WHY CANADA'S *ACCESS TO MEDICINES REGIME* CAN NEVER SUCCEED

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Early in 2004, the telephone rang in my Boston apartment. On the phone was a pleasant sounding man from the Prime Minister's Office. He had heard about a Canadian at Harvard who was researching patent laws and access to medicines in developing countries, and was phoning about a bill, called C-9, that the government had just introduced in Parliament. After pleasantries, our conversation went something like this:

> "Of course I know about the Bill. I just returned from public health meetings in Europe and Africa and all my colleagues were thrilled. Congratulations: you've made a splash. "
>
> "Nice to hear, because closer to home we're being pummelled."
>
> "Sorry to hear that. What's the problem?"
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> "Everyone hates the Bill. The activists and doctors say it doesn't go far enough and accuse us of selling out AIDS patients; the pharmaceutical industry says it goes too far and will ruin medical progress. The two sides hate each other and there's no middle ground."
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> "Welcome to the drug patents debate. When you hear criticism in stereo, consider it praise for being well balanced."
>
> "Very funny. We thought this Bill would be a good news story, but it's become toxic. The expectations are as big as the AIDS pandemic itself. I'm phoning for a little help."
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> "I'd be happy to. But you know, my research on drug patents suggests the Bill's premise is off."

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"Off? Why do you say that?"

"It's a long story, but in most poor countries, very few medicines are patented. Also, most of those drugs that are patented are already sold at a steep humanitarian discount, as if there were no patent.[2] By targeting the patent system, I'm afraid Bill C-9 will only make a marginal difference to public health."

"Yeah, we know that. The patents aren't the real problem. But we've got to do something for Africa. *You see, the Prime Minister wants it...*"

Hearing that, I soon found a polite excuse to end the phone call. Bill C-9 passed Parliament that spring—without my help. Somewhere on the way to becoming law, it acquired the tellingly megalomaniacal title of the *Jean Chrétien Pledge to Africa Act.*

Six years later, the law has been rebranded *Canada's Access to Medicines Regime* (CAMR). There is as much dissatisfaction with it as ever. As I write this in January 2010, two private members bills are making their way through the House of Commons and the Senate (Bills C-393 and S-232, respectively), to fix what the laws' advocates say are fundamental weaknesses. Charities such as Médecins Sans Frontières, Oxfam and the Canadian HIV/AIDS Legal Network have all advocated strenuously in support of CAMR and these Bills.

Is this effort well spent? To be sure, CAMR was created not as a genuine public health effort, but as a Prime Minister's vanity project. By passing it, Canada sought bragging rights as the world's first country to legislate the compulsory licensing system envisaged by the World Trade Organization in decisions from 2001 to 2003 (although Norway beat us). Had it worked, CAMR would make it possible for poor countries, in Africa and elsewhere, to buy generic versions of patented drugs manufactured in Canada, at world-beating prices.

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[2] The fact that, despite so much sound and fury, medicines are rarely patented in poor countries is notable but not the subject of this paper. The country-specific patenting data are found in two previous publications: See A. Attaran , "How Do Patents And Economic Policies Affect Access To Essential Medicines In Developing Countries?" (2004) 23 *Health Affairs* 155; A. Attaran and L. Gillespie-White, "Do Patents for Antiretroviral Drugs Constrain Access to AIDS Treatment in Africa?" (2001) 286 JAMA 1886. Further, in the few cases where patents exist, often they exist on paper only and are not enforced in any fashion impacting on public health. A recent study looking at the availability of generic drugs in Africa found that "patents are not being strictly enforced in most Sub-Saharan African countries and that the presence of patents has not uniformly deterred generic purchasing": See C. Chien, "HIV/AIDS Drugs for Sub-Saharan Africa: How Do Brand and Generic Supply Compare?" (2007) 2 PLoS ONE e278.

However, it has not worked out that way, only once has a poor country come knocking on Canada's door for medicines: in 2008, when Rwanda reached a deal to buy AIDS medicines from a leading Canadian generics company, Apotex.[3]

But since that deal, the law has stood idle and has started accumulating epitaphs. CAMR's advocates such as the Canadian HIV/AIDS Legal Network say that CAMR is too burdensome to use.[4] Apotex agrees, and barely two years after striking the deal with Rwanda referred to CAMR as "not workable."[5]

These are strange protests. It is oddly contradictory for Apotex and the law's advocates to fault CAMR as unworkable, when in the very recent past they have made it work. A less rhetorical, more factual, analysis is needed.

To begin with, the Apotex-Rwanda deal is a hopelessly misleading bellwether by which to judge CAMR. While Apotex seldom missed an opportunity to portray itself as a Canadian company thwarted by CAMR from helping multitudes of poor, dying Africans, a less hagiographic examination shows that the weak link was the company's own lack of competitiveness and not the law.

Testifying before Parliament in April 2007, Apotex's president, Jack Kay, described CAMR as a real problem, and reeled off all the efforts that his company and Médecins Sans Frontières (MSF) were together making to pitch Canadian medicines to needy countries at competitive prices.[6] The highlight of Mr. Kay's testimony was an offer that Apotex would manufacture and sell a useful, made-in-Canada AIDS treatment without profit, at its cost of thirty-nine cents (U.S.) a tablet a price he claimed was "competitive with products that would come out of India."[7]

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[3] Apotex, Press Release, "CAMR Federal Law Needs to be Fixed if Life-Saving Drugs for Children are to be Developed" (14 May 2009), online: Apotex <http://www.apotex.com/global/about/press/20090514.asp>.

[4] Canadian HIV/AIDS Legal Network, Senate Brief, "Making CAMR Work: Streamlining Canada's Access to Medicines Regime – Brief to the Senate Banking, Trade and Commerce Committee regarding Bill S-232" (21 October 2009), online: Canadian HIV/AIDS Legal Network <http://www.aidslaw.ca/publications/publicationsdocEN.php?ref=987>.

[5] *Supra* note 2.

[6] Canada, Senate, Standing Committee on Industry, Science and Technology, *Committee Evidence*, 39th Parl., 1st sess., No. 055 (23 April 2007), online: Parliament of Canada <http://www2.parl.gc.ca/content/hoc/Committee/391/INDU/Evidence/EV2858542/INDUEV55-E.PDF>.

[7] *Ibid.* The Apotex treatment is called Apo-TriAvir, and in a single tablet includes 300 mg zidovudine, 150 mg lamivudine and 200 mg nevirapine. The regular dose is two tablets daily.

Mr. Kay was mistaken. Over three years prior, MSF had already found an Indian generics company, Hetero, that undercut Apotex's price of thirty-nine cents a tablet.[8] By the time Mr. Kay pledged that Apotex would be "competitive" with India, at least four Indian companies had already bettered his stated price.[9]

Apotex's uneconomical offer left CAMR's advocates in an embarrassing bind. If they were neutral, the advocates would have conceded that impoverished countries could achieve better value by buying cheaper medicines elsewhere, but that would have meant admitting an error in touting CAMR's "buy Canadian" scheme, and some choked on the words. The Canadian HIV/AIDS Legal Network wanly argued for the use of CAMR, even if poor countries would have to pay "a few cents more per tablet than the prices set by Indian generic drug manufacturers."[10]

Meanwhile, at Apotex, Mr. Kay's parliamentary appearance painted the company into a corner. If the company charged more than the Indians did, it would be criticized, but if it failed to sell any medicine after so public an effort, it would lose face. A year passed with no customers for Apotex's overpriced treatment. In 2008, the company finally relented, and halved its price to nineteen-and-a-half cents per tablet, a price at which it almost certainly lost money.[11] Rwanda accepted Apotex's offer and became its first customer.

To ensure no precedent was set, an Apotex spokesman announced that "we will not be doing this again."[12] When Rwanda asked to double its order, Apotex said

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[8] Médecins Sans Frontières, "Untangling the web of price reductions: a pricing guide for the purchase of ARVs for developing countries" (6th ed.) (19 April 2004), online: Médecins Sans Frontières <http://www.msfaccess.org/fileadmin/user_upload/diseases/hiv-aids/Untangling_the_Web/untanglingtheweb%206.pdf>.

[9] Médecins Sans Frontières, "Untangling the web of price reductions: a pricing guide for the purchase of ARVs for developing countries" (9th ed.) (June 2006), online: Médecins Sans Frontières <http://www.msfaccess.org/fileadmin/user_upload/diseases/hiv-aids/Untangling_the_Web/untanglingtheweb%209.pdf>.

[10] Richard Thomas, "Reforming Canada's Access to Medicines Regime," Letter, 177:3 *Canadian Medical Association Journal* 270 (31 July 2007), online: Canadian Medical Association Journal <http://www.cmaj.ca/cgi/reprint/177/3/270-a.pdf>.

[11] Apotex, Press Release, "Canadian Company Receives Final Tender Approval From Rwanda For Vital AIDS Drug" (7 May 2008), online: Apotex <http://www.apotex.com/global/about/press/20080507.asp>.

[12] "Canadian to ship AIDS drugs to Rwanda for first, perhaps last time" Ottawa Citizen (22 September 2008), online: Canada.com <http://www.canada.com/topics/news/story.html?id=6bed1c14-4eeb-4462-bffb-5933cf36bad2>.

no.[13] Apotex tried to make it seem that it was declining because using CAMR was a "huge process," but actually, when Apotex applied to the Canadian government to renew its compulsory license, it received its renewal in just one week.[14]

So ends CAMR's one and only use.

The Apotex-Rwanda deal is a poor litmus test of CAMR because it gives little insight into the law itself. The episode spotlights no obvious infirmity in the law needing amendment, nor does it even show that African countries are especially keen for Canadian help. Rather, the episode teaches something more banal: poor countries shopping for AIDS medicines are informed, capable buyers, and wisely price-sensitive. From 2006 to 2008, Apotex priced its medicine at thirty-nine cents a tablet and could not make a sale—the Indian companies snatched away the action. That changed once Apotex slashed its price to a very attractive nineteen-and-a-half cents, and Rwanda bought a batch. Then, suddenly, Apotex stopped selling.

This sequence of events provides no evidence that CAMR is unworkable. On the contrary, CAMR *did* work, within the limits of competitiveness. Thanks to CAMR, Apotex got a compulsory license to manufacture its AIDS treatment, but unhappily found that it could not compete except by selling at a price below its cost and hemorrhaging cash. Beaten in the market, Apotex did what any sensible business would: it gave up.

Seen this way, there is no appropriate legal critique of CAMR because its failure is for economic reasons. *Patent or no patent, an overpriced medicine will not sell.*

Here is an inconvenient and embarrassing truth that the advocates of CAMR consistently try to paper over: Canada is perhaps the least suitable country to export generic drugs to poor countries because Canada's generics are among the

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[13] Testimony of Bruce Clark, Vice President, Regulatory and Medical Affairs, Apotex Inc. Canada, Senate, Standing Committee on Banking, Trade and Commerce, Committee Proceedings, 40th Parl., 2nd Sess., No. 11 (October 22, 2009). < http://www.parl.gc.ca/40/2/parlbus/commbus/senate/Com-e/bank-e/11evb-e.htm?Language=E&Parl=40&Ses=2&comm_id=3>.

[14] Apotex lodged its application on September 10, 2009, and Canada's Commissioner of Patents approved it on September 17, 2009. See the application online at the Canadian Intellectual Property Office <http://www.cipo.ic.gc.ca/eic/site/cipointernet-internetopic.nsf/vwapj/RCAM2009-CAMR2009-eng.pdf/$file/RCAM2009-CAMR2009-eng.pdf> and the approval online at the Canadian Intellectual Property Office <http://www.cipo.ic.gc.ca/eic/site/cipointernet-internetopic.nsf/vwapj/RCAM2009_autorisations-CAMR2009_authorizations-eng.pdf/$file/RCAM2009_autorisations-CAMR2009_authorizations-eng.pdf>.

most expensive generics in the world. In 2006, the Federal government's Patented Medicine Price Review Board studied generic drug prices here and abroad. Compared to Canada, it found generics from the United States cost 35% less; from Finland, 51% less; and from New Zealand, a whopping 77% less.[15] No country in the study had higher generic drug prices than Canada.

Now, it would be a rare and extraordinary generic drug company, at home and comfortably feathering its bed in the lucrative Canadian market, which would switch business strategies and vie aggressively against lower-cost foreign manufacturers for customers in Africa. Apotex tried to make that transition once, but vowed to never do it again. Yet it would have to be done again, repeatedly and constantly, not solely by Apotex but by other companies too, for CAMR to offer a reliable, stable supply of medicines and have real public health importance. Since that will not happen, CAMR will not work, except perhaps sporadically, like the one-off Apotex-Rwanda deal.

I have emphasized this discussion of pricing and competitiveness because it places realistic limits on what law reform can hope to achieve. Bills such as C-393 and S-232 can affect patents, certainly, but are powerless to raise the Canadian generics industry's dismal competitiveness. To see why that is, imagine that Parliament went beyond Bills C-393 and S-232, and could magically pass a law voiding *all* drug patents and making *all* drugs generic worldwide. Even such a dramatic gesture would be powerless to change the market reality that in Canada, generic drugs are uncommonly expensive. Poor countries would still be better off buying those drugs from India, the United States, Finland, New Zealand—almost anywhere but Canada.

Thus the fundamental reason for CAMR's failure today is pricing, not patents—a reason that is not amenable to any simple amendment by Parliament. Not surprisingly, the Canadian generics industry pins the blame on CAMR for being burdensome, bureaucratic, unworkable *et cetera*, for that is a much more pleasant discussion than analyzing whether the industry price-gouges when it fails to make competitively-priced drugs. Even so, occasionally the truth slips out. Here is Apotex's president, Mr. Kay, responding to a question from Senator Massicotte about his company's withdrawal from the African AIDS treatment business:

> Senator Massicotte: Why do you not increase your cost, then? While nineteen cents [actually nineteen-and-a-half cents] was good from your experience, if you made it at thirty cents would you have been interested to go through this burdensome bureaucracy and still deliver the product?

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[15] Canada Patented Medicine Prices Review Board, Non-Patented Prescription Drug Prices Reporting: Canadian and Foreign Price Trends (June 2006), online: Patented Medicine Prices Review Board <http://www.pmprb-cepmb.gc.ca/CMFiles/Canadian-Foreign_Price_Trends_-_released_July_04_0638LHG-742006-1490.pdf>. See especially Table 3.1a at 11.

> Mr. Kay: At thirty cents, they would have bought it from another country.[16]

Quite correct: if Canadian generics companies charged a price that is sustainable. Recall Mr. Kay earlier saying that his company's cost was thirty-nine cents a tablet—they would be trounced by competitors in other countries, especially India. This non-competitiveness is not a problem with CAMR. Recall that even the generic medicines sold in Canada—medicines for which CAMR does not enter the transaction—cost substantially more than generics elsewhere.

Of course, Parliament is aware of all these critiques—they came up in the Senate testimony—and yet, many in Parliament seems immovably bent on amending CAMR. It is therefore worth asking which country's law might Parliament copy to make CAMR the most effective law in the world? The answer, sadly, is none. As unsatisfactory as the CAMR experience in Canada has been, it also has the best track record of any law of its kind in the world.

Not long after Canada enacted CAMR to give effect to the WTO's compulsory licensing decisions, other countries did likewise. Currently, China,[17] the European

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[16] Testimony of Mr. Jack Kay, President and Chief Operating Officer of Apotex Inc. Canada, Senate, Standing Senate Committee on Banking, *Committee Proceedings*, 40th Parl., 2nd Sess., No. 11 (October 22, 2009). <http://www.parl.gc.ca/40/2/parlbus/commbus/senate/Com-e/bank-e/11evb e.htm?Language=E&Parl=40&Ses=2&comm_id=3>.

[17] The Chinese government offers no English or French translation of its laws. For a discussion of China's law, see Xiaohai Liu, "A Study on Patent Compulsory License System in China – With Particular Reference to the Drafted 3rd Amendment to the Patent Law of the P.R. of China" in Liber Amicorum & Joseph Straus, eds., *Patents and Technological Progress in a Globalized World* (Berlin: Springer, 2009).

Union countries,[18] India,[19] Korea,[20] Norway[21] and Switzerland[22]—32 countries in all—have such laws.[23] Yet *none* of those 32 countries' laws has ever been used. Strange as it sounds, just by having used CAMR once, Canada has done more to implement the WTO decisions than all other countries in the world combined.[24]

Seen this way, the case to amend CAMR is both paradoxical and weak. To be sure, Canada's law is hardly successful in public health terms and is nothing to brag about, but by the objective measure of frequency of use, it is unsurpassed. Most of what could be tried to improve on CAMR has already been tried in the other 32 countries having inferior laws with no result to show for it.

For instance, those who advocate Bills C-232 and S-393 propose that CAMR could be made workable by removing the existing limit that a compulsory license expires after 2 years. Take away that awkward expiry date and make compulsory licenses long-lasting, those advocates say, and CAMR will blossom.

It is an attractive argument, although it is nonsense. Unlike in Canada, in the European Union, India, Korea, Norway and Switzerland existing laws do not stipulate an expiry date. If an expiry date really is such a drag on CAMR and removing it really

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[18] EC, *Regulation (EC) No 816/2006 of the European Parliament and of the Council of 17 May 2006 on compulsory licensing of patents relating to the manufacture of pharmaceutical products for export to countries with public health problems*, [2006] O.J. L 157/1.

[19] *The Patents (Amendment) Act, 2005*, No. 15 of 2005. online: The Gazette of India <http://ipindia.nic.in/ipr/patent/patent_2005.pdf>.

[20] The Korean government offers an unofficial English translation of its law: Patent Law (promulgated 28 November 1949, as amended), Article 107(7), online: Korean Intellectual Property Office <http://www.kipo.go.kr/kpo/route/FileDown.jsp?path=/upload/efile/&fn1=PatentAct.pdf&fn2=PatentAct.pdf>.

[21] The Norwegian government offers an English backgrounder on its laws in a communication to the World Trade Organization: "Implementation of Paragraph 6 of the Doha Declaration on the TRIPS Agreement and Public Health," WTO Document IP/C/W/427 (17 September 2004), and an unofficial English translation of the Regulations to the Norwegian Patents Act (The Patent Regulations), Chapter 16, online: Norwegian Industrial Property Office <http://www.patentstyret.no/en/english/Legal_texts/Regulations-to-the-Norwegian-Patents-Act-The-Patent-Regulations/>.

[22] Confédération suisse, *Loi fédérale sur les brevets d'invention* du 25 juin 1954 (as amended), Art. 40, online: The Federal Authorities of the Swiss Confederation <http://www.admin.ch/ch/f/rs/232_14/index.html>.

[23] World Trade Organization, *Compulsory licensing of pharmaceuticals and TRIPS*, online: World Trade Organization <http://www.wto.org/english/tratop_e/TRIPs_e/public_health_faq_e.htm>.

[24] I do not think that Canada's lead will last. Now that India has a law similar to the CAMR and permits compulsory licensing for export, in the future developing countries are likely to ask India to manufacture and export medicines to them. Those requests have not been forthcoming to date, but they are likely to be in the future.

would make the transformational difference that the advocates claim, then surely those foreign laws should be successful where CAMR is not. There is no evidence of that, however, and the foreign laws' result has been to produce zero medicines under compulsory license, taken by zero patients, for zero public health benefit—a total failure.

A similar comparative law argument can be made for the other desiderata that advocates have in mind. For example, CAMR now has a list of pharmaceutical products, found in Schedule 1 of the *Patent Act*, which are eligible for compulsory licenses. The supporters argue that the list is too restrictive, and so Bills C-393 and S-292 would eliminate it and throw all medicines open to compulsory licensing.

To a casual reader, that sounds like a good idea: placing fewer restrictions surely means more compulsory licences, right? Wrong. Once again, in the European Union, India, Korea and Switzerland, the laws already resemble the broader scheme found in Bills C-393 and S-232, and contain no restrictive list of eligible medicine and yet the laws have never been used.

It would be nice to imagine that Bills C-393 and S-232 could contain a fresh, new magic amendment, one which has never before been tried, and which offers renewed hope that CAMR can be made into a law with an important public health impact. I am not aware, however, of anything in those Bills which has not already been tried elsewhere without success. When 32 other countries have laws similar to CAMR, naturally a good deal of legislative experimentation has taken place already—experimentation from which Canada could learn.

But those responsible for the two Bills are lamentably ignorant of other countries' laws. The sponsor of Bill C-393 in the House of Commons, Judy Wasylycia-Leis, misinformed her colleagues in the House that Canada's law is "the only one of its kind in the world."[25] Similarly, the sponsor of Bill S-232 in the Senate, Yoine Goldstein, wrongly told the Senate that "Canada remains practically the only country to have adopted legislation."[26] How Ms. Wasylycia-Leis and Mr. Goldstein overlooked the European Union and emerging superpowers such as China or India is puzzling, but such parochialism fosters the belief that Canada's law is unique and that the Bills propose measures that are new and therefore promising, which is not true.

Worse, the Bills' advocates and sponsors have something in mind which is appallingly negligent. The Bills contain an amendment that would *exempt* medicines

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[25] *House of Commons Debates*, No. 119 (27 November 2009) at 1415.

[26] Testimony of Yoine Goldstein, Canada, Senate, Standing Senate Committee on Banking, Trade and Commerce, *Committee Proceedings*, 40th Parl., 2nd Sess., No. 11 (October 8, 2009).

made under CAMR from the *Food and Drugs Act*, meaning that Health Canada's normal safety and efficacy regulations would no longer apply.[27] The Bills would make it good enough for Canada's Minister of Health or an importing country to give a nod to the medicine—*without* any requirement to apply scientific standards.[28]

This aspect of the Bills is not just undesirable; it is deadly. Already, the poorest countries in the world have a nightmarish problem of unregulated medicines. The World Health Organization (WHO) estimates that "up to 25% of the medicines consumed in poor countries are counterfeit or substandard," and of the many instances of bad medicines annually, WHO records that some have killed hundreds or thousands of people.[29] In a recent scientific study that colleagues and I conducted in Africa, we found that over a third of tablets sold for malaria, a life-threatening disease commonest in children, were substandard, including tablets that would not cure and could let the disease kill.[30] Few officials dare to oppose this corrupt, venal trade and those who do face threats and assassination attempts.[31]

It is baffling that the advocates and sponsors of the Bills, all friends of the poor, would risk making these problems worse by giving Canadian generics companies *carte blanche* to export medicines without scientifically based regulation. Further, that two United Nations agencies—the United Nations Children's Fund (UNICEF) and the United Nations Development Programme (UNDP)—endorsed law reform even while another United Nations agency—the WHO—decries the harm and death caused by unregulated medicines is unethical and inept.[32] The Canadian generics industry, to its credit, disagrees, and has asked that Health Canada keep regulating the exports.[33] Apotex has undergone that regulatory process, and praises it as "remarkably efficient, effective and quick."[34] Amending the system is needless and dangerous.

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[27] See s. 16 of either Bill C-393 or S-232 (the two Bills are identical in this provision).

[28] See s. 17 of either Bill C-393 or S-232 (the two Bills are identical in this provision).

[29] WHO, *Substandard and counterfeit medicines*, Fact sheet No. 275 (November 2003), online: World Health Organization <http://www.who.int/mediacentre/factsheets/2003/fs275/en/>.

[30] Amir Attaran et al., "Antimalarial Drug Quality in the Most Severely Malarious Parts of Africa – A Six Country Study" (2008) 3:5 PLoS ONE, online: PLoS ONE <http://www.plosone.org/article/info:doi%2F10.1371%2Fjournal.pone.0002132 >.

[31] Michael Lemonick, "Drug Warrior" Time (31 October 2005), online: time.com <http://www.time.com/time/magazine/article/0,9171,1124289,00.html>.

[32] Testimony of Robert Gass, UNICEF, and Tenu Avafia, UNDP, to the to the Standing Senate Committee on Banking, Trade and Commerce, *Committee Proceedings*, 40th Parl., 2nd Sess., No. 11 (October 22, 2009).

[33] Testimony of Jim Keon, President, Canadian Generic Pharmaceutical Association, to the Standing Senate Committee on Banking, Trade and Commerce, *Committee Proceedings*, 40th Parl., 2nd Sess., No. 11 (October 22, 2009).

[34] *Supra* note 12.

While it is not polite to say so, one is left with the impression that the advocates and sponsors of Bills C-393 and S-232 never felt the need to understand the complexities of patent laws, pharmaceutical markets, science or public health—it is enough that they are righteous and on the side of the angels. Yet that sort of woolly thinking is what inaugurated the unsatisfactory and ineffective *Jean Chrétien Pledge to Africa Act* in the first place. Pieties toward pitiable Africans may make some Canadians feel generous and good about themselves, but they are not what public health needs at the coal face.

The flinty, hard reality is that CAMR is a dead letter, barely relevant to public health, and beyond redemptive amendment. Those who say differently are either disregarding economic realities that have stymied CAMR to date, or lacking humility to believe they can make CAMR work, where equally well-meaning and intelligent persons in the European Union, India and Norway, have tried and failed. Well-intentioned Canadians can—and should—demand other things of their country for global health. Canada could be made to stop its deadly asbestos exports, or Canada could lead efforts to create a treaty to criminalize the murderous trade in fake medicines for instance. Throwing good effort after bad, however, to amend CAMR is a waste.