FOR THE RECORD

Health transfers and budgetary trade-offs

The federal government's contribution to health care spending in Canada will substantially decline over the next three decades as a consequence of Finance Minister Jim Flaherty's plan to limit the future growth rate of cash transfer payments to the provinces for health, Parliamentary Budget Officer (PBO) Kevin Page asserts.

"The share of federal CHT [Canada Health Transfer] cash payments in provincial-territorial health spending will decrease substantially from 20.4 per cent in 2010-11 to average 18.6 per cent over 2011-12 to 2035-36; then 13.8 per cent over the following 25 years; and, 11.9 per cent over the remainder of the projection horizon," Page stated in a report, *Renewing the Canada Health Transfer: Implications for Federal and Provincial-Territorial Fiscal Sustainability* (www.parl.gc.ca/PBO-DPB/documents/Renewing_CHT.pdf). "This would ultimately bring the level of federal cash support to historical lows observed under the 1996-97 to 2001-02 period of CHST (Canada Health and Social Transfer) funding."

Flaherty announced in December 2011 that cash transfers will grow by 6% through fiscal 2016 and then be pegged to a "three-year moving average of nominal gross domestic product [GDP]," with a minimum 3% increase, through 2024 (www.fin.gc.ca/n11/data/11-141_1-eng.asp).

But by constraining the growth rate of cash transfers for health, the federal government's overall budget picture will brighten, Page said.

"As a result of incorporating the new CHT escalator the fiscal structure at the federal level is now sustainable. Indeed, PBO projects that the federal net debt-to-GDP ratio will decline steadily from its current level, ultimately resulting in a net asset position. PBO estimates that the federal fiscal gap is now -0.4 per cent of GDP, indicating that – relative to PBO's projection – the federal government could reduce revenue, increase program spending or some combination of both (by $7 billion in 2011-12 and increasing over time in line with nominal GDP) while maintaining fiscal sustainability," the report states.

By contrast, the provinces will be harder pressed, it adds. "Provincial-territorial net debt relative to GDP is projected to increase substantially over the long term from 20 per cent in 2010-11 to over 125 per cent in 2050-51 and to over 480 per cent by 2085-86. PBO estimates that the provincial-territorial fiscal gap is now +2.9 per cent of GDP, indicating that — relative to PBO's projection — provincial-territorial governments would need to raise revenue, reduce program spending or some combination of both (by $49 billion in 2011-12 and increasing over time in line with nominal GDP) to achieve fiscal sustainability."

Page's projections are based on the assumption that the escalator formula — the three-year moving average of nominal GDP growth — used after 2024 will be unchanged during the review of transfer payments scheduled for 2024. If that's true, "growth in the CHT will continue to fall short of projected growth in provincial-territorial government health spending. For example, over the period 2025-26 to 2040-41, PBO projects growth in the CHT to average 3.8 per cent annually while growth in provincial-territorial health spending is projected to average 5.3 per cent per year."

Page also noted that the decline in the federal government's contribution to health will be substantial. By contrast, "over the period 1968-69 to 1976-77 under cost-sharing federal health cash transfers amounted to 36.1 per cent of provincial-territorial health spending on average." — Wayne Kondro, *CMAJ*

Provinces to craft health strategy

While grumbling loudly about the federal government's decision to unilaterally pronounce limits on the future growth rate of cash transfer payments to the provinces for health care, the nation's premiers have created a "Health Care Innovation Working Group" to examine scope of practice, health human resources and clinical practice issues across Canada.

The working group, to be cochaired by Prince Edward Island Premier Robert Ghiz and Saskatchewan Premier Brad Wall, will spend the next six months crafting a nationwide strategy to improve health care that they hope is so compelling it will shake down the federal government for more money. The plan will be submitted for consideration at the July 2012 Council of the Federation meeting in Halifax, Nova Scotia, the premiers stated in a press release (www.councilofthefederation.ca/pdfs/Communique_Task%20Force_Jan_17.pdf).

The premiers indicated that "in consultation with health care providers, over the next six months the working group will focus on:

- Scope of practice: examining the scope of practice of health care providers and teams in order to better meet patient and population needs in a safe, competent and cost effective manner.
- Human resources management: address health human resource challenges and explore more coordinated management to address competition across health systems.
- Clinical practice guidelines: accelerating the development and adoption of best clinical and surgical practice

guidelines so that all Canadians benefit from up-to-date practices."

"This is a bold move with real timelines," stated British Columbia Premier Christy Clark, chair of the Jan. 16–17 meeting of the council. "The message we want to send is that we are working together to innovate and provide better care for seniors and all Canadians."

"This crucial work will be done under the leadership of Premiers working with health care providers," Ghiz added. "They are the untapped strength of the system."

The premiers also created a finance working group, to be headed by Manitoba Premier Greg Selinger, "to assess the fiscal impact" of the federal government's decision to distribute future cash transfer payments to the provinces on a per capita basis (www.councilofthefederation.ca/pdfs/Communique_Finance_Jan_17.pdf).

Federal Finance Minister Jim Flaherty announced in December 2011 that cash transfers will grow by 6% through fiscal 2016 and then be pegged to a "three-year moving average of nominal gross domestic product," with a minimum 3% increase, through 2024 (www.fin.gc.ca/n11/data/11-141_1-eng.asp).

Several provinces object to cash transfer payments that are made on a per capita basis, arguing that the approach doesn't take into account demographic variables such as the age of populations. They believe preferential consideration should be given to provinces with older populations because the latter place a greater strain on their health systems. Traditionally, such considerations are the basis for separate equalization payments to the provinces, rather than cash transfers, and Prime Minister Stephen Harper has repeatedly indicated he is loathe to build equalization considerations directly into the formula for health transfers. — Wayne Kondro, *CMAJ*

Health Canada completes review of varenicline

Health Canada has announced that it has completed its review of varenicline and "the label has been updated with new information with respect to cardiovascular safety. Champix (the brand name for varenicline tartrate) is a prescription drug used to help patients quit smoking in combination with supportive counselling."

"Health Canada evaluated data from a quit-smoking clinical trial involving 700 smokers with cardiovascular disease (approximately 350 who received Champix and 350 who received a placebo or "sugar pills"). Cardiovascular disease is a broad term for any condition that affects the heart and/or blood vessels, including heart attack and stroke," the department stated in a press release (www.hc-sc.gc.ca/ahc-asc/media/advisories-avis/_2012/2012_07-eng.php).

"Although a slightly increased number of patients experienced serious heart-related events in the group treated with Champix compared to the group treated with placebo, the study was not adequately designed to be able to test the cardiovascular safety of Champix. The small study size combined with other study design weaknesses make it impossible to draw conclusions based on these data. The possibility of an increased risk of heart attack or stroke in patients with cardiovascular disease can neither be confirmed nor ruled out at this time," the release added.

"The drug labelling for Champix has been updated to include a more detailed description of the study and findings, along with precautions for patients with respect to cardiovascular safety," the release states. "Patients are advised to seek immediate medical attention if they think they might be experiencing a heart attack or stroke."

"Patients with questions or concerns about Champix should talk to their health professional," the release later adds. "Health Canada will continue to evaluate new data on the cardiovascular safety of Champix as it becomes available. Should new safety information be identified, Health Canada will take appropriate action and inform Canadians as necessary."

Health Canada had previously indicated that the review was prompted by United States Food and Drug Administration "findings from a review of new data from a clinical trial involving 700 smokers with cardiovascular disease. Cardiovascular disease is a broad term covering any disease that affects the heart and/or blood vessels. The risk for patients with cardiovascular disease taking Champix was found to be 2%, compared to 1% for those taking no drug (www.hc-sc.gc.ca/ahc-asc/media/advisories-avis/_2011/2011_84-eng.php/).

A meta-analysis of data from 14 double-blind randomized clinical trials found that people taking varenicline had a 72% higher risk of adverse heart-related events than those on placebo (www.cmaj.ca/lookup/doi/10.1503/cmaj.110218). The findings prompted Health Canada to issue a warning advising consumers of "the possibility of a slightly increased risk of heart-related side effects in patients who have cardiovascular disease."

Barbara Mintzes, a professor of epidemiology and an assistant professor in anesthesiology, pharmacology and therapeutics at the University of British Columbia in Vancouver, recently argued that an ongoing Pfizer Canada advertising campaign to persuade Canadians who want to quit smoking to use varenicline should be halted (www.cmaj.ca/lookup/doi/10.1503/cmaj.109-4087). — Wayne Kondro, *CMAJ*

Pay for access to research papers

A worldwide backlash appears to be developing among researchers, physicians and other open access advocates who oppose an American legislative proposal to scuttle the United States National Institutes of Health (NIH) requirement that all publicly funded medical research be made freely available at an online database.

The Research Works Act, cosponsored by Representatives Darrell Issa (Republican–California) and Carolyn Maloney (Democrat–New York) would reinstate a pay wall for access to any specific article and prohibit agencies such as the NIH from imposing anything like an open access requirement. "No Federal agency may adopt, implement, maintain, continue, or otherwise engage

in any policy, program, or other activity that — (1) causes, permits, or authorizes network dissemination of any private-sector research work without the prior consent of the publisher of such work; or (2) requires that any actual or prospective author, or the employer of such an actual or prospective author, assent to network dissemination of a private-sector research work," states the legislation (www.gpo.gov/fdsys/pkg/BILLS-112hr3699ih/pdf/BILLS-112hr3699ih.pdf).

It defines private sector research as "an article intended to be published in a scholarly or scientific publication, or any version of such an article, that is not a work of the United States Government (as defined in section 101 of title 17, United States Code) describing or interpreting research funded in whole or in part by a Federal agency and to which a commercial or nonprofit publisher has made or has entered into an arrangement to make a value-added contribution, including peer review or editing. Such term does not include progress reports or raw data outputs routinely required to be created for and submitted directly to a funding agency in the course of research."

The NIH public access policy, which was implemented in 2008, obliges "all investigators funded by the NIH submit or have submitted for them to the National Library of Medicine's PubMed Central an electronic version of their final, peer-reviewed manuscripts upon acceptance for publication, to be made publicly available no later than 12 months after the official date of publication" (http://grants.nih.gov/grants/guide/notice-files/NOT-OD-08-033.html).

The policy has long been opposed by the Association of American Publishers, which represents scholarly and professional publications, as an infringement of copyright (www.publishers.org/issues/5/9/).

The association immediately threw its weight behind the Research Works Act. "The professional and scholarly publishing community thanks Representatives Issa and Maloney for supporting their significant investments that fund innovations and enable the essential peer-review process maintaining the high standards of U.S. scientific research," President and CEO Tom Allen stated in a press release (www.publishers.org/press/56/). "America's PSP [professional and scholarly] publishers are making more research information available to more people, through more channels, than ever before in our history. At a time when job retention, U.S. exports, scholarly excellence, scientific integrity and digital copyright protection are all priorities, the Research Works Act ensures the sustainability of this industry."

Critics of the legislation have included the Scholarly Publishing and Academic Resources Coalition and the American Library Association.

The coalition, a nonprofit alliance of libraries, and its affiliated Alliance for Taxpayer Access, which represents physicians, patients, researchers and other health promotion groups in support of "barrier-free access to taxpayer-funded research," issued a "call to action" which asks supporters to, among other things, contact legislators to express their opposition to the legislation, "issue a public statement of support from your organization," as well as "order share 'I support Taxpayer Access buttons and stickers' (www.taxpayeraccess.org/action/)."

Critics have also noted that both Issa and Maloney have received political contributions from scientific publishers. According to Maplight, a website that tracks such contributions, Maloney received US$8500 from the world's leading scientific and medical publisher, Elsevier, in 2011, while Issa received US$2000 (http://maplight.org/us-congress/contributions?sort=asc&order=Recipient&s=1&office_party=House%2CDemocrat%2CRepublican%2CIndependent&election=2012&string=Elsevier&business_sector=any&business_industry=any&source=All). — Wayne Kondro, *CMAJ*

***CMAJ* 2012. DOI:10.1503/cmaj.109-4109**