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Health Canada

Supporting Information on Lower-Level Programs: 2015-16 Departmental Performance Report

YOUR HEALTH AND SAFETY... OUR PRIORITY.

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Supporting Information on Lower-Level Programs

Program 1.1: Canadian Health System Policy

Sub-Program 1.1.1: Health System Priorities

Description

Through the Health System Priorities program, Health Canada works closely with provincial and territorial governments, domestic and international organizations, health care providers, and other stakeholders to develop and implement innovative approaches, improve accountability, and responses to meet the health priorities and health services needs of Canadians. Key activities include increasing the supply of health professionals, timely access to quality health care services, and accelerating the development and implementation of electronic health technologies. This program uses funding from the following transfer payments: Brain Canada Foundation, Canadian Agency for Drugs and Technologies in Health, Canadian Institute for Health Information (CIHI), Canadian Partnership Against Cancer, Canadian Patient Safety Institute, Health Care Policy Contribution Program, Mental Health Commission of Canada, Mood Disorders Society of Canada, Canada Health Infoway, McMaster University's Teams Advancing Patient Experience: Strengthening Quality, Pallium Foundation of Canada, and Canadian Foundation for Health Care Improvement. The program objective is to ensure that Canadians have access to quality and cost-effective health care services.

Budgetary Financial Resources (dollars)

2015-16 Planned Spending	2015-16 Actual Spending (authorities used)	2015-16 Difference (actual minus planned)
258,498,798	327,805,944	69,307,146

Note: The variance between actual and planned spending is mainly due to statutory grant funding for electronic health information communication technologies and revised implementation timelines for contribution agreements that are not part of planned spending.

Human Resources (Full-Time Equivalents [FTEs])

2015-16 Planned	2015-16 Actual	2015-16 Difference (actual minus planned)
219	161	-58

Note: The variance in FTE utilization is mainly due to program hiring delays and personnel departures without backfills.

Performance Results

Expected Results	Performance Indicators	Targets	Actual Results
Improved and maintained strategic partnerships with key national provinces/territories regional partners (e.g., through funding such as Grants & Contributions) to advance health system priorities.	# and type of new/maintained and/or improved collaborative working arrangements and/or agreements between Government of Canada, provinces/ territories, and stakeholders to advance health system renewal..	10 by March 31, 2016	10

Sub-Program 1.1.2: *Canada Health Act Administration*

Description

The administration of the *Canada Health Act* involves monitoring a broad range of sources to assess the compliance of provincial and territorial health insurance plans with the criteria and conditions of the *Act*, working in partnership with provincial and territorial governments to investigate and resolve concerns which may arise, providing policy advice and informing the Minister of possible non-compliance with the *Act*, recommending appropriate action when required, and reporting to Parliament on the administration of the *Act*. The program objective is to facilitate reasonable access to insured health care services without financial or other barriers.

Budgetary Financial Resources (dollars)

2015-16 Planned Spending	2015-16 Actual Spending (authorities used)	2015-16 Difference (actual minus planned)
1,891,320	1,774,240	-117,080

Note: The variance 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)

2015-16 Planned	2015-16 Actual	2015-16 Difference (actual minus planned)
19	14	-5

Note: The variance in FTE utilization is mainly due to program hiring delays and personnel departures without backfills.

Performance Results

Expected Results	Performance Indicators	Targets	Actual Results
Provincial and territorial compliance with the requirements of the *Canada Health Act*.	% of *Canada Health Act* compliance issues concluded.	100 by March 31, 2016	50*

* *Canada Health Act* compliance issues that are considered for the purpose of this reporting exercise are those that were raised or resolved during the reporting period, as well as ongoing issues that resulted in the application of deductions to Canada Health Transfer payments to a province or territory. Issues are considered concluded once a province or territory has made a commitment to take definitive action to eliminate the circumstances that led to a compliance issue.

During 2015-16, six compliance issues were addressed, with three being concluded (50%). Health Canada is still in consultation with the respective provincial health ministries on the three outstanding issues.

Program 1.2: Specialized Health Services

No sub-programs

Program 1.3: Official Language Minority Community Development

No sub-programs

Program 2.1: Health Products

Sub-Program 2.1.1: Pharmaceutical Drugs

Description

The *Food and Drug Regulations*[i] provide the regulatory framework to develop, maintain and implement the Pharmaceutical Drugs program, which includes pharmaceutical drugs for human and animal use, including prescription and non-prescription drugs, disinfectants, and sanitizers with disinfectant claims. Health Canada verifies that regulatory requirements for the safety, quality, and efficacy of pharmaceutical drugs are met through risk assessments, including monitoring and surveillance, compliance, and enforcement activities. In addition, the program provides information to Canadians and key stakeholders, including health professionals, such as physicians and pharmacists, to enable them to make informed decisions about the use of pharmaceutical drugs. The program objective is to ensure that pharmaceutical drugs in Canada are safe, effective and of high quality.

Budgetary Financial Resources (dollars)

2015-16 Planned Spending	2015-16 Actual Spending (authorities used)	2015-16 Difference (actual minus planned)
56,574,855	62,364,727	5,789,872

Note: The variance between actual and planned spending is mainly due to revenues collected below authorities, and paylist requirements.

Human Resources (Full-Time Equivalents [FTEs])

2015-16 Planned	2015-16 Actual	2015-16 Difference (actual minus planned)
969	877	-92

Note: The variance 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.

Performance Results

Expected Results	Performance Indicators	Targets	Actual Results
Pharmaceutical drugs meet regulatory requirements.	% of pharmaceutical product submissions that meet regulatory requirements.	80 by March 31, 2016	81
Canadians and stakeholders are informed of risks associated with the use of pharmaceutical drugs.	% of identified risks that result in risk communications.	80 by March 31, 2016	82

Sub-Program 2.1.2: Biologics & Radiopharmaceuticals

Description

The *Food and Drug Regulations*, *Safety of Human Cells, Tissues and Organs for Transplantation Regulations*[ii], and the *Processing and Distribution of Semen for Assisted Conception Regulations*[iii] provide the regulatory framework to develop, maintain, and implement the Biologics and Radiopharmaceuticals program, which includes blood and blood products, viral and bacterial vaccines, gene therapy products, tissues, organs, and xenografts, which are manufactured in Canada or elsewhere. Health Canada verifies that regulatory requirements for the safety, quality, and efficacy of biologics and radiopharmaceuticals are met through risk assessments, including monitoring and surveillance, compliance, and enforcement activities. In addition, the program provides information to Canadians and key stakeholders, including health professionals such as physicians and pharmacists, to enable them to make informed decisions about the use of biologics and radiopharmaceuticals. The program objective is to ensure that biologics and radiopharmaceuticals in Canada are safe, effective and of high quality. This program uses funding from the following transfer payments: Canadian Blood Services (CBS),

Blood Safety and Effectiveness Research and Development, and Contribution to Strengthen Canada's Organs and Tissues Donation and Transplantation System.

Budgetary Financial Resources (dollars)

2015-16 Planned Spending	2015-16 Actual Spending (authorities used)	2015-16 Difference (actual minus planned)
57,044,453	50,076,827	-6,967,626

Note: The variance between actual and planned spending is mainly due to a reallocation of funding within the department to address program needs and priorities, and revenues collected in excess of authorities.

Human Resources (FTEs)

2015-16 Planned	2015-16 Actual	2015-16 Difference (actual minus planned)
451	432	-19

Note: The variance 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.

Performance Results

Expected Results	Performance Indicators	Targets	Actual Results
Biologics, Radiopharmaceutical and Genetic Therapies meet regulatory requirements	% of biologic and radiopharmaceutical, and gene therapy product submissions that meet regulatory requirements.	80 by March 31, 2016	98
Canadians and stakeholders are informed of risks associated with the use of biologics, radiopharmaceuticals, and gene therapies.	% of identified risks that result in risk communications.	80 by March 31, 2016	100

Sub-Program 2.1.3: Medical Devices

Description

The Medical Devices Regulations[iv] provide the regulatory framework to develop, maintain, and implement the Medical Devices program, which includes medical devices used in the treatment, mitigation, diagnosis, or prevention of a disease or an abnormal physical condition in humans. Health Canada verifies that regulatory requirements for the safety, quality, and efficacy of

medical devices are met through risk assessments, including monitoring and surveillance, compliance, and enforcement activities. In addition, the program provides information to Canadians and key stakeholders, including health professionals, such as physicians and pharmacists, to enable them to make informed decisions about the use of medical devices. The program objective is to ensure that medical devices in Canada are safe, effective and of high quality.

Budgetary Financial Resources (dollars)

2015-16 Planned Spending	2015-16 Actual Spending (authorities used)	2015-16 Difference (actual minus planned)
13,068,089	12,327,985	-740,104

Note: The variance between actual and planned spending is mainly due to a reallocation of funding within the department to address program needs and priorities.

Human Resources (FTEs)

2015-16 Planned	2015-16 Actual	2015-16 Difference (actual minus planned)
311	260	-51

Note: The variance 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.

Performance Results

Expected Results	Performance Indicators	Targets	Actual Results
Medical Devices meet regulatory requirements	% of applications (Class III and IV*) that meet regulatory requirements *(Classes I and II present very low health and safety risk to Canadians)	80 by March 31, 2016	96
Canadians and stakeholders are informed of risks associated with the use of medical devices.	% of identified risks that result in risk communications.	80 by March 31, 2016	100

Sub-Program 2.1.4: Natural Health Products

Description

The *Natural Health Product Regulations*[v] provide the regulatory framework to develop, maintain and implement the Natural Health Products program, which includes herbal remedies, homeopathic medicines, vitamins, minerals, traditional medicines, probiotics, amino acids, and essential fatty acids. Health Canada verifies that regulatory requirements for the safety, quality, and efficacy of natural health products are met through risk assessments, including monitoring and surveillance, compliance, and enforcement activities. In addition, the program provides information to Canadians and key stakeholders, including health professionals such as pharmacists, traditional Chinese medicine practitioners, herbalists and naturopathic doctors, to enable them to make informed decisions about the use of natural health products. The program objective is to ensure that natural health products in Canada are safe, effective and of high quality.

Budgetary Financial Resources (dollars)

2015-16 Planned Spending	2015-16 Actual Spending (authorities used)	2015-16 Difference (actual minus planned)
21,423,387	20,872,084	-551,303

Note: The variance between actual and planned spending is mainly due to a reallocation of funding within the Health Products Program to address program needs and priorities.

Human Resources (FTEs)

2015-16 Planned	2015-16 Actual	2015-16 Difference (actual minus planned)
184	194	10

Note: The variance in FTE utilization is mainly due to a realignment of resources within the Health Products Program based on operational requirements.

Performance Results

Expected Results	Performance Indicators	Targets	Actual Results
Natural Health Products meet regulatory requirements.	% of natural health product submissions that meet regulatory requirement.	80 by March 31, 2016	98

Program 2.2: Food Safety and Nutrition

Sub-Program 2.2.1: Food Safety

Description

The *Food and Drug Regulations* provide the regulatory framework to develop, maintain, and implement the Food Safety program. The program is the federal health authority responsible for establishing standards, policies, and regulations pertaining to food and nutrition safety; as well as for conducting reviews and for assessing the safety of food ingredients, veterinary drugs for food producing animals, food processes, and final foods (that are safe for human consumption, which would include both processed foods as well as unprocessed foods). The program conducts risk assessments pertaining to the chemical, microbiological, and nutritional safety of foods. In addition, the program plans and implements food and nutrition safety surveillance and research initiatives in support of the Department's food standard setting mandate. The program objective is to plan and implement food and nutrition safety standards to enable Canadians to make informed decisions about food and nutrition.

Budgetary Financial Resources (dollars)

2015-16 Planned Spending	2015-16 Actual Spending (authorities used)	2015-16 Difference (actual minus planned)
63,267,053	58,541,468	-4,725,585

Note: The variance between actual and planned spending is mainly due to a reallocation of funding between programs and a transfer to the Canadian Food Inspection Agency to support the Global Food Safety Partnership and the Codex Trust Fund.

Human Resources (FTEs)

2015-16 Planned	2015-16 Actual	2015-16 Difference (actual minus planned)
559	461	-98

Note: The variance in FTE utilization is mainly due to program hiring delays and personnel departures without backfills.

Performance Results

Expected Results	Performance Indicators	Targets	Actual Results
Timely response to emerging food and nutrition safety incidents including foodborne illness outbreaks.	% of health risk assessments provided to the Canadian Food Inspection Agency within standard timelines to manage	90 by March 31, 2016	100

Expected Results	Performance Indicators	Targets	Actual Results
	food safety incidents.		

Sub-Program 2.2.2: Nutrition Policy and Promotion

Description

The *Department of Health Act* provides the authority to develop, maintain and implement the Nutrition Policy and Promotion program. The program develops, implements, and promotes evidence-based nutrition policies and standards, and undertakes surveillance and monitoring activities. It anticipates and responds to public health issues associated with nutrition and contributes to broader national and international strategies. The program works collaboratively with other federal departments/agencies and provincial/ territorial governments, and engages stakeholders such as non-government organizations, health professionals, and industry associations to support a coordinated approach to nutrition issues. The program objective is to target both Canadian intermediaries and consumers to increase knowledge, understanding, and action on healthy eating.

Budgetary Financial Resources (dollars)

2015-16 Planned Spending	2015-16 Actual Spending (authorities used)	2015-16 Difference (actual minus planned)
4,571,677	5,399,927	828,250

Note: The variance between actual and planned spending is mainly due to increased requirements in the Healthy Eating Campaign and paylist requirements.

Human Resources (FTEs)

2015-16 Planned	2015-16 Actual	2015-16 Difference (actual minus planned)
35	39	4

Note: The variance in FTE utilization is mainly due to increased requirements in the Healthy Eating Campaign.

Performance Results

Expected Results	Performance Indicators	Targets	Actual Results
Stakeholders integrate information on nutrition and healthy eating	% of targeted stakeholders who integrate Health Canada's healthy eating	80 by March 31, 2016	89

Expected Results	Performance Indicators	Targets	Actual Results
	knowledge products, policies, and/or education materials into their own strategies, policies, programs and initiatives that reach Canadians.		

Program 2.3: Environmental Risks to Health

Sub-Program 2.3.1: Climate change and Health

Description

The Climate Change and Health program supports actions to minimize the impact of climate change on the health of Canadians under the Federal Clean Air Agenda. A key activity in the delivery of this program is the Heat Resiliency Project, which aims to inform and advise public health agencies and Canadians on adaptation strategies to respond to extreme heat events. This includes: development of community-based heat alert and response systems; development and dissemination of training tools, guidelines, and strategies for health professionals; collaboration with key stakeholders and partners to assess and reduce vulnerabilities to extreme heat; and scientific research on health impacts of extreme heat to support evidence-based decision-making. The program objective is to help Canadians adapt to a changing climate through measures intended to manage potential risks to their health associated with extreme heat events.

Budgetary Financial Resources (dollars)

2015-16 Planned Spending	2015-16 Actual Spending (authorities used)	2015-16 Difference (actual minus planned)
1,431,386	1,544,496	113,110

Note: The variance between actual and planned spending is mainly due to the reporting of actual costs that had been previously planned under Health Impacts of Chemicals.

Human Resources (FTEs)

2015-16 Planned	2015-16 Actual	2015-16 Difference (actual minus planned)
11	9	-2

Note: The variance in FTE utilization is mainly due to delays in staffing and pending program renewal.

Performance Results

Expected Results	Performance Indicators	Targets	Actual Results
A Use of knowledge on impacts of climate change on health and adaptation measures by Canadian communities.	# of Canadian Communities with heat alert and response systems.	12 by March 31, 2016	12*

* In addition to achieving its target of 12 communities with heat alert and response systems (HARS), the Program has been successful in reaching many more communities by working through public health units and province-wide systems. Two provinces (Alberta and Manitoba) have adopted and continue with a provincial-wide system implementation while Ontario is implementing HARS through Public Health Units. This new approach is reaching many more communities.

Sub-Program 2.3.2: Air Quality

Description

The Air Quality program assesses the health risks of indoor and outdoor pollutants, and develops guidelines and standards under the *Canadian Environmental Protection Act, 1999*. These efforts support the Government of Canada's Clean Air Regulatory Agenda, implemented in partnership with Environment Canada, to manage the potential risks to the environment and to the health of Canadians associated with air quality. The program provides health-based science and policy advice that supports actions by all levels of government to improve air quality and health of Canadians. Key activities include: leading the development of health-based air quality standards and guidelines for indoor and outdoor air; determining the health benefits of proposed actions to reduce air pollution; conducting research on the levels of exposure and health effects of indoor and outdoor air pollutants to inform the development of standards, guidelines, regulations and other actions; and, implementing the Air Quality Health Index (AQHI) in partnership with Environment Canada. The program objective is to assess the impacts of air pollution on health and to provide guidance to governments, health professionals and the general public on how to minimize those risks.

Budgetary Financial Resources (dollars)

2015-16 Planned Spending	2015-16 Actual Spending (authorities used)	2015-16 Difference (actual minus planned)
23,638,485	16,902,312	-6,736,173

Note: The variance between actual and planned spending is mainly due to lower than anticipated laboratory maintenance costs as well as delays in contracting and program hiring.

Human Resources (FTEs)

2015-16 Planned	2015-16 Actual	2015-16 Difference (actual minus planned)
114	86	-28

Note: The variance in FTE utilization and salary is mainly due to program hiring delays.

Performance Results

Expected Results	Performance Indicators	Targets	Actual Results
Canadians, stakeholders, and governments have access to information on air quality and health effects.	% of Canadians with access to the AQHI.	80 by March 31, 2016	79*
	% of planned federal air quality health assessments and risk management actions published or distributed externally.	100 by March 31, 2016	60
Government partners have access to scientific information on the impacts of air quality on health.	% of targeted knowledge transfer activities accomplished related to air quality (e.g. client meetings, poster/ conference presentations and peer-reviewed publications).	100 by March 31, 2016	100**

* The Air Quality Health Index (AQHI) continued to increase its coverage across Canada and now reaches 79% of the population in 10 provinces and one territory. An agreement has been concluded to expand and promote the AQHI in Yukon.

** Air health research KT activities: Planned = 30, Actual=60

Sub-Program 2.3.3: Water Quality

Description

The Water Quality program works with key stakeholders and partners, such as the provinces and territories, under the authority of the *Department of Health Act*, to establish the Guidelines for Canadian Drinking Water Quality[vi]. These guidelines are used by provinces, territories, and the Government of Canada as the basis for establishing their water quality requirements. The program also works with national and international standard-setting organizations to develop health-based standards for materials that come into contact with drinking water. In the delivery of this program, key activities include the development and dissemination of water quality guidelines guidance documents, strategies and other tools. The program objective is to help manage potential risks to the health of Canadians associated with water quality.

Budgetary Financial Resources (dollars)

2015-16 Planned Spending	2015-16 Actual Spending (authorities used)	2015-16 Difference (actual minus planned)
3,861,865	3,726,757	-135,108

Note: The variance between actual and planned spending is mainly due to delays in securing required goods and services.

Human Resources (FTEs)

2015-16 Planned	2015-16 Actual	2015-16 Difference (actual minus planned)
35	28	-7

Note: The variance in FTE utilization is mainly due to program hiring delays.

Performance Results

Expected Results	Performance Indicators	Targets	Actual Results
Federal, Provincial and Territorial partners use Health Canada water quality guidelines as the basis for their regulatory requirements to manage risks to the health of Canadians.	# of water quality guidelines / guidance documents approved by provinces and territories.	5 by March 31, 2016	4*

* Four final drinking water quality guidelines / guidance documents approved by provinces and territories, per revised target. They are: pH; trihalomethanes; benzo[a]pyrene; chromium

Sub-Program 2.3.4: Health Impacts of Chemicals

Description

The *Canadian Environmental Protection Act, 1999*, provides the authority for the Health Impact of Chemicals program to assess the impact of chemicals and manage the potential health risks posed by new and existing substances that are manufactured, imported, or used in Canada. 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 chemical substances in products in the purview of these program activities. The Chemicals Management Plan (CMP), implemented in partnership with Environment Canada, sets priorities and timelines for risk assessment and management for

chemicals of concern, as well as the supporting research and bio-monitoring initiatives. In addition to the above risk assessment and management activities, this program provides expert health-based advice and support to other federal departments in carrying out their mandates as well as provides technical support for chemical emergencies that require a coordinated federal response. The program objective is to identify and manage health risks to Canadians posed by chemicals of concern.

Budgetary Financial Resources (dollars)

2015-16 Planned Spending	2015-16 Actual Spending (authorities used)	2015-16 Difference (actual minus planned)
71,350,373	65,385,845	-5,964,528

Note: The variance between planned and actual spending is mainly due to a reallocation of funding within the department to address program needs and priorities, reduction in laboratory maintenance costs, and delays in hiring and securing required goods and services.

Human Resources (FTEs)

2015-16 Planned	2015-16 Actual	2015-16 Difference (actual minus planned)
558	438	-120

Note: The variance in FTE utilization is mainly due to program hiring delays and personnel departures without backfills.

Performance Results

Expected Results	Performance Indicators	Targets	Actual Results
Risks associated with chemical substances are assessed.	% of new substances for which industry has sent notification of their manufacture or import that are assessed within targeted timelines.	100 by March 31, 2016	100
	% of the 1,500 targeted substances assessed (draft and final assessment stage)	100 by March 31, 2016	97 (draft assessment stage) 33 (final assessment stage)*
Government partners have access to scientific information on how exposure to chemical substances impacts health.	% of targeted knowledge transfer activities accomplished related to chemical substances (e.g. client meetings,	100 by March 31, 2016	100

Expected Results	Performance Indicators	Targets	Actual Results
	poster/conference presentations and peer reviewed publications).		

* These results represent the cumulative total since the assessment of the 1,500 substances began in 2011-12. By March 31, 2016, a total of 97% of the targeted substances had been assessed at the draft stage (3% were assessed in 2015-16); and 33% of the targeted substances had been assessed at the final stage (5% were assessed in 2015-16). The Program has a new schedule to finalize the draft and final assessments of the remaining substances by September 2017. The 100% target reflects only the draft assessment stage.

Program 2.4: Consumer Product and Workplace Chemical Safety

Sub-Program 2.4.1: Consumer Product Safety

Description

The CCPSA and the *Food and Drugs Act* and its *Cosmetics Regulations* provide the authorities for this program to support industry's responsibility for the safety of their products and consumers' responsibility to make informed decisions about product purchase and use. Health Canada's efforts are focused in three areas: active prevention; targeted oversight; and, rapid response. Through active prevention, the program works with industry, standard setting bodies and international counterparts to develop standards and guidelines and share best practices as appropriate. The program also promotes consumer awareness of the safe use of certain consumer products to support informed decision-making. Through targeted oversight, the program undertakes regular cycles of compliance and enforcement in selected product categories, and analyses and responds to issues identified through mandatory reporting, market surveys, lab results and other means. Under rapid response, when an unacceptable risk from consumer products is identified, the program can act quickly to protect the public and take appropriate enforcement actions – including issuing consumer advisories, working with industry to negotiate recalls or other corrective measures. The Program's objective is to manage the potential health and safety risks posed by consumer products and cosmetics in the Canadian marketplace.

Budgetary Financial Resources (dollars)

2015-16 Planned Spending	2015-16 Actual Spending (authorities used)	2015-16 Difference (actual minus planned)
33,647,514	30,373,598	-3,273,916

Note: The variance between actual and planned spending is mainly due to a reallocation of funding within the department to address program needs and priorities, as well as program hiring delays and personnel departures without backfills.

Human Resources (FTEs)

2015-16 Planned	2015-16 Actual	2015-16 Difference (actual minus planned)
266	256	-10

Note: The variance in FTE utilization is mainly due to program hiring delays and personnel departures without backfills.

Performance Results

Expected Results	Performance Indicators	Targets	Actual Results
Targeted Canadian industries are aware of regulatory requirements related to consumer products and cosmetics.	% of targeted Canadian industry stakeholders indicating that they are aware of regulatory requirements.	95 by March 31, 2016	95
Early detection of potentially unsafe consumer products and cosmetics.	% of incident reports received and triaged within service standard.	90 by March 31, 2016	99

Sub-Program 2.4.2: Workplace Chemical Safety

Description

The *Hazardous Products Act* and the *Hazardous Materials Information Review Act* provide the authorities for this program to protect the health and safety of Canadian workers. Under the *Hazardous Products Act*, Health Canada regulates the sale and importation of hazardous chemicals used in Canadian workplaces by specifying the requirements for cautionary labelling and material safety data sheets. Under the *Hazardous Materials Information Review Act*, Health Canada administers a timely mechanism to allow companies to protect confidential business information, ensuring industry competitiveness, while requiring that all critical hazard information is disclosed to workers. This program sets the general standards for the Workplace Hazardous Materials Information System (WHMIS) – a system based on interlocking federal, provincial, and territorial legislation that ensures the comprehensibility and accessibility of labels and material safety data sheets, the consistent application of classification and labelling criteria, and the alignment across Canada of compliance and enforcement activities. The program objective is to ensure a coordinated national system that provides critical health and safety information on hazardous chemicals to Canadian workers.

Budgetary Financial Resources (dollars)

2015-16 Planned Spending	2015-16 Actual Spending (authorities used)	2015-16 Difference (actual minus planned)
4,041,823	4,139,493	97,670

Note: The variance between actual and planned spending is mainly due to reallocations of funding within the department to support the Global Harmonized System implementation in Canada.

Human Resources (FTEs)

2015-16 Planned	2015-16 Actual	2015-16 Difference (actual minus planned)
34	34	0

Performance Results

Expected Results	Performance Indicators	Targets	Actual Results
Service delivery standards are maintained	% of claims for exemption registered within seven-day service standard	100 by March 31, 2016	95*

* CMP research and monitoring and surveillance KT activities: Planned 120 =, Actual= 290

Program 2.5: Substance Use and Abuse

Sub-Program 2.5.1: Tobacco

Description

The *Tobacco Act* provides the authority for the Tobacco program to regulate the manufacture, sale, labelling, and promotion of tobacco products. The program also leads the Federal Tobacco Control Strategy, in collaboration with federal partners as well as provincial and territorial governments, which supports regulatory, programming, educational and enforcement activities. Key activities under the Strategy include: compliance monitoring and enforcement of the *Tobacco Act* and associated regulations; monitoring tobacco consumption and smoking behaviours; and, working with national and international partners to ensure that Canada meets its obligations under the Framework Convention on Tobacco Control. The program objective is to prevent the uptake of tobacco use, particularly among youth, help those who currently use tobacco to quit and protect Canadians from exposure to tobacco smoke.

Budgetary Financial Resources (dollars)

2015-16 Planned Spending	2015-16 Actual Spending (authorities used)	2015-16 Difference (actual minus planned)
26,662,425	20,172,791	-6,489,634

Note: The variance between actual and planned spending is mainly due to lower than anticipated provincial and territorial funding requirements for the pan-Canadian Quitline and the Canadian Student Tobacco, Alcohol and Drugs Survey

Human Resources (FTEs)

2015-16 Planned	2015-16 Actual	2015-16 Difference (actual minus planned)
121	131	10

Note: The variance in FTE utilization is mainly due to an increase in resources from plans to ensure that deliverables related to Government of Canada Tobacco priorities were met.

Performance Results

Expected Results	Performance Indicators	Targets	Actual Results
Industry is compliant with the *Tobacco Act* and its regulations	% of products that are deemed to be non-compliant with the *Tobacco Act* and its regulations related to manufacturing and importing.	< 5 by March 31, 2016	5

Sub-Program 2.5.2: Controlled Substances

Description

Through the administration of the *Controlled Drugs and Substances Act* (CDSA) and its regulations, the program regulates the possession, production, provision and disposition of controlled substances and precursor chemicals. Key activities include: reviewing and updating the regulatory framework and Schedules for controlled substances and precursor chemicals as required; administering regulations for licensing and compliance monitoring activities; analyzing seized materials (Drug Analysis Services); providing training as well as scientific knowledge on illicit drugs and precursor chemicals; providing assistance in investigating and dismantling clandestine laboratories; monitoring the use of drugs through surveys; and working with national and international partners for the recommendation of appropriate and scientifically sound drug analysis procedures. As a partner in the NADS, Health Canada supports initiatives to address illicit drug use and prescription drug abuse, including: education; prevention; health promotion;

and treatment for Canadians, as well as compliance and enforcement initiatives. The program objective is to authorize legitimate activities with controlled substances and precursor chemicals, while managing the risks of diversion, abuse and associated harms. This program uses funding from the following transfer payments: Drug Strategy Community Initiatives Fund, Drug Treatment Funding Program, and Grant to the Canadian Centre of Substance Abuse.

Budgetary Financial Resources (dollars)

2015-16 Planned Spending	2015-16 Actual Spending (authorities used)	2015-16 Difference (actual minus planned)
60,068,790	64,277,503	4,208,713

Note: The variance between actual and planned spending is mainly due to the costs for implementing regulations pertaining to the use of marijuana for medical purposes.

Human Resources (FTEs)

2015-16 Planned	2015-16 Actual	2015-16 Difference (actual minus planned)
273	345	72

Note: The variance in FTE utilization is mainly due to an increase in resources from plans for controlled substances and the implementation of the Marijuana for Medical Purposes Regulations.

Performance Results

Expected Results	Performance Indicators	Targets	Actual Results
Holders of licences, authorizations and permits for controlled substances and precursor chemicals are compliant with the CDSA and its regulations.	% regulated parties that are deemed to be compliant with the CDSA and its regulations.	95 by March 31, 2016	100
Recipients of federal funding are enabled to deliver drug treatment and prevention programs.	# of funded projects delivering drug treatment and prevention programs.	55 by March 31, 2016	55

Program 2.6: Radiation Protection

Sub-Program 2.6.1: Environmental Radiation Monitoring and Protection

Description

The Environmental and Radiation Monitoring and Protection program conducts research and monitoring activities under the authority of the *Department of Health Act* and the *Comprehensive Nuclear-Test-Ban Treaty Implementation Act*. The program covers both naturally occurring forms of radioactivity and radiation, such as radon, and man-made sources of radiation, such as nuclear power. In the delivery of this program, key activities include: implementing an education and awareness program on the health risks posed by radon in indoor air and how to reduce those risks; conducting research and risk assessment on the health effects of radiation; installing and operating monitoring stations to monitor for evidence of any nuclear explosion; and, reporting to the Comprehensive Nuclear-Test-Ban Treaty Organization and the International Atomic Energy Agency. This program is also responsible for coordinating the Federal Nuclear Emergency Plan (FNEP). In the case of a radio-nuclear emergency that requires a coordinated federal response, Health Canada coordinates the federal technical/scientific support to provinces/territories. The program objectives are to monitor and help inform Canadians of potential harm to their health and safety associated with environmental radiation.

Budgetary Financial Resources (dollars)

2015-16 Planned Spending	2015-16 Actual Spending (authorities used)	2015-16 Difference (actual minus planned)
14,714,468	14,358,312	-356,156

Note: The variance between actual and planned spending is mainly due to a decrease in spending for the Pan American Games attributable to staffing delays and requiring fewer staff than planned. In addition, there were less than anticipated requirements for capital acquisitions.

Human Resources (FTEs)

2015-16 Planned	2015-16 Actual	2015-16 Difference (actual minus planned)
101	97	-4

Note: The variance in FTE utilization is mainly due to hiring delays and personnel departures without backfills.

Performance Results

Expected Results	Performance Indicators	Targets	Actual Results
Health Canada is prepared to respond to	# of emergency preparedness exercises	2 by March 31, 2016	7*

Expected Results	Performance Indicators	Targets	Actual Results
a nuclear or radiological emergency.	performed (in accordance to expectations of internal and external partners).		
Environmental radiation is monitored.	% of national radionuclear and Comprehensive Nuclear-Test-Ban Treaty monitoring stations and laboratories that are operational.	90 by March 31, 2016	98**
Targeted partners collaborate to address health risks related to radiation/radon.	% of targeted partners participating in education and awareness and communication activities.	90 by March 31, 2016	100

* FNEP Escalation Drill, Exercise Intrepid Table Top Exercise, Exercise Intrepid Rehearsal, Exercise Intrepid, Connaught Ranges drill, British Columbia Nuclear Powered Vessel Workshop, British Columbia Nuclear Powered Vessel Table Top Exercise

** Fixed Point Surveillance stations: 98% operational
Canadian Radiological Monitoring Network: 96% operational
Comprehensive Nuclear Test Ban Treaty: 100% operational
Labs: 100% operational

Sub-Program 2.6.2 : Radiation Emitting Devices

Description

Under the authority of the *Radiation Emitting Devices Act*, this program regulates radiation emitting devices, such as equipment for clinical/analytical purposes (X-rays, mammography, ultrasound), microwaves, lasers, and tanning equipment. In the delivery of this program, key activities include: compliance assessment of radiation emitting devices at federally regulated facilities, research into the health effects of radiation (including noise, ultraviolet, and non-ionizing radiation from wireless devices such as cell phones and WiFi equipment); and, development of standards and guidelines for the safe use of radiation emitting devices. The program provides expert advice and information to Canadians, as well as to other Health Canada programs, federal departments, and provincial authorities so that they may fulfil their legislative mandates. The program objective is to manage the risks to the health of Canadians from radiation emitting devices.

Budgetary Financial Resources (dollars)

2015-16 Planned Spending	2015-16 Actual Spending (authorities used)	2015-16 Difference (actual minus planned)
5,005,319	5,012,690	7,371

Note: The variance between actual and planned spending is mainly due to the reporting of spending that was not included in the initial plans for this program.

Human Resources (FTEs)

2015-16 Planned	2015-16 Actual	2015-16 Difference (actual minus planned)
37	36	-1

Note: The variance in FTE utilization is mainly due to hiring delays and personnel departures without backfills.

Performance Results

Expected Results	Performance Indicators	Targets	Actual Results
Canadians have timely access to information on the health risks related to consumer and clinical radiation emitting devices.	% of public inquiries responded to within 10 business days.	90 by March 31, 2016	96
Institutions are enabled to take necessary action against radiation emitting devices that are non-compliant.	% of assessment and/or inspection reports completed upon request from institutions.	100 by March 31, 2016	100

Sub-Program 2.6.3: Dosimetry Services

Description

The Dosimetry Services program monitors, collects information, and reports on the exposure to radiation of its clients, occupational radiation workers under the licence of the Canadian Nuclear Safety Commission’s *Nuclear Safety and Control Act* and/or provincial/territorial regulations. Dosimetry is the act of measuring or estimating radiation doses and assigning those doses to individuals. The National Dosimetry Services provides radiation monitoring services on a cost-recovery basis to Canadians exposed to ionising radiation in their places of work, and, the National Dose Registry provides a centralized radiation dose record system. The program

objective is to ensure that Canadians exposed to radiation in their places of work who are monitored by the Dosimetry Services program are informed of their radiation exposure levels.

Budgetary Financial Resources (dollars)

2015-16 Planned Spending	2015-16 Actual Spending (authorities used)	2015-16 Difference (actual minus planned)
562,800	1,500,024	937,224

Note: The variance between actual and planned spending is mainly due to the reporting of certain actual costs that had been planned under another program.

Human Resources (FTEs)

2015-16 Planned	2015-16 Actual	2015-16 Difference (actual minus planned)
72	59	-13

Note: The variance in FTE utilization is mainly due to hiring delays and personnel departures without backfills.

Performance Results

Expected Results	Performance Indicators	Targets	Actual Results
Occupational radiation workers and their employers are informed of their exposure level.	% of dosimeters reported within 10 days of receiving client dosimeters.	90 by March 31, 2016	95
	% of dose history reports sent to clients within 10 days of receipt of request.	100 by March 31, 2016	99*
	% of overexposure readings reported to Regulatory Authorities within 24 hours of dose information received into the National Dose Registry.	100 by March 31, 2016	100

* 99% of dose history reports sent within 10-day standard. The remaining (unusually large) requests were sent to clients within timelines negotiated with the clients themselves.

Program 2.7: Pesticides

No sub-programs

Program 3.1: First Nation and Inuit Primary Health Care

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

Description

The First Nations and Inuit Health Promotion and Disease Prevention program delivers health promotion and disease prevention services to First Nations and Inuit in Canada. The program administers contribution agreements and direct departmental spending for culturally appropriate community-based programs, services, initiatives, and strategies. In the delivery of this program, the following three key areas are targeted: healthy child development; mental wellness; and healthy living. The program objective is to address the healthy development of children and families, to improve mental wellness, and to reduce the impacts of chronic disease on First Nations and Inuit individuals, families, and communities.

Budgetary Financial Resources (dollars)

2015-16 Planned Spending	2015-16 Actual Spending (authorities used)	2015-16 Difference (actual minus planned)
407,666,652	486,130,680	78,464,028

Note: The variance between actual and planned spending is mainly due to in-year funding received to maintain health promotion, disease prevention and health system transformation programs for Aboriginal populations

Human Resources (Full-Time Equivalents [FTEs])

2015-16 Planned	2015-16 Actual	2015-16 Difference (actual minus planned)
294	359	65

Note: The variance in FTE utilization is mainly due to a combination of additional resources received in-year to maintain health promotion, disease prevention and health system transformation programs for Aboriginal populations and a realignment of resources from plans in order to meet program needs.

Performance Results

Expected Results	Performance Indicators	Targets	Actual Results
The capacity of First Nations and Inuit communities to deliver community-based health promotion and disease prevention	# of workers who completed training during the reporting year for Healthy Child Development programs (specifically Maternal	423 by March 31, 2016	383

Expected Results	Performance Indicators	Targets	Actual Results
programs and services is maintained.	Child Health). (Baseline 423)		
	# of workers who completed training for healthy living programs (specifically Aboriginal Diabetes Initiatives - Community Diabetes Prevention Workers). (Baseline 455)	455 by March 31, 2016	462
	% of addictions counsellors in treatment centres who are certified workers.	77 by March 31, 2016	78

Sub-Sub-Program 3.1.1.1: Healthy Child Development

Description

The Healthy Child Development program administers contribution agreements and direct departmental spending to support culturally appropriate community-based programs, services, initiatives, and strategies related to maternal, infant, child, and family health. The range of services includes prevention and health promotion, outreach and home visiting, and early childhood development programming. Targeted areas in the delivery of this program include: prenatal health, nutrition, early literacy and learning, and physical and children's oral health. The program objective is to address the greater risks and lower health outcomes associated with First Nations and Inuit infants, children, and families. This program uses funding from the following transfer payment: First Nations and Inuit Primary Health Care.

Budgetary Financial Resources (dollars)

2015-16 Planned Spending	2015-16 Actual Spending (authorities used)	2015-16 Difference (actual minus planned)
70,378,852	106,471,004	36,092,152

Note: The variance between actual and planned spending is mainly due to in-year funding received to maintain health promotion, disease prevention and health system transformation programs for Aboriginal populations.

Human Resources (FTEs)

2015-16 Planned	2015-16 Actual	2015-16 Difference (actual minus planned)
88	109	21

Note: The variance in FTE utilization is mainly due to additional resources received in-year to maintain health promotion, disease prevention and health system transformation programs for Aboriginal populations

Performance Results

Expected Results	Performance Indicators	Targets	Actual Results
First Nations and Inuit have access to healthy child development programs and services	# of women accessing Prenatal and Postnatal Health, including Nutrition (specifically Canada Prenatal Nutrition Program). (Baseline 7,982)	7,982 by March 31, 2016	8,815
	# of children accessing early literacy and learning (specifically Aboriginal Head Start On Reserve). (Baseline 5,817)	5,817* by March 31, 2016	13,386
	# of children accessing Children's Oral Health. (Baseline 18,780)	18,780 by March 31, 2016	19,856**

* The baseline had been established through the 2009-10 program evaluation. Since that time, the data source has changed leading to improved reporting. As part of the revisions to the Performance Measurement Framework for 2016-17, the baseline was increased to 13,981 and the target to 14,000.

** (source: dental Database)

Sub-Sub-Program 3.1.1.2: Mental Wellness

Description

The Mental Wellness program administers contribution agreements and direct departmental spending that supports culturally-appropriate community-based programs, services, initiatives and strategies related to the mental wellness of First Nations and Inuit. The range of services includes prevention, early intervention, treatment, and aftercare. Key services supporting program delivery include: substance abuse prevention and treatment (part of NADS), mental health promotion, suicide prevention, and health supports for participants of the Indian

Residential Schools Settlement Agreement. The program objective is to address the greater risks and lower health outcomes associated with the mental wellness of First Nations and Inuit individuals, families, and communities. This program uses funding from the following transfer payment: First Nations and Inuit Primary Health Care.

Budgetary Financial Resources (dollars)

2015-16 Planned Spending	2015-16 Actual Spending (authorities used)	2015-16 Difference (actual minus planned)
300,440,268	295,923,758	-4,516,510

Note: The variance between actual and planned spending is mainly due to a portion of the planned spending in Mental Wellness that was allocated to other areas within Primary Health Care to meet program needs and priorities..

Human Resources (FTEs)

2015-16 Planned	2015-16 Actual	2015-16 Difference (actual minus planned)
108	125	17

Note: The variance in FTE utilization is mainly due to additional resources received in-year to maintain health promotion, disease prevention and health system transformation programs for Aboriginal populations.

Performance Results

Expected Results	Performance Indicators	Targets	Actual Results
Abstinence from drug and alcohol use after addictions treatment.	% of treatment centre clients who terminated substance use of at least one substance after completing treatment.	30* by March 31, 2016	60**
Reduced substance use following treatment.	% of treatment centre clients who reduced substance use of at least one substance after completing treatment.	50** by March 31, 2016	94**
First Nations and Inuit have access to mental wellness programs and services.	# of projects providing suicide prevention programs (specifically National Aboriginal Youth Suicide Prevention Strategy).	115 by March 31, 2016	138

Expected Results	Performance Indicators	Targets	Actual Results
	(Baseline 115)		

* A 30% success rate after completion of treatment reflects the fact that there is a high rate of recidivism among people who seek treatment for substance abuse.

** No new data. Data comes from the 2012 NNADAP Treatment Centre Outcome Study Report finalized in 2013. 2015-16 data collection is in process. Data will be available in September 2016.

** Because of the high rate of recidivism, even a reduction in at least one substance is a success.

Sub-Sub-Program 3.1.1.3: Healthy Living

Description

The Healthy Living program administers contribution agreements and direct departmental spending that supports culturally appropriate community-based programs, services, initiatives, and strategies related to chronic disease and injuries among First Nations and Inuit. This program aims to promote healthy behaviours and supportive environments in the areas of healthy eating, physical activity, food security, chronic disease prevention, management and screening, and injury prevention policy. Key activities supporting program delivery include: chronic disease prevention and management, injury prevention, the Nutrition North Canada – Nutrition Education Initiative, and the First Nations and Inuit component of the Federal Tobacco Control Strategy (being implemented in 2012-13). The program objective is to address the greater risks and lower health outcomes associated with chronic diseases and injuries among First Nations and Inuit individuals, families, and communities. This program uses funding from the following transfer payment: First Nations and Inuit Primary Health Care.

Budgetary Financial Resources (dollars)

2015-16 Planned Spending	2015-16 Actual Spending (authorities used)	2015-16 Difference (actual minus planned)
36,847,532	83,735,918	46,888,386

Note: The variance between actual and planned spending is mainly due to in-year funding received to maintain health promotion, disease prevention and health system transformation programs for Aboriginal populations.

Human Resources (FTEs)

2015-16 Planned	2015-16 Actual	2015-16 Difference (actual minus planned)
98	125	27

Note: The variance in FTE utilization is mainly due to additional resources received in-year to maintain health promotion, disease prevention and health system transformation programs for Aboriginal populations.

Performance Results

Expected Results	Performance Indicators	Targets	Actual Results
First Nations and Inuit have access to healthy living programs and services.	% of communities providing healthy living programs (specifically Aboriginal Diabetes Initiatives).	90 by March 31, 2016	92
	% of projects that deliver physical activities under the Aboriginal Diabetes Initiatives.	63*by March 31, 2016	88
	% of projects that deliver healthy eating activities under the Aboriginal Diabetes Initiatives.	66* by March 31, 2016	81

* This target reflects the fact that contribution agreement recipients will choose to deliver projects based on the needs of their communities.

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

Description

The First Nations and Inuit Public Health Protection program delivers public health protection services to First Nations and Inuit in Canada. In the delivery of this program, the key areas of focus are communicable disease control and management, and environmental public health. The First Nations and Inuit Public Health Protection program administers contribution agreements and direct departmental spending to support initiatives related to communicable disease control and environmental public health service delivery including public health surveillance, research, and risk analysis. Communicable disease control and environmental public health services are targeted to on-reserve First Nations, with some support provided in specific instances, (e.g., to address tuberculosis), in Inuit communities south of the 60th parallel. Environmental public health research, surveillance, and risk analysis are directed to on-reserve First Nations, and in some cases, (e.g., climate change and health adaptation, and biomonitoring), also to Inuit and First Nations living north of the 60th parallel. Surveillance data underpins these public health activities and all are conducted with the understanding that social determinants play a crucial role. To mitigate impacts from factors beyond the public health system, the program works with First Nations, Inuit, and other organizations. The program objective is to address human health risks for First Nations and Inuit communities associated with communicable diseases and exposure to hazards within the natural and built environments by increasing community capacity to respond to these risks.

Budgetary Financial Resources (dollars)

2015-16 Planned Spending	2015-16 Actual Spending (authorities used)	2015-16 Difference (actual minus planned)
97,719,813	98,516,023	796,210

Note: The variance between actual and planned spending is mainly due to a reallocation of funding within this strategic outcome to address program needs and priorities.

Human Resources (FTEs)

2015-16 Planned	2015-16 Actual	2015-16 Difference (actual minus planned)
377	332	-45

Note: The variance in FTE utilization is mainly due to a realignment of resources from plans in order to meet program needs and priorities.

Performance Results

Expected Results	Performance Indicators	Targets	Actual Results
The community capacity to respond to health emergencies is improved.	% of First Nations communities with integrated Pandemic Preparedness/ Response Plans and Emergency Preparedness/ Readiness Plans.	75 by March 31, 2016	70
Environmental health risks relating to water quality are reduced.	% of on-reserve public water systems that met weekly national testing guidelines for bacteriological parameters (e.g. based on testing frequency recommended in the Guidelines for Canadian Drinking Water Quality).	50.6* by March 31, 2016	48
	% of First Nations communities that have access to a trained Community-based Drinking Water Quality Monitor or an Environmental Health	100 by March 31, 2016	100

Expected Results	Performance Indicators	Targets	Actual Results
	Officer to monitor their drinking water quality.		

* The target of 50.6% represents a 15% improvement over the 2010 levels of 44%. It should be noted that First Nations undertake this monitoring and Health Canada provides assistance.

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

Description

The Communicable Disease Control and Management program administers contribution agreements and direct departmental spending to support initiatives related to vaccine preventable diseases, blood borne diseases and sexually transmitted infections, respiratory infections, and communicable disease emergencies. In collaboration with other jurisdictions communicable disease control and management activities are targeted to on-reserve First Nations, with support provided to specific instances (such as to address tuberculosis), in Inuit communities south of the 60th parallel. Communicable Disease Control and Management activities are founded on public health surveillance and evidence-based approaches and reflective of the fact that all provincial and territorial governments have public health legislation. Key activities supporting program delivery include: prevention, treatment and control of cases and outbreaks of communicable diseases; and, public education and awareness to encourage healthy practices. A number of these activities are closely linked with those undertaken in the Environmental Health program (3.1.2.2), as they relate to waterborne, foodborne and zoonotic infectious diseases. The program objective is to reduce the incidence, spread, and human health effects of communicable diseases for First Nations and Inuit communities. This program uses funding from the following transfer payment: First Nations and Inuit Primary Health Care.

Budgetary Financial Resources (dollars)

2015-16 Planned Spending	2015-16 Actual Spending (authorities used)	2015-16 Difference (actual minus planned)
57,327,291	64,444,287	7,116,996

Note: The variance between actual and planned spending is mainly due to the need to respond to urgent communicable disease outbreaks.

Human Resources (FTEs)

2015-16 Planned	2015-16 Actual	2015-16 Difference (actual minus planned)
212	182	-30

Note: The variance in FTE utilization is mainly due to a realignment of resources from plans in order to meet program needs and priorities.

Performance Results

Expected Results	Performance Indicators	Targets	Actual Results
Improved rates of treatment adherence.	% of patients diagnosed with active tuberculosis who completed treatment.	90 by March 31, 2016	91*
Public awareness and knowledge of vaccine preventable diseases and immunization is improved.	% of on-reserve caregivers who recognize the importance of childhood vaccination.	85 by March 31, 2016	93**
	% of communities conducting immunisation education and awareness activities	95 by March 31, 2016	59***

* Based on data from the Canadian Tuberculosis Reporting System (PHAC) in 6 FNIHB Regions (B-C excluded).

** Data comes from the First Nations and Inuit Immunization Campaign Report, 2014.

***A new data source/ methodology was used for 2015-16 (CBRT instead of Public Opinion Research).The target has been revised in the PMF 2016-17 to 65% and the baseline to 59%.

Sub-Sub-Program 3.1.2.2: Environmental Public Health

Description

The Environmental Public Health program administers contribution agreements and direct departmental spending for environmental public health service delivery. Environmental public health services are directed to First Nations communities south of the 60th parallel and address areas such as: drinking water; wastewater; solid waste disposal; food safety; health and housing; facilities inspections; environmental public health aspects of emergency preparedness response; and, communicable disease control. Environmental public health surveillance and risk analysis programming is directed to First Nations communities south of the 60th parallel, and in some cases, also to Inuit and First Nations north of the 60th parallel. It includes community-based and participatory research on trends and impacts of environmental factors such as chemical contaminants and climate change on the determinants of health (e.g., biophysical, social, cultural, and spiritual). Key activities supporting program delivery include: public health; surveillance, monitoring and assessments; public education; training; and, community capacity building. The program objective is to identify, address, and/or prevent human health risks to First Nations and Inuit communities associated with exposure to hazards within the natural and built environments. This program uses funding from the following transfer payment: First Nations and Inuit Primary Health Care.

Budgetary Financial Resources (dollars)

2015-16 Planned Spending	2015-16 Actual Spending (authorities used)	2015-16 Difference (actual minus planned)
40,392,522	34,071,736	-6,320,786

Note: The variance between actual and planned spending is mainly due to the reallocation of funds to Communicable Disease Control and Management to respond to urgent communicable disease outbreaks.

Human Resources (FTEs)

2015-16 Planned	2015-16 Actual	2015-16 Difference (actual minus planned)
165	150	-15

Note: The variance in FTE utilization is mainly due to a realignment of resources to Communicable Disease Control and Management to respond to urgent communicable disease outbreaks.

Performance Results

Expected Results	Performance Indicators	Targets	Actual Results
Decision makers have access to information about environmental public health hazards, with a focus on risk identification and mitigation.	# of communities undertaking surveillance, monitoring and assessment projects on environmental public health hazards. (Baseline 18).	25 by March 31, 2016	29

Sub-Program 3.1.3 : First Nations and Inuit Primary Care

Description

The First Nations and Inuit Primary Care program administers contribution agreements and direct departmental spending. These funds are used to support the staffing and operation of nursing stations on-reserve, dental therapy services and home and community care programs in First Nation and Inuit communities, and on-reserve hospitals in Manitoba, where services are not provided by provincial/territorial health systems. Care is delivered by a collaborative health care team, predominantly nurse-led, providing integrated and accessible health care services that include: assessment; diagnostic; curative; case-management; rehabilitative; supportive; respite; and, palliative/end-of-life care. Key activities supporting program delivery include Clinical and Client Care in addition to Home and Community Care. The program objective is to provide primary care services to First Nations and Inuit communities.

Budgetary Financial Resources (dollars)

2015-16 Planned Spending	2015-16 Actual Spending (authorities used)	2015-16 Difference (actual minus planned)
304,452,231	303,394,855	-1,057,376

Note: The variance between actual and planned spending is mainly due to a reallocation of funding within this strategic outcome to address program needs and priorities.

Human Resources (FTEs)

2015-16 Planned	2015-16 Actual	2015-16 Difference (actual minus planned)
682	646	-36

Note: The variance in FTE utilization is mainly due to a realignment of resources from plans in order to meet program needs and priorities.

Performance Results

Expected Results	Performance Indicators	Targets	Actual Results
Primary care services based on assessed need are provided to First Nations and Inuit communities.	Utilisation rate per 1,000 eligible on-reserve population (home and community care and clinical and client care).	368.8 by March 31, 2016	This indicator is under review, as the current data collection methodology does not provide a representative result for the on-reserve population.
Coordinated responses to primary care services.	% of First Nations communities with collaborative service delivery arrangements with external primary care service providers.	50 by March 31, 2016	69

Sub-Sub-Program 3.1.3.1: Clinical and Client Care

Description

The Clinical and Client Care program is delivered by a collaborative health care team, predominantly nurse-led, providing integrated and accessible health and oral health care services that include assessment, diagnostic, curative, and rehabilitative services for urgent and non-urgent care. Key services supporting program delivery include: triage, emergency resuscitation and stabilization, emergency ambulatory care, and out-patient non-urgent services; coordinated

and integrated care and referral to appropriate provincial secondary and tertiary levels of care outside the community; and, in some communities, physician visits and hospital in-patient, ambulatory, and emergency services. The program objective is to provide clinical and client care services to First Nations individuals, families, and communities. This program uses funding from the following transfer payment: First Nations and Inuit Primary Health Care.

Budgetary Financial Resources (dollars)

2015-16 Planned Spending	2015-16 Actual Spending (authorities used)	2015-16 Difference (actual minus planned)
199,272,910	191,683,428	-7,589,482

Note: The variance between actual and planned spending is mainly due to a reallocation of funding to Home and Community Care to address program needs and priorities.

Human Resources (FTEs)

2015-16 Planned	2015-16 Actual	2015-16 Difference (actual minus planned)
609	584	-25

Note: The variance in FTE utilization is mainly due to a realignment of resources from plans in order to meet program needs and priorities.

Performance Results

Expected Results	Performance Indicators	Targets	Actual Results
First Nations and Inuit populations have access to clinical and client care services.	% of eligible on-reserve population accessing clinical and client care services.	29* by March 31, 2016	This indicator is under review, as the current data collection methodology does not provide a representative result for the on-reserve population.
	Ratio of clinical care visits to public health visits.	4 by 1 by March 31, 2016	Insufficient information available. This indicator has been removed in Performance Measurement Framework (PMF) 2016-17.
	% of urgent Clinical and Client Care visits provided after hours in	35** by March 31, 2016	10

Expected Results	Performance Indicators	Targets	Actual Results
	nursing stations and health centres with a treatment component.		

* This target is based on service utilization and maintaining service levels for those in need. It is not anticipated that the entire eligible on-reserve population will need to use clinical and client care services.

** Clients are visiting nursing stations and health centres with a treatment component after hours for urgent and non-urgent care. In 2012-13, approximately 30% of after hour visits were urgent. The target represents a 5% decrease in the use of after hour care for non-urgent visits.

Sub-Sub-Program 3.1.3.2: Home and Community Care

Description

The Home and Community Care program administers contribution agreements with First Nation and Inuit communities and territorial governments to enable First Nations and Inuit individuals with disabilities, chronic or acute illnesses, and the elderly to receive the care they need in their homes and communities. Care is delivered primarily by home care registered nurses and trained certified personal care workers. In the delivery of this program First Nations and Inuit Health Branch provides funding through contribution agreements and direct departmental spending for a continuum of basic essential services such as: client assessment and case management; home care nursing, personal care and home support as well as in-home respite; and, linkages and referral, as needed, to other health and social services. Based on community needs and priorities, existing infrastructure, and availability of resources, the Home and Community Care program may be expanded to include supportive services. These services may include: rehabilitation and other therapies; adult day programs; meal programs; in-home mental health; in-home palliative care; and, specialized health promotion, wellness, and fitness services. The program objective is to provide home and community care services to First Nations and Inuit individuals, families, and communities. This program uses funding from the following transfer payment: First Nations and Inuit Primary Health Care.

Budgetary Financial Resources (dollars)

2015-16 Planned Spending	2015-16 Actual Spending (authorities used)	2015-16 Difference (actual minus planned)
105,179,321	111,711,427	6,532,106

Note: The variance between actual and planned spending is mainly due to increases in demand for the Home and Community Care program.

Human Resources (FTEs)

2015-16 Planned	2015-16 Actual	2015-16 Difference (actual minus planned)
73	62	-11

Note: The variance in FTE utilization is mainly due to a realignment of resources from plans in order to meet program needs and priorities.

Performance Results

Expected Results	Performance Indicators	Targets	Actual Results
Home and community care services are provided in First Nations and Inuit communities.	Utilisation rate per 1,000 on-reserve population.	71.2 by March 31, 2016	69*
Service delivery arrangements with internal and external delivery partners are provided in First Nations and Inuit communities.	% distribution of Home and Community Care hours of care provided for home care nursing.	8.6 by March 31, 2016	9.6**
	% of communities with collaborative service delivery arrangements with external service delivery partners.	50 by March 31, 2016	49

* Indicator is driven by demands and can vary each year. Data reflects Fiscal Year (FY) 2013-14 information. Communities have up to 18 months following the end of a FY to upload data in the reporting system. 2015/16 data will be available in October 2017.

** Data reflects FY 2013-14 information. Communities have up to 18 months following the end of a FY to upload data in the reporting system. 2015/16 data will be available in October 2017.

Program 3.2: Supplementary Health Benefits for First Nations and Inuit

No sub-programs

Program 3.3: Health Infrastructure Support for First Nations and Inuit

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

Description

The First Nations and Inuit Health System Capacity program administers contribution agreements and direct departmental spending focusing on the overall management and implementation of health programs and services. This program supports the promotion of First Nations and Inuit participation in: health careers including education bursaries and scholarships; the development of, and access to health research; information and knowledge to inform all aspects of health programs and services; and, the construction and maintenance of health facilities. This program also supports efforts to develop new health governance structures with increased First Nations participation. Program engagement includes a diverse group of partners, stakeholders, and clients including: First Nations and Inuit communities, district and tribal councils; national Aboriginal organizations and non-governmental organizations; health organizations; provincial and regional health departments and authorities; post-secondary educational institutions and associations; and, health professionals and program administrators. The program objective is to improve the delivery of health programs and services to First Nations and Inuit by enhancing First Nations and Inuit capacity to plan and manage their programs and infrastructure.

Budgetary Financial Resources (dollars)

2015-16 Planned Spending	2015-16 Actual Spending (authorities used)	2015-16 Difference (actual minus planned)
185,931,742	209,519,830	23,588,088

Note: The variance between actual and planned spending is mainly due to the need to make essential and priority investments in First Nations and Inuit Health infrastructures.

Human Resources (FTEs)

2015-16 Planned	2015-16 Actual	2015-16 Difference (actual minus planned)
127	106	-21

Note: The variance in FTE utilization is mainly due to a realignment of resources from plans in order to meet program needs and priorities.

Performance Results

Expected Results	Performance Indicators	Targets	Actual Results
Quality in the delivery of programs and services is improved.	# of communities accessing accredited health services. (Baseline 59)	77 by March 31, 2016	138
Health facilities managed by First Nations and Inuit are safe.	% of health facilities subject to an Integrated Facility Audit that do not have critical property issues. (Baseline 55)	58* by March 31, 2016	18

* This target represents an increase of 5% from the previous measure.

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

Description

The Health Planning and Quality Management program administers contribution agreements and direct departmental spending to support capacity development for First Nations and Inuit communities. Key services supporting program delivery include: the development and delivery of health programs and services through program planning and management; on-going health system improvement via accreditation; the evaluation of health programs; and, support for community development activities. The program objective is to increase the capacity of First Nations and Inuit to design, manage, evaluate, and deliver health programs and services. This program uses funding from the following transfer payment: First Nations and Inuit Health Infrastructure Support.

Budgetary Financial Resources (dollars)

2015-16 Planned Spending	2015-16 Actual Spending (authorities used)	2015-16 Difference (actual minus planned)
121,440,021	114,083,322	-7,356,699

Note: The variance between actual and planned spending is mainly due to fewer requirements than initially planned. Funding was redirected to other initiatives within this strategic outcome to address program needs and priorities.

Human Resources (FTEs)

2015-16 Planned	2015-16 Actual	2015-16 Difference (actual minus planned)
74	63	-11

Note: The variance in FTE utilization is mainly due to fewer resources required than initially planned. Resources were redirected to other initiatives within this strategic outcome to address program needs and priorities.

Performance Results

Expected Results	Performance Indicators	Targets	Actual Results
The capacity to deliver health programs and services is increased.	# of organizations that provide accredited community health services. (Baseline: 35)	53 by March 31, 2016	58

Sub-Sub-Program 3.3.1.2: Health Human Resources

Description

The Health Human Resources program administers contribution agreements and direct departmental spending to promote and support competent health services at the community level by increasing the number of First Nations and Inuit individuals entering into and working in health careers and ensuring that community-based workers have skills and certification comparable to workers in the provincial/territorial health care system. This program engages many stakeholders, including: federal, provincial and territorial governments and health professional organizations; national Aboriginal organizations; non-governmental organizations and associations; and, educational institutions. Key activities supporting program delivery include: health education bursaries and scholarships; health career promotion activities; internship and summer student work opportunities; knowledge translation activities; training for community based health care workers and health managers; and, development and implementation of health human resources planning for Aboriginal, federal, provincial, territorial, health professional associations, educational institutions, and other stakeholders. The program objective is to increase the number of qualified First Nations and Inuit individuals working in health care delivery. This program uses funding from the following transfer payment: First Nations and Inuit Health Infrastructure Support.

Budgetary Financial Resources (dollars)

2015-16 Planned Spending	2015-16 Actual Spending (authorities used)	2015-16 Difference (actual minus planned)
5,284,630	5,792,705	508,075

Note: The variance between actual and planned spending is mainly due to in-year funding received for the Aboriginal Health Human Resources Initiative.

Human Resources (FTEs)

2015-16 Planned	2015-16 Actual	2015-16 Difference (actual minus planned)
17	11	-6

Note: The variance in FTE utilization is mainly due to a realignment of resources from plans in order to meet program needs and priorities.

Performance Results

Expected Results	Performance Indicators	Targets	Actual Results
Greater participation of Aboriginal people in post-secondary education leading to health careers.	# of bursaries and scholarships provided to Aboriginal people per year. (Baseline 340)	425 by March 31, 2016	764

Sub-Sub-Program 3.3.1.3: Health Facilities

Description

The Health Facilities program administers contribution agreements and direct departmental spending that provide communities and/or health care providers with the facilities required to safely and efficiently deliver health programs and services. Direct departmental spending addresses the working conditions of Health Canada staff engaged in the direct delivery of health programs and services to First Nations and Inuit. Key activities supporting program delivery include: investment in infrastructure that can include the construction, acquisition, leasing, operation, maintenance, expansion and/or renovation of health facilities and security services; preventative and corrective measures relating to infrastructure; and, improving the working conditions for Health Canada staff so as to maintain or restore compliance with building codes, environmental legislation, and occupational health and safety standards. The program objective is to support the development and delivery of health programs and services through investments in infrastructure. This program uses funding from the following transfer payment: First Nations and Inuit Health Infrastructure Support.

Budgetary Financial Resources (dollars)

2015-16 Planned Spending	2015-16 Actual Spending (authorities used)	2015-16 Difference (actual minus planned)
59,207,091	89,643,803	30,436,712

Note: The variance between actual and planned spending is mainly to reflect essential and priority investments in First Nation and Inuit Health Infrastructure.

Human Resources (FTEs)

2015-16 Planned	2015-16 Actual	2015-16 Difference (actual minus planned)
36	32	-4

Note: The variance in FTE utilization is mainly due to a realignment of resources from plans in order to meet program needs and priorities.

Performance Results

Expected Results	Performance Indicators	Targets	Actual Results
Health facilities that support program delivery are safe.	% of "high priority" recommendations stemming from Integrated Facility Audits are addressed on schedule. (Baseline 23)	50* by March 31, 2016	74
Health programs and services are supported through effective community capacity to manage their health plans.	# of recipients that have signed contribution agreements that start in 2011-12 or later that have developed plans for managing the operations and maintenance of their Health Infrastructure	15 by March 31, 2016	126

* Health Canada works toward improving its collaborative process with First Nations communities to address facility deficiencies. The baseline of 23% was set in 2012-13, and the target of 50% is set to be achieved by March 31, 2016.

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

Description

The First Nations and Inuit Health System Transformation program integrates, coordinates, and develops innovative publicly funded health systems serving First Nations and Inuit individuals, families, and communities through the administration of contribution agreements and direct departmental spending. This program includes the development of innovative approaches to primary health care, sustainable investment in appropriate technologies that enhance health service delivery, and support for the development of new governance structures and initiatives to increase First Nations and Inuit participation in, and control over, the design and delivery of health programs and services in their communities. Through this program, Health Canada engages and works with a diverse group of partners, stakeholders, and clients including: First Nations and Inuit communities, tribal councils, Aboriginal organizations, provincial and regional health departments and authorities, post-secondary educational institutions and associations, health professionals and program administrators. The program objective is that First Nations and Inuit health systems are more effective and efficient.

Budgetary Financial Resources (dollars)

2015-16 Planned Spending	2015-16 Actual Spending (authorities used)	2015-16 Difference (actual minus planned)
28,981,507	41,016,231	12,034,724

Note: The variance between actual and planned spending is mainly due to in-year funding received to maintain health promotion, disease prevention and health system transformation programs for Aboriginal populations.

Human Resources (FTEs)

2015-16 Planned	2015-16 Actual	2015-16 Difference (actual minus planned)
92	82	-10

Note: The variance in FTE utilization is mainly due to a realignment of resources from plans in order to meet program needs and priorities.

Performance Results

Expected Results	Performance Indicators	Targets	Actual Results
Key stakeholders in Aboriginal health are engaged in the integration of health services.	% of provincial/ territorial Advisory Committees in which key stakeholders in the integration of health services (First Nations and Inuit/ provincial/territorial) are represented.	100 by March 31, 2016	100

Sub-Sub-Program 3.3.2.1: Systems Integration

Description

The Systems Integration program administers contribution agreements and direct departmental spending to better integrate health programs and services funded by the federal government with those funded by provincial/territorial governments. This program supports the efforts of partners in health services, including: First Nations and Inuit, tribal councils, regional/district health authorities, regions, national Aboriginal organizations, and provincial/territorial organizations to integrate health systems, services, and programs so they are more coordinated and better suited to the needs of First Nations and Inuit. This program also promotes and encourages emerging tripartite agreements. Two key activities supporting program delivery include: development of multi-party structures to jointly identify integration priorities and plans for further integrating

health services in a given province/territory; and, implementation of multi-year, large-scale health service integration projects consistent with agreed-upon priorities (i.e., a province-wide public health framework or integrated mental health services planning and delivery on a regional scale). The program objective is a health system that is efficient and integrated resulting in increased access to care and improved health outcomes for First Nations and Inuit individuals, families, and communities. This program uses funding from the following transfer payment: First Nations and Inuit Health Infrastructure Support.

Budgetary Financial Resources (dollars)

2015-16 Planned Spending	2015-16 Actual Spending (authorities used)	2015-16 Difference (actual minus planned)
2,263,231	10,286,497	8,023,266

Note: The variance between actual and planned spending is mainly due to in-year funding received to maintain health promotion, disease prevention and health system transformation programs for Aboriginal populations.

Human Resources (FTEs)

2015-16 Planned	2015-16 Actual	2015-16 Difference (actual minus planned)
26	27	1

Note: The variance in FTE utilization is mainly due to in-year resources received to maintain health promotion, disease prevention and health system transformation programs for Aboriginal populations.

Performance Results

Expected Results	Performance Indicators	Targets	Actual Results
Collaborative planning for, and integration of, Aboriginal health services is increased	% of First Nations and Inuit communities involved in a Health Services Integration Fund project, which affirms increased collaboration among the respective jurisdictions involved in planning, delivering and/or funding health services.	100 by March 31, 2016	73

Sub-Sub-Program 3.3.2.2: e-Health Infostructure

Description

The eHealth Infostructure program administers contribution agreements and direct departmental spending to support and sustain the use and adoption of appropriate health technologies that enable front line care providers to better deliver health services in First Nations and Inuit communities through eHealth partnerships, technologies, tools, and services. Direct departmental spending also supports national projects that examine innovative information systems and communications technologies and that have potential national implications. Key activities supporting program delivery include: public health surveillance; health services delivery (primary and community care included); health reporting, planning and decision making; and, integration/compatibility with other health service delivery partners. The program objective is to improve the efficiency of health care delivery to First Nations and Inuit individuals, families, and communities through the use of eHealth technologies for the purpose of defining, collecting, communicating, managing, disseminating, and using data. This program uses funding from the following transfer payment: First Nations and Inuit Health Infrastructure Support.

Budgetary Financial Resources (dollars)

2015-16 Planned Spending	2015-16 Actual Spending (authorities used)	2015-16 Difference (actual minus planned)
26,718,276	30,729,734	4,011,458

Note: The variance between actual and planned spending is mainly due to a portion of statutory expenditures reported here that was not allocated to other program areas within this Strategic Outcome.

Human Resources (FTEs)

2015-16 Planned	2015-16 Actual	2015-16 Difference (actual minus planned)
66	55	-11

Note: The variance in FTE utilization is mainly due to a realignment of resources from plans in order to meet program needs and priorities.

Performance Results

Expected Results	Performance Indicators	Targets	Actual Results
Access to e-Health Infostructure service is improved.	# of First Nations communities using Panorama or equivalent public health information system.	24 by March 31, 2016	20

Expected Results	Performance Indicators	Targets	Actual Results
	(Baseline 0)		
Integration of the health systems serving First Nations and Inuit.	# of telehealth sites implemented. (Baseline 240)	250 by March 31, 2016	248

Sub-Program 3.3.3: Tripartite Health Governance

Description

FNIHB's longer-term policy approach aims to achieve closer integration of federal and provincial health programming provided to First Nations, as well as to improve access to health programming, reduce instances of service overlap and duplication, and increase efficiency where possible. The BC Tripartite Initiative consists of an arrangement among the Government of Canada, the Government of BC, and BC First Nations. Since 2006, the parties have negotiated and implemented a series of tripartite agreements to facilitate the implementation of health projects, as well as the development of a new First Nations health governance structure. In 2011, the federal and provincial Ministers of Health and BC First Nations signed the legally-binding BC Tripartite Framework Agreement on First Nation Health Governance. This BC Tripartite Framework Agreement commits to the creation of a new province-wide FNHA to assume the responsibility for design, management, and delivery/funding of First Nations health programming in BC. The FNHA will be controlled by First Nations and will work with the province to coordinate health programming. It may design or redesign health programs according to its health plans. Health Canada will remain a funder and governance partner but will no longer have any role in program design/delivery. Funding under this program is limited to the FNHA for the implementation of the BC Tripartite Framework Agreement. The program objective is to enable the newly formed FNHA to develop and deliver quality health services that feature closer collaboration and integration with provincial health services. This program uses funding from the following transfer payment: First Nations and Inuit Health Infrastructure Support.

Budgetary Financial Resources (dollars)

2015-16 Planned Spending	2015-16 Actual Spending (authorities used)	2015-16 Difference (actual minus planned)
420,550,597	421,740,263	1,189,666

Note: The variance between actual and planned spending is mainly due to additional funding transferred to the First Nation Health Authority in British Columbia to support comprehensive health planning activities.

Human Resources (FTEs)

2015-16 Planned	2015-16 Actual	2015-16 Difference (actual minus planned)
0	0	0

Performance Results

Expected Results	Performance Indicators	Targets	Actual Results
Reciprocal accountability amongst tripartite governance partners, as stated in section 2.2 of the BC Tripartite Framework Agreement on First Nations Health Governance.	% of planned partnership and engagement activities implemented, as committed in section 8 of the BC Tripartite Framework Agreement.	100 by March 31, 2016	100

Endnotes

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i Food and Drugs Regulations, http://laws-lois.justice.gc.ca/eng/regulations/c.r.c.,_c._870/index.html

ii Safety of Human Cells, Tissues and Organs for Transplantation Regulations, http://laws-lois.justice.gc.ca/eng/regulations/SOR-2007-118/

iii Processing and Distribution of Semen for Assisted Conception Regulations, http://laws.justice.gc.ca/eng/regulations/SOR-96-254/

iv Medical Devices Regulations, http://laws-lois.justice.gc.ca/eng/regulations/sor-98-282/

v Natural Health Product Regulations, http://laws-lois.justice.gc.ca/eng/regulations/sor-2003-196/

vi Guidelines for Canadian Drinking Water Quality, http://www.hc-sc.gc.ca/ewh-semt/pubs/water-eau/sum_guide-res_recom/index-eng.php