (cannabis, amphetamines, MDMA (ecstasy), hallucinogens including salvia, heroin and cocaine) in the past 12 months decreased from 20.6% in 2012-13 to 17.6% in 2014-15. While the program's target for illicit drug use was not met for 2016-17, comprehensive efforts will be made in 2017-18 to further address this area using new authorities and activities now at the Department's disposal.

In 2016-17, Health Canada continued its ongoing efforts to address problematic substance use and the national opioid crisis through a targeted public health response under the pillars of prevention, treatment, harm reduction and enforcement. Health Canada made addressing the opioid crisis a top priority and implemented several activities under the Federal Action on Opioids, which was announced in June 2016 and was updated in the Joint Statement of Action to Address the Opioid Crisis at the Opioid Summit, co-hosted by Health Canada, on November 19, 2016. Through these federal actions, Health Canada and other federal departments committed to better informing Canadians about the risks of opioids; supporting better prescribing practices; reducing easy access to unnecessary opioids; supporting better treatment options for patients; and enhancing the evidence base upon which policy decisions are made. Specifically in 2016-17, Health Canada implemented a video campaign to share stories of Canadians affected by problematic substance use; made regulatory changes to schedule fentanyl precursors under the Controlled Drugs and Substances Act; amended regulations to enable access to diacetylmorphine (pharmaceutical grade heroin) through the Special Access Programme; supported the establishment of supervised consumption sites through legislative changes; took steps to facilitate access to naloxone and opioid substitutions; and co-hosted a Best Brains Exchange on how to develop a Canadian Drugs Observatory.

In addition to addressing the opioid crisis, Health Canada continued to modernize its overall approach with respect to controlled substances. On December 12, 2016, the Minister of Health announced the Government of Canada's new drug policy, the Canadian Drugs and Substances Strategy. This strategy replaces the National Anti-Drug Strategy with a new, more balanced and public health-focused approach. In December 2016, Health Canada also introduced Bill C-37, an Act to Amend the Controlled Drugs and Substances Act and to make Related Amendments to Other Acts, in the House of Commons, and the bill received Royal Assent on May 18, 2017. This legislation supports a more flexible, modern regulatory regime for controlled substances, and is designed to better equip both health and law enforcement officials to reduce the harms associated with problematic substance use in Canada.

Further, in 2016-17, Health Canada implemented a pilot for a new risk-based approach for pharmacy inspections. Under this new approach, more rigour and consistency are being applied through the use of standardized and improved risk criteria and compliance definitions. Due to this improved approach, Health Canada's Controlled Substances Program is anticipating that this more stringent approach will better facilitate the identification of targeted inspections in order to better respond to risks and emerging trends.

Health Canada also worked with the Department of Justice, the Department of Public Safety and with provincial/territorial governments on the legalization, strict regulation and restriction of access to cannabis, a ministerial priority. The proposed Cannabis Act (Bill C-45) was introduced

in the House of Commons on April 13, 2017, and sets out the strict framework for controlling the production, distribution, sales and possession of cannabis, in order to help keep it out of the hands of youth and to keep profits out of the hands of criminals and organized crime.

Results achieved

Expected Results	Performance Indicators	Target	Date to achieve target	Actual Results		
				2016-17	2015-16	2014-15
Decrease in current (daily and occasional) smoking prevalence.	% of Canadians (aged 15+) who smoke either daily or occasionally. (Baseline 15)	<15*	March 31, 2017	13**	N/A***	15****
	% of Canadians (grades 6-12) who smoke either daily or occasionally. (Baseline 4)	<4	March 31, 2017	3*** **	N/A***	4*** ***
Decrease in illicit drug use among Canadians.	% of Canadians (aged 15+) who report using at least one of six illicit drugs (cannabis, cocaine or crack, speed, ecstasy, hallucinogens or heroin). (Baseline 11)	<10	March 31, 2017	12.6*** *** *	N/A***	10.9****
	% of Canadians (grades 7-12) who report using at least one of six illicit drugs (cannabis, cocaine or crack, speed, ecstasy, hallucinogens	<21	March 31, 2017	17.6*** **	N/A***	21*** ***

Expected Results	Performance Indicators	Target	Date to achieve target	Actual Results		
				2016-17	2015-16	2014-15
	or heroin). (Baseline 21)					

*The targets for this program are all lower than the baselines because the objective is to decrease the percentage of Canadians who smoke and/or use illicit drugs; therefore, lower targets are desirable.

**Source. 2015 CTADS. Note: The CTADS is conducted biennially; the next survey is planned to be conducted in 2017, with new data available for reporting in 2018-19.

***Data are not available for this reporting year, as the CTADS/CSTADS are conducted biennially.

****Source. 2013 CTADS.

*** **Source. 2014-15 CSTADS. Note: This number refers to the 2014-15 CSTADS that was conducted from October 2014 to May 2015, and published in 2016-17. The CSTADS is conducted biennially; the next survey is planned to be conducted in 2016-17, with new data available for reporting in 2018-19.

*** ***Source. 2012-13 Youth Smoking Survey.

*** *** *Source. 2015 CTADS. Note: The CTADS is conducted biennially; the next survey is planned to be conducted in 2017, with new data available for reporting in 2018-19. The reported increase from the previous cycle (10.9% in 2013), in prevalence of use of at least one of six drugs, results from an increase in use of cannabis, hallucinogens and ecstasy: in 2015, the prevalence of past-year reported cannabis use was 12%, an increase compared to 2013 (11%); 1.2% reported using hallucinogens, an increase from 0.6% in 2013; and, almost one percent (0.7%) of Canadians reported using ecstasy, an increase from 0.4% in 2013. Given the Government's goal for legalizing, strictly regulating, and restricting access to cannabis, this indicator and target will be revisited.

Budgetary financial resources (dollars)

2016–17 Main Estimates	2016–17 Planned Spending	2016-17 Total Authorities Available for Use	2016-17 Actual Spending (authorities used)	2016-17 Difference (actual minus planned)
87,797,766	87,797,766	95,374,170	94,866,751	7,068,985

Note: The variance of $7.1M between actual and planned spending is mainly due to the costs for the preparation to regulate and legalize cannabis.

The variance of $7.6M between planned spending and total authorities is mainly due to a reallocation of resources within the Department to support the preparation to regulate and legalize cannabis.

Human resources (FTEs)

2016–17 Planned	2016-17 Actual	2016-17 Difference (actual minus planned)
394	522	128

Note: The variance of 128 in FTE utilization is mainly due to a reallocation of resources within the Department for the preparation to regulate and legalize cannabis and to ensure that deliverables related to Government of Canada tobacco priorities were met.

Program 2.6: Radiation Protection

Description

The Department of Health Act, the Radiation Emitting Devices Act, and the Comprehensive NuclearTest-Ban Treaty Implementation Act[vi] provide the authority for the Radiation Protection program to monitor, regulate, advise, and report on exposure to radiation that occurs both naturally and from man-made sources. In addition, the program is licensed under the Nuclear Safety and Control Act[vii] to deliver the National Dosimetry Service, which provides occupational radiation monitoring services. The key components of the program are environmental and occupational radiation monitoring; management of inter-organizational plans, procedures, capabilities and committees for a nuclear emergency that requires a coordinated federal response; delivering a national radon outreach program; and regulation of radiation emitting devices. The program objective is to inform and advise other Canadian government departments, collaborate with international partners, and inform Canadians about the health risks associated with radiation and strategies to manage associated risks.

Results

Health Canada is the lead federal department responsible for coordinating the response to a nuclear emergency under the Federal Nuclear Emergency Plan (FNEP). As part of a series of exercises to test the revised FNEP (FNEP, 5th edition), Health Canada participated in Exercise Huron Resolve in October 2016 with the Province of Ontario, other FNEP partners and an electricity generation company (Bruce Power), to test the response to an emergency at the Bruce Nuclear Generating Station. In addition, Health Canada also conducted a number of drills to identify any problems, inadequacies, or gaps in preparedness and response plans and operational arrangements so that issues may be resolved prior to a real emergency.

The Department continues to increase awareness on the risks, health impacts and mitigation strategies related to radon gas - the leading cause of lung cancer for non-smokers. Results from the Statistics Canada 2015 Households and the Environment Survey showed that Canadians' general awareness of radon increased (up to 55%, from 45% in 2013), and their ability to describe it continues to increase (up to 59%, from 53% in 2013). The percentage of households surveyed who had tested for radon increased only slightly (up to 6%, from 5% in 2013). To motivate behaviour change related to radon, Health Canada will focus efforts on encouraging the development of regional and community-based programs that promote radon testing. Health Canada will also collaborate with key stakeholder partners to target at-risk populations, such as smokers, low-income populations and areas of the country with high radon to promote testing and action to reduce radon exposure. Health Canada supported and participated in the 4th annual National Radon Action Month in November 2016 led by the Canadian Lung Association. Health Canada's National Radon outreach program participated in

> Did you know…
>
> Radiological health risk assessments and guidance for managing these risks were provided to the public, provincial/territorial authorities, federal government departments, and regulatory authorities within the Health Portfolio. This included interpretation and application of the Guidelines for Naturally Occurring Radioactive Materials (NORM), concerns about possible radiation exposures, and risk assessment for background radioactivity in imported goods.

over 150 outreach events, responded to over 1,200 public inquiries and distributed over 1.4 million radon outreach materials across Canada. The aim is to encourage all Canadians to test the levels of radon gas in their homes, and to reduce the radon levels, if necessary.

Environmental radioactivity surveillance data was posted to the Health Canada website (3600 new data points) and Open Data Canada website (6,129 new data points), which allows Canadians to view monthly summaries of various environmental radioactivity level data from across Canada, improving access to and understanding of their radioactivity exposure from natural and man-made sources. Following the 2016-17 Evaluation of Health Canada's Radiation Protection Activities 2010-11 to 2014-15, the program committed to enhancing public communications and data access by focusing on the timeliness of environmental radiation data postings on the Health Canada website.

The Department developed a regulatory proposal to amend the Dental X-Ray Equipment Standard of the Radiation Emitting Devices Regulations (Schedule II, Part II) to align the Canadian standard with the radiation safety requirements of new international standards and to reflect the current state of dental x-ray equipment design and technology. The proposed amendments were pre-published for public consultation in Canada Gazette, Part I in June 2016. Final amendments will be published in Canada Gazette, Part II next fiscal year (2017-18). Health Canada also published information on hand-held lasers and laser pointers. This guidance document informs Canadians about laser hazard classification and the concerns of using Class 3 B and 4 hand-held lasers and laser pointers. Furthermore, this guidance helps Canadians identify and reduce risks from laser pointers.

Did you know…

The report on the Canadian Computed Tomography (CT) Survey - National Diagnostic Reference Levels was published in June 2016. The report provides information to stakeholders on radiation levels from 75% of computed tomography equipment in Canada and helps make the most effective use of patient exposure readings from CT exams. The survey was conducted using a highly collaborative approach between Health Canada, provincial and territorial governments as well as medical associations and health care professionals.

Results achieved

Expected Results	Performance Indicators	Target	Date to achieve target	Actual Results		
				2016-17	2015-16	2014-15
Canadians, institutions and Government partners have the guidance they need to respond to potential and actual radiation risk.	% of targeted guidance documents accessed by Canadians, institutions and Government partners. (Baseline to be set in March 2017)	100	March 31, 2017	100	N/A*	N/A*

*Actual results for previous years are not available as this is a new performance indicator developed to enhance reporting on program results. The Department will continue to strengthen reporting to Canadians on results achieved as it implements the Treasury Board Policy on Results.

Budgetary financial resources (dollars)

2016–17 Main Estimates	2016–17 Planned Spending	2016-17 Total Authorities Available for Use	2016-17 Actual Spending (authorities used)	2016-17 Difference (actual minus planned)
13,148,978	13,148,978	20,084,261	19,866,574	6,717,596

Note: The variance of $6.7M between actual and planned spending is mainly due to in-year resources received for Addressing Air Pollution.

The variance of $6.9M between planned spending and total authorities is mainly due to in-year resources received for Addressing Air Pollution.

Human resources (FTEs)

2016–17 Planned	2016-17 Actual	2016-17 Difference (actual minus planned)
184	180	-4

Note: The variance of 4 in FTE utilization is mainly the result of management's efforts to stabilize and control salary requirements through personnel departures and delays in staffing vacant positions.

Program 2.7: Pesticides

Description

The Pest Control Products Act provides Health Canada with the authority to regulate and register pesticides under the Pesticides program. In the delivery of this program, Health Canada conducts activities that span the lifecycle of a pesticide, including: product assessment for health and environmental risks and product value; risk management; post-market surveillance, compliance and enforcement; changes in use, cancellation, or phase-out of products that do not meet current standards; and, consultations and public awareness building. Health Canada is also an active partner in international efforts (e.g., North American Free Trade Agreement; Organisation for Economic Co-operation and Development, Regulatory Cooperation Council) to align regulatory approaches. These engagements provide access to the best available science to support regulatory decisions and promote consistency in the assessment of pesticides. The program objective is to protect the health and safety of Canadians relating to the use of pesticides.

> What's new…
>
> In 2016-17, Health Canada completed work to implement a new cost recovery regime, effective April 1, 2017. Fees were updated to reflect the increased cost of doing business over the past 20 years. The Pest Control Products Fees Regulations will replace the former fee regulations for pest control products and were published in Canada Gazette, Part II on February 22, 2017.

Results

Health Canada continued to deliver on its responsibilities under the Pest Control Products Act through the evaluation and re-evaluation of pesticide products, compliance and enforcement, and outreach and risk reduction strategies. Health Canada maintained quality and exceeded performance targets on all core regulatory activities through prudent management of its pesticide program.

The Department has undertaken the necessary steps to improve the predictability and timeliness of the re-evaluation of registered pesticide products by publishing the Management of Pesticides Re-Evaluation Policy (DIR2016-04) and completed consultations with stakeholders on the Policy on Cancellations and Amendments Following Re-Evaluation and Special Review.

A five-year Strategic Plan was published, along with the development of a draft communication and outreach strategy in order to meet the commitments under Health Canada's Regulatory Transparency and Openness Framework, while continuing to build public confidence and awareness through transparent communication of pesticide-related regulatory decisions by maximizing the use of innovative approaches and social media. Both of these activities respond to recommendations outlined in the 2015 Evaluation of the Pesticide Program 2010-11 to 2013-14.

> Did you know…
>
> As part of its compliance and enforcement program, Health Canada began posting pesticide registrant inspection reports online in 2016. Users can now view the compliance ratings of registrants that are inspected by Health Canada inspectors in a searchable online database, furthering Health Canada's commitment to openness and transparency.

The Department published updates to the Pest Control Product Fees and Charges Regulations (including fee schedules) on February 22, 2017. With the new Cost Recovery Regime coming into force on April 1, 2017, Health Canada revised its business policies, processes for fee collection (applications and annual charges), and published a revised guidance document that reflected the changes under the new regime to ensure a smooth transition.

Finally, business requirements for all phases have been completed to advance the modernization of the electronic pesticide regulatory system (ePRS) through the Department's Investment Plan gating process, in support of the pesticide business environment.

Results achieved

Expected Results	Performance Indicators	Target	Date to achieve target	Actual Results		
				2016-17	2015-16	2014-15
Industry meets the Canadian regulatory requirements for new pesticides.	% of submissions that meet regulatory requirements. (Baseline 90)	80*	March 31, 2017	94	92	94
Pesticides in the marketplace continue to meet modern scientific standards.	% of re-evaluations initiated for registered pesticides according to the Re-Evaluation Work Plan. (Baseline 90)	80*	March 31, 2017	100	100	86
International collaboration is leveraged to maximize access to global science for the risk assessment of pesticides.	% of new pesticides reviewed in collaboration with international partners. (Baseline 90)	80*	March 31, 2017	100	100	100

*This target will be revisited moving forward given that past performance has consistently exceeded the established target.

Budgetary financial resources (dollars)

2016–17 Main Estimates	2016–17 Planned Spending	2016-17 Total Authorities Available for Use	2016-17 Actual Spending (authorities used)	2016-17 Difference (actual minus planned)
40,238,976	40,238,976	42,638,272	42,621,685	2,382,709

Note: The variance of $2.4M between actual and planned spending is mainly due to revenues collected in excess of authorities.

Human resources (FTEs)

2016–17 Planned	2016-17 Actual	2016-17 Difference (actual minus planned)
461	434	-27

Note: The variance of 27 in FTE utilization is mainly the result of management's efforts to stabilize and control salary requirements through personnel departures and delays in staffing vacant positions.

Strategic Outcome 3: First Nations and Inuit communities and individuals receive health services and benefits that are responsive to their needs so as to improve their health status

Program 3.1: First Nations and Inuit Primary Health Care

Description

The Department of Health Act and the Indian Health Policy (1979)[viii] provide the authority for the delivery of the First Nations and Inuit Primary Health Care program to First Nations and Inuit in Canada. Primary health care includes health promotion and disease prevention, public health protection (including surveillance), and primary care (where individuals are provided diagnostic, curative, rehabilitative, supportive, palliative/end of life care, and referral services). The Department administers contribution agreements and direct departmental spending related to child development, mental wellness and healthy living, communicable disease control and management, environmental health, clinical and client care, as well as home and community care. The program objective is to improve the health and safety of First Nations and Inuit individuals, families, and communities.

> Did you know…
>
> Health Canada implemented Jordan's Principle – A Child-First Initiative with over 13,994 products and services approved through the Service Access Resolution Fund (as of July 31, 2017).

Results

In 2016-17, Health Canada successfully supported the delivery of sustainable, quality health care programs and services in remote and isolated First Nations communities. To ensure access by First Nations communities to collaborative models of care, all nursing stations receiving Clinical and Client Care services directly from Health Canada had access to collaborative service delivery arrangements with external primary care providers. There has also been an increase of complementary health professionals, such as nurse practitioners, who are qualified to perform a broader scope of practice within clinical health care teams, as well as other professionals (e.g., paramedics). The inclusion of mental wellness teams, elders and others, such as occupational therapists, is expanding the services provided in communities.

In Budget 2017, the Government of Canada contributed an additional investment of $828 million over five years in maternal and child health, mental wellness, home and palliative care, primary care, infectious diseases, program, and drug strategy - harm reduction measures. Health Canada is working with First Nations and Inuit partners in all regions to strategically allocate these additional investments.

As part of the Government of Canada's commitment to work with Indigenous partners to support innovative and transformative health care solutions, an investment of $6M over five years was announced in Budget 2017 for demonstration projects to increase access to culturally-safe, healthy pregnancy-oriented midwifery services in First Nations and Inuit communities. Going forward in 2017-18, this investment will support engagement and planning processes to bring back Indigenous birthing practices closer to communities.

In response to the mental health crisis in First Nations and Inuit communities, immediate measures were put in place to enhance the suite of mental wellness services available to First Nations and Inuit people. These included: an increased number of mental wellness teams; capacity building and training, including trauma-informed approaches; a toll-free 24/7 culturally safe Hope for Wellness phone line; and, other crisis response measures. These investments build on the findings of the 2016 Evaluation of the First Nations and Inuit Mental Wellness Programs 2010-11 to 2014-15, which pointed to improved outcomes associated with the introduction of mental wellness teams and the integration of culture, but also noted ongoing gaps in areas such as crisis planning and response.

The 2016 evaluation also highlighted the ongoing need to support community capacity building and to continue implementation of the First Nations Mental Wellness Continuum Framework (FNMWCF). Consistent with these findings, the FNMWC Implementation Team developed two First Nations service delivery models - Crisis Response and Prevention, and Land-Based Programs - and a FNMWC Implementation Guide to assist communities in developing culture- and strength-based approaches to mental wellness that meet their local needs.

To improve the delivery of health services, a Monitoring and Performance Framework for Tuberculosis (TB) Programs for First Nations on-reserve was developed and implemented. This resulted in the assessment of communities for TB and the deployment of testing and case management tools to address any cases of TB, with a focus on high-risk communities.

The Department continued efforts to improve immunization coverage among First Nations living on-reserve by enhancing skills and knowledge. In addition to routine training in immunization competencies delivered at the regional level, enhanced specialized training was provided at a national event to over 40 First Nations and Inuit Health Branch licensed regional and front-line health care professionals. This specialized training focussed on the burden of vaccine preventable diseases in Indigenous populations, coverage assessment among First Nations living on-reserve, and best practices/success stories in delivering immunization programming in First Nations communities. In 2015, regional immunization programs reported an estimated overall coverage rate for Measles, Mumps and Rubella (MMR) vaccine of 81.5% in First Nations Communities on-reserve.

Health Canada worked collaboratively with the Public Health Agency of Canada, Indigenous Partner Organizations, and other partners to host an Indigenous Stakeholder engagement gathering to identify concrete actions to address Sexually Transmitted and Blood-Borne Infections (STIBBI) in Indigenous communities in Canada.

Health Canada continued to strengthen its collaboration with other federal departments responsible for early learning and child care on-reserve. This effort will inform the work underway with Indigenous partners and government departments to develop an Indigenous Early Learning and Child Care Framework to support the delivery of affordable, high quality, flexible and inclusive child care on-reserve.

The Department continued to deliver on the ministerial priority to support a renewed Nation-to-Nation relationship with First Nations and Métis and an Inuit to Crown relationship by working collaboratively with Indigenous and government stakeholders to advance reconciliation and shared priorities in the area of health which are also informed by the Truth and Reconciliation Commission health-related Calls to Action.

In addition, as part of the Government’s commitment to advance Indigenous self-determination, Health Canada has begun work with Indigenous partners to support innovative and transformative health care solutions through the advancement of community driven models that will transform the delivery of healthcare to Indigenous peoples. Health Canada is working collaboratively with partners to co-develop measures to strengthen the foundations of health systems, build capacity for Indigenous health governance and service delivery, and expand Indigenous control to advance self-determination in health.

Results achieved

Expected Results	Performance Indicators	Target	Date to achieve target	Actual Results		
				2016-17	2015-16	2014-15
First Nations and Inuit are healthy and safe.	% of First Nations living on-reserve and Inuit adults reporting being in excellent or very good health. (Baseline First Nations: 44.1; Inuit: 42.2)	45*	March 31, 2017	First Nations: 44.1** Inuit: 42.2***	First Nations: 44.1 Inuit: 42.2	First Nations: 44.1 Inuit: 42.2
	% of First Nations and Inuit who reported being injured in the past 12 months. (Baseline First Nations: 18.6; Inuit: 16.4)	15*** ***	March 31, 2025	First Nations: 18.6**** Inuit: 16.4*****	N/A*** *** *	N/A*** *** *
	Life expectancy of First Nations. (Baseline First Nations Males: 70.4; First Nations Females: 75.4)	First Nations Males: 71.2***** ** First Nations Females: 76.2*** *** **	March 31, 2025	First Nations Males: 76.4 First Nations Females: 79.3	N/A*** *** *	N/A*** *** *

*The percentage of First Nations living on-reserve who rate their health "excellent" or "very good" has increased by 10% since 2002-03. Achievement of this target (i.e. 45%) will represent an additional increase of 2%. The percentage of Canadians overall who rate their health as “excellent” or “very good” has remained relatively stable over the same period, at around 57%. Health Canada continues to work with partners to aim for the best health system and health outcomes for First Nations and Inuit. In some instances, annual targets do not represent the desired final outcome, but rather interim targets based on the best evidence available that Health Canada can monitor for progress, on an annual basis. Health Canada continues to monitor trends over time to support refinement of its targets and improved results achieved.

**More First Nations men (46.4%) than women (41.8%) reported thriving (excellent or very good) health. Data for this indicator is collected approximately every five years through the First Nations Regional Health Survey. Data in

this table represent results from the 2010 Regional Health Survey. Note that new Regional Health Survey data will be available in March 2018.

***More Inuit men (45.8%) than women (39.3%) reported thriving (excellent or very good) health. Data for this indicator is collected approximately every five years through the First Nations Regional Health Survey. Data in this table represent results from the 2010 Regional Health Survey. Note that new Regional Health Survey data will be available in March 2018.

****More First Nations men (21.3%) than women (15.8%) aged 18 or over reported being injured in the 12 months prior to the survey. Data for this indicator is collected approximately every five years through the First Nations Regional Health Survey. Data in this table represent results from the 2010 Regional Health Survey. Note that new Regional Health Survey data will be available in March 2018.

*** **More Inuit men (20.2%) than women (13.3%) aged 18 or over reported being injured in the 12 months prior to the survey. Data for this indicator is collected approximately every five years through the First Nations Regional Health Survey. Data in this table represent results from the 2010 Regional Health Survey. Note that new Regional Health Survey data will be available in March 2018.

*** ***The target is lower than the baseline as the objective is to decrease the percentage of First Nations and Inuit who report being injured in the last 12 months; therefore, a lower target is desirable.

*** *** *Actual results from previous years are not available as this is a new performance indicator developed to enhance reporting on program results. The Department will continue to strengthen reporting to Canadians on results achieved as it implements the Treasury Board Policy on Results.

*** *** **This target will be revisited moving forward given that past performance has consistently exceeded the established target.

Budgetary financial resources (dollars)

2016–17 Main Estimates	2016–17 Planned Spending	2016-17 Total Authorities Available for Use	2016-17 Actual Spending (authorities used)	2016-17 Difference (actual minus planned)
843,780,295	843,780,295	1,016,427,606	940,569,090	96,788,795

Note: The variance of $96.8M between actual and planned spending is mainly due to in-year resources received for the First Nations Water and Wastewater Action Plan, Mental Wellness Interventions and Service Enhancements for First Nations and Inuit, Nutrition North Canada, Clean Growth and Climate Change, Jordan's Principle - A Child First Initiative, and the Indian Residential Schools Resolution Health Support program.

The variance of $172.6M between planned spending and total authorities is mainly due to in-year resources received for the above-mentioned programs.

The variance of $75.9M between total authorities and actual spending is mainly the result of the re-profile of funds for Jordan's Principle - A Child First Initiative to support more First Nations children in need as they are identified.

Human resources (FTEs)

2016–17 Planned	2016-17 Actual	2016-17 Difference (actual minus planned)
1,352	1,363	11

Note: The variance of 11 in FTE utilization is mainly due to in-year resources received for the above mentioned programs.

Program 3.2: Supplementary Health Benefits for First Nations and Inuit

Description

Under the Supplementary Health Benefits for First Nations and Inuit program, the Non-Insured Health Benefits (NIHB) Program provides registered First Nations and recognized Inuit residents in Canada with a specified range of medically necessary health-related goods and services, which are not otherwise provided to eligible clients through other private or provincial/territorial programs. NIHB Program benefits include: pharmaceuticals; medical supplies and equipment; dental care; vision care; short-term crisis intervention mental health counselling; and, medical transportation to access medically required health services not available on-reserve or in the community of residence. Benefits are delivered through registered, private sector health benefits providers (e.g., pharmacists and dentists) and funded through NIHB's electronic claims processing system or through regional offices. Some benefits are also delivered via contribution agreements with First Nations and Inuit organizations and the territorial governments in Nunavut and Northwest Territories. The program objective is to provide benefits in a manner that contributes to the improved health status of First Nations and Inuit. This program uses funding from the following transfer payment: First Nations and Inuit Supplementary Health Benefits.

Results

Health Canada continued to engage First Nations and Inuit partners on improving the delivery of NIHB benefits. To advance recommendations and priorities identified through Joint Reviews with First Nations and Inuit partners, the NIHB Program has been: working with independent dental professionals to review coverage of preventative services; working to expand the mental health counselling benefit to include traditional healer services; expanding the medical transportation benefit to cover escorts for all pregnant women travelling for childbirth; and, establishing NIHB Navigator resources for Inuit clients in Nunavut and scoping requirements for an Inuit Navigator resource in the Northwest Territories.

Health Canada's NIHB Program continued its surveillance activities over the course of 2016-17 by monitoring prescribing patterns through a review of prescriptions claims data for Prescription Drug Abuse (PDA) drugs of concern. Since the implementation of dose limits for opioids (2013), benzodiazepines (2013), gabapentin (2013) and stimulants (2015), regular reviews of high-dose cases have been conducted by the NIHB Program to monitor the appropriate use of these drugs and to improve client safety. The Prescription Monitoring Program (PMP) continues to be an important component of the NIHB Program's PDA Strategy to increase client and community safety. Clients are monitored through the PMP, which also tracks clients that are receiving opioid addiction treatment. The NIHB Program also provides coverage for naloxone kits (to help treat opioid overdoses) as an open benefit (no prior approval required). Kits are dispensed by pharmacies under a prescription or provided as an "Over-the-Counter" benefit.

The NIHB Program has continued to provide claims processing and adjudication services on behalf of the British Columbia First Nation Health Authority (FNHA), ensuring continued access to pharmacy, dental, and medical supplies and equipment benefits by First Nations in British Columbia (BC). This has enabled the FNHA to focus on the development of its partnership with the BC Ministry of Health and to explore options for administration of the remaining NIHB areas to complete the transfer of responsibility for a health benefits program for BC First Nations. Please see Program 3.3: Health Infrastructure Support for First Nations and Inuit for progress on

the implementation of the BC Tripartite Framework Agreement on First Nations Health Governance.

Results achieved

Expected Results	Performance Indicators	Target	Date to achieve target	Actual Results		
				2016-17	2015-16	2014-15
First Nations and Inuit have access to non-insured health benefits.	% of eligible First Nations and Inuit population who accessed at least one Non-Insured Health Benefit. (Baseline 71.2)	72	March 31, 2017	71*	72**	71.2***
	% of eligible First Nations and Inuit clients accessing defined preventative dental services per year which includes scalings and fluoride applications. (Baseline 70.6)	71	March 31, 2017	71.9	N/A****	N/A****
Dental-Predeterminat ion Centre (DPC) requests are handled within a 10 day service standard.	% of DPC requests handled within a 10 day service standard. (Baseline 90)	95	March 31, 2017	65*** **	N/A****	N/A****

*Clients may have accessed benefits that are not entered into the claims processing system, and, therefore, may not be reflected in the results. More First Nations and Inuit women (77%) than men (64.7%) accessed at least one NIHB.

**More First Nations and Inuit women (76.5%) than men (64.6%) accessed at least one NIHB.

***More First Nations women (73%) than men (61.5%) accessed at least one NIHB.

****Actual results from previous years are not available as this is a new performance indicator developed to enhance reporting on program results. The Department will continue to strengthen reporting to Canadians on results achieved as it implements the Treasury Board Policy on Results.

*** **The DPC is working towards increasing its staffing complement to meet the established service standards.

Budgetary financial resources (dollars)

2016–17 Main Estimates	2016–17 Planned Spending	2016-17 Total Authorities Available for Use	2016-17 Actual Spending (authorities used)	2016-17 Difference (actual minus planned)
1,180,001,880	1,180,001,880	1,252,363,148	1,251,632,266	71,630,386

Note: The variance of $71.6M between actual and planned spending is mainly due to the demand driven nature of this program.

The variance of $72.4M between planned spending and total authorities is mainly due to in-year resources received, as well as a reallocation of resources from other First Nations and Inuit programs within this strategic outcome to support the NIHB Program.

The variance of $0.7M between total authorities and actual spending is mainly due to resources held frozen that are not available for use.

Human resources (FTEs)

2016–17 Planned	2016-17 Actual	2016-17 Difference (actual minus planned)
385	489	104

Note: The variance of 104 in FTE utilization is mainly due to FTEs reallocated from other First Nations and Inuit programs within this strategic outcome to support the NIHB Program.

Program 3.3: Health Infrastructure Support for First Nations and Inuit

Description

The Department of Health Act and the Indian Health Policy (1979) provide the authority for the Health Infrastructure Support for First Nations and Inuit program to administer contribution agreements and direct departmental spending to support the delivery of health programs and services. The program promotes First Nation and Inuit capacity to design, manage, deliver, and evaluate health programs and services. To better meet the unique health needs of First Nations and Inuit individuals, families, and communities this program also supports: innovation in health program and service-delivery; health governance partnerships between Health Canada, the provinces, and First Nation and provincial health services; and, improved integration of First Nation and provincial health services. The program objective is to help improve the health status of First Nations and Inuit people, to become comparable to that of the Canadian population over the long-term; and to help improve First Nations and Inuit capacity to influence and/or control the delivery of health programs and services to First Nations and Inuit individuals, families and communities.

Results

According to the 2016 Evaluation of the First Nations and Inuit Health Branch's Services Integration Fund 2010-11 to 2014-15, integration and alternative service delivery model projects brought multiple communities, stakeholders and partners together to collaborate on health services integration through partnership development, planning support, capacity building activities, and coordination of health services. These projects were found to contribute to a better understanding of the enabling factors and systemic barriers that impact First Nations' access to quality health services.

Did you know…

Health Canada supported First Nations health facility capital investment in 135 maintenance and minor repair projects; the design and construction of 42 major renovations to and/or expansions of major health facility capital projects; and, the repair and/or replacement of 29 facilities used by First Nations for the delivery of their Aboriginal Head Start on-Reserve program.

For example, First Nation organizations and communities are working together at the province-wide level in Saskatchewan, Manitoba and Quebec to propose new models to increase First Nations control over the design, decision-making and delivery of the health services that serve their communities. In Ontario, the Approaches to Community Wellness (ACW) model is a collaborative effort between the Sioux Lookout First Nations Health Authority (SLFNHA), Health Canada, the Province of Ontario and 31 First Nations communities. The ACW model will be implemented in phases over multiple years but significant progress has already been made on devolving the public health elements to the SLFNHA.

In addition to the alternative service delivery projects, Health Canada funded 53 integration projects in 2016-17 that aimed to improve the coordination and integration of federally and provincially funded health services for First Nations. These projects share in common the primary objective to increase the access to, and quality of, health services for First Nations and Inuit across the spectrum of care, including mental wellness, suicide prevention, chronic disease management, primary care, and renal health.

Health Canada actively engaged in trilateral tables across all regions to support greater collaboration with First Nations and Inuit organizations, and provincial and territorial governments, a ministerial priority. Activities for 2016-17 focussed on enhancing the quality and accessibility of health services through the development of joint health plans, to support greater control by First Nations and Inuit over health resources, and to coordinate collective responses to emerging health crises.

A total of 81 community health centres and four nursing stations (serving a total of 152 communities) are in the accreditation process to support the improvement of quality health services. A national standing offer was set up for regional offices to pursue accreditation of Health Canada-managed nursing stations.

In 2016-17, an Assembly of First Nations/First Nations and Inuit Health Branch Joint Forum was established and a joint Reporting and Health Planning work plan was developed. In addition, a review of existing material and development of new content for the Health Planning Guide was conducted in collaboration with First Nations representatives, regions, programs and consultants.

Efforts continued toward the development and integration of federal/provincial eHealth tools in order to improve access to and delivery of health services, including the implementation of 24 new telehealth sites and six Electronic Medical Records systems. Additional efforts to improve access to health care services through remote presence technologies (e.g., telerobotics etc.) in remote and isolated (R/I) First Nations and Inuit communities have been supported through the Budget 2017 announcement of $5M over five years to invest in digital health innovation. This approach aligns with the findings of the 2017 Evaluation of the e-Health Infostructure Program 2011-12 to 2015-16, which recommended advancing work with provinces, federal partners and other stakeholders to integrate e-Health tools into the delivery of health care services, and use internet connectivity to provide equitable access to underserved First Nations communities.

Health Canada supported the principles and practices of Gender-Based Analysis Plus (GBA+) by analysing disaggregated data based on ethnicity (Indigenous), gender and other intersecting identity factors to strengthen primary care and public health service delivery models and to better inform decision-making, performance measurement and reporting. In 2016-17, Health Canada continued to support the development of national surveys of Indigenous people living in Canada, such as the First Nations Regional Health Survey (RHS), and the Aboriginal Peoples Survey (APS).

As part of the work to respond to the Declaration of Public Health Emergencies, Health Canada in partnership with Nishnawbe Aski Nation (NAN) and the province of Ontario jointly identified and supported NAN health priorities and began the process of joint planning and strategy development for health system transformation. The Charter of Relationship Principles, an accountability document for the federal and provincial governments and NAN leadership was signed on July 24, 2017, by the Government of Canada, the Government of Ontario and the NAN. The Charter's principles ensure that partners better understand and commit to respectful action and processes towards a responsive and system-wide approach to health for communities in NAN territory. Health Canada will report on progress towards health system transformation in the Nishnawbe Aski Nation in the 2017-18 Departmental Results Report.

Health Canada continued to support the implementation of the BC Tripartite Framework Agreement on First Nations Health Governance, which included assisting the First Nations Health Authority in meeting its governance and accountability requirements.

Results achieved

Expected Results	Performance Indicators	Target	Date to achieve target	Actual Results		
				2016-17	2015-16	2014-15
First Nations and Inuit are collaborating with federal, provincial and territorial partners in the delivery of health programs and	# of new inter-jurisdictional health agreements or arrangements that address health system access, quality of	2	March 31, 2017	4*	N/A**	N/A**

Expected Results	Performance Indicators	Target	Date to achieve target	Actual Results		
				2016-17	2015-16	2014-15
services.	care, or data sharing (Baseline 0)					
	% of activities of the provincial/ territorial trilateral health committees' joint work plans that are completed on time. (Baseline: First data collection has not yet occurred)	66	March 31, 2017	N/A***	N/A***	N/A***
First Nations and Inuit are able to influence and/or control (design, deliver and manage) health programs and services.	% of First Nations and Inuit communities assuming control over the design, delivery and management of health programs and services. (Baseline 70)	80	March 31, 2017	80	75	76.6

*This result is based upon the data available at the time of this report.

**Actual results for previous years are not available as this is a new performance indicator developed to enhance reporting on program results. The Department will continue to strengthen reporting to Canadians on results achieved as it implements the Treasury Board Policy on Results.

***Data for this indicator are not available. This indicator will be retired in Health Canada's performance reporting starting in 2018-19.

Budgetary financial resources (dollars)

2016–17 Main Estimates	2016–17 Planned Spending	2016-17 Total Authorities Available for Use	2016-17 Actual Spending (authorities used)	2016-17 Difference (actual minus planned)
683,792,972	683,792,972	790,081,621	781,886,051	98,093,079

Note: The variance of $98.1M between actual and planned spending is mainly due to in-year resources received for Social Infrastructure and a reallocation of resources from other programs within this strategic outcome to meet program needs and priorities.

The variance of $106.3M between planned spending and total authorities is mainly due to the above-mentioned in-year resources received to make essential and priority investment in First Nations and Inuit Health infrastructures.

Human resources (FTEs)

2016–17 Planned	2016-17 Actual	2016-17 Difference (actual minus planned)
229	183	-46

Note: The variance of 46 in FTE utilization is mainly due to a reallocation of resources to meet program needs and priorities.

[ix]Supporting information on results, financial and human resources relating to Health Canada's lower-level programs is available on TBS InfoBase and on the departmental website[x].

Internal Services

Description

Internal Services are those groups of related activities and resources that the federal government considers to be services in support of programs to meet corporate obligations of an organization. Internal Services refers to the activities and resources of the 10 distinct service categories that support Program delivery in the organization, regardless of the Internal Services delivery model in a department. The 10 service categories are: Management and Oversight Services; Communications Services; Legal Services; Human Resources Management Services; Financial Management Services; Information Management Services; Information Technology Services; Real Property Services; Materiel Services; and Acquisition Services.

Results

Advances in key internal services initiatives were made in 2016-17 which helped the Department to fulfill its organizational priority commitment to recruit, maintain and foster an engaged, high performing and diverse workforce.

Human Resources

The Department continued to support a culture of high performance through various initiatives such as the Performance Management Initiative and the Post-Secondary Recruitment Program. The completion rate in the Department for performance management year-end assessments was 86%, well above the public service average. Health Canada hired 177 new employees in 2016-17 through the Post-Secondary Recruitment Program, achieving 136% of the yearly target.

The Department continued the implementation of initiatives such as the Multi-Year Diversity and Employment Equity Plan, which raised awareness of the importance of promoting a diverse, inclusive and respectful workplace and supporting open mental health dialogue. Representation rates for women, Indigenous peoples, persons with disabilities and visible minorities continue to be represented at levels exceeding their respective availability in the labour market.

Health Canada also continued its work in support of the Multi-Year Strategy for Mental Health and Wellness in the Workplace, which saw a number of initiatives taking place throughout the Department in 2016-17, including the implementation of National Standard for Psychological Health and Safety in the Workplace action plans and the delivery of Mental Health First Aid sessions. In 2016-17, 126 sessions were offered and approximately 2,240 employees participated, bringing the total number of Health Canada employees successfully completing sessions to over 4,300.

In its first year of operation, the independent Ombudsman, Integrity and Resolution Office (OIRO) supported a high-performing and healthy workforce. OIRO interacted with approximately 30% of Health Canada employees through training and other intervention services.

Real Property, Information Management and Information Technology

The multi-departmental single window project to increase usage of a single window through which importers can electronically submit information necessary to comply with government import regulations [led by the Canada Border Services Agency (CBSA)] was officially closed on March 31, 2017. Health Canada, along with CBSA and other participating government departments, engaged with industry multiple times throughout the year and anticipate live transactions to begin by fall 2017. A final release is set for production in June 2017 that will improve reporting and implement some enhancements to the system. National retraining for users is planned for August and September of 2017 to prepare for live transactions.

The Department made progress in modernizing the workplace with continued implementation of a number of projects, including: modernized workspaces, kitchenettes, meeting rooms and collaborative areas; preliminary work on the implementation of the GCDOCS records management system including a pilot project; and, continued work with Public Services and Procurement Canada to address current pay modernization challenges which impact the implementation of the My Government of Canada Human Resources system.

Management and Oversight

The Department is in its fourth year of ongoing monitoring for internal control over financial reporting. Key financial controls have also been audited each year for the past six years. All the recommendations from previous years' audits have been fully implemented. The Department has further standardized transfer payments transactions across the regions by implementing a common Grants and Contributions Information Management System supported by Indigenous and Northern Affairs Canada. Health Canada has also continued to meet or exceed performance metrics across all areas of financial management.

Did you know…

Health Canada continues to innovate in its processes and systems for financial operations and management. The Department successfully implemented a new procurement process that includes full electronic authorizations. Health Canada will move to the next iteration of the SAP financial platform, which will introduce a model for the integration of operational and financial information to support decision-making.

The 2016-17 Management Accountability Framework results indicate that the Department fared well in the area of Management of Acquired Services and Assets for strong overall procurement practices and materiel management strategies.

The Treasury Board Secretariat (TBS) also stated that Health Canada appears to be in a good position to ensure implementation of the Government's Delivery and Results Agenda and the new TBS Policy on Results given the governance and processes that have been established.

The Department has mobilized branch resources to develop a new results framework and supporting program profiles. Performance information within these structures is aligned and tells a coherent story about the results Health Canada is achieving for Canadians. Implementing the Policy will improve the quality, availability, and utility of the Department's performance information.

Health Canada continued work to develop and implement an enterprise-wide system that integrates operational and financial information to facilitate informed departmental financial and program decision-making.

Communications

Health Canada worked to ensure that Canadians had access to the information they needed to take action on their health and safety. Throughout the past year, the Department developed numerous initiatives to engage and inform Canadians and to support the Minister in communicating with the public.

The Department took a digital first approach on a number of files, including Indigenous health, health care systems, cannabis legalization and regulation, self-care and healthy eating. Health Canada developed innovative communications products and services, including social marketing campaigns and initiatives to help raise awareness and knowledge of key health and safety issues such as problematic prescription drug use (focusing on opioids), tobacco cessation and nutrition labelling.

Health Canada used business intelligence gathered from sources such as media monitoring, social media performance, and analysis of media habits of target audiences to inform decisions on how to better communicate with clients, stakeholders and Canadians on matters affecting them. Health Canada also conducts consultations to ensure the views of Canadians and stakeholders are considered in its policies, programs and services.

Did you know…

Healthy Canadians social media posts were viewed more than 44 million times. This year this included:

- 1,904 Facebook posts
- 4,881 tweets
- 56 new YouTube videos

Budgetary financial resources (dollars)

2016–17 Main Estimates	2016–17 Planned Spending	2016-17 Total Authorities Available for Use	2016-17 Actual Spending (authorities used)	2016-17 Difference (actual minus planned)
265,223,547	265,223,547	317,645,591	303,735,385	38,511,838

Note: The variance of $38.5M between actual and planned spending is mainly due to in-year resources received from the operating budget carry forward used in part to fund investment projects in Information Management/Information Technology and Real Property, and internal services resources received from various Treasury Board-approved initiatives.

The variance of $13.9M between total authorities and actual spending is mainly due to changes in the timing of investment plan projects.

Human resources (full-time equivalents [FTEs])

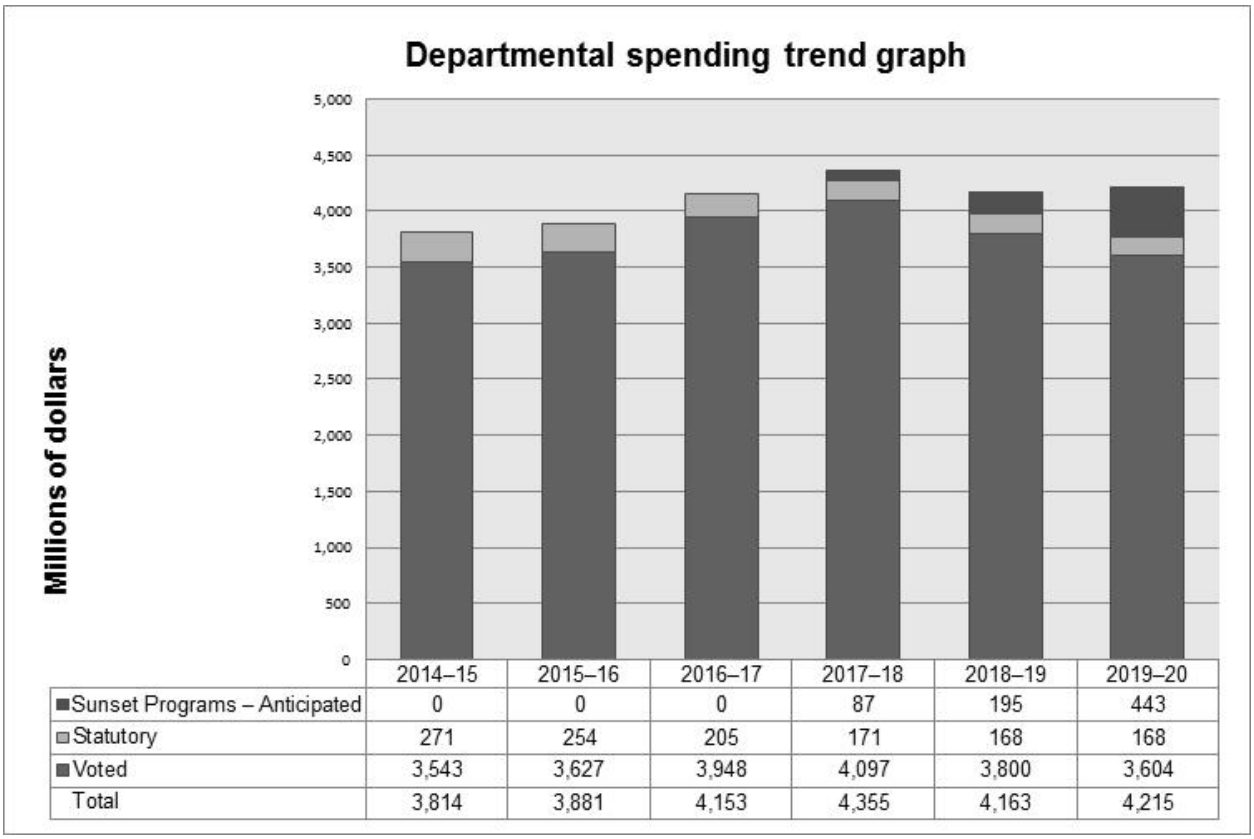
2016–17 Planned	2016-17 Actual	2016-17 Difference (actual minus planned)
1,994	2,243	249

Note: The variance of 249 in FTE utilization is mainly due a combination of the transfer of FTEs to Health Canada from Public Health Agency of Canada which is associated with the health portfolio Shared Services Partnership model and additional resources received in-year for the internal support services from various Treasury Board-approved initiatives.

Analysis of trends in spending and human resources

Actual expenditures

Departmental Spending Trend



	2014–15	2015–16	2016–17	2017–18	2018–19	2019–20
Sunset Programs – Anticipated	0	0	0	87	195	443
Statutory	271	254	205	171	168	168
Voted	3,543	3,627	3,948	4,097	3,800	3,604
Total	3,814	3,881	4,153	4,355	4,163	4,215

Budgetary performance summary for Programs and Internal Services (dollars)

Programs and Internal Services	2016–17 Main Estimates	2016–17 Planned Spending	2017–18 Planned Spending	2018–19 Planned Spending	2016–17 Total Authorities Available for Use	2016–17 Actual Spending (authorities used)	2015–16 Actual Spending (authorities used)	2014–15 Actual Spending (authorities used)
Strategic Outcome 1: A health system responsive to the needs of Canadians								
1.1 Canadian Health System Policy	260,866,701	260,866,701	297,012,268	270,905,619	331,314,881	329,454,933	329,580,184	334,273,289
1.2 Specialized Health Services	18,685,517	18,685,517	18,326,068	18,325,867	14,921,829	13,588,652	15,260,199	13,650,940
1.3 Official Language Minority Community Develop-ment	38,093,638	38,093,638	35,328,730	35,328,730	38,085,206	37,435,684	37,221,431	36,653,712
Strategic Outcome 2: Health risks and benefits associated with food, products, substances, and environmental factors are appropriately managed and communicated to Canadians								
2.1 Health Products	146,005,296	146,005,296	147,322,313	147,770,952	149,533,205	149,469,788	145,641,623	166,617,222
2.2 Food Safety and Nutrition	68,562,778	68,562,778	67,881,855	67,333,133	71,165,659	69,079,818	63,941,395	66,365,087
2.3 Environ-mental Risks to Health	72,844,578	72,844,578	96,356,868	88,905,975	92,644,414	84,862,213	87,559,410	97,967,114
2.4 Consumer Product and Workplace Hazardous Materials	37,562,015	37,562,015	38,015,185	38,010,419	36,131,274	34,148,234	34,513,091	34,325,604
2.5 Problematic Substance Use.[4]	87,797,766	87,797,766	88,941,061	87,966,715	95,374,170	94,866,751	84,450,294	69,339,368

[4] Formerly Substance Use and Abuse

Programs and Internal Services	2016–17 Main Estimates	2016–17 Planned Spending	2017–18 Planned Spending	2018–19 Planned Spending	2016–17 Total Authorities Available for Use	2016–17 Actual Spending (authorities used)	2015–16 Actual Spending (authorities used)	2014–15 Actual Spending (authorities used)
2.6 Radiation Protection	13,148,978	13,148,978	18,294,915	12,757,653	20,084,261	19,866,574	20,871,026	20,709,033
2.7 Pesticides	40,238,976	40,238,976	39,983,502	36,761,642	42,638,272	42,621,685	41,360,034	44,319,169
Strategic Outcome 3: First Nations and Inuit communities and individuals receive health services and benefits that are responsive to their needs so as to improve their health status								
3.1 First Nations and Inuit Primary Health Care	843,780,295	843,780,295	1,099,570,276	1,009,855,421	1,016,427,606	940,569,090	888,041,558	870,774,017
3.2 Supplementary Health Benefits for First Nations and Inuit	1,180,001,880	1,180,001,880	1,238,036,465	1,181,106,370	1,252,363,148	1,251,632,266	1,138,729,982	1,075,694,038
3.3 Health Infrastructure Support for First Nations and Inuit	683,792,972	683,792,972	796,373,302	724,055,660	790,081,621	781,886,051	672,276,324	640,190,204
Subtotal	**3,491,381,390**	**3,491,381,390**	**3,981,442,808**	**3,719,084,156**	**3,950,765,546**	**3,849,481,739**	**3,559,446,551**	**3,470,878,797**
Internal Services	265,223,547	265,223,547	286,918,200	248,785,416	317,645,591	303,735,385	321,685,601	343,595,169
Total	**3,756,604,937**	**3,756,604,937**	**4,268,361,008**	**3,967,869,572**	**4,268,411,137**	**4,153,217,124**	**3,881,132,152**	**3,814,473,966**

Note: At the outset of the 2016-17 fiscal year, Health Canada's planned spending was $3,756.6M. Additional in-year funding received for Treasury Board approved initiatives and the operating and capital budget carry forwards, increased Health Canada's total authorities to $4,268.4M. The Department's actual spending for the fiscal year was $4,153.2M.

The additional funding received during 2016-17 relates mainly to the following initiatives: Social Infrastructure, Jordan's Principle - A Child First Initiative, Indian Residential Schools Resolution Health Support program, Non-Insured Health Benefits for First Nations and Inuit, First Nations Water and Wastewater Action Plan, Canada Health Infoway, and Mental Wellness Interventions and Service Enhancements for First Nations and Inuit.

The variance of $115.2M between total authorities and actual spending in 2016-17 is mainly the result of the re-profile for Jordan's Principle - A Child First Initiative to support more First Nations children in need, as they are identified, and a portion of the operating budget was carried forward to support strategic investments in 2017-18.

Actual human resources

Human resources summary for Programs and Internal Services (full-time equivalents [FTEs])

Programs and Internal Services	2014–15 Actual	2015–16 Actual	2016–17 planned	2016–17 Actual	2017–18 Planned	2018–19 Planned
Strategic Outcome 1: A health system responsive to the needs of Canadians						
1.1 Canadian Health System Policy	182	175	238	177	238	238
1.2 Specialized Health Services	181	179	260	178	255	255
1.3 Official Language Minority Community Development	8	7	10	8	10	10
Strategic Outcome 2: Health risks and benefits associated with food, products, substances, and environmental factors are appropriately managed and communicated to Canadians						
2.1 Health Products	1,764	1,763	1,923	1,733	1,974	1,983
2.2 Food Safety and Nutrition	502	500	596	500	602	598
2.3 Environmental Risks to Health	588	561	712	553	720	683
2.4 Consumer Product and Workplace Hazardous Materials	295	290	295	289	305	305
2.5 Problematic Substance Use.[5]	409	476	393	522	415	415

[5] Formerly Substance Use and Abuse

Programs and Internal Services	2014–15 Actual	2015–16 Actual	2016–17 planned	2016–17 Actual	2017–18 Planned	2018–19 Planned
2.6 Radiation Protection	195	192	202	180	202	184
2.7 Pesticides	416	428	461	434	489	464
Strategic Outcome 3: First Nations and Inuit communities and individuals receive health services and benefits that are responsive to their needs so as to improve their health status						
3.1 First Nations and Inuit Primary Health Care	1,361	1,337	1,447	1,363	1,436	1,346
3.2 Supplementary Health Benefits for First Nations and Inuit	449	473	385	489	460	460
3.3 Health Infrastructure Support for First Nations and Inuit	190	188	235	183	187	170
Subtotal	6,540	6,569	7,157	6,609	7,293	7,111
Internal services	2,216	2,171	2,051	2,243	1,968	1,917
Total	8,756	8,740	9,208	8,852	9,261	9,028

Note: For the 2014-15 to 2016-17 periods, FTEs are based on actual utilization of personnel. The 2016-17 Forecast is based on total authorities from all Parliamentary appropriation sources: Main Estimates and Supplementary Estimates.

The variance between 2015-16 Actuals and 2016-17 Forecast FTEs is mainly due to management's efforts to stabilize and control future salary requirements through personnel departures and delays in staffing vacant positions, and resources being realigned from initial plans in order to meet program needs. In addition, the calculation of Forecasted FTE figures is based on programs using their full revenue authority.

The variance between the 2016-17 Forecast and Actual FTEs is mainly due to Planned FTE figures being based on the Department using its full revenue authority. FTE utilization is a reflection of workforce requirements based on actual workload. Management took steps to stabilize and control salary requirements through personnel departures and delays in staffing vacant positions.

The increase in the 2017-18 Planned FTEs is mainly due to funding level increases related to Jordan's Principle - A Child-First Initiative and additional revenue authority for Pesticides.

The decrease in the 2018-19 Planned FTEs is mainly due to the expiry of authorities related to the Indian Residential Schools Resolution Health Support program, First Nations Water and Wastewater Action Plan, Social Infrastructure, Federal Infrastructure, and Addressing Air Pollution.

Expenditures by vote

For information on Health Canada's organizational voted and statutory expenditures, consult the Public Accounts of Canada 2017.[xi]

Alignment of spending with the whole-of-Government framework

Alignment of 2016–17 planned spending with the whole-of-Government framework[xii] (dollars)

Program	Spending Area	Government of Canada activity	2016–17 Actual Spending
1.1 Canadian Health System Policy	Social Affairs	Healthy Canadians	329,454,933
1.2 Specialized Health Services	Social Affairs	Healthy Canadians	13,588,652
1.3 Official Language Minority Community Development	Social Affairs	Healthy Canadians	37,435,684
2.1 Health Products	Social Affairs	Healthy Canadians	149,469,788
2.2 Food Safety and Nutrition	Social Affairs	Healthy Canadians	69,079,818
2.3 Environmental Risks to Health	Social Affairs	Healthy Canadians	84,862,213
2.4 Consumer Product and Workplace Hazardous Materials	Social Affairs	Healthy Canadians	34,148,234
2.5 Problematic Substance Use [6]	Social Affairs	Healthy Canadians	94,866,751
2.6 Radiation Protection	Social Affairs	Healthy Canadians	19,866,574
2.7 Pesticides	Social Affairs	Healthy Canadians	42,621,685
3.1 First Nations and Inuit Primary Health Care	Social Affairs	Healthy Canadians	940,569,090
3.2 Supplementary Health Benefits for First	Social Affairs	Healthy Canadians	1,251,632,266

[6] Formerly Substance Use and Abuse.

Program	Spending Area	Government of Canada activity	2016–17 Actual Spending
Nations and Inuit			
3.3 Health Infrastructure Support for First Nations and Inuit	Social Affairs	Healthy Canadians	781,886,051

Total spending by spending area (dollars)

Spending area	Total planned spending	Total actual spending
Economic affairs	0	0
Social affairs	3,491,381,390	3,849,481,739
International affairs	0	0
Government affairs	0	0

Financial statements and financial statements highlights

Financial statements

Health Canada's financial statements [unaudited] for the year ended March 31, 2017, are available on Health Canada's web site[xiii].

Financial Statements Highlights

Condensed Statement of Operations (unaudited) for the year ended March 31, 2017 (dollars)

Financial information	2016–17 Planned results	2016–17 Actual	2015–16 Actual	Difference (2016–17 actual minus 2016–17 planned)	Difference (2016–17 actual minus 2015–16 actual)
Total expenses	4,143,838,000	4,496,980,000	4,147,755,000	353,142,000	349,225,000
Total revenues	341,125,000	301,042,000	292,034,000	(40,083,000)	9,008,000
Net cost of operations before government funding and transfers	3,802,713,000	4,195,938,000	3,855,721,000	393,225,000	340,217,000

The Department's total expenses were $4.5B in 2016-17.

There was an increase of $353.1M when comparing actual expenditures to planned results for 2016-17. This is primarily a result of an increase in funding for: annual growth to First Nations and Inuit Health programs and services; Federal Infrastructure; Social Infrastructure; Jordan's Principle – A Child First Initiative; Canada Health Infoway; Canadian Foundation for Healthcare Improvement; Mental Wellness Interventions and Service Enhancements for First Nations and Inuit; and the Canada Brain Research Fund.

There was an increase of approximately $349.2M when comparing year-over-year actual expenditures. The significant changes were:

- an increase of $185.1M in transfer payments due primarily to annual growth in First Nations and Inuit Health programs and services, and incremental funding for: social infrastructure projects, Jordan's Principle – A Child First Initiative, Canada Health Infoway, Canadian Foundation for Healthcare Improvement, Mental Wellness Interventions and Service Enhancements for First Nations and Inuit, and the Canada Brain Research Fund;
- an increase of $60.5M in other expenses primarily as a result of the provision for contingent liabilities;
- an increase of $42.2M in utilities, materials and supplies mainly due to an increased demand in the provision of pharmacy and medical supplies and equipment benefits to First Nations and Inuit under the Non-Insured Health Benefits (NIHB) Program;
- an increase of $34.3M in the cost of operational expenditures associated with travel for NIHB clients as a result of increased costs of transportation and a higher demand experienced during the year as compared with the prior year;
- an increase of $29.5M in professional and special services primarily related to the NIHB Program as these expenses are demand-driven and can vary from year-to-year; and,

- a decrease of $6.6M in salaries and employee benefits largely due to a decrease in the provision for severance pay.

The Department's total revenues were $301.0M in 2016-17 representing a decrease of $40.1M from planned results and an increase of $9.0M over the prior year actual revenues. This year-over-year variance is primarily a result of increased accrued revenues for services of a regulatory nature from a higher volume of applications for drug submissions.

Condensed Statement of Financial Position (unaudited) as at March 31, 2017 (dollars)

Financial Information	2016–17	2015–16	Difference (2016–17 minus 2015–16)
Total net liabilities	497,243,000	462,633,000	34,610,000
Total net financial assets	305,331,000	283,342,000	21,989,000
Departmental net debt	191,912,000	179,291,000	12,621,000
Total non-financial assets	141,057,000	135,225,000	5,832,000
Departmental net financial position	(50,855,000)	(44,066,000)	(6,789,000)

Total net liabilities were $497.2M at the end of 2016-17, representing an increase of $34.6M from the previous year. This variance is comprised mainly of an increase of $60.5M in the provision for contingent liabilities, an $11.8M increase in external year-end payables recorded, primarily as a result of problems with the new government payroll system and increased transfer payments, a $6.3M increase in accrued salaries and wages, and a $3.9M increase in the liability for vacation pay. These increases were partially offset by $38.0M reduction in the liability to Canada Health Infoway Inc. originating from the 2007 and 2009 Budgets and $11.9M decrease in employee future benefits resulting from a lower factor prescribed by the Treasury Board Secretariat to estimate the severance benefit liability.

The year-over-year increase in total net financial assets of $22.0M is primarily a result of an increase in accounts receivable and employee advances arising from implementation of the new government pay system.

Total non-financial assets increased $5.8M resulting from capital asset acquisitions net of amortization.

Supplementary information

Corporate information

Organizational profile

Appropriate Minister: The Honourable Ginette Petitpas Taylor, P.C., M.P.

Institutional Head: Simon Kennedy

Ministerial Portfolio: Health

Enabling Instrument(s): Canada Health Act[xiv], Canada Consumer Product Safety Act[xv],, Controlled Drugs and Substances Act[xvi], Food and Drugs Act[xvii], Tobacco Act[xviii], Hazardous Products Act[xix], Hazardous Materials Information Review Act[xx], Department of Health Act[xxi], Radiation Emitting Devices Act[xxii], Pest Control Products Act[xxiii].

List of Acts and Regulations[xxiv]

Year of Incorporation / Commencement: 1913

Other: Canadian Food Inspection Agency joined the Health Portfolio in October 2013.

Reporting framework

Health Canada's Strategic Outcomes and Program Alignment Architecture of record for 2016–17 are shown below.

1 **Strategic Outcome:** A health system responsive to the needs of Canadians

- **1.1 Program:** Canadian Health System Policy
  - **1.1.1 Sub-Program:** Health System Priorities
  - **1.1.2 Sub-Program:** Canada Health Act Administration
- **1.2 Program:** Specialized Health Services
- **1.3 Program:** Official Language Minority Community Development

2 **Strategic Outcome:** Health risks and benefits associated with food, products, substances, and environmental factors are appropriately managed and communicated to Canadians

- **2.1 Program:** Health Products
  - **2.1.1 Sub-Program:** Pharmaceutical Drugs
  - **2.1.2 Sub-Program:** Biologics and Radiopharmaceuticals
  - **2.1.3 Sub-Program:** Medical Devices

2.1.4 Sub-Program: Natural Health Products

2.2 Program: Food Safety and Nutrition

2.2.1 Sub-Program: Food Safety

2.2.2 Sub-Program: Nutrition Policy and Promotion

2.3 Program: Environmental Risks to Health

2.3.1 Sub-Program: Air Quality

2.3.2 Sub-Program: Water Quality

2.3.3 Sub-Program: Health Impacts of Chemicals

2.4 Program: Consumer Product and Workplace Hazardous Materials

2.4.1 Sub-Program: Consumer Product Safety

2.4.2 Sub-Program: Workplace Hazardous Materials

2.5 Program: Problematic Substance Use[7]

2.5.1 Sub-Program: Tobacco Control

2.5.2 Sub-Program: Controlled Substances

2.6 Program: Radiation Protection

2.6.1 Sub-Program: Environmental Radiation Monitoring and Protection

2.6.2 Sub-Program: Radiation Emitting Devices

2.6.3 Sub-Program: Dosimetry Services

2.7 Program: Pesticides

3 Strategic Outcome: First Nations and Inuit communities and individuals receive health services and benefits that are responsive to their needs so as to improve their health status

3.1 Program: First Nations and Inuit Primary Health Care

3.1.1 Sub-Program: First Nations and Inuit Health Promotion and Disease Prevention

3.1.1.1 Sub-Sub-Program: Healthy Child Development

3.1.1.2 Sub-Sub-Program: Mental Wellness

3.1.1.3 Sub-Sub-Program: Healthy Living

3.1.2 Sub-Program: First Nations and Inuit Public Health Protection

[7] Formerly Substance Use and Abuse.

3.1.2.1 Sub-Sub-Program: Communicable Disease Control and Management

3.1.2.2 Sub-Sub-Program: Environmental Public Health

3.1.3 Sub-Program: First Nations and Inuit Primary Care

3.1.3.1 Sub-Sub-Program: Clinical and Client Care

3.1.3.2 Sub-Sub-Program: Home and Community Care

3.2 Program: Supplementary Health Benefits for First Nations and Inuit

3.3 Program: Health Infrastructure Support for First Nations and Inuit

3.3.1 Sub-Program: First Nations and Inuit Health System Capacity

3.3.1.1 Sub-Sub-Program: Health Planning and Quality Management

3.3.1.2 Sub-Sub-Program: Health Human resources

3.3.1.3 Sub-Sub-Program: Health Facilities

3.3.2 Sub-Program: First Nations and Inuit Health System Transformation

3.3.2.1 Sub-Sub-Program: Health Systems Integration

3.3.2.2 Sub-Sub-Program: e-Health Infostructure

3.3.3 Sub-Program: Tripartite Health Governance

Internal Services

IS 1: Management and Oversight Services
IS 2: Communications Services
IS 3: Legal Services
IS 4: Human resources Management Services
IS 5: Financial Management Services
IS 6: Information Management Services
IS 7: Information Technology Services
IS 8: Real Property Services
IS 9: Materiel Services
IS 10: Acquisition Services

Supporting information on lower-level programs

Supporting information on results, financial and human resources relating to Health Canada's lower-level programs is available on TBS InfoBase and on the departmental website.

Supplementary information tables

The following supplementary information tables are available on the Health Canada website[xxv].

- Departmental Sustainable Development Strategy
- Details on transfer payment programs of $5 million or more
- Horizontal initiatives
- Internal audits and evaluations
- Response to parliamentary committees and external audits
- Status report on projects operating with specific Treasury Board approval
- Status report on transformational and major Crown projects
- Up front multi-year funding
- User fees, regulatory charges and external fees

Federal tax expenditures

The tax system can be used to achieve public policy objectives through the application of special measures such as low tax rates, exemptions, deductions, deferrals and credits. The Department of Finance Canada publishes cost estimates and projections for these measures each year in the Report on Federal Tax Expenditures[xxvi]. This report also provides detailed background information on tax expenditures, including descriptions, objectives, historical information and references to related federal spending programs. The tax measures presented in this report are the responsibility of the Minister of Finance.

Organizational contact information

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Appendix: definitions

Appropriation (crédit)

Any authority of Parliament to pay money out of the Consolidated Revenue Fund.

Budgetary expenditures (dépenses budgétaires)

Operating and capital expenditures; transfer payments to other levels of government, organizations or individuals; and payments to Crown corporations.

Core Responsibility (responsabilité essentielle)

An enduring function or role performed by a department. The intentions of the department with respect to a Core Responsibility are reflected in one or more related Departmental Results that the department seeks to contribute to or influence.

Departmental Plan (Plan ministériel)

Provides information on the plans and expected performance of appropriated departments over a three-year period. Departmental Plans are tabled in Parliament each spring.

Departmental Result (résultat ministériel)

A Departmental Result represents the change or changes that the department seeks to influence. A Departmental Result is often outside departments' immediate control, but it should be influenced by program-level outcomes.

Departmental Result Indicator (indicateur de résultat ministériel)

A factor or variable that provides a valid and reliable means to measure or describe progress on a Departmental Result.

Departmental Results Framework (cadre ministériel des résultats)

Consists of the department's Core Responsibilities, Departmental Results and Departmental Result Indicators.

Departmental Results Report (Rapport sur les résultats ministériels)

Provides information on the actual accomplishments against the plans, priorities and expected results set out in the corresponding Departmental Plan.

Evaluation (évaluation)

In the Government of Canada, the systematic and neutral collection and analysis of evidence to judge merit, worth or value. Evaluation informs decision making, improvements, innovation and accountability. Evaluations typically focus on programs, policies and priorities and examine questions related to relevance, effectiveness and efficiency. Depending on user needs, however, evaluations can also examine other units, themes and issues, including alternatives to existing interventions. Evaluations generally employ social science research methods.

Full-time equivalent (équivalent temps plein)

A measure of the extent to which an employee represents a full person-year charge against a departmental budget. Full-time equivalents are calculated as a ratio of assigned hours of work to scheduled hours of work. Scheduled hours of work are set out in collective agreements.

Government-wide priorities (priorités pangouvernementales)

For the purpose of the 2016–17 Departmental Results Report, government-wide priorities refers to those high-level themes outlining the government's agenda in the 2015 Speech from the Throne, namely: Growth for the Middle Class; Open and Transparent Government; A Clean Environment and a Strong Economy; Diversity is Canada's Strength; and Security and Opportunity.

Horizontal initiatives (initiative horizontale)

An initiative where two or more federal organizations, through an approved funding agreement, work toward achieving clearly defined shared outcomes, and which has been designated (for example, by Cabinet or a central agency) as a horizontal initiative for managing and reporting purposes.

Management, Resources and Results Structure (Structure de la gestion, des ressources et des résultats)

A comprehensive framework that consists of an organization's inventory of programs, resources, results, performance indicators and governance information. Programs and results are depicted in their hierarchical relationship to each other and to the Strategic Outcome(s) to which they contribute. The Management, Resources and Results Structure is developed from the Program Alignment Architecture.

Non-budgetary expenditures (dépenses non budgétaires)

Net outlays and receipts related to loans, investments and advances, which change the composition of the financial assets of the Government of Canada.

Performance (rendement)

What an organization did with its resources to achieve its results, how well those results compare to what the organization intended to achieve, and how well lessons learned have been identified.

Performance indicator (indicateur de rendement)

A qualitative or quantitative means of measuring an output or outcome, with the intention of gauging the performance of an organization, program, policy or initiative respecting expected results.

Performance reporting (production de rapports sur le rendement)

The process of communicating evidence-based performance information. Performance reporting supports decision making, accountability and transparency.

planned spending (dépenses prévues)

For Departmental Plans and Departmental Results Reports, planned spending refers to those amounts that receive Treasury Board approval by February 1. Therefore, planned spending may include amounts incremental to planned expenditures presented in the Main Estimates.

A department is expected to be aware of the authorities that it has sought and received. The determination of planned spending is a departmental responsibility, and departments must be able to defend the expenditure and accrual numbers presented in their Departmental Plans and Departmental Results Reports.

Plans (plans)

The articulation of strategic choices, which provides information on how an organization intends to achieve its priorities and associated results. Generally a plan will explain the logic behind the strategies chosen and tend to focus on actions that lead up to the expected result.

Priorities (priorité)

Plans or projects that an organization has chosen to focus and report on during the planning period. Priorities represent the things that are most important or what must be done first to support the achievement of the desired Strategic Outcome(s).

Program (programme)

A group of related resource inputs and activities that are managed to meet specific needs and to achieve intended results and that are treated as a budgetary unit.

Program Alignment Architecture (architecture d'alignement des programmes)

A structured inventory of an organization's programs depicting the hierarchical relationship between programs and the Strategic Outcome(s) to which they contribute.

Results (résultat)

An external consequence attributed, in part, to an organization, policy, program or initiative. Results are not within the control of a single organization, policy, program or initiative; instead they are within the area of the organization's influence.

Statutory expenditures (dépenses législatives)

Expenditures that Parliament has approved through legislation other than appropriation acts. The legislation sets out the purpose of the expenditures and the terms and conditions under which they may be made.

Strategic Outcome (résultat stratégique)

A long-term and enduring benefit to Canadians that is linked to the organization's mandate, vision and core functions.

Sunset program (programme temporisé)

A time-limited program that does not have an ongoing funding and policy authority. When the program is set to expire, a decision must be made whether to continue the program. In the case of a renewal, the decision specifies the scope, funding level and duration.

Target (cible)

A measurable performance or success level that an organization, program or initiative plans to achieve within a specified time period. Targets can be either quantitative or qualitative.

Voted expenditures (dépenses votées)

Expenditures that Parliament approves annually through an Appropriation Act. The Vote wording becomes the governing conditions under which these expenditures may be made.

Endnotes

i Treasury Board of Canada Secretariat, https://www.canada.ca/en/treasury-board-secretariat.html

ii. The Minister's mandate letter, http://pm.gc.ca/eng/mandate-letters

iii Official Languages Act, http://laws-lois.justice.gc.ca/eng/acts/o-3.01/

iv Canadian Environmental Protection Act, 1999, http://laws-lois.justice.gc.ca/eng/acts/c-15.31/

v Cosmetic Regulations, http://laws-lois.justice.gc.ca/eng/regulations/C.R.C.,_c._869/

vi Comprehensive Nuclear-Test-Ban Treaty Implementation Act, http://laws-lois.justice.gc.ca/eng/acts/C-36.5/

vii Nuclear Safety and Control Act, http://laws-lois.justice.gc.ca/eng/acts/N-28.3/

viii Indian Health Policy 1979, http://www.hc-sc.gc.ca/ahc-asc/branch-dirgen/fnihb-dgspni/poli_1979-eng.php

ix TBS Info Base, https://www.tbs-sct.gc.ca/ems-sgd/edb-bdd/index-eng.html#start

x Supporting Information on Lower Level Programs, https://www.canada.ca/en/health-canada/corporate/transparency/corporate-management-reporting/departmental-performance-reports.html

xi. Public Accounts of Canada 2017, http://www.tpsgc-pwgsc.gc.ca/recgen/cpc-pac/index-eng.html

xii. Whole-of-government framework, http://www.tbs-sct.gc.ca/ppg-cpr/frame-cadre-eng.aspx

xiii Financial Statements, https://www.canada.ca/en/health-canada/corporate/transparency/corporate-management-reporting/departmental-performance-reports.html

xiv Canada Health Act, http://laws-lois.justice.gc.ca/eng/acts/C-6/

xv Canada Consumer Product Safety Act, http://laws-lois.justice.gc.ca/eng/acts/c-1.68/

xvi Controlled Drugs and Substances Act, http://laws-lois.justice.gc.ca/eng/acts/c-38.8/

xvii Food and Drugs Act, http://laws.justice.gc.ca/eng/acts/F-27/

xviii Tobacco Act, http://laws-lois.justice.gc.ca/eng/acts/T-11.5/

xix Hazardous Products Act, http://laws-lois.justice.gc.ca/eng/acts/H-3/index.html

xx Hazardous Materials Information Review Act, http://laws-lois.justice.gc.ca/eng/acts/H-2.7/

xxi Department of Health Act, http://laws-lois.justice.gc.ca/eng/acts/H-3.2/index.html

xxii Radiation Emitting Devices Act, http://laws-lois.justice.gc.ca/eng/acts/R-1/

xxiii Pest Control Products Act, http://laws-lois.justice.gc.ca/eng/acts/P-9.01/

xxiv List of Acts, http://www.hc-sc.gc.ca/ahc-asc/legislation/acts-reg-lois/acts-reg-lois-eng.php

xxv Supplementary Information Tables, https://www.canada.ca/en/health-canada/corporate/transparency/corporate-management-reporting/departmental-performance-reports.html

xxvi Report on Federal tax expenditures; http://www.fin.gc.ca/purl/taxexp-eng.asp