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True North in
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Commentary

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Structure and Design: Why More Funding is Not Necessarily Better for Health and Medical Research

Sean Speer

Introduction

A recent MLI paper (Speer 2018a) tracks the history of the federal role in health care. Our aim was to contextualize current debates on what Ottawa does and should do in the nearly 100-year history of the federal Department of Health. The findings should be chastening for those with activist predispositions. The history of Ottawa's role in health care is generally marked by a cautious approach that recognizes the primacy of the provinces and territories in health care delivery and administration.

The paper argues that a healthy respect for federalism is not just a theoretical matter but a practical one. The lesson from recent episodes of health care reform is that progress tends to be correlated with a more circumscribed federal involvement. There are various reasons for this – including the perverse incentives associated with an infusion of federal dollars and conditions, and the limits of top-down, centralized priority-setting.

This, of course, does not mean that there is no federal role in health care or health care related areas. Properly circumscribing the federal role does not mean full withdrawal. There are health-related areas that fit naturally with Ottawa including data collection, pandemic response, tax preferences for supplementary insurance, public health promotion, and so on. This short essay is part of an MLI series that critically examines the federal Department of Health and its attendant agencies.

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Primer on the Canadian Institutes of Health Research

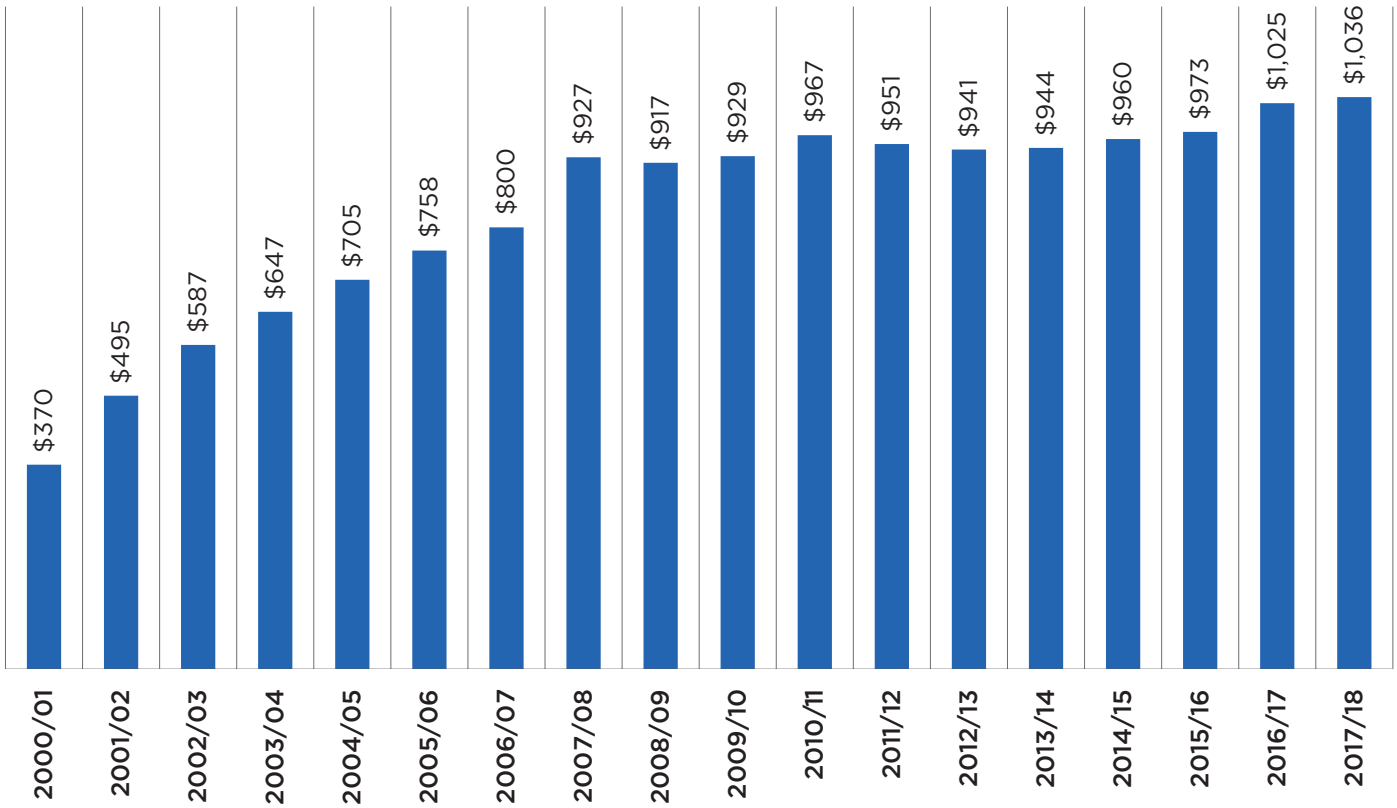
One area where Ottawa can and should continue to play a role is in funding health research through the Canadian Institutes of Health Research (CIHR).

The CIHR is the major federal agency responsible for funding health and medical research in Canada. It was established in 2000 to consolidate various federal initiatives related to health research and in so doing succeeded the **Medical Research Council of Canada (2000)**. The council had been around for more than 40 years at the time of transition.

> "The CIHR is the major federal agency responsible for funding health and medical research in Canada."

The Medical Research Council's **budget in 1999/2000** (its final year in operation) was $310 million. The CIHR's (2018a) **annual budget** is now more than $1 billion (see below).

CHART 1: CIHR TOTAL SPENDING, 2000/01 TO 2017/18, ($MILLIONS)



Source: CIHR 2018a.

CIHR consists of 13 "virtual" institutes,"[1] each headed by a scientific director and assisted by an institute advisory board. They work together to shape the research agenda in their respective areas – including determining successful applications from individual researchers.

The work in these various areas obviously reflects different issues and priorities. But the CIHR's work is rooted in four pillars of health research:

1. biomedical;
2. clinical;
3. health services; and
4. population health.

All in all, CIHR (2018a) supports more than 13,000 researchers each year. It reports on the distribution of its funding by region, subject, and individual grant recipients on a semi-quarterly basis (CIHR 2018c).

The Case for Health-Related Research

Support for health research and CIHR in particular has been the subject of a political consensus in Canada. Successive Canadian governments have increased its funding as well as funding for other health-related research organizations such as Genome Canada and Brain Canada.

Why is that? What is the policy argument for federal funding for health and medical research?

This research is broadly seen as a public good that market forces alone cannot address.

Think of it this way. When a physician, clinician, or medical researcher identifies a new way to treat an ailment, that information enters society's pool of medical knowledge. It can have far-reaching benefits for other physicians, patients, and the broader society that exceed the return that the originator may receive. Yet the gap between private returns and public benefits means that we will get less research than is socially efficient. Government can respond in different ways to close this gap.

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The first is through patents. The government grants the researcher a patent on the new process or product to give him or her a temporary monopoly in order to recoup some of these broader benefits. Pharmaceutical patents are an obvious example. MLI has written extensively on the importance of a strong patent regime to encourage and support medical innovation, investment, and jobs in the pharmaceutical sector, and access to new medicines (Critchley and Owens 2018).

Another approach is to adjust for the "positive externalities" from health and medical research by subsidizing such research (Speer 2017). Direct research funding requires taxation to raise the necessary resources and taxation imposes economic costs (known as *deadweight loss*) on its own. But if the externalities from the government-funded research exceed the cost of the research, including the deadweight loss, overall welfare can increase.

This basic idea is widely shared across the federal political spectrum and is the basis for CIHR in particular and federal support for health and medical research in general. In addition, the logic for the federal role in this area

(as opposed to it being a merely provincial function) is that the positive externalities will necessarily spill over provincial boundaries. The benefits of new and important research can ultimately have global implications.

This does not mean that any or all federal funding for health and medical research is justified. It is certainly possible that certain programs can be inefficient or that particular projects are unworthy or, as we will see, the design and structure of research funding can produce inadvertent consequences. But as a basic idea, even those who believe in a limited scope for the state recognize some role in encouraging and supporting health and medical research – including through direct funding.

"Design and Structure" of Health Funding Matters

There are certainly good and bad models for government funding. It is beyond the scope of this short essay to make judgments about the design of CIHR's programs, its peer-review process (Picard 2018), or other operational considerations.

Instead the remainder of this essay will examine the role of the timing, predictability, and stability of health and medical research funding, and how a failure to consider them can produce inadvertent consequences. This line of analysis stems from an interesting conversation between former White House health policy advisor Yuval Levin and Vox's editor-at-large and founder Ezra Klein (2016).

Their discussion, which was released in the form of a podcast in July 2016, covered a wide range of topics including Levin's (2016) book, *The Fractured Republic*. But it was their exchange about increased funding for the National Institutes of Health (NIH), which is Washington's equivalent of CIHR, that is relevant for Canadian policy-makers.

Levin observed that the doubling of the NIH budget between 1998 and 2003 and the slowdown in funding growth that followed produced considerable controversy among the medical research community. His insights on the reason for this are instructive, and worth excerpting in some detail (those who wish to listen can find a hyperlink in the reference list; see Klein 2016 at 38:15):

> I came to think by 2005/06 that a lot of that [controversy about stem cell research] had to do with a bipartisan mistake in the way that the increase of the National Institutes of Health budget had taken place. At the end of the Clinton years and the beginning of the Bush years, the budget was doubled over five years. And then returned to normal growth levels of 2–3 percent per year.
>
> And that was done with good intentions and actually thought of as a kind of bipartisan success. Newt Gingrich supported it very much. As did a lot of Democrats. President Clinton loved it. President Bush ran on continuing it.
>
> What ended up happening is because the NIH basically supports academic institutions, doubling the budget over five years meant that many, many more graduate students were dragged into – allowed into – biomedical research. And then as soon as their training was done, the funding ended.
>
> And the American medical research community found itself in a very bizarre position. So at the beginning of 2005, I found myself getting a lot of meeting requests from big research institutions. People would come in and say that they were under enormous funding pressures – that there were huge problems.

My first reaction to them was to think that these people are just unbelievably spoiled. We just doubled their budget. I started going into these meetings – I would ask the NIH examiner at the Office of Management and Budget to give me a chart of the funding of the specific labs of the people I was about to meet with. And when they started complaining I would pull out a chart and say your budget just went up by 80 percent. Why are you here?

This made the university lobbyists nervous. But the scientists were not fazed by it. And they gave me an answer. And over time I came to realize that the answer was correct. That they were right, and I had been wrong. And that the way that the budget had been doubled was just perfectly designed to frustrate the academic process by which American biomedical research happens and grows.

I think there are a lot of lessons of how we fund science . . . the budget was doubled over five years. Huge, huge growth . . . It does not go back down. But it starts growing more slowly. It starts growing more normally in the way that the federal budget grows. There was growth of almost 20 percent per year for five years and then growth of 3 percent per year after that. And so over those five years, institutions made investments. They got a lot more money. It was generally the same institutions. The growth was so fast we were not creating new research institutions. But those top 20 research institutions were getting much more money than they had. So they had money. They could bring in new graduate students. They could start new labs. They could build new lines of research. And then five years into it, just as the first graduate students were starting to leave and build their own careers, the growth slowed down dramatically. These same institutions began to need all of the money that they were getting just to sustain the growth they had been through. The new graduate students found themselves competing with their own mentors for grants. They were losing the competitions. And everybody was very frustrated.

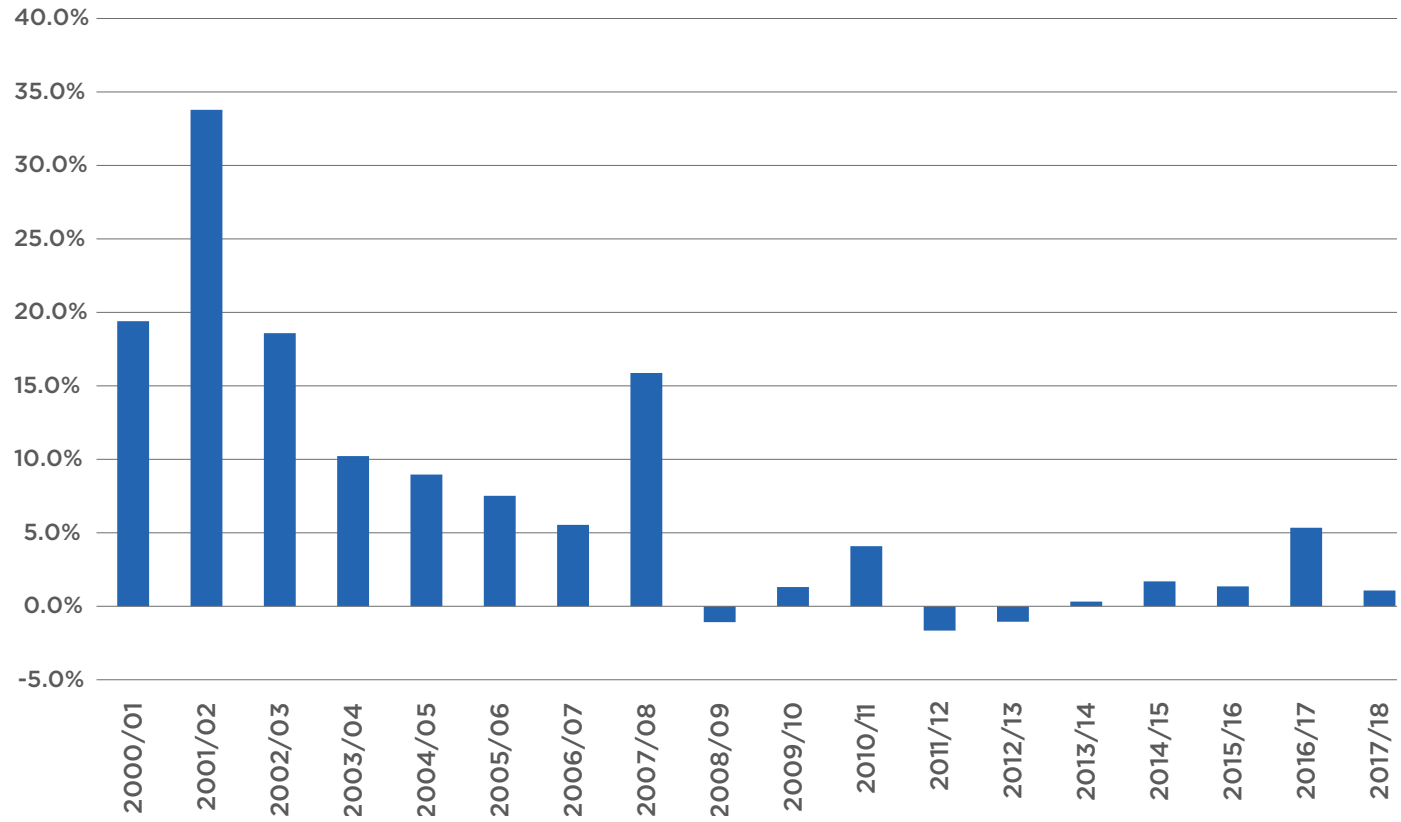
"The way that the budget had been doubled was just perfectly designed to frustrate the academic process by which American biomedical research happens and grows."
—Yuval Levin

I think had the growth been 5 percent a year for 10 years or 15 years, it would have been much more manageable and much more effective.

But I would argue that in the first 10 years that followed that from 2005 until just about now, on the whole the doubling of the NIH budget probably hurt medical research in America more than it helped it. We are now in a place where it has been digested and it is certainly is doing more good than harm. And of course on the whole there is more research going on and more opportunities for breakthroughs and advances. But as a research enterprise – as an academic enterprise – American biomedical research was very badly hurt by the structure, by the design, of that increase. And nobody saw it. Nobody on either side saw it coming. There were people who opposed the doubling because they did not want to spend the money. But there was really no one who made the argument that it should go slower. And I think we have learned that lesson and now that would happen.

These insights are a useful tool to evaluate CIHR's year-over-year budget growth since its creation in 2000/01 (see chart below).

Chart 2: CIHR SPENDING GROWTH, 2000/01 TO 2017/18 (% CHANGE)



Source: CIHR 2018a.

I have often wondered if the Canadian experience shared any of the characteristics with Levin's description of the large spike in the NIH's budget. The bars in the table indeed show marked growth over roughly the same timeframe and then much more moderate growth thereafter.

CIHR's budget experienced a huge jump during what is sometimes called the "reinvestment period" (Naylor et al. 2017). The causes are complicated and multi-faceted – including the deployment of fiscal surpluses after long-running budgetary deficits, an effort by the then-Liberal government to mollify political criticism for its cuts to health spending in the mid-1990s, and perhaps to notionally match the impressive growth of NIH's budget. As then-Finance Minister Paul Martin put it in his 2000 budget speech: "the Canadian Institutes of Health Research [is] an initiative that will transform the way research is done in this country."

The government matched his rhetoric with substantial funding growth. CIHR's budget grew, on average, by 18 percent annually in its first five years between 2000/01 and 2004/05. But then it started to slow. It fell to an average of 5.8 percent in the next five years and 0.7 percent in the subsequent five years.

Put differently: CIHR's budget grew by 150 percent in its first eight years and only 6 percent in the subsequent eight years.

And these trends cannot be attributed to partisan differences. CIHR's budget grew, on average, by 3.3 percent during the Harper government. It has grown by 2.6 percent under the Trudeau government.

This drop in CIHR's funding growth has likely contributed to its low application success rate (13 percent in 2016; CIHR 2016) and the recent focus on "early career researchers" who were increasingly critical of the scarce resources available for research funding (CIHR 2018b). The media landscape was marked by headlines such as "Scientists protest in frustration over federal research funding chaos" (Crowe 2016), "Researcher on CIHR funding drought: 'It is called eating your young'" (Payne 2015), and "Research stays frozen in Canadian budget" (Kondro 2017). These representative headlines, which have run since the 2015 election campaign and thus cannot be merely attributed to Conservative probity, sound highly similar to the circumstances described by Levin.

It would take more extensive qualitative and quantitative analysis to fully test his working hypothesis against the Canadian experience, but the data seem to point in that direction. It is a good reminder that the "design and structure" of health and medical funding requires as much as deliberation as any arguments about the right level of funding.

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What does it mean for the future?

This is relevant in light of the forthcoming federal budget in winter 2019. Last year's budget granted the three granting councils (including CIHR) $925 million in basic research funding over five years (Audette-Longo 2018). But make no mistake: there is an ongoing appetite among researchers (ACCRU 2018) and health organizations (HealthCare*Can* 2018) for further funding.

Their advocacy is aided by the observations and recommendations of the high-profile *Canada's Fundamental Science Review* (known as the Naylor Report; Naylor et al. 2017), which was released in April 2017. The report noted, among other things, that:

> CIHR's expansive mandate is not appropriately supported; its budget is sharply lower on a per capita basis than the counterpart US National Institutes of Health, even taking into account the standard differences in funding models between U.S. and Canadian agencies.

This may be a legitimate argument. And indeed there is a good case for the federal government to support health and medical research. But Ottawa should resist the temptation for large and unsustainable increases. It may provide a short-term boost – particularly in the context of an election year (Speer 2018b) – but the lesson from the United States and possibly here is that a large spike in funding may cause long-term, structural challenges.

It does not mean, of course, that the federal government needs to be silent on supporting health and medical research in the budget. But it does require that any new policies or spending look beyond the immediate term.

One option would be to set out a strategic vision for the CIHR for the long-term. This would involve a combination of stable, predictable funding increases over a 10-year period as well as greater prioritization based on Canada's comparative research advantages. The Naylor Report highlights in a number of areas that CIHR has a "broader mandate" than the NIH's in spite of less funding even on an adjusted basis. A new, long-term vision with more graduated funding increases would ostensibly have much of the political upside without risking some of the substantive downsides described by Levin and seemingly evident in Canada.

Another would be to update the government's intellectual property strategy (Innovation, Science and Economic Development Canada 2018) to encourage greater private sector investment in biomedical research and development. Ottawa has grappled with a series of policy choices – including pending reforms to the Patented Medicine Prices Review Board (Critchley and Owens 2018) and stronger patent protection in the USMCA (Owens 2018) – that will ultimately affect the investment environment for pharmaceutical research and investment. There is room for greater ambition to establish an intellectual property regime that makes Canada a leading jurisdiction for biomedical research. It could provide a long-term boost to investment and employment in the sector, including for those scholars who came-of-age during CIHR's "reinvestment period." And the best part is it would have little or no effect on Ottawa's ongoing budget deficit.

"There is room for greater ambition to establish an intellectual property regime that makes Canada a leading jurisdiction for biomedical research."

The key takeaway though is notwithstanding good intentions, more funding is not necessarily better, particularly if it produces unsustainable pressures on the part of research institutions. The federal government should thus work to establish a better structure and design for promoting and supporting health and medical research in Canada.

About the Author

Sean Speer is a Munk Senior Fellow at the Macdonald-Laurier Institute. He previously served in different roles for the federal government including as senior economic advisor to the Prime Minister and director of policy to the Minister of Finance. He has been cited by *The Hill Times* as one of the most influential people in government and by *Embassy Magazine* as one of the top 80 people influencing Canadian foreign policy. He has written extensively about federal policy issues, including personal income taxes, government spending, social mobility, and economic competitiveness. His articles have appeared in every major national and regional newspaper in Canada (including the *Globe and Mail* and *National Post*) as well as prominent US-based publications (including *Forbes* and *The American*). Sean holds an M.A. in History from Carleton University and has studied economic history as a PhD candidate at Queen's University.

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Endnotes

1 The 13 institutes include: (1) Institute of Aging, (2) Institute of Cancer Research, (3) Institute of Circulatory and Respiratory Health, (4) Institute of Gender and Health, (5) Institute of Genetics, (6) Institute of Health Services and Policy Research, (7) Institute of Human Development, Child and Youth Health, (8) Institute of Indigenous Peoples' Health, (9) Institute of Infection and Immunity, (10) Institute of Musculoskeletal Health and Arthritis, (11) Institute of Neurosciences, Mental Health and Addiction, (12) Institute of Nutrition, Metabolism and Diabetes, and (13) Institute of Population and Public Health.

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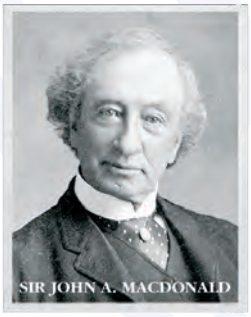
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CONTACT US: Macdonald-Laurier Institute
323 Chapel Street, Suite #300
Ottawa, Ontario, Canada
K1N 7Z2

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