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Chair

Mr. James Rajotte

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● (1530)

[*English*]

The Chair (Mr. James Rajotte (Edmonton—Leduc, CPC)): Ladies and gentlemen, we will call the 54th meeting of the Standing Committee on Industry, Science and Technology to order.

Pursuant to Standing Order 108(2), we are continuing our study, our second meeting, on Canada's access to medicines regime.

Ladies and gentlemen, we have scheduled three hours of witnesses here for us today. Unfortunately there are votes at 5:45, so we will have to leave shortly after 5:30. I understand Mr. Lewis has graciously agreed to somewhat shorten his presentation so we could add more time for the non-governmental organizations, of which we have six today.

So the first hour was scheduled for Mr. Lewis.

Mr. Lewis, I want to thank you for taking the time to be with us from Toronto today by videoconference. We have you scheduled for an hour. Of course, you're well-known to all of us as the former UN Special Envoy for HIV/AIDS in Africa, as are your experiences there.

I think what we'll do is go right to your presentation. I understand you have about a five-minute opening presentation. and then we'll go to questions from members. If we can keep it to 45 minutes, then we will allow more time for witnesses, for the NGOs, to present.

Mr. Lewis, you can begin at any time. Thank you very much for being with us today.

Mr. Stephen Lewis (Former United Nations Special Envoy for HIV/AIDS in Africa, Stephen Lewis Foundation): Thank you, Mr. Chair.

I actually have an opening presentation that is a bit longer, but I won't violate the endurance of the committee. I very much appreciate the possibility to appear before you, albeit from a distance. I think I glimpsed a portrait of my father on the wall of the committee room; therefore, I'm feeling vastly more secure than would otherwise be the case.

I'd like to make some brief opening remarks, primarily by way of context. Please allow me to say at the outset that I claim no special grasp of the details of the legislation before you. I am appeased in that regard, however, by the presence of a number of NGOs, my friends in the HIV/AIDS Legal Network, and MSF in particular, who have submitted briefs of intelligence, clarity, and precision, and the more time you have with them, I think, the better it will serve the committee. My wish, rather, is to sketch for you a personal view of the lost opportunity of this legislation, as I've thought about it during my time as the UN envoy for Africa.

In September 2003, the regional AIDS conference for Africa was held in Nairobi. By fascinating coincidence, it followed immediately on the heels of the WTO decision to allow for the issuance of a compulsory licence that would permit the manufacture and export of generic drugs to developing countries, drugs that could treat many different illnesses. The AIDS conference was, of course, agog at the prospect, and when it seemed possible, right in the middle of the conference, that Canada would become the first country in the western world to act on the decision, there was, amongst many African activists and advocates, a tremendous surge of excitement and hope.

You must remember that it was only in 2003 that antiretroviral treatment for AIDS began to take hold. It was that very year when the World Health Organization launched its three-by-five plan to put three million people into treatment by the end of 2005. Canada seemed to be emerging as the strongest ally in this Herculean effort to subdue the pandemic and keep millions of people alive. We contributed $100 million—far more than any other country—to WHO to support the roll-out of treatment, primarily through Africa, and we set in train Bill C-9, the Jean Chrétien pledge to Africa. It took a tortuous route and a very long time to consummate the legislation, but I can say with confidence that the international sense was that Canada would play a leading western role in the fight against the pandemic. In 2003, 2004 and 2005, our position as a country seemed destined to be even more potent than that of the United States and the President's emergency plan. Why? Because his plan was based on brand-name drugs at high cost, whereas Canada was evidently proceeding with generics at a cost that African countries could afford.

In the post-2003 period, as our legislation was wending its unexpectedly slow way through the bureaucratic and parliamentary process, I was constantly being asked where things stood. The former high commissioner of Kenya to Canada called me to Ottawa to plead for his country to have access to our drugs. The same message was subsequently conveyed to me by Kenya's minister of health. The high commissioner of Tanzania to Canada made similar inquiries. The then head of the Rwanda AIDS commission raised it directly with me. I won't soon forget a meeting I had in Addis Ababa with the President of Ethiopia in mid-May of 2004; he ended a long conversation with the words, “So, Mr. Envoy, will we have the drugs from Canada? We're all waiting. When will we have the drugs from Canada?”

I hope the committee understands that expectations were pitched very high in Africa. There is complete bewilderment that the expectations and promises and legislation came to nought. I share that bewilderment. I believed we would make the legislation work; there was no reason why it shouldn't have been made to work. I believed that Canada realized it was on the threshold of a dramatic contribution in the battle against the pandemic, a contribution that had the potential of limiting the carnage for countless numbers of lives and reducing dramatically the tidal wave of orphans that has engulfed country after country. I was wrong: we failed. We failed lamentably.

I'm not interested in thrashing about assigning blame. It's clear to everyone that the legislation is deeply flawed. It's surely clear that we must find a way to make the issuance of a compulsory licence easier to achieve; that we must resist the curious inclination to impose conditions that go beyond the requirements of the TRIPS provisions of the WTO; that we must find a way of protecting the recipient country from any retaliatory measures; and that the brand-name pharmaceuticals and the generic industry must have a legislative regimen that results in a licence rather than an impasse. Public health is at stake, and the primacy of public health is specifically acknowledged under the TRIPS provisions.

● (1535)

I would argue that the achievement of all of this is possible. I would argue, having read other briefs to be submitted to you today, that it's possible within the identifiable flexibilities provided by the WTO agreement decision.

Mr. Chair, Canada has a huge role to play. No one should see this legislation, even with the passage of time, as redundant or beyond repair. The needs are monumental. There is a report this week from UNICEF, UNAIDS and WHO indicating that although 1.3 million people are now receiving treatment in Africa, at least five million more need it right now, today. The capacity to produce fixed-dose combination first-line drugs is what this legislation should provide.

Furthermore, over 300,000 children died last year from AIDS-related illnesses. With pediatric drug formulations, they could be alive. Moreover, 10% to 15% of all those who enter treatment develop resistance within four to five years. They require second-line drugs. Those drugs are not yet available in generic form, and the present prices are astronomical for poor countries.

Tragically, it's worth remembering that there are 40 million people in the world who will require treatment either now or in the future every single day for a large part of their lives, and the numbers are growing. We're talking about billions and billions of pills. But remember, the UN report also shows a 93% survival rate at the end of the first year for those receiving treatment. It's an amazing endorsement of what this legislation is designed to effect. There is a clear role for Canada. There is a clear role for this legislation.

In conclusion, let me say that no one is suggesting the impoverishment of the brand name pharmaceuticals. I, with others, am simply reaffirming the use of the WTO decision dating back to August 30, 2003, that makes it possible to manufacture and export generic drugs.

There are those who say there are other needs internationally. I say that's absolutely right, but this legislation is designed to address one of the imperative needs, incorporating several of the millennium development goals, and it should not be seen as subordinate to other priorities. For those who say that a large part of the problem is really health systems and health resources, I concede there's some truth in that, but if this legislation ensures the basis for long-term treatment, then Canada, and others, and the African countries themselves will have the confidence to restore the fractured infrastructures.

I beg you to put other considerations aside and make the changes to the legislation that will allow it to work. I don't want to sound maudlin, Mr. Chair. It's really just a measure of what churns in my mind when I think of what I've seen over the last five years. But , Mr. Chair, people are so courageous in Africa. They're dying in such appalling numbers, especially young women. They're fighting so hard for survival. It would mean the world if Canada would emerge as the pre-eminent ally in the struggle to confront the pandemic.

Thank you, sir.

● (1540)

The Chair: Thank you very much, Mr. Lewis, for your brief and eloquent statement. We appreciate that very much.

We will go right now to members with their questions. We will start with Mr. McTeague for six minutes.

Hon. Dan McTeague (Pickering—Scarborough East, Lib.): Mr. Lewis, thank you for being here today and for your very appropriate and adroit comments. Also, certainly on behalf of my constituents, I want to thank you for all your work over the years.

You gave a speech at the Chateau Laurier in 2002 about what the needs were and about the consequences of inaction, which spurred many members, including me, to try to convince our government of the day of the need to provide a relaxation of the existing drug regime to address a human catastrophe, as I think you called it back then.

Since then, of course, we have watched this and have been, as have you, rather surprised at the fact that not one single pill has gone to help.

I also had the opportunity to speak to Mark Fried and others from Oxfam and Médecins Sans Frontières, and I wrote a letter some years ago explaining the situation in detail. It seemed to me at the time, as you quite rightly pointed out, that Canada was very much at the leading edge. We had NGOs on the spot. We couldn't be everywhere, but we certainly had the ability to distribute these drugs.

I'm here with my colleague Keith Martin, who will ask a question in just a moment, and who has a rather direct understanding of the situation in Africa as well.

But I want to ask you whether there are nations, in your mind, notwithstanding all of the good intentions that we have provided in Canada without result, that have actually made breakthroughs, that have in fact been bold enough to address this pandemic, this underlying catastrophe?

Mr. Stephen Lewis: When you say “nations”, Mr. McTeague, do you mean in the west or in Africa?

Hon. Dan McTeague: Anywhere. Any nation that has been able to do what Canada has not been able to do despite these incredible odds.

Mr. Stephen Lewis: I believe there is legislation in place, as I guess is evident from the policy or discussion paper before you, from disparate groups like Norway, Holland, Switzerland, etc. That legislation, not all of which is as well developed as Canada's, has not yet been acted on. Nor have the African countries as yet sought a compulsory licence, largely because I think no African country wants to be the first to go forward if their names are not protected. There is a tendency to retaliation, both threats from, often, the United States and explicit threats from pharmaceutical companies.

Look at what's happening right now in Thailand. The Thailand government issued a compulsory licence for the production of a generic equivalent of a drug called Kaletra, which is produced by Abbott Laboratories. Abbott engaged in quite an astonishing act of retaliation by saying that it would withdraw all its current drugs or any further drug development from the Thai market. Abbott has received a great deal of criticism because of that, but you can imagine the sense of vulnerability amongst African countries unless there is a regime in place that secures initially their confidence and then the flow of drugs.

Hon. Dan McTeague: Mr. Lewis, the Minister of Finance, Jim Flaherty, made an announcement a week or so ago in Mississauga, a place known as Pill Hill in Toronto. I'm wondering if you would like to make some comments as to whether or not you think that will be effective in concert with this legislation, and whether you will see that as an opportunity to begin the ball rolling towards getting these necessary drugs to those who truly need our help in Africa.

Mr. Stephen Lewis: I feast on almost all the words of the minister, but I missed that particular Mississauga announcement. Maybe I didn't, but didn't know it was from Mississauga. What are we speaking of?

Hon. Dan McTeague: I'll leave it to my Conservative colleagues on the other side to explain what had happened, but it was really to deal with a renewed effort by brand-name pharmaceuticals to provide access to affordable medicines to that part of the world. I'll leave it to them to ask questions, so that they can build on what they've announced. But I've heard this kind of thing before, obviously, and I've been very concerned that five years after this great vaunted declaration we are still nowhere near living up to our commitments.

So let me ask this question. Companies in India, a company like Rambaxy, for instance—would those companies that may be in violation of international norms be the way if we can't proceed successfully with getting Canadian drugs to Africa?

● (1545)

Mr. Stephen Lewis: There is no question that India is now the source of most of the drugs that are providing antiretroviral treatment around the world, and overwhelmingly the source for drugs in Africa. They're being used increasingly even by the American presidential initiative.They're being used by the Global Fund to Fight AIDS, Tuberculosis and Malaria. They're being used by the Clinton Foundation. They form the basis for most of the treatment, but it's not endless. They have production limitations, and there is some uncertainty as to the nature of the amendments to the Patent Act in India whether those drugs can continue to be produced in such large quantums.

There is also the question of the second-line drugs, which are desperately needed, and for whom the downward price negotiation has not yet occurred. And indeed the flow is not guaranteed.

So there is always room, there would absolutely be room for Canadian legislation, manufacture, and export. There is no question about it—and the demand, given the huge numbers that are required. And it looks as though, relatively speaking, we could compete. It might be a matter of a few cents either way.

Hon. Dan McTeague: If we fail to get this right, Mr. Lewis, would you be in favour of the Canadian government simply providing and footing the bill to pay for these drugs? Frankly, if we can't get through the rhetoric, the battles, and the obfuscation that's going on to contain a disease that knows no boundaries in terms of its decimation of human beings and innocent individuals, do you believe the federal government should be duty-bound then to cut a bloody cheque?

Mr. Stephen Lewis: I've always believed that the federal government, if it increases its percentage of GNP for ODA—and we're going down, I noticed—could use a large chunk of that to support drug purchase and improvement of health systems, infrastructure, etc.

But frankly, it would be a much greater contribution to have a systematic flow of drugs to these countries over the years that are required, because the promise of cutting a cheque varies from administration to administration, and the amounts vary. As I said, our ODA contribution declined between 2005 and 2006 as a percentage of GNP. and it may decline further.

So the drug regimen is really, I think, the basis on which to proceed.

The Chair: Thank you very much, Mr. McTeague.

We'll now go to Madame Brunelle.

[*Translation*]

Ms. Paule Brunelle (Trois-Rivières, BQ): Good afternoon, Mr. Lewis. I'm very pleased to see you again. Since you were the United Nation's special envoy to Africa for HIV/AIDS, I suppose you have a very good grasp of what is going on there. The fact that not a single pill has been sent to Africa makes me believe that there are practical and political issues at play.

My colleague asked you earlier if the government should just write a check. However, we all know that, in some of those countries, drugs may be diverted and never reach the hospitals or clinics that really need them.

Do you have any recommendations about this?

[*English*]

Mr. Stephen Lewis: As the legislation is now constituted, the measures in to identify the drugs by way of colour or container in a specific fashion would prevent diversion, and that is true of many of the drugs that are coming from various sources.

The problem isn't so much, frankly, one of diversion. That hasn't been a vexing difficulty in most of the African countries with high prevalence rates. What they need is security—sustainability of supply and of resources. They obviously need some help with training and retraining to fill the gaps of human capacity, and they obviously need some help in the repair of the infrastructure, but if we could be sure that there were countries of significant capability, both within Africa and outside Africa, who could supply a flow of generic drugs at a very low price, then I think that if the G8 delivers on the promises it has made in terms of financing, we would be able ultimately to confront the pandemic.

[*Translation*]

Ms. Paule Brunelle: We know that there is a huge lack of infrastructures in some African countries. There is a lack of access to clean water and to good sanitation. It may be very well to talk about treating patients but do you not think that we should solve those problems of sanitation before sending drugs? Both could be done in parallel though.

● (1550)

[*English*]

Mr. Stephen Lewis: Madame Brunelle, that's a very good point, and it's a point with which I would not take issue. I think what you're essentially saying is that we have what we call the millennium development goals. Each and every one of them should be attended to; each and every one of them places a moral imperative on the western world to supply resources, reduce debt, and set up international fair trade rules.

One of those millennium development goals is to turn back the communicable diseases of AIDS, tuberculosis, and malaria, and one of those goals is to reduce poverty and hunger, and the others are maternal mortality reduction and infant mortality reduction. Yes, if CIDA were able to target funds to the other imperatives, along with the crucial imperative of dealing with the pandemic—The pandemic is destroying development in so many countries that you can't even make progress on the other goals, because there is such a level of disease and death; you have to secure the health first, before you can secure the development. That point has been made quite eloquently by the economist Jeffrey Sachs. He calls it the disease burden and says that unless you deal with the burden of disease, you can't deal with the other phenomena.

[*Translation*]

Ms. Paule Brunelle: It is very difficult to get rid of AIDS, a disease which leads to other diseases such as TB. Obviously, we have to do something. Pharmaceutical companies tell us that they already send generous quantities of drugs to Africa. Do you believe that it is enough, which might explain why this legislation is so little used, because it is not really required?

[*English*]

Mr. Stephen Lewis: I think it's worth noting that the brand name pharmaceutical industry cannot begin to compete with the prices that have been negotiated for generic drugs. The brand names, even at best, are between $500 and $800 per person per year.

The Clinton Foundation negotiated a price initially of $139 per person per year, and that price is coming down. Even if the brand names lower their prices further, they will still be higher than the generic costs. And when you're dealing with countries where people are living at less than $1 a day, obviously the generic equivalents become the dominant force.

Yes, the legislation, in its dormancy, is disappointing, but I don't think we should be deterred. We still have a very major contribution to make through this legislation to complement and supplement whatever the brand names are doing.

At the moment, the brand names are providing the second-line drugs and they're providing the pediatric drugs, but gradually the generic equivalents are emerging. And Canada could be a force on every front, not only for the fixed-dose combination first-line drugs, but for further developments if this legislation works.

[*Translation*]

Ms. Paule Brunelle: Thank you.

The Chair: Thank you, Mrs. Brunelle.

[*English*]

We'll go now to Mr. Carrie, please.

Mr. Colin Carrie (Oshawa, CPC): Thank you very much, Mr. Chair.

And thank you very much, Mr. Lewis, for coming before us at this very important time, as we look at this legislation and see what we can do to improve what we do as a country. I think it is something that is extremely non-partisan. Everyone here on the committee wants to work together to see what we can do to make the best effort possible.

My Liberal colleague did mention one of the things that the government did recently under budget 2007. There was a measure where corporations donating medicines can claim a tax deduction equal to the cost of the donated medicine, or half the amount by which the fair market value of the donated medicine exceeds its cost —whichever is less.

I think what he wanted was your opinion. Do you think this would be a step in the right direction?

Mr. Stephen Lewis: Undoubtedly it's a step, but I hope people realize that it's only a step. And relative to the need, it will never be an adequate step.

The situation in some respects is so overwhelming. I don't consider that we can't deal with it, but it is vast. And everyone is trying to chip away at some responses, however incremental.

The difference between those steps and this piece of legislation is that this legislation could make a really significant dent on the problem. The steps merely chip away at the margins.

● (1555)

Mr. Colin Carrie: With your experience on the ground in Africa and other parts of the developing world, what actors or agencies are doing the best work in addressing public health crises like HIV/AIDS, malaria, and tuberculosis? Would you say it's the NGOs? Is it the United Nations? Is it the pharmaceutical companies, or is it the host country governments themselves? Who is really right on track with this, or is anybody?

Mr. Stephen Lewis: That's a terribly interesting question. Thank you for asking it.

I think that some of the host governments are doing a superlative job. The Government of Botswana, the Government of Rwanda, the Government of Uganda—these governments are working very hard and quite effectively. I'm very impressed by the recent efforts of the governments of Zambia and Malawi. So the governments themselves are now seized with the problem; they're moving heaven and earth to overcome it.

I'm also enormously impressed with the Clinton Foundation. It moves with a sense of urgency that is rarely seen in response to communicable diseases. It's a bit analogous to the Gates Foundation. It doesn't have that kind of money, but it has people on the ground and it has the power of the President's charismatic inclusiveness, and you have an organization that is really quite remarkable in the way it responds.

There are some international development agencies in the bilaterals. The U.K. agency DFID and the Irish are making particular efforts in various countries to break through. And I'm perfectly ready to acknowledge that the presidential initiative in the United States has managed to provide treatment for more than one million people worldwide now, which is in its own way significant. I may disagree with aspects of the program, but I have to acknowledge the truth of that.

CIDA, other than the tremendous contribution to WHO, seems less engaged than it might be, although my sense is that CIDA wants to be more engaged if it can find the resources.

I'm quite disappointed with a number of the UN agencies, although I think the World Food Programme distinguishes itself and the World Health Organization distinguishes itself. I think UNICEF has been less effective, and the United Nations Development Programme has been less effective over the last few years. There's a real problem around children, which shouldn't exist. Frankly, the NGOs can be terrific, some of them, really strong on the ground—Save the Children, CARE, World Vision. Doctors Without Borders does a magnificent job on the ground. I'd almost lay my life down for Doctors Without Borders. And there's an American outfit called Partners In Health, which is extremely effective on the ground.

So I think it's a mixed bag, but you can always find very good actors, indigenous and external, that are making a difference.

Mr. Colin Carrie: You mentioned a couple of governments—Botswana, Rwanda. Are you able to describe for us what they are doing that the other countries aren't? Are they putting things like appropriate distribution mechanisms in place to deliver the drugs to affected areas? Are they working with us a little bit better on the international level? What are they doing that the other governments aren't?

Mr. Stephen Lewis: I think, in one sense, it's the quality of the political leadership that has made of the pandemic a *cause célèbre*, and everybody is intensely involved. What many of them have done is remove all costs from drugs, so that drugs are free. They then understood that you shouldn't concentrate it only in the urban centres, you should move it out through the rural hinterland. And it wasn't always necessary to have a doctor do the work; it could be done by nurses and by community health workers.

They've also instituted very intensive training and retraining programs to attempt to fill the gap of the loss of workers in the health care system. And they have this encouragement to people getting counselled and tested. They have, beginning with Botswana, what they call routine testing, where everyone who presents themselves... even if you have a cold or you have cancer, if you present yourself to a doctor or nurse they will ask if you'd like to take an HIV test, so you get much higher levels of testing.

In a little country like Lesotho, they're now going door to door through the entire country and offering a test to everyone over the age of 12. They've trained 7,000 community health workers. It's worth noting, sir, that these countries are really working very hard at resisting the consequence of the pandemic.

● (1600)

Mr. Colin Carrie: Thank you very much.

The Chair: Mr. Carrie, we're out of time. Thank you for that line of questioning.

We'll go now to Mr. Masse.

Mr. Brian Masse (Windsor West, NDP): Thank you, Mr. Chair.

Thank you, Mr. Lewis, for appearing here today.

I think it's ironic that as we discuss this, I'm looking at a poster from Tommy Douglas' Humanity First campaign, and the poster says, “People before profits”. Three years ago when we talked about this bill, it seemed there wasn't the political will to actually do the right thing to make the bill the best it could be.

What concerns me—and I mentioned this Monday in our hearings—is that it seems we're treating this as being the first and foremost country in setting a template to be the champions for this. I'm worried about whether or not our legislation actually poisoned the well in terms of setting a standard that other governments followed subsequently. We haven't seen any action anywhere.

I'm concerned; I would describe what's happening as a genocide. We have treatable measures that can help people, and we wilfully, for one reason or another, one excuse or another, do not act on it.

What is happening over there with regard to the loss of individuals who are professionals—the teachers, doctors, nurses? If we actually get treatment over there—to Rwanda, for example, and other places—will their lives be extended? Will they help stop children from being the heads of households? What is the capacity of human ingenuity and learning that's being lost by our not addressing this? Are we losing the capacity over there day by day to actually improve the conditions?

Mr. Stephen Lewis: The loss of human capacity is a nightmare. I think it's acknowledged everywhere that the damage to many sectors—health, education, agriculture—is severe, and deeply severe. One of the problems in rolling out treatment is that we've lost so many people, we often don't have enough professionals or quasi-professionals to be able to make it all possible.

There is a tremendous effort to train and to retrain. Now, the World Health Organization says that Africa is a million health care workers short, which obviously is a huge number to overcome. But that is now under way in many countries.

When we do put useful things in place.... For example, DFID of the United Kingdom provided a package of close to $300 million over five years to enhance the salaries, the benefits, and the living conditions of the civil service in Malawi, with a particular focus on the health sector. People stopped leaving the country and looking for other places to work. They had some security of income and jobs. The Irish are doing the same in Lesotho.

When in Swaziland there was a wellness centre established for nurses and other health care workers, not only did they feel treated in a special way—one must do that with many of the health care workers, because they feel self-conscious about standing in the same lineups for treatment as the people to whom they will then be dispensing treatment—but in truth it stopped the bleeding of nurses into other countries.

So we have learned that by various interventions, we can maintain what professionals we have. Then you work like the devil to make sure that additional people are added, and you rely on some expatriate help to fill the gap.

But the loss is terrible. Just look at what's happening to the life expectancy in many of these countries; it's dropping to between the ages of 36 and 45. I mean, that's almost less than half of the life expectancy in Canada.

Mr. Brian Masse: You mentioned in your presentation the issue over intimidation, feeling that if your country goes first, you could have repercussions from pharmaceutical companies. You mentioned the situation in Indonesia.

We also had that situation during the last go-round here, when Bayer contacted me to lobby to get Avelox off the schedule list, because we'd decided to go the route of a schedule list of treatments available.

Can you describe greater the concern about setting a standard or precedent that could then be used against a country later? The repercussions probably go well beyond even just HIV and AIDS medications. There are probably other medications they're concerned about being shut out from their citizens.

Mr. Stephen Lewis: Yes, and I think my NGO colleagues would want to argue strongly that this was never intended purely and solely for HIV. That's my preoccupation, not theirs. They would argue, I think, equally that this listing of particular drugs is not compatible with the open opportunity that was given by the TRIPS and WTO arrangement. We've added our own particular stamp, which is a limiting stamp.

I think the sense of intimidation lies in the feeling that all of these countries are tremendously susceptible to pressure around international trade agreements. The pharmaceutical industries have very powerful friends, particularly in the United States.

You'll remember that when South Africa wanted to lower the prices of drugs, a consortium of over 40 pharmaceutical companies took the South African government to court. How much stronger could the sense of “Don't you dare confront us” be displayed? The pharmaceutical companies were forced to back off, with a degree of ignominy and humiliation, only because the world responded. It was just outrageous that the pharmaceutical companies could think they could bludgeon a whole government into submission by taking them to court, and threatening to pull out, and all of that.

It's a very delicate situation. I've never fully understood it, because I don't see that the brand name pharmaceuticals have a very large market in Africa. They're not losing a lot; they're protected for their prices in the western world, where they make their profits and do their research. I would think this piece of legislation could be repaired and made real.

● (1605)

The Chair: I'm sorry, Mr. Masse, your time is up.

Mr. Brian Masse: Thank you, Mr. Chair.

The Chair: Thank you.

We'll move now to Mr. Byrne, and then quickly to Mr. Martin.

Hon. Gerry Byrne (Humber—St. Barbe—Baie Verte, Lib.): Thank you, Chair.

Mr. Lewis, I want to explore that concept of intimidation. We heard from witnesses just the other day, representing the Government of Canada and key government departments, that we're somewhat bankrupt to be able to explain why this legislative process, the compliance with the TRIPS waivers, is not leading to a better access to medicines regime on behalf of Canadian companies, generic producers. I'm just wondering whether there's some element of intimidation not just of the importing countries, the recipient countries, but as well of Canadian companies who might be involved in this.

You mentioned that India is punching above its weight currently. It has the regulatory environment to be able to produce this, but it also seems to me that it has the business case to offer. It has cheap labour, its production costs are much lower, and so it is now the warehouse of antiretrovirals.

I would like your opinion as to whether Canada, if we were to alter our business case—It seems to me that you are of the opinion that our legislation is pretty good; that notwithstanding the naming of specific countries of import, the legislation is pretty sound. What's happening here in Canada is that the business case is not all that strong for the generic producers to become involved in this.

I'm wondering whether there's a better or stronger role for CIDA to participate in this sort of activity, in much the same way as they provide official development assistance for other types of services, whether it be remote sensing of environments or provision of clean water supplies. CIDA goes out, contracts with existing Canadian companies to partner on official development assistance projects, and often contributes financially to that initiative.

If a generic company were to partner with an importing country and have CIDA partner financially in the project, could that be a better model for the Canadian rollout of the Canadian access to medicines regime?

Mr. Stephen Lewis: I think I would say two or three things: number one, that I believe the intent of the legislation is good but do not believe the legislation is good. I believe the legislation is deeply flawed and have said so, and I think it needs pretty significant amendment to make it work. But I think the intention was absolutely a decent and worthwhile one. It took advantage of the amendment to the WTO decision, the decision that came out in August of 2003 and then was consecrated permanently in 2005.

Secondly, I think that what we're really looking at here is a way in which to get a compulsory licence issued, as other countries have done, a way that is streamlined, can be handled comfortably, and need not throw up all of the tensions and all of the difficulties that seem to be inherent in this piece of legislation.

The third point is, sure, CIDA can help in this realm, as it helps in other development realms. But you still have to have, if the generic companies are going to be able to produce drugs that are sold at low prices in developing countries.... Whether they're purchased en route by CIDA or by anybody else, they're still going to have to have the compulsory licence issued.

In other words, the legislation still has to obtain before CIDA can be useful, unless we're prepared to use public money to buy very high-priced drugs, which doesn't make sense.

● (1610)

Hon. Gerry Byrne: Thank you very much.

The Chair: Thank you, sir.

Hon. Keith Martin (Esquimalt—Juan de Fuca, Lib.): Thank you very much, Mr. Lewis, for being here today. I have three quick points to ask your opinion on.

In the legislation, do you not think we have two options for rolling out meds immediately? First, through CIDA, Canada could fund medications through Health Partners International—not only ARVs but all the other meds required by the recipient country, as determined by them.

Second, the legislation could be written in such a way that both brand name and generic companies could compete within a fixed period of time. If the generics won they'd receive a compulsory licence. In that way, the meds could be rolled out with CIDA's financial help.

Finally, could you let us know how the Clinton Foundation rolled out an incredible plan within one month for Lesotho? That would be instructive for all of us.

Mr. Stephen Lewis: I don't know enough about the second item you mentioned, on the competition between the generics and the brand names, Keith—it's nice to be able to call you Keith, and I know Brian, so at least I know a couple of people on a first-name basis. I think it would raise enormous complications around international intellectual property rights law, and it would be very difficult to draft legislation that actually worked on the second suggestion you made.

On the first suggestion you made about CIDA effectively purchasing drugs and getting them into the countries that require them, again I think you have a real problem unless you have legislation that results in the issuing of a compulsory licence. Apparently we're not going to get a voluntary licence; that went by the boards in the negotiating period over the last two or three years. If you're going to have a voluntary licence you need to have a vehicle to get that licence in place pretty quickly, whether or not CIDA is involved.

It seems to me the focal point of this committee's deliberations—forgive my presumption—is how to get a compulsory licence. How do you manage to have a generic company produce the kinds of medications that will be absolutely treasured in Africa and result in the saving of huge numbers of lives? Whether at some point after the compulsory licence CIDA is able to intercede the way other purchasers have—UNICEF intercedes as a purchaser and a distributor, and the Global Fund intercedes, etc.—the compulsory licence has to be available. They intercede now with India where it isn't a problem, but I suspect they would intercede with Canada if we issued a compulsory licence for fixed-dose combinations, first-line therapies.

On Lesotho, the Clinton Foundation said to Lesotho within one month of the problem being raised, “We will sign a memorandum of undertaking with you that we will negotiate the price of drugs downwards.” It was with Lesotho that they gave the price of $139 per person per year. They offered it literally within a month of having the problem raised with them, simply because they had constructed an apparatus to negotiate with the generics in India. They would negotiate with generics in Canada and be a vehicle. We would be part of the realm that the Clinton Foundation or others used to provide the drugs for Africa.

So I think everything is essentially in place in Canada, except that we have—forgive me—lousy legislation that doesn't work. If we could make it work, Canada would have this pre-eminent role. I love that thought for my country. I think it's a wonderful thought.

The Chair: Thank you very much, Mr. Lewis.

We're in a bit of a tough spot here. We're at 4:15, and because we have votes at 5:45 we have to end the session at 5:30. That means the NGOs' time has been cut by an hour.

As the chair, I suggest we have Mr. Lewis speak until 4:15. I was on the list and we also had another member on this list, so I guess I'm looking for guidance from the committee. My recommendation is that we move on to the NGOs at this point. I know Mr. Lewis is a very good witness and we'd like to hear more from him, but we have six members of six NGOs, and I think we should give them at least an hour and 15 minutes.

Is that okay with the committee? That's acceptable.

Mr. Lewis, I apologize. There are many more questions we'd like to ask you. If there's anything further you'd like the committee to know, please feel free to submit it in writing to either me or the clerk. We'd be happy to pass that on. But thank you very much for taking the time to be with us here today.

● (1615)

Mr. Stephen Lewis: You're very kind, Mr. Chair, and you're about to deal with people who really know what they're talking about.

Thank you.

The Chair: Thank you.

I'll suspend for a few minutes while the NGOs come to the table.

● (1615)

(Pause)

● (1620)

The Chair: Ladies and gentlemen, I call the meeting to order.

We have six witnesses with us here today. From the University of Toronto we have Sarah Perkins from the international human rights program, faculty of law. We have Mr. Richard Elliott from the Canadian HIV/AIDS Legal Network. From Oxfam Canada we have Mr. Robert Fox, the executive director. From the Interagency Coalition on AIDS and Development we have Mr. Michael O'Connor, the executive director. From Médecins Sans Frontières we have Carol Devine, access to essential medicines adviser. And from Health Partners International of Canada we have Mr. John Kelsall, the president.

We'll have five-minute opening statements, and we'll start right away with Ms. Perkins.

Ms. Sarah Perkins (Acting Director, International Human Rights Program, Faculty of Law, University of Toronto): Thank you, and thank you for providing me with the opportunity to speak to you today. I'm appearing on behalf of the International Human Rights Program's access to drugs initiative, based out of the University of Toronto's faculty of law.

In my submission today and my accompanying written brief, I will touch upon three major obstacles that are built into the access to medicine regime.

As much as possible, we have tried to approach our review of CAMR from the perspective of Ghana, one of the countries that were intended to use this legislation. Officials from Ghana have now travelled halfway across the world twice to visit Canada and to learn how Canada might provide Ghana with access to treatment for the tens of thousands of Ghanaians who are dying of HIV/AIDS, but despite their efforts, Canada's regime has proved to be impenetrable.

To remedy this, I would urge you to consider the concrete amendments proposed by the Canadian HIV/AIDS Legal Network, but we would also like to implore you to ensure that a revised system includes the three recommendations that follow.

First, you must ensure that CAMR is compatible with standard international procurement protocols. It is unacceptable for Canada to adopt a system that seems to encourage developing countries to break their own domestic procurement laws in order to have access to Canadian medicine. Standard procurement protocols require governments to issue calls for tender based on the supply of medicine, and to select the top tenderer based on objective criteria. CAMR does not facilitate the implementation of these procurement laws.

Under CAMR, a compulsory licence can only be obtained once the manufacturer and the importing country have already reached an agreement. This means that at the point that a manufacturer would come forward to bid on an international tender, this bid would have to be conditional upon receipt of a prospective licence. Such a tender would not be compatible with Ghanian tender laws, and even if it were compliant with these laws, it would be so uncertain as to nullify the bid. CAMR must be amended to permit a manufacturer to apply for a licence prior to entering into an agreement with an importing country. To facilitate this, the manufacturer should not be required to specify the person or entity to whom the product is to be sold.

Our second recommendation is that CAMR must explicitly permit licences to supply regional trade groups. Small countries have insufficient market potential to benefit from the economies of scale that bulk purchasing can achieve. CAMR's failure to explicitly include subsection 6(i) of the general council's decision of August 30, 2003, must be remedied to permit developing and least-developed countries to take advantage of all of the TRIPS flexibilities that were specifically made available to them, including the ability under subsection 6(i) to regionally redistribute medicine under the authority of one compulsory licence.

Our third recommendation is that CAMR must eliminate schedule 1 and specify that the regime includes active pharmaceutical ingredients.

With respect to schedule 1, the existence of this list serves as an immediate detractor to developing-country government officials. I have seen the faces of foreign ministers of health as they read this list. They are confused, they are disappointed, and they are angry. This list contains virtually none of the medicines they are most interested in and most desperate to provide to their populations.

The restricted list of medicines further exacerbates uncertainty and establishes a perception—and rightly so—that Canadian companies would be unable to respond promptly to tenders to fill drug needs.

With respect to active pharmaceutical ingredients, much of our analysis of CAMR has focused on the supply of finished pharmaceutical products to the developing world. In 2001 the WTO pledged to make positive efforts to ensure that developing countries would have a share in the growth of world trade through capacity-building programs. They also pledged to address the marginalization of these developed countries in international trade.

The August 30, 2003, decision also supported these commitments, specifying that this regime should be used in a way that would promote the facilitation of local production of medicine in developing and least-developed countries. Canada would be greatly remiss if we failed to look beyond the supply of medicine to other ways in which we can support a long-term and sustainable supply globally, including helping to promote local production.

The Economic Community Of West African States, which Ghana belongs to, is increasingly looking to bulk procurement and domestic production of essential medicine as viable alternatives to imports. Such efforts will not render CAMR moot. Rather, CAMR will be just as vital for the active pharmaceutical ingredients that it can provide. Canada and Canadian generic producers should be providing technology transfer and capacity building in local pharmaceutical sectors, as specifically contemplated by the general council decision.

In conclusion, corporate Canada and our elected representatives have made sweeping promises to address the continuing lack of access to medicine in the developing world. We need to start thinking creatively about ways in which we can make access a reality. It would mean the world to those who otherwise face certain death, and if we keep our word this time, we just might be the leaders that this crisis is demanding.

Thank you.

● (1625)

The Chair: Thank you, Ms. Perkins.

We'll go now to Mr. Elliott.

Mr. Richard Elliott (Deputy Director, Canadian HIV/AIDS Legal Network): Thank you, Mr. Chair.

[*Translation*]

My name is Richard Elliott. I am a lawyer and the deputy director of the Canadian HIV/AIDS Legal Network. We have sent you a summary of our brief containing several recommendations on how Canada's Access to Medicines Regime should be amended.

As we all know, Canada's Access to Medicines Regime has not met the promise made by Canada to help developing countries to get affordable medicines. We believe there are several reasons for that. Our recommendation today is to implement a different system which might allow Canada to fulfill its promise.

[*English*]

As we all know, Canada's access to medicines regime has failed to deliver in the three years since it was passed. With the recommendations that we put before you today, we hope to give you very concrete proposals for amendments that would simplify greatly and streamline the existing process, which is at the heart of the problem. We will be submitting to the committee a more detailed brief in the days to come. You have, attached to the material that has already been circulated to you, concrete proposals showing specific statutory provisions that should be removed from the legislation, and others that should be inserted, to put in place the recommendations that I hope to outline for you in the next few minutes.

But first of all, why has the Canadian regime not worked? We know it's not because there is no need for medicines. We heard earlier from Mr. Lewis, and we've seen the UN report that came out earlier this week that said that almost three-quarters of people living with HIV in the developing world are still, despite the progress that has been made in the last couple of years, not getting access to the antiretrovirals they need. There's no question, as we've also heard, that there is still a woeful lack of financing overall for scaling up the response to the global AIDS pandemic.

Funding is being mobilized. It has been mobilized in the last few years. More is needed, but treatment scale-up is happening. So the lack of resources is not, as some might suggest, a sufficient explanation for why Canada's regime has not worked, and indeed why other countries' regimes that are fundamentally similar have not delivered either. Rather, in our view, it is becoming abundantly clear that three and a half years after the WTO adopted a decision that was supposed to let developing countries make effective use of compulsory licensing to get lower-cost medicines, and since a number of countries, including Canada, have adopted that particular mechanism, the problem is with the mechanism itself.

Let me first of all, however, just note a couple of things that are Canadian-specific flaws in the implementation of that WTO decision.

[*Translation*]

There is a limited list of drugs which may be manufactured by generic companies for export. That limited the list should be abolished. All the medicines are required, whatever they may be. We should be able to manufacture affordable generic versions of drugs for export. We should also abolish the requirement for NGOs wanting to provide affordable generic medicines to get an authorization from the importing country.

[*English*]

We should eliminate the additional unnecessary and unjustified double standard that has been imposed for developing countries that do not belong to the WTO in order to import Canadian-made generics. We also need to eliminate the provisions in the Canadian access to medicines regime that create additional opportunities for brand-name companies to go to court and engage in vexatious litigation that will tie things up further.

We need to get rid of the arbitrary two-year limit on the term of a compulsory licence that is currently found in the Canadian regime. It is a completely arbitrary limit that was completely unrequired by the WTO decision that is the basis for this legislation.

More fundamentally, beyond those particular Canadian quirks of implementing this particular WTO decision, the fundamental problem is with the WTO decision itself. The mechanism has been the basis not just for our legislation, but for the legislation of half a dozen other jurisdictions, none of which have worked yet either.

The problem is that the WTO decision itself is unnecessarily complicated, time-consuming, and risky. It sets out a process for obtaining a compulsory licence that is unrealistic, is user-unfriendly, and does not speak to the needs and the realities of developing countries and the practical considerations that face generic pharmaceutical manufacturers, which are primarily commercially motivated actors, as we all know, just as the brand name companies are.

It is difficult to escape the conclusion that something is wrong with the system itself. On Monday, we heard from government representatives before this committee who were asked to explain what the current process is under the legislation. It took a full minute to explain just the first step of that process before the government representative was interrupted. Let me therefore tell you the full process so that you understand how complicated it is.

For every single drug order that a developing country might wish to place for a generic version of a patented drug, it must, as you've heard from Ms. Perkins, negotiate a contract with a generic producer here in Canada. The contract can only be tentative, because there is no licence issued at that point, and the producer must then go through an entire process of first seeking a voluntary licence and trying to negotiate a royalty. At the end of all that, the producer might then actually get a licence that will allow it to supply that particular product, in that quantity, to that particular country.

That process must be gone through every single time. In our view, it would be much simpler and more direct, much more streamlined, if you were to get the licence at the beginning of the process, as Ms. Perkins has suggested. That would permit the generic manufacturer to export that product to any of the eligible countries under this legislation, with the condition that they periodically remit the applicable royalties to the brand-name companies here in Canada.

One licence at the beginning of the process allows for competition from the generics, covers the eligible countries, and doesn't require the process every single time. As we've submitted to you, this is also consistent with our WTO obligations.

Thank you.

● (1630)

The Chair: I'm sorry to cut in on you, but we do have four other witnesses we have to get to.

Mr. Fox, we'll go to you, please.

Mr. Robert Fox (Executive Director, Oxfam Canada): It's a pleasure to be here with you this afternoon. As you know, I'm the executive director of Oxfam Canada. Oxfam is very much involved in the work in southern Africa and around the world on these issues, both on the front lines in working day-to-day with creative, courageous people who are taking on these struggles, but also in global fora at the WTO, in the United Nations, and before this Parliament. We have appeared before you on this issue in the past.

I was in Zimbabwe the week before last and had an opportunity to meet with a range of people there who are dealing with these issues as part of their lives and, in some instances, as part of their looming deaths. Nothing focuses the mind like sitting in a cardboard space with someone who is withering before you, and then walking out and meeting someone you met six months ago when you were last in southern Africa who was in that same situation, and she is now one of the community organizers, one of the health promoters who is out there and is vital, active, and a leader in her community, is looking after her children, and is trying to make a living in Zimbabwe—which is not easy, but that's a whole other story for the moment—because she has now finally had access to ARVs. We talk about the Lazarus effect, but when you see it, it is absolutely incredible and it is absolutely compelling. That's the sort of issue we need to deal with.

This isn't only around HIV/AIDS. We recognize that there are increasing numbers of millions of people in developing countries for whom cancer is a real risk. The projected number of people with diabetes, for example, is supposed to increase from 30 million to 330 million in the next number of years.

This question of affordability of drugs is absolutely critical for all of us. There is no question that there are serious barriers that we have an obligation to overcome. The world bought into that. That's what the declaration in Doha was all about, but we have allowed the world's intent to be thwarted by corporate profits and the interests that back them.

When we look at what is happening right now at the global level in terms of the role of the United States government most particularly, the U.S. is being very aggressive in negotiating bilateral trade agreements and regional trade agreements that are actually TRIPS-plus. They're actually making it more difficult for people to access the drugs they need, not easier, and they're creating ever more barriers to affordable health care.

We look at the role of big pharma and we look at the rhetoric of big pharma. They talk about how much they need to invest in R and D. Let's face it. Only 14% of their revenues are invested in R and D, as opposed to 32% in administration and marketing. When we talk about their commitment to the south, of the 1,556 drugs that they have sought patent protection for in the last number of years—I have forgotten the number, but I'll find it for you, because it's in our brief—only 21 deal with diseases that are typical to the south, like malaria or bilharzia. These are the sorts of issues that are actually life-and-death not for those who consume designer drugs in the north, but for those who are living on less than a dollar per day in the south.

Yet big pharma has the nerve to be very aggressive in taking on countries in the south that are trying to assure access to drugs in the south. Novartis has the nerve to be taking the Government of India to court right now to indicate that it has to strike from its books legislation that will allow it to produce a cancer drug that would mean the difference between millions of people in India and around the world having access to treatment and not having it.

In Canada, of course, they didn't try bullying. Instead, they tried lobbying, but they were equally successful. We've tied our regime into so many knots of red tape that our capacity to break through this has in fact been completely stymied. Yet again, the will of Parliament and the will of Canadians has been thwarted by legislation that is far too timid and far too deferential to issues that have nothing to do with humanity, nothing to do with human rights, and nothing to do with getting people access to health care, and everything to do with protecting privilege and protecting profit.

When we look at what's on the agenda of the G8 summit in June, for example—the G8 summit that's supposed to return to the question of Africa—we look at the section of the draft agreements, because these things are all cooked up months in advance, as you know. The section of the accord at the G8 summit that deals with intellectual property is all about piracy. It's all about tightening the screws. It's all about ensuring that no one anywhere, under any circumstances, can more equitably and cheaply produce those drugs, instead of being about how we can in fact turn it around.

● (1635)

If we can take a drug that had been $10,000 per person per year and through generic production produce it for $139 per person per year, that should end the discussion. All of our efforts should be around how we ensure that this drug gets to people who are dying without it.

Thank you.

The Chair: Thank you, Mr. Fox.

We will go now to Mr. O'Connor.

Mr. Michael O'Connor (Executive Director, Interagency Coalition on AIDS and Development): Thank you very much, Mr. Chair, for the opportunity to speak to the committee as you review this legislation.

I am with the Interagency Coalition on AIDS and Development, which is an umbrella group of 150 member agencies: front-line AIDS groups working in Canada, development agencies, professional associations, and labour organizations. I represent ICAD on international bodies like the Global Fund to Fight AIDS, Tuberculosis and Malaria and the United Nations AIDS program.

We had an opportunity to address this committee in 2004. As I look back at my notes, it is really quite interesting to compare some of the things that were brought up. Our concerns at the time are still coming up and need to be spoken about again.

At that time we noted that this was a very important piece of legislation. This is part of a comprehensive Canadian response to a health crisis in the world. As you know, there are three million people dying of AIDS every year, two million dying of TB, and a million dying, unnecessarily, of malaria. That commitment was made by Canadians, through their Parliament, and it was made with the best intentions.

Since 2004, a number of things have changed, which I would like to highlight. There is a bigger political commitment now than there was in 2004. At the G8 meetings in 2005, the world, including Canada, made a commitment that by 2010 everyone who needs access to HIV/AIDS treatment will have it. That was called the universal access commitment. It was bold. It was then reinforced at the United Nations, where all countries in the world endorsed it in June 2006.

There has been a change in terms of the financing, the money that is needed. The Global Fund, which is the main mechanism for disbursing funds for AIDS, TB, and malaria programs, was just getting started in 2004. But funding has been ramped up. The Global Fund has $7.1 billion worth of funding for AIDS, TB and malaria programs in 136 countries. By 2010, they will probably have about $8 billion for funds, the majority of which is going to drugs and other health consumables. The money is there.

That piece of the puzzle needs to be reaffirmed every year. Canada has made a reasonable contribution to the global fund of about 4%, and we are hoping it will continue with that level of commitment.

There was talk of bottlenecks. There is always a concern about bottlenecks, but they are being addressed very aggressively. As you know, at the G8 meeting last year, Prime Minister Harper made a very bold commitment of $450 million over 10 years, which is being spent on strengthening health systems.

This program is being rolled out by CIDA over the next few years. It is the kind of program that will address not only the infrastructure problems that exist in some countries but some of the health professional shortages, by providing enhanced environments and training.

There is a clear need. I think that has been underlined by what Stephen and my colleagues have said. People are going to be on treatment forever. Right now, as Stephen mentioned, there should be five million people on treatment. By 2010, there should be eight million to ten million people on treatment. That means treatment for HIV for life. Bigger numbers will need the second-line treatments.

There is also a need for the complex treatments related to TB. Increasing numbers of people are not able to have treatment with the off-patent TB drugs. We need much more of the fancy drugs that Canada can produce.

In conclusion, I believe the suggestions that the HIV/AIDS Legal Network and the University of Toronto are putting forward concerning fixing this legislation should be taken into consideration.

● (1640)

I am convinced, more than ever, that the legislation is worth fixing. As you look at these things, you wonder if this effort is worth it. Well, it is. You're damn right it is. You are going to save a lot of people's lives. This is an important piece of work that can have an impact not only in the short term, but also in the long term, and I think Canadians can be justifiably proud if it is fixed properly and we make this important step to a comprehensive response.

Thank you.

The Chair: Thank you, Mr. O'Connor.

We'll go to Ms. Devine.

Ms. Carol Devine (Access to Essential Medicines Advisor, Doctors Without Borders): Thank you, Mr. Chair, honourable members, for giving Médecins Sans Frontières the opportunity to appear here today.

[*Translation*]

I thank you for allowing us to appear before your committee today.

[*English*]

I am here representing MSF as a humanitarian. I'm not an intellectual property lawyer or a patent specialist. I've worked in Rwanda, Sudan, East Timor, and Peru with MSF, and I've witnessed the devastation of AIDS and other untreated infectious diseases firsthand. I've also seen the consequences of monopoly pricing of medicines. I was involved in the early consultations of Bill C-9, or the JCPA, in 2006.

Today MSF is working in 70 countries worldwide, providing independent medical assistance. In 30 of those countries, we're treating 80,000 people with antiretroviral medicines, as well as providing integrated HIV treatment, prevention, and care programs, so we also see firsthand the reality of drug procurement and the need for reliable access to affordable drugs. Every year we're spending many millions of dollars on drug procurement, some of which comes from the $22 million donated by the Canadian public last year.

The Doha declaration on TRIPS and public health by the World Trade Organization in 2001 recognized the problems many countries experience with accessing newer medicines. While Doha clarified countries' rights to take measures to overcome patent barriers to access medicines for all, it left the issue of exporting medicines produced under compulsory licence unresolved, which is what we're discussing today.

When the solution was announced in 2003, MSF and others said that the August 30 decision was too onerous and cumbersome. It was wrapped in red tape. Still, MSF committed to seeing if it could somehow be workable and urged: “Countries must act now to use the Doha Declaration to access the best priced medicines for their populations. The experience they gain by doing so will test the limits of the WTO rules and be invaluable to revising WTO patent rules after Cancun.” And we still have that opportunity.

Laudably, Canada was the first country to try to implement the solution. I worked very closely on this process, urging Canada to set a workable precedent, and many others here today did—and internationally.

My colleague Michael O'Connor mentioned that in February 2004 MSF testified before this committee. We stated that we foresaw that the Canadian bill in its existing state could not work unless fundamental flaws, indeed some fatal limitations beyond what TRIPS required, were removed. Some were removed and some remain.

In good faith, we tried to place a drug order under the Canadian access to medicines regime. We have spent over two years with other stakeholders holding in the Canadian government, trying to make it work. In short, we've liaised with a Canadian generic pharmaceutical company that rather quickly developed a fixed-dose combination—FDC—antiretroviral medicine that at the time did not exist in an approved state. We have received notification from both Health Canada and the World Health Organization that this drug is approved. They've approved the quality of the drug, but not a single developing country has notified the TRIPS of its desire to use this regime.

It's been mentioned by Stephen that it's a drug-by-drug, country-by-country solution with so many bureaucratic hurdles. In the meantime, the same FDC has come out by Indian generic companies. These products have also been pre-qualified by the WHO.

To purchase these products, no additional procedures exist, no notification to the WTO is demanded, and logically, countries are preferring to take this route. Recent developments in Thailand and India illustrate painfully why this is, and we've heard a few points on that already.

So I wish to make two main points.

For the past three years, MSF has tried in earnest to deliver medicines using the Canadian access to medicines regime. Not a single pill has left Canada or any other countries that have implemented the August 30 decision. We've concluded, therefore, that the WTO decision is not expedient and is therefore not a solution, but we also think that it can be changed.

Today, sources of generic medicines still exist in India, but in the years to come these sources will dry up as India starts granting pharmaceutical product patents. At that point it will be crucial that production for export under compulsory licence becomes as easy as it is now.

We urge Canada to implement TRIPS-compliant, workable solutions in Canada—some examples have been given—to improve the legislation and make a better model to the world, and also to remind us here today that it's to take it back to the WTO. We have commitments that we've made to the Canadian public, but we have commitments that we made at Doha as one of the WTO members, this idea of medicines for all that was adopted.

So secondly and lastly, access to medicines is a continued serious daily concern to MSF. People must be prioritized over patents, as in this poster that was referred to earlier, both in the Canadian legislation and at WTO. In our experience, generic competition has been one key way to provide access to medicines for millions. Over 80% of the patients we're treating are on Indian generic medicines, and those medicines risk drying up because of TRIPS compliance and global patenting. Since Doha we've seen that commercial interests are able to trump facilitating access to medicines.

● (1645)

I would just mention to you that we have talked about second-line medicines, and the urgent need for second-line medicines. Canada can play a part in making second-line medicines in pediatric formulations.

We encourage you to take the logical next steps to fulfil your promises.

Thank you.

The Chair: Thank you very much, Ms. Devine.

We'll go finally to Mr. Kelsall.

Mr. John Kelsall (President, Health Partners International of Canada): Thank you, Mr. Chairman, for this opportunity to address the committee about a topic that's very close to my heart.

My name is John Kelsall, and I'm president of Health Partners International of Canada. HPIC is a Canadian non-profit medical aid agency that is having a significant impact by providing needed essential medicines, medical supplies, and vaccines to people in many of the poorest countries of the world.

We are pleased that the Government of Canada is taking a closer look at the workings of the access to medicines regime to help prevent death and alleviate suffering related, in particular, to the shocking effects of the HIV/AIDS pandemic. We unequivocally support the aim of the regime, namely, to get aid to the people who so desperately need it.

Since the International AIDS Conference in Toronto last August, most Canadians have come to know about the HIV/AIDS situation, particularly as it affects sub-Saharan Africa. Many have seen, through the media, the devastation caused by this affliction. Anyone with eyes to see their desperate plight, ears to hear their horrifying stories, and a heart to feel compassion must be moved to help in whatever way they can. I personally have seen the devastation and heard the cries for help.

According to UNAIDS, every minute of every day a child under the age of 15 becomes infected. Ninety percent of the more than five million children who have been infected were born in Africa. In sub-Saharan Africa, women make up 57% of people living with the disease. Three-quarters of young people infected on the continent are young women aged 15 to 24.

We applaud the federal government's commitment to ensure the delivery of affordable essential medicines to help alleviate the suffering. We are also very much aware of the need for ARVs, and that these must be delivered in a coordinated framework that includes patient counselling, home-based care, trained medical professionals, blood testing laboratories, and the consistent supply of ARVs, along with other medicines and medical supplies.

It is our belief that government policy should enable Canadian aid organizations such as ours to be the outstretched hand of Canadians in a way that is both reasonable and responsible. We are aware, however, that this review must resolve practical policy and regulatory issues regarding to whom medicines are sold, and in what conditions. And we trust that people with a heart to do so will find workable and equitable solutions.

The comments that we provided for the review are already on the record. For the purpose of this discussion, l'd just like to highlight our key recommendations.

First, take an integrated approach to dealing with HIV/AIDS. HPIC recommends that the government, as well as aid agencies, industry, and civil institutions, ensure that there is a balance in funding and allocation of other resources to all aspects of the battle against HIV/AIDS, including treatment of opportunistic infections, and other public health initiatives that support HIV/AIDS interventions.

Second, simplify the process as much as possible and ensure that information regarding CAMR is clearly communicated to countries that could benefit. HPIC recommends that the government undertake programs to facilitate access to essential medicines through Canada's access to medicines regime by involving developing countries, especially sub-Saharan Africa, by encouraging use of its provisions, and by making adjustments if necessary.

Third, favour practical solutions of manageable scale. HPIC recommends that the government focus on support of suitable facilities with the supply of ARVs and other appropriate medicines from Canadian sources in order to develop a template for the effective treatment of HIV/AIDS, particularly in sub-Saharan Africa.

Last, protect the anti-diversion provisions of the current regime. HPIC recommends that the government take all reasonable steps to ensure that medicines originating from Canadian sources not be diverted from their intended consignee.

What appears evident to us, Mr. Chairman, is that Canada must better understand the reasons why provisions of the regime have not yet been operationalized. The government would profit from hearing the voices of African governments, for example, that have a major stake in the outcome. Many have acted courageously, against daunting odds, to implement bold national strategies that deal with the shocking prevalence of HIV and AIDS. As well, African nations should be encouraged to explore local manufacturing and procurement options, perhaps with the assistance of the Canadian government.

Canada has a brilliant reputation as a land of compassionate people. But the problems associated with AIDS in Africa are too big for compassion alone. They call for the mobilization of all developed countries and all segments of Canadian society. They call for responsible action.

● (1650)

The Canadian access to medicines regime is only one tool designed to deal with a larger set of issues, and it is not even the most important one. Decisions regarding CAMR, therefore, must be both cautious and courageous. They will require goodwill and ingenuity from all political parties, all segments of the Canadian population, as well as all sectors of industry. We are confident this will occur.

Thank you.

The Chair: Thank you very much, Mr. Kelsall.

We'll go right to questions from members. I ask members to be as brief as possible, so we can get to as many other members as we can.

We'll go now to Mr. Byrne, please.

Hon. Gerry Byrne: Thank you very much, panellists. It's been very, very informative.

One of the things I think we need to get further information on as a committee is specific recommendations as to what you would collectively, or individually, envision as changes to the legislation. If possible, if not at this forum, could you submit specific recommendations to the chair.

I know the Canadian HIV/AIDS Legal Network has done so in their presentation. If there's anything further, it would be extremely helpful to us, especially if done in an expeditious fashion. If there are specific things you can put forward right now, they would be very helpful to us.

I would like to follow up on Ms. Perkins' advice. Basically, if I remember correctly, Ms. Perkins, you just suggested we should not request or expect importing countries to contravene their own laws. Is there anything specific being recommended here that would put Canada in contravention of WTO TRIPS requirements and the specific provisions within the waivers they have allocated or granted?

● (1655)

Ms. Sarah Perkins: No, under the WTO rules, it would be permissible and TRIPS compliant for Canada to permit the exporting manufacturer to obtain a compulsory licence prior to entering into a formal agreement with the importing country. So it is TRIPS compliant and something that Canada could do. In doing so, you would allow foreign governments, particularly governments like Ghana with domestic procurement laws, to respect their laws and enter into these international tender agreements, and have companies here come forward in good faith with a licence in hand to say, we can fill that tender and here's our price.

We can beat others out there. It's possible, and it's TRIPS compliant, and it's probably the way that would work best.

Hon. Gerry Byrne: So that is basically the only expression of concern you would have about the one element that puts it in potential contravention with importing countries' own legal requirements?

Ms. Sarah Perkins: Yes, that's the one that is the most apparent, and from our perspective and our work with Ghana, it has been the biggest obstacle to accessing this legislation. There seems to be a perception, perhaps amongst generic companies and others, that the African countries are going to come to Canada—perhaps sitting down with a company in a room—to talk about specifically what medicines they need.

From the foreign government perspective, from the Ghanaian perspective, that cannot happen, as it's a violation of their domestic laws. So it has to happen the other way around: our companies here have to approach them with the licence in hand.

Hon. Gerry Byrne: Thank you.

The Chair: Thank you, Mr. Byrne.

We'll go to Monsieur Vincent.

[*Translation*]

Mr. Robert Vincent (Shefford, BQ): Thank you, Mr. Chairman.

I want to thank the witnesses for explaining the whole range of problems they are facing. Has any of you ever provided any medecines or other products to another country, which would have allowed through WTO their introduction somewhere else? Have you received any orders in answer to any offers you would have made through any type of process?

[*English*]

Ms. Carol Devine: We have been discussing this with one country, and they will not do TRIPS notification. We've also brought this, and MSF's potential interest as an organization procuring a lot of drugs, to the attention of other developing countries, and to our knowledge, they have not done any take-up of the Canadian legislation.

[*Translation*]

Mr. Robert Vincent: How should the legislation be changed to allow you to export drugs to other countries? What would be the best solution to help you export drugs?

[*English*]

Mr. Richard Elliott: I can speak to that.

Our central recommendation, which I think would help answer your question, and it's something that Ms. Perkins has already mentioned, is to simplify this process by letting the generic manufacturer here in Canada get one compulsory licence at the beginning of the process, before there are any particular contracts negotiated with any particular country or countries. With that legal authorization in hand, the generic manufacturer can then bid through transparent international tendering processes that many developing countries will have. They can negotiate with multiple developing countries on the list of eligible countries and achieve a certain degree of economy of scale, because they can actually negotiate larger-sized contracts, which means they can negotiate with suppliers of active pharmaceutical ingredients to get the prices of producing the pill down even further, and they will not be required to go through the process every single time, for every single drug order from each particular country.

So it's a simple process, and all that would be required is that they would then periodically pay royalties based on the formula that is already found in the legislation, which is actually the single best feature of the Canadian regime. The Canadian regime is not all bad. The royalty provisions for calculating the royalties that are payable is actually, I think, a very good model for the world. It's unfortunate that few other jurisdictions have copied that particular provision. But that would be a much simpler way of doing it, in our view.

To follow up on the question that was posed before about TRIPS compliance and to reiterate what Ms. Perkins has said, in fact it would be consistent with Canada's obligations as a WTO member to legislate that kind of process. It would be a different approach from what is currently in the regime and different from what the 2003 WTO decision contemplates, but that doesn't mean that what that decision contemplates is the only game in town. In fact, that decision said, and WTO members said specifically in that decision, that it was without prejudice to the other kinds of flexibilities that countries have under the patent rules of the WTO.

One of those flexibilities that have not yet been explored, but could be by Canada, is to define limited exceptions to patent rights here in Canada that would permit the kind of process that I've just outlined. It would give you the licence at the beginning, and then let you negotiate the contracts and pay the royalties on an ongoing basis.

● (1700)

[*Translation*]

Mr. Robert Vincent: First, one has to get a license to manufacture the drug. However, I believe the problem is to get contracts from other countries. One may get a license and go through the whole process but what is more important than anything else is to get a contract from another country.

Does the legislation help you to obtain contracts from other countries? Whether you have a license or not, if you cannot qualify, that is a major obstacle. How can you sell it if you don't have a contract? Is it difficult for you to qualify and to get contracts?

[*English*]

Mr. Richard Elliott: It has in fact proven to be a problem, and that's why we're suggesting the simpler, slightly different process that we've outlined.

As you heard from MSF, despite all of their efforts, because the Canadian legislation requires that there be a tentative contract with a particular country already, and because the process set out at the WTO and in the Canadian legislation requires that the name of a country be disclosed before there's any guarantee that the generic manufacturer can get a licence, there has been a reticence, and unfortunately a fatal reticence, for countries to actually come forward.

We heard Mr. Stephen Lewis say earlier today that there is a history of intimidation here. This is not something to be taken lightly. When we see what the U.S. government has done, when we see the steps that have been taken by the brand name pharmaceutical industry to prevent countries from using compulsory licensing, it's not surprising that developing countries will be reluctant to say yes, we'll sign a contract with you, knowing that what you will then need to do as a generic manufacturer is approach the brand name company in Canada and disclose the fact that we're talking to you, asking for a cheaper medicine, which fact will then get to the U.S. government, who will put pressure on our trade ministry. We have to tell the WTO all of this before we even know whether you're going to get the licence that's going to let you produce the product we're interested in and supply it to us.

This process is backward. It needs to be reversed, and the Canadian legislation could do that if we legislate the kinds of changes that we've proposed to you in our brief.

The Chair: Okay, thank you.

We'll go now to Mr. Van Kesteren, please.

Mr. Dave Van Kesteren (Chatham-Kent—Essex, CPC): Thank you, Mr. Chair, and thank you, everyone, for coming.

This is a very complex file. I hope you appreciate that. We certainly appreciate your coming here.

We heard from the government people yesterday, or two days ago, and they explained their position, the things they're experiencing. We now have the privilege of having you here, and we now are hearing whole new frustrations. We will get a chance to talk to the pharmaceuticals too somewhere along the line.

I think we all realize that Canadians and everybody look at this, and it's a horrible thing to see that the aid is not getting out there. We all really want to come to a solution. It's frustrating for everybody. It has to be frustrating for you. It has to be frustrating for us to be redoing an act now. Mr. Chrétien had a promise to Africa, and this thing is just falling apart. So it's in all our interests, and we really want to find a solution.

I want to talk about CAMR. I think I want to ask Mr. Fox this, from Oxfam. Are you competing with other drug delivery systems used by the Canadian government? Is CAMR competing with other methods we provide to get the money out there, to get the drugs out. Are you competing with others in CAMR?

Mr. Robert Fox: I would say no. That is to say, there are parallel dynamics here.

First are the various avenues the Canadian government has and the Canadian people have to provide support to people to access drugs. CIDA has funding. We provide funding to support programs of WHO. We provide funding to support various other multilateral channels.

Then the question is how much people are paying for the drugs that are being delivered through those channels. These intersect in terms of their consequence, but they're two different dynamics. What CAMR is doing is affecting the price people are paying for drugs produced in Canada. And because it isn't working, Canadian suppliers are only supplying high-cost drugs to those systems, and as a consequence, they aren't the producers of choice, because there are other countries—Brazil and India, in particular, but others—that are actually meeting the need.

So if you had a million dollars of aid money to spend on drugs, you would not go to one of the brand name drug manufacturers to buy those things. Right? And that's the situation we are in. It isn't that they're completely unrelated, but CAMR is not about avenues for delivering drugs or the effectiveness of delivering drugs; it's about how much we're spending in order to access those drugs.

● (1705)

Mr. Dave Van Kesteren: I don't have much time, so I'll go quickly. Are any of you promoting CAMR in Africa, specifically?

Ms. Carol Devine: I mentioned that when Canada announced that it would be the first to implement the legislation, immediately we spoke with our colleagues. As I said, we are in many countries. We decided that we would try to use it, for a couple reasons: first, to see if it's workable, and second.... We don't think Canada is going to solve the access to medicine crisis, but it can contribute. We've seen the effect of generic competition, so another generic is excellent.

We thought Canada could also play a part, as I mentioned, with second-line medicines, with innovation, with new medicines, and with pediatric formulations. So we did see a role for Canada. We spoke about it internationally in our programs. We had a lot of endorsement from our field teams working in these 30 countries.

I think it's so important to reiterate that the changes that can be made can make it less complex and can make it work. But the way it is now, no country wants to take it up. If it's simplified and if it really follows the WTO paragraph 6 idea to allow generic competition, to allow export of generic medicine to developing countries, this can really contribute.

You speak about competition. Well, India right now, we know, is producing many of the generics, but that's at risk. So we need more solutions, and Canada can be in that.

Mr. John Kelsall: Just to quickly add to that, we actually have worked with one African country with a view to sourcing antiretroviral drugs from Canada. In fact, that particular country, after a process and an examination, really wanted investment in their own country to produce the antiretrovirals locally. They already were producing antiretrovirals for 60,000 people, and they were looking at opportunities to manufacture in their own country.

It's interesting to see that the African Union ministers of health just met in South Africa, and one of the discussion points was to try to increase the manufacture of antiretroviral drugs in Africa.

The Chair: You have 40 seconds.

Mr. André Arthur (Portneuf—Jacques-Cartier, Ind.): I think I'll follow your lead and pass on the time. I'll come back at my turn.

The Chair: Thank you.

Mr. Masse.

Mr. Brian Masse: Thank you, Mr. Chair.

One of the benefits of Parliament and this committee is *Hansard*. You get a chance to go back and review the past and how things were developed.

We hear more and more what a dog's breakfast this legislation really it, and how simple the solution could be. But it took 550 days to craft that piece of legislation and have it passed to become what it is today. We have to keep that in mind.

To the panel—and Ms. Devine, I'm particularly interested in your response—in that time were there any Canadian champions, either politically, bureaucracy-wise, or department-wise, who, once you got stuck at a certain point, helped move the log jam of what you were facing or identified the problem and brought some solutions back? Whatever comes out of the pipeline here, I'm concerned about whether or not we need to appoint some type of champion who will make sure this legislation moves and shakes throughout the world—if it actually does work.

Ms. Carol Devine: Thank you for your question.

This legislation had every champion in the government when it was passed. It had all-party agreement. So it started out with every government person championing it.

At MSF we are able to work in war zones and in difficult countries because of our mandate of neutrality, so it's not my place to name specific champions. But it can certainly be said that we've seen people working very hard on this. We were in endless meetings from mid-fall 2003 until recently, and during the AIDS conference, so we've seen champions. This drug was approved quite quickly by Health Canada, even though we felt it didn't need that extra step that was TRIPS-plus.

So there certainly have been champions, but the championing has been undermined. If you look at the report we've submitted to you, and in a point to honourable member Byrne, we have set out several NGOs and what the particular problems have been. I think it's quite easy to figure out who was the source of those blocks.

But we believe it can be championed again, and the main part now is fixing the legislation. The European Parliament wrote a good 52-word description of how this WTO solution could work, and it has turned into 3,000 to 5,000 words. So I think we just need more champions, and today is the possibility.

● (1710)

Mr. Brian Masse: Would anyone else care to add to that? I'll move to the next question.

Mr. Elliott, you've outlined a simpler process and specific recommendations on this legislation. What's happening with other governments? Are they identifying that their legislation doesn't work, and are they are trying to fix it right now? Are there comparable issues amongst our countries, so if we are able to come up with better legislation to fix this, we could go to them and bring them along in the process as well?

Mr. Richard Elliott: To the best of my knowledge, none of the other half-dozen or so jurisdictions that have adopted something similar to the Canadian regime have moved to the step of doing the kind of review Canada is now doing. That's probably partly because Canada was one of the first to move on this. So we have the most experience under our belt with this so far. Unfortunately, it hasn't brought us to the desired objective.

I am quite optimistic that if Canada, at the end of this review process, were to actually legislate some of the reforms we are proposing to streamline and simplify our compulsory licensing for the export process, that would be of significant interest to a number of other jurisdictions that have adopted similar sorts of processes based on the same flawed underlying WTO decision. I think Canada is in a very good position at this point to say it doesn't work, having tried in good faith to make this WTO system work.

We've had all this expenditure of time and energy by groups like MSF. We've had a generic drug company actually come to the table to develop a product. It's been through a number of the hurdles after much work, and we're still not able to actually get this product out the door.

Something needs to change, and if Canada were to set that precedent and actually say, “We're going to use other flexibilities in the WTO rules to legislate a simple, straightforward process with one licence at the beginning and that's it”, that would embolden a number of other countries to re-examine their own regimes and perhaps think about doing something similar. I think that would be a tremendous contribution for Canada to make.

Mr. Brian Masse: Just quickly to Mr. Fox, it's important we understand that this isn't just about AIDS and HIV. You mentioned in your presentation that tuberculosis and malaria were particularly noted in the last go-round. Can you quickly give us a couple of particular examples of where other types of treatments could be of real benefit?

Mr. Robert Fox: Well, before we leave AIDS, I think the point that was made around children's formulas, around the appropriate dosage and treatment for children, around the whole question of second- and third-round treatment, is that these are the sorts of things we're still beginning to understand, and they're really important.

The fact is that for many people in the south, we're talking about.... Just to state the obvious for a moment, these are people who earn less than a dollar a day in income. There isn't a medical system. For them, the biggest barrier to health care is the cost of the drugs themselves. A lot of them are purchasing these privately, on a market, through a market system. A range of issues, including, as I say, cancer, diabetes, or TB treatments—TB tends to get caught through the medical care system, but other things not necessarily—can have a phenomenal impact on people's lives, livelihoods, and communities.

You can cite all sorts of examples of where, because of pressure on governments in the south, the cost of drugs is actually increasing significantly—in Peru, in Bolivia, in Colombia, in countries in sub-Saharan Africa. The accessibility of drugs has been significantly retarded as a consequence of those pressures and the impact of regional trade agreements.

● (1715)

The Chair: Thank you.

We'll go now to Mr. Martin.

Hon. Keith Martin: Thank you very much, all of you, for the work you do to save the lives of the voiceless. I've been a big admirer and supporter of what you do, so thank you, and thank you for being here.

Just as a preceding comment, we all know, and I hope we put it in this context, that unless we have the medical personnel, unless we have the clean water, the adequate nutrition, the diagnostics, and the integrated health care system required in order to roll this out in an appropriate fashion, then we're not going to do what all of us are here to do, which is to ensure that this sick patient is going to get the care they need when they need it, and that it's affordable.

To whoever is here from CIDA, I hope we put this in the context of Canada taking a leadership role to fulfill those health care human resources, and the diagnostics and other components required to fulfill this.

I have a couple of questions. The first one I had posed to Mr. Lewis.

Let's say Canada were to change its legislation in such a way that both brand name companies and generic companies were able to compete in an RFP that was directed by CIDA. So CIDA would put out the RFP for medications for a particular country, and whoever wanted.... If it's the brand names, they fill it. If it's the generics, they receive a compulsory licence and they fill it. But that connects the group with the financial resources with the group that can actually manufacture. Would that not be a way of actually rolling out the medications to the countries that need it?

Second, to Ms. Devine, what would prevent you from being able to work with Mr. Kelsall to get the medications you need for the excellent work that MSF does? Because in the case of Mr. Kelsall's group, Health Partners, we were able to get $19 million worth of medications—it's a beautiful partnership—post-tsunami in Southeast Asia within two weeks. If Mr. Kelsall had the resources from the Government of Canada, MSF could work together with him, and he would be able to fulfill your group's needs on the ground. Is that possible?

Ms. Carol Devine: To your first question, I don't feel an appropriate place to comment about CIDA, and working with...I mean, we have a WTO commitment, a WTO decision that Canada was part of. We have legislation that's not working. We put a lot of effort into seeing if it would work, and then having the experience to share here today. So that for me is a possibility, but it distracts from the fact that Canada still has a commitment and that this needs to be solved.

On the second question, we might work together. As I said, MSF does drug procurement in many countries. We're always looking for opportunities. We're looking for the best price, looking for quality drugs. We may get involved in a smaller level in Canada, but then we have to remember that we're an international organization. Right now 82% of our drugs are coming from India. We are trying to think laterally and look for other resources. That's why we're involved with patent issues. We have a commitment to our patients who are being treated now, and with second-line, sometimes the drug prices are from 12% to 50% more.

So indeed, we might do a partnership.

The Chair: Can Mr. Elliott and Mr. O'Connor briefly comment?

Mr. Richard Elliott: Thank you, Mr. Chair.

Let me comment briefly on your first question. Certainly, I don't think any of the NGOs that are working in the struggle against HIV or for health generally would be unhappy to see CIDA put up more money to help support health in developing countries. Indeed, many of us have called for that and continue to call for it.

I would caution, however, that we not run afoul by falling into tied aid; that we don't somehow think that by putting up a bunch of Canadian taxpayers' dollars through CIDA we can somehow buy our way out of the fundamental problems with the Canadian regime and the compulsory licensing process. I think that would be, if one is to be cynical for a moment, almost a way of trying to paper over the more fundamental problem with the compulsory licensing process. You might, as a result of it, grease the wheels enough by subsidizing Canadian companies to maybe get one or two things out of the pipeline.

I think the fundamental challenge is to actually make the process work in a more sustainable way, so that compulsory licensing is actually easily done, not just when CIDA might put up enough money tied to purchasing from Canadian suppliers, if in fact there might be a better deal from some other supplier.

The Chair: Mr. O'Connor.

● (1720)

Mr. Michael O'Connor: I think the Canadian contribution through CIDA would be a drop in the bucket. We're talking about a lot of drugs over a long period of time, and the RFPs you're suggesting are not the way business is being done.

And I think it's for good reasons. Countries are responsible for their own health care. Botswana is responsible for addressing the needs of people in Botswana. If Botswana and a lot of countries are putting plans in place to address their HIV health issues, we should be supporting them as countries to do that. The main impact of this legislative change is creating opportunities, for the $8 billion that's out there to buy the drugs, to start their coming from Canada—making the competition happen.

The Chair: I have Mr. Kelsall.

Unfortunately, our time is up, Keith.

Mr. Kelsall.

Mr. John Kelsall: Just to add to that, I would say that for Health Partners International of Canada, all of the product we source in Canada is actually donated. When we send overseas, it's donated. CIDA assists us in terms of costs, or private donors do.

In terms of working with MSF, I was just whispering that in fact we have worked with MSF in Bosnia and have worked in partnership before.

All I would say is this. I have seen this overall scheme as kind of transitional. Frankly, I think the African countries, as has been mentioned before, have to come to the table themselves. They have a responsibility. They are interested in investment; they are interested in producing within their own borders. I think that is really to be encouraged.

The Chair: Okay, thank you.

Thank you, Mr. Martin.

We'll go now to Monsieur Arthur.

Mr. André Arthur: Thank you, Mr. Chair.

Good afternoon, everybody.

My question would be specifically for those of you who I understand have workers on the ground over there, namely Monsieur Fox, Madam Devine, Monsieur Kelsall.

More than three years after WTO laid this egg, we are still unable to count one single dose of medicine that has been shipped over there, either by Canada or by more than 30 countries that have tried to do the same. I'm quite sure that a failure of such magnitude cannot be attributed to one single cause. It's most probably a galaxy of causes.

Of all the things that have been mentioned here two days ago and today, and by you, we seem to realize that the countries that could be receiving those medicines simply don't ask for them. There are many other factors, I'm sure, legal and otherwise, political and otherwise, but they simply don't ask for the medicine that would be available if they asked for it in the proper, complicated way.

That brings me to the fact—and only Madame Brunelle has alluded to it, when she talked about the diversion of medicine—that most of those countries are dirt poor, that most of those countries would accept all Canadian funds that could be sent their way, that they would never say no to money, but yet they say no to medicines.

That brings us to the inevitable questions of corruption. Most of those countries have people who live on $1 a day, but have elites who are very rich and have bank accounts in Switzerland. Is it possible that they will accept all the money we'd send their way but are not interested in asking for our medicines because medicines are much more difficult to send to Switzerland? Is this a problem of corruption also?

Mr. Robert Fox: I think it's really important that we be really clear that the countries of the south are asking for this every single day. They're not asking Canada persistently, because it's not apparent, until we get one pill out of this country, that it's worth asking for a pill from this country. They've got people dying, so what they need to be doing is going to India and going to Brazil and going to other sources today, because they don't have the luxury of waiting for us to make this legislation work.

As soon as it works, and as soon as there are Canadian manufacturers producing those drugs, they will be here buying from Canadians. But this isn't about corruption, and it isn't about their using money for something else. This is about as soon as we can deliver, they will be here to buy.

● (1725)

Mr. André Arthur: Madame Devine.

Ms. Carol Devine: I would agree with you about the galaxy of problems and the real politics of why these countries are not asking for drugs.

I won't go down the corruption route, because MSF is concerned too. We're spending Canadian and international and Swiss money, and we have donations from all around the world. We're concerned that our money go to the patients, so we're watching that, but we see the diversion question or the corruption question in this case as not the fundamental question.

I think if we look at the Thailand case, where they did issue a compulsory licence, they got their knuckles rapped publicly and badly. One thing Canada can do besides fix the legislation would be to publicly and vocally support Thailand's pursuit of the compulsory licence. I think we can support those countries.

On corruption, I would agree with Robert that these countries want the drugs, and it's just that the rich countries have made it too difficult.

[*Translation*]

Mr. André Arthur: Mr. Kelsall.

[*English*]

Mr. John Kelsall: Just to add to that, I would say that I'm a businessman from way back—I've been involved in an NGO now for 15 years—and it's very important to know your costs of inputs, costs of shipping, and costs of distribution. That's why I say this is really a transitional strategy. The African countries need to be encouraged to produce it on their own.

It would be interesting for the committee to determine whether, in those African countries that are producing their own ARVs, there is subsidization from the Clinton Foundation or other global types in order to make the final cost to the patient affordable. If ARVs were produced in Canada, basic intuition would say that there would need to be some kind of subsidization so the prices could actually be met by the person receiving the ARVs.

Mr. André Arthur: All three of you answered my question as if Canada were the only country with that problem. Do you realize that there are 30 countries that have exactly the same problem, including the European Union? Nobody can get one single order from those countries for generic medicine, not one.

The Chair: Unfortunately, we're out of time. I will have to let that be a statement.

I'll move on to Madame Brunelle.

[*Translation*]

Ms. Paule Brunelle: I would like to talk about the list of schedule 1. Mrs. Perkins, you say in your third recommendation that eligible pharmaceuticals should not be limited to the list in schedule 1 because those that are most needed are not on the list.

Mr. Elliott, you have also recommended to eliminate this schedule 1. I did not take part in the drafting of this legislation but I suppose there would have been a long debate before coming to an agreement on the list. There must have been some kind of consensus.

I wonder how that agreement was achieved when we know that things happen very quickly in R&D. Certainly, new drugs are created regularly. So, should we get rid of that list of schedule 1? Is there any danger in doing that? Would there be any problems? Is that the solution to really implement the legislation?

[*English*]

Ms. Sarah Perkins: Thank you very much for your question.

I just want to clarify. I believe—and Richard Elliott can probably correct me if I'm wrong—that Canada is actually the only country that has implemented this decision, that has included the schedule. So the schedule 1 list of medicine is not a requirement by the WTO for compliance. So we could eliminate this decision for the factors that you point out.

Research and development are happening very, very quickly. As drugs come up, we want them to be instantly available if there's a generic manufacturer who's ready to step forward and produce that drug. So we can take off this list and leave it open, and that would be compliant with our WTO obligations.

[*Translation*]

Mr. Richard Elliott: First, I want to clarify something. When the legislation was being discussed, there was no consensus on the fact that there should be a list. On the contrary, all the NGOs were opposed to the creation of that limited list. As Mrs. Perkins explained, we said that there was no need to include such a list in the Canadian legislation since none was required by the WTO decision.

As far as we are concerned, it is not difficult to identify what is a pharmaceutical product. The only requirement should be to obtain a compulsory license to manufacture the product. It is not difficult to determine what is a pharmaceutical product and it is not necessary to have a limited list.

Thank you.

● (1730)

Ms. Paule Brunelle: One may think that in case of a pandemic, for example, the existence of this list of medicines could delay the process and prevent the rapid distribution of drugs. So, eliminating the list could be a solution in case of a pandemic.

Mr. Richard Elliott: That should be part of the solution but it is not the only recommendation we have made in our brief. There are other important recommendations, especially on the compulsory license process which should be simplified. Eliminating the list is part of the solution but is not the whole solution.

Ms. Paule Brunelle: Thank you.

Mr. Richard Elliott: Thank you.

[*English*]

The Chair: *Merci, madame Brunelle.*

Members, we have about 13 minutes. I have a couple of questions, and I have the next spot.

I'm not going to hold members here. I know they have to get to the House. But for the witnesses, if you wouldn't mind staying for a few more minutes, I will add my questions, and if we have time, we can get in a couple of more questions as well.

First of all, I want to follow up on Madame Brunelle's discussion with Ms. Perkins and Mr. Elliott with respect to the schedules.

You're correct in the sense that we do not have to have the schedules in the legislation. In fact, I think other countries do not have schedules in their legislation. But when I asked this of the Industry Canada representative, he said that if we don't have schedules in the legislation, it will in fact make the process longer because litigation over the patents will result. So it was Industry Canada's view that if you had the schedules and you had the identified pharmaceuticals, you'd actually make the process simpler.

I want to get your response to that statement.

Ms. Sarah Perkins: I would disagree. As I mentioned, when developing countries look at this list, the drugs they want and most desperately need are not on it, like second-line treatment.

In the case of Ghana, Ghana actually has been the first West African country to issue a compulsory licence. They issued that licence to import from India. They often issue that type of thing on an emergency basis when they find that they have a sudden drug shortage on their shelves, because planning can be very, very difficult in African countries. To have legislation that's responsive and swift, we cannot have that sort of scheduled list, because the drug they need might not be on it.

The Chair: That's a fair point, but that's not what I'm asking. There is a process to add pharmaceuticals to the list, and it may be cumbersome or it may not be. But my question is more that Industry Canada stated that if you did not have schedules, you would in fact make the process longer by having litigation over patents between the generics and the brand names.

You're stating that is not your position. Why not?

Mr. Richard Elliott: With great respect to our colleagues at Industry Canada, I find it hard to imagine that a brand name pharmaceutical company is going to be able to go credibly before a court in Canada and say that particular tablet is not a pharmaceutical product.

If your legislation says you can get a compulsory licence on any pharmaceutical product, I don't think there's much risk of litigation here. Is Glaxo really going to go to the Federal Court of Canada and say that tablet of 3TC is not a pharmaceutical product? I think the concern is overstated, frankly.

The Chair: No, the concern would be that they would say the patent was being broken, and that's what ties it up.

Mr. Richard Elliott: Well, that's the entire purpose of this legislation, to allow for the patent to be overridden and to authorize a generic manufacturer to make it. But the notion that we need a list of specifically named drugs in order to resolve any confusion about whether a particular drug is a pharmaceutical product, to me, does not seem particularly logical.

The Chair: I'm sorry, Ms. Devine, I have a second question. Perhaps you can start with this one.

Following up on what Mr. Martin said, respectfully I would say the big problem here is that we're setting up a model where you're just allowing....

Any time you get into patent legislation, the same as competition legislation or a lot of other legislation, it's so complicated and involves so many interests. It seems to me that Mr. Martin's question is completely valid in the sense that it says, let's step outside of that and let's put out an RFP, and let's in fact realize that the brand names are the ones actually creating these medicines in the first place, and then you give them an opportunity. He said you simplify the licence system.

That seems to me to be an entirely valid question, especially with the amount of foundation funds that are out there with the Gates Foundation and other foundations. It seems to me much simpler to actually say, here's what the Government of Canada is coming to the table with through CIDA, here's perhaps the Gates Foundation, and here's an opportunity for either the brand name or the generic to come forward and supply the medicine. The goal is to get the medicine from here to a person, as Mr. Fox said, so that person's life improves. It's not to get involved in a patent debate in Canada.

Ms. Devine, maybe you want to respond to that again.

● (1735)

Ms. Carol Devine: Thank you.

For Médecins Sans Frontières' viewpoint, we have a certain amount of money to spend on the drugs. We want to treat as many people as possible with quality drugs, so we're going to keep going the generic route. We haven't had enough success in having enough affordable medicines from the brand names to not depend on the generics, so unless there's a fundamental change in the pricing—and we can say with certainty that ad hoc, there have been some good initiatives—it's not the route to go if we're talking about saving lives now, if we're talking about the AIDS pandemic.

The Chair: But the reason I like Mr. Martin's proposal is that it actually says to the brand names, okay, if you guys want to come to the table, come to the table. The Government of Canada's coming to the table. The foundations are coming to the table. You have the opportunity to come to the table.

Ms. Carol Devine: We've been urging that for years, frankly, so—

The Chair: Okay.

Mr. O'Connor, you wanted to respond.

Mr. Michael O'Connor: Yes, I just wanted to say that for us as an organization that has been looking at what CIDA does and how we spend our development assistance money for a number of years, I think that a move like that, if that's what comes out of the recommendations from this committee, would be a move backwards. It is back towards tied aid. It's not really taking the full potential of this legislation, and I think it would be counterproductive.

The Chair: Okay.

Well, I'd love to continue the discussion. I thank you all for coming in. I thank members for staying and allowing me a couple of questions.

I want to apologize for the shortness of the time, but obviously votes in the House are beyond our control. If there's anything further you'd like to submit to the committee, please do so through me or the clerk.

Thank you all for coming in. Thank you, members.

The meeting is adjourned.

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