In his recent *CMAJ* commentary, Amir Attaran significantly downplayed the importance of exceptions in patent law that permit generic drug production.¹ It is misleading to talk about the number of pharmaceutical patents in developing countries without mentioning the fact that India manufactures and provides the majority of the developing world's affordable generic medicines and well over 50% of its generic anti-retroviral therapies.² Now that India must provide 20 years of patent protection on pharmaceuticals, it is uncertain where, and to what extent, affordable generic versions of patented drugs will be produced.³ Given this grim prospect, abandoning Canada's Access to Medicines Regime would be short-sighted and careless. Attaran's all-or-nothing approach dismisses any role for Canadian generic drug manufacturers and fails to acknowledge the uncertainty in future sources for affordable, generic products.

Canadian products can still be competitively priced. Last year, Apotex manufactured a fixed-dose combination antiretroviral product intended for shipment under Canada's Access to Medicines Regime and announced that it can offer the product to Médecins Sans Frontières at \$0.39 per pill, a price comparable to that offered by Indian generic drug manufacturers.⁵

Finally, Attaran mentioned that poor countries are not using compulsory licensing but failed to mention one of main reasons for this: developing countries face formidable political pressure when trying to use such options, as illustrated most recently in Thailand.^{6,7} In the context of this political reality, bold amendments to the Canadian legislation would give developing countries much-needed support for their legal right to take advantage of flexibilities in patent law to address their nations' public health needs.

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Amir Attaran's arguments that Parliament should not bother to reform Canada's Access to Medicines Regime¹ are not persuasive. First, experts have debunked his simplistic claim that patents have no significant impact on access to AIDS drugs in Africa because of limited patent coverage.² In any event, the law addresses the situation in which patent holders in Canada can bar the export of generic versions of their medicines. In some cases, there may be additional hurdles to overcome in the developing country importing the drugs, including the possibility that a compulsory licence will have to be issued in that country. However, this does not mean it is pointless to change Canada's law to make it easier for generic drug exporters to overcome the patent barriers in Canada.

Second, Attaran claims that Canadian manufacturers are unlikely to offer competitive pricing. Oddly, he cites generic drug prices in Canada, when it is the prices at which the drugs are offered to developing countries that are relevant. So far, one product, an AIDS drug, has been developed for possible export under Canada's Access to Medicines Regime; the manufacturer has stated publicly that it can and is willing to sell this drug for only a few cents more per tablet than the prices set by Indian generic drug manufacturers and that the price will come down further if the company succeeds in procuring the necessary active pharmaceutical ingredients more cheaply.^{3,4}

Finally, Attaran accepts that Canada's law is "inefficient" and "user-unfriendly." Indeed, the law mandates a cumbersome process in which generic drug manufacturers must seek separate compulsory licences for each order, by a single country, of a predetermined quantity of a drug, after attempting in each instance to negotiate a voluntary licence from the company

holding the Canadian patent. However, Attaran merely asserts that reforming Canada's law is pointless because a developing country has yet to use this law or the fundamentally similar laws enacted in other countries, all of which were implemented in response to a 2003 World Trade Organization agreement.⁵ He identifies none of the factors that are likely to explain why no poor countries have yet notified the World Trade Organization of their intention to import generic drugs produced elsewhere under compulsory licence, as required under the 2003 agreement; these include a history of threats from multinational brand-name pharmaceutical companies and the United States government against countries that have used or contemplated obtaining compulsory licences, as demonstrated most recently in the reaction to Thailand taking such a step.^{6,7}

Rather than contemplate that the problem might lie, in part, with the World Trade Organization mechanism implemented by Canada, Attaran incorrectly suggests that there is no alternative process consistent with the World Trade Organization agreement. In fact, we have proposed that Canada legislate a different, streamlined process to obtain compulsory licences for export, one that avoids the flaws of the 2003 World Trade Organization decision but is still permissible under other World Trade Organization rules and that recognizes both the logistical practicalities of drug procurement and the political realities faced by developing countries.⁸

Obviously, Parliament cannot legislate away bullying by other countries. But at least, in light of this political reality, it should craft simpler legislation that emboldens developing countries by minimizing not only the effort (in time and costs) to obtain lower cost generic drugs under compulsory licence, but also the risk of retaliation. For example, as we have proposed, a revised law should make it easy for a generic drug manufacturer to obtain, in advance of negotiating a contract with any particular purchaser, a single compulsory licence allowing it to export its generic

medicine to any of the eligible developing countries, without predetermined restrictions on quantity or time, in exchange for applicable royalties based on the subsequent use of the licence by the generic drug manufacturer. With this legal authorization in hand, generic drug manufacturers could compete effectively with bids to supply multiple developing countries, thereby achieving economies of scale, and the law would require neither advance disclosure of individual purchasing countries nor separate licensing processes for each individual drug order.

Fixing Canada's law will not, by itself, be sufficient to overcome the various hurdles that developing countries face in meeting the medical needs of their populations, but it is a necessary part of a larger effort to improve access to treatment.

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Corrections

In a recent *CMAJ* commentary,¹ the y-axis of Figure 2 was labelled "Percentage of survivors," whereas this should have read "Percentage." We apologize for this error, which appears only in the print version of the journal.

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In a recent Practice article,¹ an author's name was mis-spelled and should have appeared as Omar AbouEzzeddine. We apologize for this error.

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In a recent article,¹ the following information should have been included. In common with his coauthors, Dr. van Walraven is a member of the Clinical Epidemiology Program, Ottawa Health Research Institute, Ottawa, Ont. We apologize for this omission.

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