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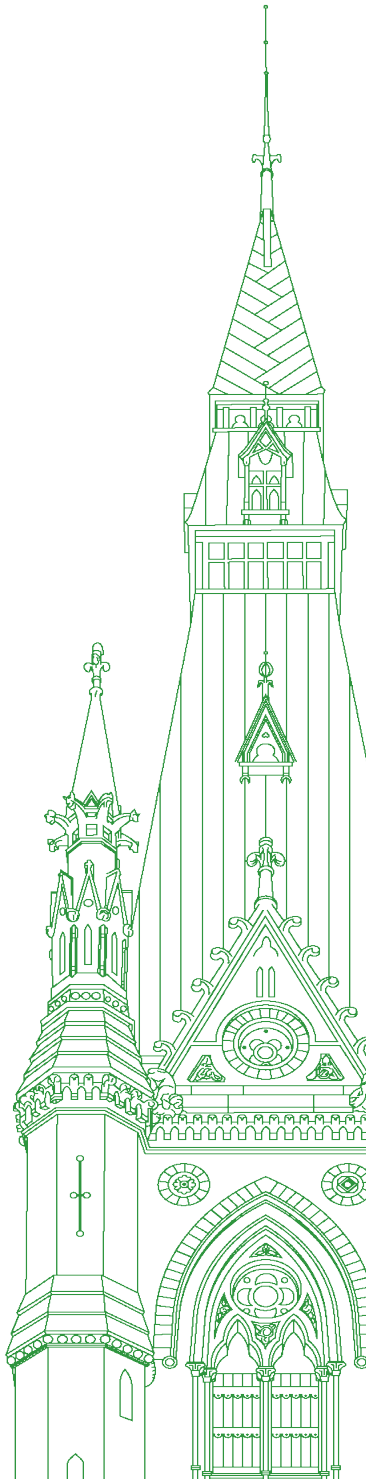

Chair: Mr. Sven Spengemann

Standing Committee on Foreign Affairs and International Development

Monday, May 9, 2022

● (1105)

[*Translation*]

The Chair (Mr. Sven Spengemann (Mississauga—Lakeshore, Lib.)): Good morning, colleagues, and welcome to meeting No. 19 [x] of the Standing Committee on Foreign Affairs and International Development.

[*English*]

Pursuant to the motion adopted on January 31, the committee is meeting this morning on its study of vaccine equity and intellectual property rights.

[*Translation*]

As always, interpretation is available through the globe icon at the bottom of your screen. Simply click on the icon to select a language. For members participating in person, keep in mind the Board of Internal Economy's guidelines for mask use and health protocols.

[*English*]

I would like to take the opportunity to remind all participants that screenshots and taking photos of your screen are not permitted.

[*Translation*]

Before speaking, please wait until I recognize you by name. When speaking, please speak slowly and clearly. When you are not speaking, your mic should be on mute. A reminder that all comments by members and witnesses should be addressed through the chair.

[*English*]

Colleagues, I would now like to welcome our witnesses for panel one, who are back before the committee, and to thank them for agreeing to return.

We have with us today from the Ministry of Foreign Affairs of the Plurinational State of Bolivia, Benjamin Juan Carlos Blanco Ferri, vice-minister, foreign trade and integration.

[*Translation*]

From Doctors Without Borders, we welcome Adam Houston, Medical Policy and Advocacy Officer and Dr. Jason Nickerson, Humanitarian Representative to Canada.

[*English*]

[*Chair spoke in Spanish, interpreted as follows:*]

Vice-Minister, welcome to the committee. You will have five minutes for your intervention.

[*English*]

Vice-Minister, we will now go to you for your opening remarks, please.

Mr. Benjamin Blanco Ferri (Vice-Minister, Foreign Trade and Integration, Ministry of Foreign Affairs of the Plurinational State of Bolivia): [*Witness spoke in Spanish, interpreted as follows:*]

Good morning, distinguished members of the Standing Committee on Foreign Affairs and International Development of the House of Commons.

I'd first like to thank you for this opportunity to speak, on behalf of my country, about the tremendous injustice that less developed countries have suffered when it comes to the distribution of vaccines.

Thank you for your understanding and for rescheduling this appearance following the death of my father.

In the first stage of the COVID-19 pandemic, vaccines were not available to all. The beneficiaries were the countries with the greatest purchasing power, leaving the less developed countries without the possibility of having the vaccines that would protect people's lives.

Vaccine coverage in the face of global interest meant that vaccines became a market good like any good, thus limiting what should have been a public good. It seems there are people of first and second class, and some people who don't have a right to health or vaccines.

The COVAX mechanism was created with the intention of helping with equitable distribution, but we know that COVAX results haven't been what was hoped for, and still today 20% of the global population hasn't been reached, even though doing so was the goal at the beginning of last year. The developed world began distributing vaccines through COVAX when they were about to expire, vaccines that wouldn't last much longer, to developing countries like ours with many people in rural areas that are difficult to access.

Bolivia trusted in the multilateral plan for global crisis and proposed using the flexibility of compulsory licences contemplated in articles 31 and 31*bis* of the Agreement on Trade-Related Aspects of Intellectual Property Rights, TRIPS.

To this end, Bolivia has worked with Knowledge Ecology International, KEI, an organization dedicated to accessing medicines and vaccines, with offices in Washington, D.C., and Geneva. KEI collaborates with the Canadian company Biolyse Pharma, which has the capacity to manufacture approximately 20 million COVID-19 vaccines per year. Therefore, this Canadian company could have immunized 20 million people in the world if the compulsory licences had been granted.

Bolivia signed an agreement with this company in May 2021, so they could manufacture and import 50 million Johnson & Johnson single-dose vaccines, and this was subject to obtaining a compulsory licence, which is required to respect TRIPS. A year later many people have died from COVID because they haven't had vaccines in a timely fashion even though the production capacity was there.

Bolivia initiated the compulsory licence process by providing notification of its use as an importing country and requested that Canada, in accordance with its legislation, provide notification of its intention to be an exporting country, which was necessary, and Canada needed to indicate this at the WTO. Biolyse Pharma is based in Canada, so it had to be produced in Canada for this contract to work and for Bolivia to obtain the 50 million doses it needed at the time. The political will of Canada was necessary for this compulsory licence to be effective.

● (1110)

During November and December 2021, the Bolivian position was heard through virtual press conferences and was supported by the Canadian population with 4,500 signatures that made it possible to formalize a petition before the Canadian government's House of Commons. The petition was submitted on December 15, 2021, by member of Parliament Niki Ashton of the New Democratic Party.

The Canadian government's official response noted that Canada is a member of the COVAX mechanism to support countries with difficult access to vaccines and, with respect to the WTO Agreement on Trade-Related Aspects of Intellectual Property Rights, the Canadian government indicated that it would continue to work closely with all WTO members in seeking a consensus-based multilateral outcome to address any intellectual property challenges related to COVID-19.

I want to say clearly that Bolivia is respectful of the response of the Government of Canada. However, Bolivia's request was not to receive vaccines through the COVAX mechanism. Bolivia is already part of COVAX and received a few vaccines through that mechanism, but we could not wait for the consensus of the WTO member countries to change multilateral norms.

Bolivia's request was clear and direct with Canada. It only required the political will to grant the compulsory licence to Biolyse Pharma. Bolivia already had a contract for 15 million vaccine doses, and Bolivia could then have had access to the vaccines. This was when there were no vaccines and Bolivians were dying of COVID. The granting of this compulsory licence would have been proof that the discourse on vaccine equity is accompanied by action.

It could have left an important lesson for international companies that look after only their own economic interests more than public health and people's lives, and for the powerful countries that stockpiled vaccines in the most critical stage of the pandemic, sometimes even letting them expire, leaving the rest of humanity to their fate. This weakens the COVAX mechanism and the spirit of the mechanism due to the lack of availability of vaccines.

Mr. Chair, I want to thank you for having granted this time and space. By way of reflection, what remains for me to say is that the COVID-19 pandemic has changed the life of humanity. We've had social, sanitary and economic crises but, unfortunately, the bureaucracy and the economic interest of some international companies have not changed. The economic interest of profit has won out over human life.

Bolivia had the hope that this path of the use of compulsory licences would mark an alternative to accelerate global vaccination and defeat the COVID-19 pandemic together. It has been shown that the multilateral mechanism, when it comes to intellectual property rights, doesn't work and doesn't provide equitable access to the world's populations.

Thank you very much, Mr. Chair, for this time.

The Chair: Vice-Minister Blanco Ferri, thank you very much for your opening remarks.

On behalf of the entire committee, I would like to reiterate our deepest condolences and thank you for being with us on this important issue at this difficult time.

Colleagues, Dr. Houston and Dr. Nickerson submitted their opening remarks at the last session. They are available for questions as we go forward.

With that, I would like to go straight into round one.

Colleagues will be familiar with the method of timekeeping at this committee. I'm holding up a 30-second card. When you're within 30 seconds of your questioning or testimony time just keep an eye on the screen. In that respect, it will help us to manage the time we have this morning.

Round one consists of six-minute allocations. Leading us off this morning is Mr. Genuis for six minutes.

Please, go ahead.

● (1115)

Mr. Garnett Genuis (Sherwood Park—Fort Saskatchewan, CPC): Thank you very much, Mr. Chair.

Thank you to the witnesses. Doctors Without Borders does incredible work around the world, and it's been my pleasure to engage with them on a broad range of issues.

I want to start my questions with Vice-Minister Blanco Ferri.

Thank you so much for being with us today. I always particularly appreciate when we have the opportunity at the foreign affairs committee to directly engage with leaders and officials from other countries.

I thought your comment was interesting about whether we view vaccines as a market good or a public good.

It seems to me that we are a bit inconsistent, in some ways, in how we treat vaccines. On the one hand, pharmaceutical companies seek protection in terms of intellectual property that comes with being a market good, but in other respects, we've created vaccines like a public good. There have been grants that have been given for the development of vaccines, and also vaccine manufacturers have been protected through indemnification clauses.

We heard previously at this committee that COVAX has an indemnification mechanism, whereby people who bring forward complaints about vaccine injuries can be compensated through a no-fault fund, but industry does not contribute to that fund.

It seems to me that on some level industry gets the benefits of a market goods structure, that is, the protection for intellectual property, while also seeking the benefits of a public goods structure, that is, to be insulated from liability in the event of problems as well as to receive grants for production.

Vice-Minister, I wonder if you can reflect on that question and whether you agree or not with the description I offered.

Also, could you share a bit about how, in practice, the indemnification clauses work for your country? My understanding is that countries are expected to sign on to indemnification agreements if they want to get access to particular vaccines. If they have concerns about the indemnification structure, then they won't be able to access those vaccines. I wonder if you could comment on that and what the process has been like from your end.

Mr. Benjamin Blanco Ferri: [*Member spoke in Spanish, interpreted as follows:*]

Thank you very much for the question.

COVID vaccines must be public goods. As we have said, however, these treatments have become commercial products. Of course, the laboratories gave priority to countries that could pay, since there was limited production. Vaccines should be treated as public goods. Vaccination in Bolivia is free for Bolivians without discrimination.

Because of the multilateral trade system, vaccines were not available for less developed countries due to cost. When we wanted to purchase vaccines, it was a problem for Bolivia, which has to be able to respond to any request from a citizen about a vaccine and provide them with a vaccine. In the current system of international companies, we haven't been able to provide these services. We had to sign a contract or we could not get any vaccine. The situation was a difficult one.

These vaccines should be considered—as we consider them—public goods. The current system prevented us from getting vaccines without entering into a contract with these countries. Some providers spoke of having a contract. Others spoke of previous agreements. It was not possible to enter into agreements with those companies.

Thanks to COVAX, we received vaccines from Pfizer. We had to enter into an agreement with the COVAX mechanism, and that was how we got Pfizer. We could not sign direct bilateral agreements with the producers, because that would have threatened our constitutional obligations and abilities.

● (1120)

Mr. Garnett Genuis: *Gracias*.

The Chair: Mr. Genuis, thank you very much. You're at six and a half minutes. We'll have to leave it there in the interest of time. I apologize.

Please go ahead, Mr. Sarai. You have six minutes.

Mr. Randeep Sarai (Surrey Centre, Lib.): Thank you.

Again, you have my condolences, Mr. Blanco Ferri, on the loss of your father. Thanks for coming back.

My question is for Doctors Without Borders. Maybe Dr. Nickerson can answer this one.

In November 2021, a CARE International presentation highlighted the gender gap in COVID-19 vaccination rates in low- and middle-income countries. In 22 of 24 of the countries in which it operates, CARE noted that women are less likely to be vaccinated and less likely to feel that vaccines are safe. What is more, women make up 70% of health workers worldwide, and are therefore more likely to be in roles that expose them to COVID-19.

Why are women in low- and middle-income countries less likely to be vaccinated than men?

Dr. Jason Nickerson (Humanitarian Representative to Canada, Doctors Without Borders): Thank you for the question.

Unfortunately, I can't speak specifically to the CARE report because it's their data, their analysis.

What I can say from what we have seen throughout the COVID pandemic is that it has been very much along these lines, and there has been clearly a differentiated impact along the lines of gender in many of the places where we work. For example, at the start of the pandemic, we saw many health services that became suspended either because resources were diverted to COVID-19 response or—and again we've seen this throughout the pandemic—health staff are either sick or infected or have been exposed to COVID-19, and that's led to the closure of many health facilities, the suspension of health activities and so on. Therefore, we have seen throughout the pandemic a significant impact on women, women's health and women's health programming.

As far as COVID vaccination specifically goes, I don't believe we have data on this from our programs, but I'm happy to look into that and get back to the committee.

Mr. Randeep Sarai: Would you know how to remove some of those barriers, to remove the hesitancy that women have in those countries?

Dr. Jason Nickerson: Yes, absolutely.

In our programs everything we do is done on the basis of a needs assessment. We are an impartial organization. We provide medical assistance on the basis of need alone. A fundamental starting point for any medical intervention that we do is a needs assessment to understand what a community's health needs are, what their priorities are and how we can best meet those needs. Part of doing a needs assessment is, of course, looking at access to health care and understanding what some of the barriers to access are, and that can be done in a number of different ways.

We go to health facilities and we look at who's standing in line. Is there clearly a gender differential in who's accessing health services? We speak with communities to understand what the particular barriers might be for men, women, boys and girls. You look at a number of different factors. Targeting programs to meet the needs of different communities and often structural barriers that different populations may have is absolutely a key part of what we do. It's very nuanced and it's very specific based on different communities, different countries, different populations and so on. There's not a one-size-fits-all model, and that needs to be baked into the process of doing these needs assessments and designing interventions.

● (1125)

Mr. Randeep Sarai: Thank you.

Vice-Minister Ferri, according to the our world in data project at the University of Oxford, 61% of the Bolivian population has received at least one dose of COVID-19 vaccine.

How and from whom did the Bolivian government acquire the COVID-19 vaccine doses they've administered so far?

Mr. Benjamin Blanco Ferri: [*Witness spoke in Spanish, interpreted as follows:*]

Thank you very much for the questions.

We received vaccines from various sources. In January 2021, we started receiving vaccines from Russia and China. We did this through a bilateral agreement with the heads of state concerned, and there was a great deal of political will to facilitate receipt of vaccines by Bolivia for the vulnerable population and the general population.

Following that we received vaccines from countries like Mexico and Argentina—these are also developing countries—and we received other vaccines as well through the COVAX mechanism, so the bilateral agreements were a major factor in the vaccines we had available. Many of the vaccines we received were provided free of charge; however, their shelf life was very short and they started to expire by August 2021.

I hope I've answered your question.

The Chair: Mr. Sarai, thank you very much.

We'll have to leave it there, in the interest of time.

[*Translation*]

Mr. Bergeron, you have the floor for six minutes.

Mr. Stéphane Bergeron (Montarville, BQ): Thank you, Mr. Chair.

Thank you to the witnesses.

I'd like to continue with Mr. Sarai's question.

Mr. Ferri's answer shows what happens when neglect by western countries unfortunately pushes the developing countries into Russia's and China's embrace, particularly when there is no reliable information about the efficacy of the Chinese and Russian vaccines. I would therefore like to ask Mr. Ferri two questions.

Firstly, why do you think the Canadian Access to Medicines Regime did not function well enough to enable you to quickly obtain vaccines through Biolyse Pharma?

Secondly, did you have discussions with the Canadian government about obtaining some of the additional doses that Canada was planning to give to developing countries, whether on a bilateral basis, or through COVAX?

[*English*]

Mr. Benjamin Blanco Ferri: [*Witness spoke in Spanish, interpreted as follows:*]

Thank you very much for the question.

We received many of the vaccines through COVAX, which redistributes the vaccines provided. We received direct supplies of vaccines from any countries that offered them. We have not received any vaccines from Canada, either through COVAX or directly, bilaterally, from Canada. As far as gifts from Mexico or Argentina, that was outside of the COVAX mechanism. Within COVAX, we received no vaccines from Canada.

Now, thanks to the embassy of Canada, we have excellent relations with Canada. However, we have not received any vaccines through COVAX or bilateral agreements.

● (1130)

[*Translation*]

Mr. Stéphane Bergeron: Thank you.

On the other hand, we still don't understand what failed to work properly with the Canadian Access to Medicines Regime. In any event, there will definitely be other opportunities to look into this matter in greater depth at a later date.

My other question is for the Doctors Without Borders representatives. According to a report published by Doctors Without Borders on April 26, Canada ought to take a position in favour of exemptions from intellectual property agreements. For several weeks now, however, we've been hearing from others who disagree.

Mr. Joshua Tabah, the Director General, Health and Nutrition at the Department of Foreign Affairs, Trade and Development, said to us here on March 21 that the problem was not so much one of supply, but rather one of demand. It would appear that there were problems with getting available vaccines to developing countries. Perhaps Mr. Ferri would also like to comment on what Mr. Tabah said.

On April 25, we welcomed Mr. Seth Berkley, from the Gavi organization, which administers the COVAX initiative. He told us that even if patent restrictions were removed, it would not necessarily facilitate the decentralization of manufacturing to developing countries, because there would be a capacity problem, not only at the industry level, but also in terms of knowledge.

How do you react to these assessments stating that removing restrictions from intellectual property agreements would not necessarily solve any problems, because we are in a different phase now?

[*English*]

Dr. Jason Nickerson: Thank you for the question. I'll answer quickly because I think you also wanted Mr. Ferri to jump in.

There are a couple of things.

First of all, I'll say that our position has always been that removing intellectual property barriers was one part of the solution. I think it has always been clear that removing the patent issue from the equation was never going to be entirely sufficient. We have always said that, in addition to this, there needs to be effective technology transfer to manufacturers in low- and middle-income countries. I think it is also clear that there is capacity in countries to produce vaccines if they have the legal right to do so and if the technology is transferred to them along with manufacturing know-how and so on.

I agree—and we said this in our statement as well—that we are in a different phase of the pandemic, where supply is no longer the predominant issue, but that's a relatively recent development. We also have always maintained that what countries needed was a stable, predictable supply of vaccines from the start.

We work in roughly 70 countries around the world, and we supplement and provide vaccination campaigns and activities in many low-income countries. We're familiar with the difficulties of running even basic vaccination campaigns in difficult circumstances. Under-resourced health systems were always going to have a difficult time scaling up vaccination campaigns, but the solution to that was to make vaccines available equitably and throughout the pandemic, so that countries had the ability to scale up their vaccination activities and be able to plan for them and roll them out.

● (1135)

The Chair: We'll have to leave it there.

Next is Ms. McPherson, please, for six minutes.

Ms. Heather McPherson (Edmonton Strathcona, NDP): Thank you very much.

I would also like to echo the comments by our chair and express my condolences to Vice-Minister Blanco Ferri.

I think I'd like to start with some questions for you, Vice-Minister, following up on what my colleague Mr. Bergeron talked about.

The Canadian access to medicines regime is the process through which you tried to get that licensing and tried to get the vaccines for the people in Bolivia. Can you talk a bit about the barriers you faced? I know that you spoke about this, but I want all of us to very clearly understand that this is a broken system and that CAMR was not possible for you to work through. How can we make sure it is fixed in future pandemics?

Can you talk about the barriers you faced and whether you would recommend another country to go this route? Also, what can be done to improve the process for CAMR, Canada's access to medicines regime?

Mr. Benjamin Blanco Ferri: [*Witness spoke in Spanish, interpreted as follows:*]

Thank you very much.

We began the compulsory licence process, which is part of the multilateral norm, with TRIPS. TRIPS foresees this type of global crisis, this type of emergency, so there is the compulsory licence process and the voluntary licence process.

Bolivia, with this pharmaceutical company based in Canada, Biolyse Pharma.... The first thing it did was to see about the possibility of producing vaccines for us. First they tried to obtain a voluntary licence, to see if they could have the licence without further bureaucracy, because we were in a global crisis. They were not able to obtain that licence directly from Johnson & Johnson, which didn't respond to them, so we went the route of compulsory licences. That's the second mechanism in TRIPS under the World Trade Organization.

This process indicates that you need to have political will from the importing and the exporting country. In the case of Bolivia, we didn't have capacity at that time to produce our own vaccines, so we had to contact this Canadian company.

As an importing country, we notified the WTO, as indicated in the requirements. We said we had requested this and that we all know the pandemic is a global problem and that this mechanism should apply. However, the second part of the mechanism indicates that the exporting country also has to notify of its intention to export under the compulsory licence program. Canada needed to include the vaccines against COVID as part of an annex to products that fall under these compulsory licences. That's why we made the request for Canada to include it in that appendix, which would have meant that Biolyse Pharma would have been able to produce 15 million doses for Bolivia.

We already had the price negotiated with Biolyse Pharma. The only thing we were missing was that licence. It would have been Canada that would notify the WTO that the vaccines could be exported from its country. That's where we ran into difficulty. As I mentioned through press conferences, we received support from Canadians. We gathered 4,500 signatures. There was a petition in the House of Commons. However, the government response went otherwise. They said that they work with COVAX and that, under the WTO, they will continue working with all countries, but they didn't answer us regarding whether they would export the vaccines from Biolyse Pharma.

Basically, it hasn't been possible. We've been waiting for over a year for this authorization, and Bolivia.... I'll echo what the Doctors Without Borders representative said. The problem with supply was last year, when we didn't have direct access to vaccines. Countries like Bolivia didn't have vaccines. For future opportunities, when this type of pandemic or emergency occurs, it's important to be able to modify these processes. National standards shouldn't put bureaucratic obstacles in place.

● (1140)

Ms. Heather McPherson: I'm sorry to interrupt. I have a just few more seconds, and I wanted to clarify that it was lack of political will. Biolyse was able to produce the vaccine without the tech transfer. The only barrier was on intellectual property.

I want it to be very clear: The government failed to provide that authority. They failed to provide that political will.

Is that accurate?

Mr. Benjamin Blanco Ferri: [*Witness spoke in Spanish, interpreted as follows:*]

Yes, that's correct. There was not enough political will for the compulsory licence that would have allowed Bolivia to have 15 million doses of vaccines. Biolyse Pharma was ready to produce them. We had a contract signed with them. The only thing missing was the authorization from the Canadian government, which a year later we still don't have.

Ms. Heather McPherson: I'm so sorry that people died because of our failure.

The Chair: Thank you very much.

Thank you, Ms. McPherson and Vice-Minister Blanco Ferri.

Colleagues, this takes us to the end of our scheduled time with this panel. We have a second panel that's waiting to speak to us. We also have some time set aside at the end of the meeting to discuss drafting instructions for the report on this study, which is critical to our pathway towards actually releasing a report before we break.

With the concurrence of the committee, I would like to thank our witnesses in the first panel for being with us.

Vice-Minister Blanco Ferri, Dr. Nickerson and Dr. Houston, thank you all for your time, your expertise and the work that you do. We will let you disconnect and then transition to our second panel.

We will suspend briefly.

● (1140)

_____(Pause)_____

● (1140)

[*Translation*]

The Chair: I'd now like to welcome the second group of witnesses.

This morning, we are welcoming Dr. Marc-André Gagnon, Associate Professor, School of Public Policy and Administration, Carleton University, and Dr. Madhukar Pai, Canada Research Chair in Epidemiology & Global Health, McGill University.

[*English*]

We will give each of our witnesses five minutes for opening remarks. After that, we will go into questions by members.

For the benefit of our witnesses, I have a manual way of signalling when there are 30 seconds remaining in your questioning or testimony time. Please keep an eye on that card for the purpose of time management.

We will go ahead.

[*Translation*]

Professor Gagnon, you have the floor now to begin your opening address.

You have five minutes.

Dr. Marc-André Gagnon (Associate Professor, School of Public Policy and Administration, Carleton University, As an Individual): Thank you very much.

Thank you for your invitation.

My remarks today will be about intellectual property with respect to COVID-19 vaccines, and about ways of reviewing institutional structures to make vaccine production faster and more equitable in Canada and abroad during pandemics, and I'm not talking only about COVID-19.

I have over 150 publications to my credit and my area of specialization is political economy in the pharmaceuticals sector. Apart from my role as an expert witness for Justice Canada in connection with a trial on the regulation of patent medicine prices conducted in 2020 in the Quebec Superior Court, I have no conflicts of interest to declare.

One year ago, I testified before the Standing Committee on International Trade on the issue of suspending certain provisions of the Agreement on Trade-Related Aspects of Intellectual Property Rights, or TRIPS, on COVID-19 technologies. More than a year later, here I am again to discuss the same subject.

Since it was a year ago, allow me to remind you that early on in the COVID-19 pandemic, it was impressive to see researchers from around the world working together and following open-science principles by systematically exchanging research data, whether to sequence the virus genome, monitor its evolution and its variations, or produce protective and detection equipment.

In May 2020, the World Health Organization, the WHO, established C-TAP, which stands for the COVID-19 Technology Access Pool, based on open science principles, to promote the exchange and transfer of technological expertise and knowledge that would help combat COVID 19.

The Medicines Patent Pool, or MPP, funded by Unitaid, also broadened its mandate to allow for the voluntary sharing of patents related to COVID 19.

At the outset, we thought we were headed towards a scientific effort based on technological collaboration and an exchange of data to ensure that every country could maximize its efforts in combatting COVID-19. Unfortunately, the old proprietary science reflexes based on patents, trade secrets and technological monopolies quickly got the upper hand. No company has yet agreed to reveal its vaccine technologies to C-TAP or to the MPP. Each company has been working in a silo to maximize future revenue. For example, companies that own vaccines have generally been very reluctant to negotiate licensing agreements that would help boost production.

Open science and patent sharing would be the most effective and equitable ways to optimize the production and distribution of vaccines during a pandemic. The dynamics of vaccine nationalism, which pits countries against one another to obtain vaccines from patent holders, allows these companies to maximize revenue by artificially creating a scarcity of the technologies essential to international public health. Two weeks ago, in response to a request from the Dominican Republic to use compulsory licences for Paxlovid, which is not a vaccine, but a form of treatment, Pfizer argued that intellectual property was a human right. That's total bullshit!

Don't get me wrong, patents represent one of several means to *Technical difficulty*, and in some circumstances, they are extremely useful. By their definition and nature, patents exist to encourage long-term innovation by slowing down the dissemination of innovations in the short term. During a pandemic or a health emergency, patents are counterproductive and become a barrier to international public health. There are other ways of speeding up the development of new technologies. By eliminating the risks inherent in private investment, measures like public grants and market guarantees have been essential incentives for the development of vaccines to combat COVID-19.

In that kind of context, patents are superfluous and even harmful to the development of and access to new technologies. Even though governments invested hundreds of billions of dollars on the development of vaccines, we continue to consider it normal for vaccines to remain entirely in the hands of private-sector monopolies. All that a defence of patents does is increase earnings for shareholders by artificially creating scarcity. Don't forget that in 2021, Pfizer doubled its revenue because of its vaccine and tripled its profits. The company also expects to increase its revenue by 25% in 2022.

Every time there is a health emergency or a pandemic, and I'm not just talking about COVID-19, certain provisions of the TRIPS Agreement should be suspended for relevant technologies and other means should be used to encourage innovation and technological development. In South Africa, for example, reverse engineering had to be done on the Moderna vaccine without any technical assistance from the company. It took several additional months to develop a vaccine similar to Moderna's. An mRNA vaccine to combat COVID 19 was also successfully developed even before the spread of the Omicron variant. However, because the Moderna patent holder refused to release its data, South Africa had to conduct its own clinical trials to obtain the necessary approvals. That led to a delay of several months after the Omicron variant wave before the vaccine could be distributed.

As you have already discussed exemptions from certain provisions of the TRIPS Agreement, I will skip that section.

● (1145)

To conclude, Canada has to stop being part of the problem. Health products for COVID-19 should be added immediately to schedule 1 of the Patent Act. We need to immediately support an exemption to the TRIPS Agreement for all COVID-19 treatments and vaccines, and to ensure that such a suspension could readily be triggered for any future pandemics.

And we need to start right now to encourage initiatives that would lead to sharing of open science technologies for all products to combat COVID-19 and for any health research for which proprietary science has become a barrier to public health.

I'm counting on Canada to get on the right side of history for pandemics. Unfortunately, I have been extremely disappointed so far.

I'd be happy to answer any questions you may have.

● (1150)

The Chair: Thank you, Professor Gagnon, for appearing and for your opening address this morning.

[*English*]

I would now like to give the floor to Dr. Pai for opening remarks of five minutes. Please go ahead, sir.

Dr. Madhukar Pai (Canada Research Chair in Epidemiology & Global Health, McGill University, As an Individual): Thank you very much for giving me this opportunity. I would like to make my remarks about the critical importance of self-sufficiency in vaccine production in all cases.

Firstly, I want to acknowledge that last year, around this time, I was very lucky to get my vaccine shot here in Montreal. I'm extremely grateful to Canada for making that available to all of us. At the same time, India was going through a catastrophic delta wave crisis. I was struggling to reconcile my two worlds, where my family and I, even my child, had easy access to vaccines here, but my friends and family, brothers and sisters, and everyone in India was struggling. In fact, the delta wave ripped through an unvaccinated country. When the dust settled, the WHO just estimated that India may have lost 4.7 million people over two years.

I have no words to capture the devastation. I'm still traumatized by seeing so many people die. I just can't stomach why we would allow country after country to get devastated by this virus. Letting this virus rip through the world is a very bad strategy, and 15 million lives, at a minimum, have been lost. We have to do better than this.

Today India is in a much better place. Why? First, it's because India manufactures its own vaccines. Second, it has vaccinated most Indians, at least with two doses. Why should every country in the world not have the same access in this catastrophic crisis we are facing?

Only 16% of the population of low-income countries have had even one dose. Even as my province, Quebec, just made fourth doses available to me and anyone over the age of 18, I am appalled that nearly three billion people around this world had not even had a single dose of vaccine.

This pandemic is far from over. Please do not believe anyone who is telling you to move on. We cannot move on when this virus is absolutely mutating at a very fast pace. We are already seeing subvariants cause so much damage and new waves. Long COVID is further damage that none of us have really calculated. Allowing this virus to mutate and infect more people will result in long-term consequences for all of us.

We cannot vaccinate just Canada or rich countries and boost our way out of this crisis. Vaccinating the world equitably and distributing tests and antivirals are the only long-lasting solutions for us as Canadians. Let us remember this, please: There is no way out of this mess if we do not equitably vaccinate the world.

I am truly disappointed with what we have done so far. I know, in terms of our intent, our Prime Minister has said explicitly that vaccine equity matters to us as Canadians. In terms of our actions, we only donated 15 million doses. What will we do with all of the extra doses? Last year, when there was so much devastation all around, why did we not donate them and save more lives? Why have we acquired the reputation of being a vaccine hoarder globally? That's not a reputation we want as Canadians. We are better than this.

I want to say that giving money is a great thing. I'm glad we're giving money, but I think every country is now saying that charity is not what they're looking for. They're looking for justice and self-sufficiency. I cannot imagine anyone better than Dr. John Nkengasong with Africa's CDC, who put it so eloquently in one of his articles. He said, “Never ever should we have had to keep counting on externalities to take care of our own security needs. A key pathway for collective global security is an Africa that is self-sufficient.”

Self-sufficiency is something we should get as Canadians. Why? In the early days of the pandemic we had no Canadian vaccine. We had no ability to manufacture. We were at the bottom of the list and were desperately looking for shipments from Moderna and Pfizer, and from all parts of the world. Today we have a Canadian vaccine. We are starting manufacturing in Montreal. We are investing in domestic manufacturing. Now please tell me why other countries don't deserve to do the same. If we believe in vaccine self-sufficiency, why should every country in the world not aspire to have their own ability to make antivirals, tests and vaccines?

Our lack of TRIPS waiver action is disappointing to me for that reason. A TRIPS waiver alone is not enough, but in combination with tech transfers, mRNA hubs and other initiatives by the WHO and others, it can completely change the game not only in this pandemic but also for future crises.

● (1155)

The best way to protect the world is to have as many countries in the world be self-sufficient in terms of their own ability to make vaccines, tests and antivirals.

In closing, I would love for us to do three things as Canadians.

Immediately and publicly back the TRIPS IP waiver, not only for vaccines but also for tests and antivirals.

We must also fund the WHO and the African Union to develop their own mRNA hubs and promote self-sufficiency. Vaccine self-sufficiency by other countries should be our explicit stated goal. That is what will keep us safe, not only now but in the future. Let's please donate and honour our pledge for 200 million doses. Let's do it and put a timeline on it. Within the next six months, I would love to see all 200 million doses successfully donated. Also, let's provide more funding for vaccine delivery so that we can support our accelerator and other initiatives.

Lastly, even as rich countries are declaring the pandemic over and cutting back on funds for global vaccination efforts—as the White House is doing—the scientific model and economic case for vaccine equity remains extraordinarily powerful. Please, Canada, let us do the right thing.

Thank you.

The Chair: Dr. Pai, thank you very much for your opening remarks.

We'll go straight into round one, with six-minute allocations to start. Leading us off is Mr. Chong.

Please go ahead.

Hon. Michael Chong (Wellington—Halton Hills, CPC): Thank you, Mr. Chair.

I'm just going to take a minute before, through you, I pass the floor over to Mr. Morantz.

I want to give notice of a motion for consideration at Thursday's meeting, and I would ask if you could set aside the final 10 minutes of that meeting for consideration of the motion I'm going to give notice for. It is:

> That the Standing Committee on Foreign Affairs and International Development support the full participation of Taiwan in the International Civil Aviation Organization and its 41st Triennial Assembly to be held on September 27, 2022 – October 14, 2022; that this be reported to the House as soon as possible; and that the committee request a government response.

It's very similar to a notice of motion I gave some time ago, but it adds to it the clause that the committee request a government response, which would preclude us from moving concurrence in the House for four months and, hopefully, will allow all members of the committee to support this motion on Thursday.

Thank you, Mr. Chair. That's all I wanted to do at today's meeting.

The Chair: Thank you, Mr. Chong.

Am I correct that you're delegating the rest of this time to Mr. Morantz?

You have about four and a half minutes left in the allocation.

Mr. Marty Morantz (Charleswood—St. James—Assiniboia—Headingley, CPC): Thank you, Mr. Chair.

Dr. Pai, I take your point with respect to domestic capacity. I know that the Government of Canada made a SIF grant of $173 million for that purpose to a company called Medicago. The problem is that they developed a vaccine, the Covifenz vaccine—and you may be aware of this issue—but when they applied to the World Health Organization for an emergency permit, they were denied.

They were denied because the Philip Morris tobacco company has a major stake in Medicago, and the World Health Organization has a policy that they won't do business with tobacco companies. Do you see this as a failure of due diligence on the part of the Government of Canada and a misstep in terms of trying not only to develop domestic capacity but to meet our COVAX obligations as well?

Dr. Madhukar Pai: Thank you, sir.

I am pretty sure.... I'm not an expert in tobacco, but the tobacco regulation that all UN agencies have to comply with is very old. It wasn't developed just around COVID. In other words, if anyone would have done their due diligence, they should have picked up that tobacco company involvement in it would eventually hit against the UN policy or regulation.

At a minimum, just by calling the WHO and asking them, “If this were to be developed and a tobacco company were involved, what would happen to the approval?”, they would have learned very quickly that it might not be approved, in which case the government could have then invested the money in some other deserving company.

All I would say is, we should have anticipated this.

● (1200)

Mr. Marty Morantz: Thank you for that important response.

Dr. Gagnon, I just wanted to clarify. You made a comment with respect to patent holders maximizing their revenue throughout this whole COVID episode, but there's a CARE report out that says that for every $1 donors spend on vaccine doses, they're spending roughly $5 on actually delivering the vaccine.

It seems to me that for those two things, the cost of delivery, if not equal to, is actually even more important than the cost of donating the vaccine. Have you done any research on, or do you have any concerns over, why it costs so much to deliver these vaccines?

Dr. Marc-André Gagnon: We're talking about the cost of donating the vaccine. That is, basically, the manufacturing cost and the money that goes to the company versus what needs to be paid for delivery—getting the vaccine into the arms of people.

The issue of intellectual property is not based on the problem of distribution costs, but these are important costs that need to be taken into account when we provide donations. It's not just about shipping over stacks of vaccines. It's about making sure that we're helping different countries that are able to run vaccination campaigns in a proper way.

Keep in mind that just giving away the vaccines we don't want, such as AstraZeneca, for example.... When we saw there were safety issues with AstraZeneca, we said, “Okay, now we're going to give this away and—”

Mr. Marty Morantz: I'm sorry to interrupt. I have such limited time. I do appreciate the response, though.

I have one quick question for either of you.

The WHO reports that 6.24 million people have died from COVID-19. I know that Dr. Pai mentioned it is more like 12 million. The Economist has its own analysis, which shows that COVID-19 deaths are, in fact, far higher than officially reported numbers. Its estimate is based on tracking excess deaths over the baseline norm.

I'm wondering if you could comment on which number, in your opinion, is more accurate. Is it the WHO's 6.24 million or the 21.2 million that The Economist predicted?

The Chair: Mr. Morantz, we're out of time in this round.

Very briefly, perhaps either witness can just answer A or B, or submit their thoughts in writing. That's acceptable, as well.

Dr. Madhukar Pai: The WHO just published an excess death report last week, and their estimate is closer to 15 million than six million. I think everybody in the world agrees that everybody is undercounting the number of COVID-19 deaths. The reality is somewhere around 15 million.

The Chair: Thank you very much.

Dr. Fry, please go ahead for six minutes.

Hon. Hedy Fry (Vancouver Centre, Lib.): Thank you very much, Mr. Chair.

I want to thank everyone for coming. It's nice to see Marc-André Gagnon here with us again, because he's such an expert on so many things. I really respect his thinking and the work he's doing.

I want to ask a couple of questions.

We're talking about the compromise. I want to talk about the compromise text and the fact that the United States, the European Union, India and South Africa are having trouble coming to grips with getting this compromise text done.

First and foremost, the whole concept included more than just vaccines. We talk a lot about vaccines, but I think we need to talk about testing, tracking and surveillance. How do we know if it's 15 million or six million deaths? If you're not testing, tracking and surveilling, how do you know what cases you have? That's my first question.

The second one is, why are treatments being left out of this agreement? How does this compromise fail to address the non-IP components or trade secrets? What can we do to move this along? What can Canada do to get this compromise agreement passed? What are the stumbling blocks? Do any of you know?

● (1205)

Dr. Marc-André Gagnon: I can jump in, if you like.

This is an important question. Let's keep in mind that the compromise text is a compromise in a way I consider to be very problematic. We're just focusing on article 31 of TRIPS and putting aside article 39, which is about non-IP or trade secrets. This is unfortunate, especially because, in the last 20 years, there has been an evolution in the organization of intellectual property and patents, where, more and more, the patent offers very little understanding of the technology itself and is way more focused on trade secrets.

The thing is, if you give away the recipe without the trade secrets that go along with it, when the trade secrets have become a central part of your capacity to produce the technology to vaccine, in the end, this compromise will not go very far.

What's important during times of pandemic? We're talking about COVID-19. We could have a new variant emerge that is very bad and the vaccine could stop working. Then we will be in the same movie again. We could have a different pandemic—ebola, for example.

We need to prepare for a capacity of sharing both the know-how and the technology. This is in article 39, which is excluded from the compromise. As well, we need to make sure that if there is help and technology transfer among countries, this will not bring a rainfall of lawsuits and litigation.

Hon. Hedy Fry: Thank you. I want to ask another question.

We are studying vaccine distribution, but there is the whole issue, for instance, of testing and tracking and surveillance. However, we've been told by some witnesses that it isn't about vaccine supply anymore. It's about how countries that get the vaccines can distribute them and can make it happen. We're talking here about basic infrastructure, about personnel to give vaccines. We're talking about a whole lot of things.

Why aren't we focusing a lot on that and on the issue of therapeutics? If you're trying to get vaccines now, when the pandemic is on, it's like closing the door after the horse has run off. We need to be focusing on things like therapeutics.

What do you advise that Canada should do in looking at providing infrastructure for distribution of vaccines within the country of reception, and what are we going to do about things like therapeutics? How are we going to push that forward?

Dr. Madhukar Pai: Go ahead, Marc-André. I will go after you.

Dr. Marc-André Gagnon: One element I would like to bring in, which for me is important, is that the WHO has this little organization when it comes to flu, which is called the global influenza surveillance and response network. Basically, they're taking care of seasonal flu. The whole organization is working with different countries. Everything is open science. Everything is in calibration. This is the best way to do the screening and monitoring of what's going on, and the evolution of the different diseases. This is working very well. This is the type of infrastructure we needed from the start when it came to COVID-19, and when it comes to other influenza pandemics as well.

One great example is this global influenza surveillance and response network at the WHO.

Hon. Hedy Fry: That's about that, but what about the issue of therapeutics? I'm focusing on that because we need to treat people faster now, rather than trying to prevent the virus from spreading. I mean, it's already spread.

Dr. Marc-André Gagnon: When it comes to therapeutics, I mentioned there's the C-TAP to develop the technology. The MPP is a patent pool from Unitaid, but it is a voluntary patent pool.

Both Merck and Pfizer have been using this—for example, Pfizer with Paxlovid—but at the same time, they can impose the conditions. Basically they said they would exchange the technology and make the patent accessible, but only for low-income countries under specific conditions. When Dominican Republic said that it wanted to use the compulsory licence for the therapeutic Paxlovid, Pfizer simply refused, claiming that this was their human right to decide what they want to do. This is nonsense.

● (1210)

[*Translation*]

The Chair: Thank you, Ms. Fry, Mr. Gagnon and the other witnesses.

Mr. Bergeron, you have the floor for six minutes.

Mr. Stéphane Bergeron: Thank you, Mr. Chair.

I would also like to thank the witnesses for being here today and for sharing their informative comments with us.

Mr. Gagnon, I'd like to begin with a question that has already drawn your attention, and the attention of one of the witnesses we heard earlier, a representative of Doctors Without Borders.

My question is about the grants that would have been required, and paid for by Canada, for the development of lipid nanoparticle technology, and created by spinoff companies from the University of British Columbia.

In that event, I'd like to quote the following: "If most of the funding for designing vaccines comes from public sources, and the price includes a premium for patents, are we not paying for the vaccine twice?"

That's a question I raised with the president of AstraZeneca at a meeting held on April 25. I asked her whether AstraZeneca had supplied its vaccine in quantities equal to the grants paid, and had decided to make the vaccine profitable only once the grants had been repaid. I was not really given a proper answer to the question. I was rather told that they were continuing to give the vaccine to developing countries, but charging for it in developed countries in order to make it somewhat profitable.

What do you think about this response from AstraZeneca?

What do you think about the possibility that we could have also funded research and development into lipid nanoparticle vaccines?

Dr. Marc-André Gagnon: We're talking about the AstraZeneca vaccine, but it's important to mention that it was the Oxford University vaccine, which was transferred to AstraZeneca under certain specific conditions set out in the licensing contract. These conditions made AstraZeneca the only company for which some technology transfer had been requested, which did happen. It had also agreed to sell its vaccine at cost for as long as the pandemic lasted. The first time I saw a press release saying that the COVID-19 pandemic was over, and described as only endemic, was in an AstraZeneca press release. It was very quick to say that the pandemic over, which was rather peculiar.

It's important to understand that for patents, it's not a single company that creates a technology. There are networks of corporations working on the same things. How the patent network is organized is therefore important.

The University of British Columbia's technology became the property of the Canadian firm Genevant, which owns many of the patents *Technical difficulty* presented with someone from Providence Therapeutics…

Mr. Stéphane Bergeron: Excuse me for interrupting, Mr. Gagnon, but we missed part of what you were saying. After "patents", we missed about 30 seconds of what you said.

I'm sorry to have to ask you to repeat it, but for the benefit of the committee members, it would be a good idea to go back a bit.

Dr. Marc-André Gagnon: Okay.

I had finished talking about AstraZeneca and was talking about the Canadian firm Genevant, which owns many of the patents for messenger RNA vaccines. Providence Therapeutics, an Alberta company which wanted to work on messenger RNA technology transfers for vaccines, was interfered with systematically. It was impossible to go forward.

Biolyse Pharma wasn't the only company that could produce vaccines. PnuVax, next door to the National research Council of Canada in Montreal, could produce some. Canada's Providence Therapeutics could handle the technology transfer, but was institutionally prevented from doing so.

● (1215)

Mr. Stéphane Bergeron: If you are willing, Mr. Chair, I'd like to continue this discussion.

In a few moments, we will be meeting the Vice Minister, Foreign Trade and Integration, from the Bolivian Ministry of Foreign Affairs. He spoke to us about the problems encountered by Biolyse Pharma in connection with the Canadian Access to Medicines Regime, and to technology transfer that would have made it possible to produce vaccines in Bolivia. The Canadian Access to Medicines Regime never really proved to be particularly effective, because after it was established, only one country, Rwanda in 2007, submitted an application, because the procedure was so complicated.

Why do you feel the system isn't working and why, as you have just explained, are we witnessing the same Canadian institutions organizing things in a way that makes sure they won't work?

Dr. Marc-André Gagnon: I believe it's a clear case of regulatory capture. It's a regime that was designed in partnership with pharmaceutical firms, which ensured they would be able to set up all kinds of administrative impediments to make things extremely complex.

Don't forget that in 2011, Canada passed an act to reform the Canadian Access to Medicines Regime. A parliamentary majority voted to eliminate some of the administrative impediments, but then elections were triggered and the Senate had not yet adopted the bill, which meant it was was now dead on the Order Paper.

Everyone in Canada working in the field of intellectual property is well aware of the fact that the Canadian Access to Medicines Regime doesn't work. On top of everything else, right in the middle of the COVID-19 pandemic, Canada refused to amend schedule 1 of the Patent Act to allow technologies used to combat COVID-19 to be included among those that could be made available if a country were to have a go at getting around all the administrative roadblocks to try and obtain them.

That, in the end, is what Bolivia did, but Canada refused to help that country by amending the basket of treatments, medicines and vaccines available during pandemics and health emergencies.

The Chair: Thank you very much, Mr. Bergeron and Professor Gagnon.

[*English*]

Ms. McPherson, please, you have six minutes.

Ms. Heather McPherson: Thank you, Mr. Chair.

Thank you very much to our witnesses for being here today. This is such important testimony.

It is my 50th birthday today, so this is a perfect birthday present for me actually. Thank you so much.

I'm going to start with Dr. Pai. I read an article you wrote last week, Dr. Pai. I will submit it to the analysts so they can have a look at it as well.

You talked about how ensuring that global vaccine equity happens is the most selfish thing we can do, that in fact it is the thing that will protect us the most. It protects us health-wise from future pandemics. If we can't do it because it saves lives, can we not do it simply because it's good for our own health and also good for our economy?

Could you speak to that a little bit more? I would like to give you some opportunity to do that

One other quick thing before I stop is that I know you didn't have a chance to respond to some of the previous questions, so please take some time to respond to them too.

Dr. Madhukar Pai: Thank you, ma'am, and happy birthday.

Yes, I did a whole segment for CTV News, along with Dr. Joanne Liu and Dr. Richard Gold, which was telecast last week, where I said that the most selfish thing that we could do is to help vaccinate the world.

The rationale is very simple. We are already in the third year of this pandemic because this virus is running unchecked. Reducing the overall transmission of the virus is the surest way to reduce the number of new patients and bad variants.

First, bad variants are absolutely coming our way, which is what I wanted to mention to Dr. Fry as well. It is never too late to vaccinate, because we don't know what bad variant is coming our way. Already we are seeing that the subvariants are even more transmissible—every single subvariant—and all it takes is another new patient perhaps to make it as deadly as the delta variant, and we would be in an all-out crisis all over again. I don't think we can deal with that.

Second, we're not just talking about transmission. The consequences of long COVID are terrible, disastrous, for the whole world, so it's a very good reason to vaccinate even to prevent long COVID and its complications.

In terms of the selfishness, I cannot do better than Joseph Stiglitz, the Nobel Prize economist. He just published an article last week in the journal that I edit. The title is “Vaccinating the world...is a no-brainer” as an economic investment.

The Economist magazine called it the “deal of the century”, with an economic return in the order of several thousand souls. In other words, there is no better investment anybody can come up with than vaccinating the world, which is why the G7, including us, should have done this more than a year ago. We could have put down $50 billion, or whatever is required to vaccinate the world, and by now we could have saved multiple trillions of dollars. That's the difference between paying billions now and being done with it, or continuing this pandemic into year four and dealing with all of the consequences—deaths of 15-plus million, long COVID and economic damage. The Economist magazine and the IMF have already estimated that trillions of dollars in economic losses have happened.

It is foolish to hold onto anything that will prevent this virus from multiplying. Stockpiling vaccines, not supporting domestic manufacturing, is absolutely foolish because we will be paying for it in the coming years.

I would rather that we pay now and pay less rather than holding back vaccines, not doing the right thing and suffering with trillions of dollars in economic losses.

Moreover, our borders are open. No matter how hard you try, new variants are going to keep coming in. We saw it. Every single variant came from somewhere else and devastated our health system. Can we afford a single variant more? Are we ready to go into another lockdown? We are not. That's why I'm saying that the most selfish thing we could ever imagine is to help vaccinate the world and share the therapeutics.

Ma'am, you're right: Antivirals are absolutely critical as well. There was a beautiful article in The New York Times saying that Paxlovid is pretty much not going to be available for low- and middle-income countries. Why do the richest nations gobble up all of the supplies? It will be the same thing if there's a new vaccine available for new variants, an omicron vaccine. Again, the high-income countries will take everything. Low-income countries will be at the bottom of the pile. That is why their self-sufficiency gives them a chance to modify their vaccine as and when they need to.

● (1220)

Ms. Heather McPherson: Thank you, Dr. Pai.

I'm going to ask this one question of both of you because I think it's something we really need to get on the record.

Do you feel now that with the response we have seen globally, particularly from the Canadian government, there is any likelihood that if there were a new pandemic, a new variant, an expansion, a different result would happen, a different result from when you look at CAMR, when you look at COVAX, when you look at our vaccine response?

Dr. Pai, I will start with you, but if you wouldn't mind saving some time for Dr. Gagnon as well, I would appreciate it.

Dr. Madhukar Pai: The answer is a resounding no. Given the selfishness, greed and myopia of the world's richest countries that we have seen, the naked display of that in the last two years, I'm one hundred per cent convinced that in the next crisis we will behave the exact same way. We will go nationalist. We will go isolationist. We will only look inward. We will not even look beyond our boundaries, and we'll be back in the same crisis all over again.

Things like the climate crisis and pandemics cannot be solved with this nationalistic way of thinking.

Ms. Heather McPherson: Thank you.

Dr. Gagnon.

Dr. Marc-André Gagnon: I say a resounding no as well, but the difference is that, the next time, we will have no excuse for not making these choices.

The Chair: Ms. McPherson, thank you very much.

Colleagues, we have about 15 minutes left until 12:40, at which point we're scheduled to go briefly in camera to talk about drafting instructions.

With your concurrence, I would suggest that we have three-minute and one-and-a-half-minute rounds. That should complete a second round, but with pithy shorter questions. If that's amenable, then we will go ahead with Mr. Aboultaif for three minutes.

Mr. Aboultaif, please go ahead.

Mr. Ziad Aboultaif (Edmonton Manning, CPC): Thank you, Chair.

Dr. Pai, the Canadian government invested $173 million in Medicago to produce the Covifenz vaccine in order to donate 200 million doses of vaccine to the world—to countries who most need it—yet WHO denied an emergency permit to do so because Philip Morris is the largest tobacco manufacturer in the world and has a big stake in the Medicago. How do you explain that?

Where is the fairness in distribution and in getting vaccines to the most needy when WHO stands in the way? Couldn't they provide some solutions to that, given the need for vaccination?

● (1225)

Dr. Madhukar Pai: Thank you, sir.

Unfortunately, I'm not an expert on this particular issue of how tobacco company involvement is seen or not. Like I said, I do not think the WHO would do this only to one company. This is their policy and they're probably applying it to all companies regardless of who is involved or not. I'm afraid I'm not able to tell you what WHO should be doing or not.

Mr. Ziad Aboultaif: However, people like you and others are also asking for a patent to be given away to facilitate making vaccines available. This is another way to do so. Why do we have a double standard? Why can't you call for that too? Why is this an exception while other calls are not an exception?

Dr. Madhukar Pai: I'm guessing that the WHO and UN agencies have to walk a tight line here, because tobacco company involvement has been proven to be challenging for them across the disease areas. For them, I think it's not just a COVID issue but probably a system-wide policy to not engage with tobacco companies, and to change that would require a whole another country-level discussion at the World Health Organization.

Mr. Ziad Aboultaif: However, that's again another way of standing in the way of providing vaccines to where they are most needed. We are facing a once-in-a-century challenge with this pandemic that we're going through. Once in a lifetime—in a century—could the WHO make an exception on this or not?

Dr. Marc-André Gagnon: Since I think Dr. Pai's connection is frozen, I'll jump in.

We need not underestimate what tobacco means in terms of the global health crisis as well. Robert Proctor has discussed this in his book the *Golden Holocaust*, for example, which looks at the history of this. A move like the one by WHO to be proactive on this was very important. Basically the agreement was that they would not be doing business with arms companies and tobacco companies. That is the policy.

Now we can disagree with that policy in times of sanitary emergency, but at the same time WHO would have been criticized even more if it had refused to enforce its policy at that time. This is very sad and we can blame Canada for basically funding this. At the same time, we need to understand that it is not the role of Philip Morris to be doing this type of research. It could have been very easy—

The Chair: Professor Gagnon, I apologize, but just in the interests of time, we'll have to leave it there.

Colleagues, we have lost the connection to Dr. Pai and we're working to get him back.

In the meantime, we will have Ms. Vandenbeld, please, for three minutes.

Ms. Anita Vandenbeld (Ottawa West—Nepean, Lib.): Thank you very much.

Thank you to both of you for being here. I do hope we get Dr. Pai back because some of my questions were specifically for him.

I'll start with Professor Gagnon, although some of my questions were specifically for Dr. Pai. Just going back through some of the testimony, I know that Dr. Pai had mentioned that Canada has only contributed 15 million vaccines, but in fact, there's an additional 87 million doses that have already gone to the global south and are in people's arms because of the cash equivalence. That also includes the syringes, which we heard of in previous testimony.

That's not my specific question. It's more about all of the other things. This is about so much more than doses. For instance, when you look at manufacturing capacity, Canada is partnering with South Africa on the COVAX manufacturing task force to look at that as a pilot project. I'd be interested in your views on that. There's the fact that a lot of countries need assistance with regulatory processes, with procurement processes and with their communication with their public. One of the examples is $50 million that Canada has provided to the Pan American Health Organization. With regard to what Dr. Fry mentioned about testing, treating and health systems, Canada is either first or second to the ACT accelerator in each of those areas.

My specific question is really on this idea that somehow we haven't learned from this process and that if there's a future pandemic, we wouldn't do any better. The fact is that there's almost $300 million in budget 2022, additional money on top of the $2.7 billion we've already provided, that's specifically for health systems. We heard previous testimony that health systems are the biggest indicator of the countries that either failed or succeeded.

Can you comment on the support that Canada has given in all of these other areas—more than other countries—and also the support we are now committing to for improving health systems in future pandemics?

● (1230)

Dr. Marc-André Gagnon: I see that Dr. Pai has come back, and in fact, I would like him to answer this question because I have not followed the help that we've been providing to the health systems.

I want to say one thing in terms of COVAX and donations. For me, COVAX emerged in response to C-TAP, the COVID-19 technology access pool, which wanted to develop the technology in collaboration, sharing information, etc. COVAX was organized, first and foremost, as a way to maintain the patent technology in place and respect the patent system. You pay the manufacturer, and then you deliver the drug. It's not about creating self-sufficiency in different countries.

On the health care systems, I will let Dr. Pai answer that.

The Chair: Thank you very much.

Ms. Vandenbeld, unfortunately, that's your allotment. These are very short rounds now, a compressed second round, but maybe there's a chance in the final round for the Liberal party to have a follow-up.

[*Translation*]

Mr. Bergeron, I'm sorry to have to assign you such a short amount of speaking time, but you do have the floor for a minute and a half.

Mr. Stéphane Bergeron: Thank you, Mr. Chair.

I'm going to try and counterbalance the rather rosy picture that the Parliamentary Secretary to the Minister of International Development, Ms. Vandenbeld, has just painted.

Mr. Gagnon, I'd like to allow you to return briefly to the reply you gave us with respect to Canada's actions to short-circuit the possibility of giving developing countries access to the Canadian Access to Medicines Regime, the CAMR.

Dr. Marc-André Gagnon: The basic short-circuit that prevents things from moving forward is the fact that, even if Bolivia and Biolyse Pharma had succeeded in going through all the required hoops, Canada refused to include it in schedule 1, leaving no other recourse.

What was absolutely deplorable in my view, was when Canada, in December 2020, took a position at the World Trade Organization, the WTO, by simply saying that if no one had called upon the CAMR, that simply showed that there was no need to work toward an exemption from certain provisions of the TRIPS Agreement, or from some aspects of intellectual property rights pertaining to trade.

This declaration was quite simply dishonest, to put it mildly. I don't know who, in the group working on international trade patents, decided to take that position, but it was simply nonsense.

The Chair: Thank you, Mr. Gagnon.

Thank you, Mr. Bergeron.

[*English*]

Ms. McPherson, please go ahead for one and a half minutes.

Ms. Heather McPherson: Thank you so much Mr. Chair.

Again, thank you to our witnesses. I'm going to put this question to Dr. Pai, and if we have time, to Dr. Gagnon.

We have a system right now, CAMR. We can see very clearly that it's a system that does not work. We heard testimony about that earlier. We have a TRIPS waiver that the government has intentionally not made a decision on, and because it hasn't made a decision, that is, in effect, a decision. We've seen examples of hoarding and not giving the vaccines that we could.

Do you feel that the Canadian government has stopped action and, in effect, its failure to act or make decisions is, in fact, an action in and of itself?

Dr. Madhukar Pai: How can it not be a global crisis? Every month, millions of people are affected by this crisis.

I'll just give you India as an example. In just three months, April, May and June of last year, 2.7 million Indians died. That is almost a million deaths a month. That is how devastating this virus can be. Every year we fail to act is adding more and more deaths and economic losses.

To me, time is of the essence. Just sitting on this for years and years.... The fact that we're even doing a study on vaccine equity in the third year is so disappointing to me in and of itself. What is there to study? We have to act. Lives are at stake, and our own security is at stake. Canada will pay for this. I'm sorry. We will be suffering for many months to come if we don't act purely out of selfishness. If we don't want to do the right thing for altruistic reasons, fine. Let's do it for pure selfish internal-looking reasons. Let's do the right thing.

● (1235)

The Chair: Thank you, Dr. Pai, and thank you, Ms. McPherson.

Mr. Aboultaif, please go ahead for three minutes.

Mr. Ziad Aboultaif: Dr. Pai and Dr. Gagnon, I'll go back to the obstacles to providing the vaccine and getting this whole process going from A to Z without any interruption.

Could the two of you list, in priority, what the obstacles looked like, from the patents and licensing to the delivery of the vaccines, to the infrastructure and the resources that you had on the donor side and recipient side? Would you be able to list, in priority, where the obstacles were for a complete vaccination to take place?

Dr. Madhukar Pai: To me, the biggest obstacle was that the richest nations essentially cornered all of the vaccine supply last year. There was virtually nothing available for low- and middle-income countries. COVAX donations came down to a trickle. The world just sat by and allowed this virus to run through the whole place. To prevent this from happening again and again, we need architectural changes—

Mr. Ziad Aboultaif: I'm interested in a whole list of priorities, not just—

Dr. Madhukar Pai: You would need to give me more than 60 seconds to give you the list. My point is that we need structural changes, and we need money and then—

Mr. Ziad Aboultaif: It would be nice if you could summarize it.

Dr. Madhukar Pai: Yes, I'm trying.

Like I said, there are structural changes that prevented low-income countries from getting supply. Now that there is a supply, they are struggling to vaccinate because they don't have the resources to deliver them.

We need to fix both. We need a short, predictable supply. Countries need to be self-reliant on their own and not depend on our charity, or anybody else's charity. They need their own delivery mechanisms that the world should be supporting.

Mr. Ziad Aboultaif: Thank you. That's fair enough.

Dr. Gagnon, can you comment on that too, please?

Dr. Marc-André Gagnon: The first thing would be to list COVID-19 treatments and vaccines under schedule 1 of the Patent Act and support the TRIPS waiver.

What for me is very important.... Basically, we had massive public subsidies and advanced market agreements in order to make sure that we were de-risking investment to make sure we moved as fast as possible.

We need to make sure that these alternatives to patents can be used when necessary. When countries get together, it's just, “Okay, we will be publicly and massively funding this,” but then they should not stick with structures where the production of scarcity is central to the profitability of some of the stakeholders.

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

Our final intervention this afternoon goes to Mr. Sarai for three minutes.

Mr. Randeep Sarai: Thank you.

My first question goes to Mr. Pai. You used India as an example of four and a half million people dying, but India is a manufacturer and has two of the largest manufacturing facilities in the world, producing up to 160 million or 190 million vaccines a month. My understanding, from what I have read, is that their deaths have nothing to do with the availability of vaccines, but the fact that they had one of the world's largest fairs. Over 100 million people came to one place in the country and then merged back. They also didn't use the actual vaccines they produced and had.

How would a TRIPS waiver help a place like India, when they already had 200 million doses a month being manufactured?

Dr. Madhukar Pai: Firstly, you're right. There are lots of things that went wrong in India, and I wrote a whole article on it in The Washington Post. For sure, there were missteps, but when the delta wave emerged in India, only 10% of India was vaccinated. Essentially, this deadly little strain of the virus ripped through the whole country, and that led to the carnage. Yes, India could have done many things to limit the spread of the virus.

The TRIPS waiver may not necessarily help a country like India, China or Russia. The big BRIC countries are not what we are really worried about. We are worried about many other countries, especially on the African continent, where after all of these decades and centuries, they do not have the ability to manufacture their own vaccines. It's not just for COVID. They can't even make a malaria rapid test on the continent, despite having the most malaria anywhere in the world.

My plea is to have domestic manufacturing on the African continent, which is the best way to prepare the continent for whatever is coming next.

● (1240)

Mr. Randeep Sarai: On that same note, I find that a bit surprising too, because people who have manufacturing facilities can't get the materials for them. Even if you get the patent or the formula to make it, if you can't get the raw materials, it doesn't solve the problem. When a pandemic happens, the whole world is seeking the same ingredients and, therefore, even if they have manufacturing facilities, I don't see how they could solve that problem.

You will always have concentration of manufacturing in places that can specialize in it and make millions daily, if not hundreds of millions monthly. The problem is a lot more complex than giving a waiver of some sort, because when you come to things like this, you also have to have the ingredients and the manufacturing ability to make it and the wherewithal and the will of the country to deliver those.

We're noticing that more of a problem is not so much the vaccines' availability as delivering them into the arms that need them. How we improve that is the real issue, rather than giving rights to manufacture them without giving the necessary ingredients and the ability to put them in people's arms.

Dr. Madhukar Pai: We all agree that this is a multi-faceted problem that requires multiple interventions. The TRIPS waiver is only one among them.

Mr. Randeep Sarai: I'm trying to—

The Chair: Mr. Sarai, I apologize. We'll have to leave it there. You're a bit over your time.

Colleagues, on our collective behalf, I'd like to thank Professor Gagnon and Dr. Pai for their expertise, for their appearance today and for their testimony.

[*Translation*]

Thank you very much. We're very grateful to you.

[*English*]

With that, colleagues, we'll ask our witnesses to disconnect. We will take a moment to resurface in camera for a discussion on drafting instructions on this report.

The meeting is suspended for a couple of minutes.

[*Proceedings continue in camera*]