## 1

#### COUNTERPLAN –Federal governments of member nations of the WTO should maintain intellectual property protections for medicines and establish a national single-payer healthcare system covering all essential medicines and services.

#### Single-payer solves the pandemic by covering the uninsured

Galvani 20 [Alison P. Galvani, Burnett and Stender Families Professor of Epidemiology at Yale, 6-1-2020, "The imperative for universal healthcare to curtail the COVID-19 outbreak in the USA," EClinicalMedicine, https://www.thelancet.com/journals/eclinm/article/PIIS2589-5370(20)30124-3/fulltext]/Kankee

The COVID-19 outbreak in the United States is growing steeply and spreading widely. As of March 26, national incidence surpassed every other country, and as of April 28 has reported over a million cases. The COVID-19 crisis is exposing the systemic frailties in our healthcare system. More than 78 million people in America do not have access to adequate health insurance [[1]]. Given that health insurance in the US is typically provided by employers, millions more are at risk of losing their healthcare coverage as unemployment surges. Here we discuss how the pervasive healthcare insecurity in the US hampers control of COVID-19. Further, we argue that universal healthcare would alleviate the cost barriers that are impeding control of this pandemic. Outbreak mitigation relies on prompt diagnosis and case-isolation, in which mild cases are quarantined at home and more severe cases are hospitalized. These measures must be implemented rapidly in order to be effective. However, for the millions of people who are either uninsured or underinsured, concern about the medical expenses that could be incurred delays diagnosis and treatment. While the Families First Coronavirus Response Act recently approved by Congress stipulates that COVID-19 diagnostic testing is nominally free for everyone, treatment is not covered. Those who are hospitalized may face major medical expenses. For instance, the cost of 12 days in the ICU on ventilation would likely exceed US $80,000 [[2],[3]], even without considering the additional hospital care before and after ICU admission. In addition to the burden on the uninsured, the under-insured are obligated to pay substantial out-of-pocket sums, including thousands of dollars in deductibles and copays. Although the Coronavirus Aid, Relief, and Economic Security Act has invested $100 billion into the Public Health and Social Service Emergency Fund for healthcare providers, less than one third of this sum can be used to fund the treatment of uninsured COVID-19 patients. Compounding the crisis, legal action being pursued by the current Administration is jeopardizing the Affordable Care Act, which would lead to the loss of health insurance for as many as 30 million people [[4]]. The COVID-19 pandemic also underscores the precariousness of a system in which insurance is linked to employment. Initial unemployment claims rose from 282,000 for the week ending March 14 to 6.6 million, 5.2 million and 4.4 million, for the weeks ending April 4, April 11, and April 18, respectively, compared with a previous record high of 695,000 from 1982 [[5]]. Many of these newly unemployed individuals will lose their health insurance. Although they are permitted to purchase insurance on the federal exchange, switching networks disrupts continuity of care, which is particularly detrimental for those living with chronic health conditions. Furthermore, the majority of families are unable to afford health insurance upon becoming unemployed, given that more than half of American families live paycheck to paycheck [[6]]. Racial and economic disparities in the US healthcare system are being magnified by the pandemic. Rates of adequate health insurance coverage are much lower among people of color [[7]]. With less access to preventative healthcare, people of color are disproportionately affected by comorbidities, such as diabetes, obesity, asthma, and cardiovascular disease. These comorbidities exacerbate the severity of COVID-19 clinical outcomes, including death [[8]], as does delay in seeking care due to concerns about medical bills. COVID-19 is widening socioeconomic fissures facing people of color as well. Since the start of the outbreak, Latino populations have reported much higher rates of job and wage loss than Americans at large [[9]]. The solution to these challenges is the provision of comprehensive healthcare as a human right. Further, universal healthcare will be most cost-effectively achieved by a single-payer system, such as that proposed in the Medicare for All Act [[1]]. Not only would Medicare-for-All save lives, it would resolve costly inefficiencies that currently make our healthcare system the most expensive in the world. Among the major sources of savings, a single-payer system would consolidate administrative costs, reduce overhead, empower pharmaceutical price negotiations, and truncate executive pay. A single-payer system is also incentivized to invest in cost-effective preventative services that can avert life-threatening clinical outcomes and expensive downstream treatment. Another advantage of Medicare-for-All during this pandemic would be its implementation of a standard billing and payment system, which would accelerate COVID-19 case reporting. Billing procedures currently vary across dozens of insurers, and for private insurance is proprietary. Within a consolidated system, patterns in the billing data can signal outbreak hotspots to public health surveillance officials. This consideration is not hypothetical – the single-payer system in Taiwan has facilitated exhaustive COVID-19 data collection and reporting [[10]]. Universal healthcare is fundamental to the continued prosperity of our country in the wake of this and future infectious disease threats. Obstacles to prompt diagnosis and case isolation not only impact the individual, but pose a broader societal risk. A pandemic illustrates an omnipresent truth: that we are each only as safe as the most vulnerable member of our society. We urge investment now in the common good of healthcare security, by extending comprehensive insurance to all who currently lack it. Then, we should move swiftly to create a single-payer system, such as Medicare for All, which is the more efficient way to provide universal coverage [[1]]. By eliminating financial obstacles to healthcare, we can pave the way for more efficient outbreak control, in both this pandemic and the next.

#### Single-payer aids innovation, but patents are key to sustaining US biotech

Lemley et al. 20 [MARK A. LEMLEY, William H. Neukom Professor of Law, Stanford Law School, LISA LARRIMORE OUELLETTE, Associate Professor of Law and Justin M. Roach, Jr. Faculty Scholar, Stanford Law School, and RACHEL E. SACHS, Associate Professor of Law, Washington University, 04-2020, “THE MEDICARE INNOVATION SUBSIDY,” NYU Law Review, https://www.nyulawreview.org/wp-content/uploads/2020/04/NYULAWREVIEW-95-1-LemleyOuelletteSachs.pdf]/Kankee

II PHARMACEUTICAL SUBSIDIES AS INNOVATION INCENTIVES Governments have created the complex array of prescription drug allocation mechanisms described in Part I because those drugs are costly and public payers face tradeoffs about how to allocate scarce resources. As noted above, the ability of drug manufacturers to set prices well above the cost of production stems from the IP used to protect R&D investments.168 This ex post, market-set incentive is provided not only through patent law, but also through other forms of IP, including trade secrets, trademarks, and regulatory exclusivity.169 It is hard to disentangle the effects of these different forms of IP, but companies generally report that the pharmaceutical industry is the sector in which patents are most effective,170 and scholars often agree.171 But patents and other forms of IP come with significant drawbacks. They raise prices, impose administrative costs, and can discourage follow-on innovation. As discussed below, market-based IP rewards are misaligned from social value for a variety of biomedical innovations, including for goods that generate positive externalities or for which the social value exceeds consumers’ ability to pay. Governments can offset these IP-related biases with other innovation policies, including R&D tax incentives, direct funding through grants and research at national labs, and prizes.172 Here, we focus on one such policy tool—one that policymakers have rarely seemed to think of as implementing innovation policy at all: government subsidies for particular drugs through health insurance programs like Medicare and Medicaid. From an incentive perspective, reimbursement programs can function as market-based prizes, in which the reward incorporates both a government assessment of social value and market information based on consumer choices.173 For example, suppose policymakers decide that the expected IP-based market reward is insufficient for incentivizing a vaccine for a particular disease.174 The government could offer an additional fixed prize—say, $1 billion for the first firm to develop a cure. But to encourage distribution of the vaccine and to tie the reward to some measure of patient preference, policymakers could also offer a market-based prize—say, $100 per patient vaccinated. Particularly for interventions with positive externalities or high disparities between patients’ ability and willingness to pay, administering this kind of additional incentive through government health insurance programs improves the alignment between the returns to innovation and social value. The incentive effect of demand-side healthcare subsidies depends critically on details of institutional design. Section II.A shows how Medicare-like programs can provide a significant subsidy to drug manufacturers beyond expected profits in an unsubsidized market. Section II.B discusses the effect of this kind of subsidy on overall pharmaceutical innovation. Finally, Section II.C examines how subsidies from government insurance can bias innovation incentives in favor of particular biomedical technologies. But those details should not obscure the larger point, to which we turn in Part III: Healthcare reimbursements are innovation incentives. Indeed, they may be among the largest innovation incentives in the pharmaceutical sector. A. The Medicare Innovation Subsidy To illustrate how pharmaceutical profits under Medicare reflect more than the “market value” of a drug, we begin with an ordinary, unsubsidized market in which a seller has monopoly power, as illustrated in Figure 1. The demand curve (D) represents how much quantity of the drug (Q) consumers will purchase at a given price (P); an ordinary market has a downward-sloping demand curve because more consumers are typically able to purchase a good at lower prices.175 The supply curve (S) represents the quantity of drug that will be sold at a given price. Monopoly pricing involves reducing sales in order to increase the price. Why do monopolists reduce output while increasing prices? The key to this “normal” monopoly is the absence of price discrimination. The patentee would like to sell to everyone who is willing and able to pay more than it costs to sell them a drug: that is, everyone for whom the demand curve is higher than the supply curve. But if they lower the price to reach those who can afford to pay less, they also lower the price for all the other buyers, too, reducing the marginal revenue from adding a new sale. Monopolists, then, price not where the supply curve meets the demand curve (the competitive market price),176 but instead where the supply curve meets the marginal revenue curve (MR), resulting in a higher price (Pmonop) and lower quantity (Qmonop) than in a competitive market. If they cut the price any further, the money they would lose from existing customers would counteract the additional sales, making the additional sale unprofitable. If this monopoly price is used to allocate access to the drug, consumers who value the drug above the cost of production but below the monopoly price are unable to access the drug. The social loss due to these lost transactions is known as deadweight loss (DWL), represented by the striped triangle in Figure 1. In the context of essential medicines, this represents patients who will be unable to access the treatments they need. IP policy tolerates this allocative inefficiency on the theory that it will be exceeded by gains in dynamic efficiency: The prospect of monopoly profits will incentivize a producer to create this drug in the first place. In other words, the development of the drug is necessary to provide any access at all. IP policy is thus typically described as representing a tradeoff between short-term access and longer-term innovation.177 The full interaction between IP and pharmaceutical access is more complicated than this simple model suggests. One of us has recently questioned the conventional view that the fundamental tradeoff in IP is between dynamic and allocative efficiency: IPfacilitated market power does create incentives to restrict quantity and thus decrease consumption, but it also has consumptionexpanding effects.178 But for our purposes, the standard monopolypricing model suffices to illustrate the basic effect of insurance and demand-side subsidies. In Figure 2 we add the effect of coinsurance, in which an insurer covers a fixed percentage of medical costs. Compared to a market without insurance, a coinsurance system expands demand, moving the demand curve to the right. The curve pivots rather than simply shifting because coinsurance pays a percentage of the total cost, so it magnifies the effect of a consumer’s existing willingness and ability to pay. If insurance pays 80% of the cost, a consumer who can pay $100 out of pocket can buy a $500 drug. But a consumer who can pay $1000 ($900 more than her neighbor) can buy a $5000 drug.179 The effect of adding insurance is to expand the patent owner’s profits beyond the monopoly profit without insurance. Because consumers effectively can pay more (with the help of their insurers), a monopolist can charge each consumer more and can also sell to more consumers. Note that as patients’ share of costs decreases, the demand curve pivots further to the right, and more consumers gain access to the drug. This effect is generally framed in the health economics literature in terms of the resulting moral hazard problem in which patients may choose treatments that are more expensive than the value they actually receive.180 But there has been less attention to the way insurance greatly increases prices and profits for a seller with market power. If patients’ share of costs declines to zero (such as through insurance that requires only a flat copayment), then there would be no upper bound on price. That’s why, as a practical matter, public or private insurance systems providing free or low-cost care must have some other mechanism to contain costs. For example, as described in Part I, Medicaid links prices to private markets, the VA and UK systems can exclude drugs from coverage, and the German system will only reimburse up to a reference price. Coinsurance systems in which insurers cover a large percentage of costs typically also have some cost-control mechanism, including copayments, deductibles, and formulary management tools. But even if there is some mechanism for limiting price, the patentee may still receive additional profits in a market in which all patients have coinsurance as compared with the “normal” monopoly market, as we illustrate in Figure 3.181 A mechanism for limiting prices is particularly necessary if the model moves from one in which all consumers have coinsurance (requiring them to pay some percentage of the price) to one in which all consumers have generous access to drugs with no cost-sharing, as suggested by some Medicare for All proposals.182 As we illustrate in Figure 4, even if prices are limited to the original monopoly price, providing coverage for all patients with no cost-sharing leads to a substantial additional profit for the patentee.183 Real-world pharmaceutical markets are substantially more complex than any of the simplified models shown in Figures 1–4. The important conceptual point, however, is that when insurance-related policies effectively shift demand upward or to the right, the seller of a drug with market power can receive higher profits for that drug. These added profits grow as patients’ share of pharmaceutical costs shrinks, particularly in the absence of robust cost-containment mechanisms. To some degree, this is what Medicare’s prescription drug benefits do. Medicare beneficiaries generally are responsible for only twenty to twenty-five percent of brand-name drug costs under Parts B and D,184 and millions of patients receive government subsidies lowering these amounts.185 Many of these are people who didn’t have private insurance or who had insurance that was less generous,186 who can now effectively pay much more for drugs than they used to. Medicare also increases overall demand for drugs by causing beneficiaries to live longer.187 These factors tend to push the demand curve upward to the right, artificially adding to the number of people who can pay the monopoly price. And unlike private insurers, who have greater legal authority to negotiate prices freely and to refuse to cover drugs that cost too much, Medicare Parts B and D often impose coverage requirements with little ability for the government to negotiate prices beyond the price set in the private market, giving drug manufacturers significant leverage in setting prices.188 Expanding the demand curve in this way increases the patentee’s profits even further beyond what they would make without government insurance. The patentee no longer has to worry about cutting prices to match demand for customers who can pay less; some combination of the government and supplemental private insurance will pay the monopoly price for almost everyone. Medicare does expand access to consumers who value the drug more than its cost of production but less than the unsubsidized monopoly price (the striped DWL triangle in Figure 1). But it also transfers a great deal of additional profit to the patent owner. The scope and duration of the patent hasn’t changed, but it is generating a lot more profit for the simple reason that, thanks to the government subsidy, there are many more customers who can pay and they all pay the monopoly price or close to it, even if they value the drug at less than that price. We call this added profit the Medicare innovation subsidy. The real world has more complications than this stylized model, of course. Here are four important ones: First, not all pharmaceutical patents confer market power, though they are more likely to than patents in other fields.189 Even where drugs face quite a lot of competition, as with antidepressants, patentees may not face effective price competition if doctors don’t view the drugs as substitutes for any given patient or if Medicare must cover all FDA-approved drugs for certain illnesses.190 Second, Medicare plans and the PBMs that negotiate on their behalf do have some bargaining leverage, including threatening to cover only certain drugs for non-protected classes, using prior authorization or step therapy, and threatening to move drugs to less desirable formulary tiers.191 This leverage has allowed them to lower prices for drugs with competition in a particular therapeutic class, although their bargaining power is limited by the government’s inability to directly negotiate and by the plans’ inability to walk away from the table in most cases.192 As Figure 3 illustrates, however, patentees still receive substantial additional profits even with tools for limiting price. Third, Medicare Part D covers primarily Americans aged over sixty-five. For drugs that affect only the elderly, the model just described is accurate. But it doesn’t apply to drugs for diseases that only affect children, and it applies only partially to drugs taken by patients of all ages. We discuss the biases this may cause in more detail in Section II.C. Finally, the above graphs assume that Part D was created against a baseline in which seniors did not have prescription drug insurance. This was true for twenty-seven percent of seniors,193 creating a demand expansion effect among this population. Before Part D implementation, sixty-six percent of Medicare-eligible seniors already had some prescription drug insurance plan.194 However, at least some of those patients also increased pharmaceutical returns when substituting into Medicare—nine million patients moved from lowerreimbursement Medicaid coverage to higher-reimbursement Part D coverage.195 Effects may be more variable for the beneficiaries substituting from private insurance into Medicare. Despite these complications, the Medicare innovation subsidy is real. It has significantly increased the returns to pharmaceutical patent owners. Medicare now accounts for thirty percent of U.S. retail prescription drug spending,196 even though it applies primarily to people over sixty-five, who make up just thirteen percent of the population,197 and not all of whom even opt-in to Medicare. Medicare, then, is a big source of additional money for drug companies, both because it increases the number of people who can afford drugs and because it may increase the price companies can charge for those drugs. B. Effect on Innovation Above-baseline-monopoly profits aren’t necessarily bad. Few dispute that higher profits for certain innovations increase incentives to produce those knowledge goods,198 and a number of empirical studies have found increases in private-sector R&D investment following legal changes that increased market size in the contexts of vaccines and orphan drugs.199 Based on analysis of time-series data of drugs entering clinical development, Margaret Blume-Kohout and Neeraj Sood conclude that “passage and implementation of Medicare Part D is associated with significant increases in pharmaceutical R&D for therapeutic classes with higher Medicare market share.”200 They found that this was largely new investment, not substitution away from other drugs, and that the effect was smaller for drugs that had been previously covered under Part B and larger for drugs in protected Part D classes.201 (In contrast, the original introduction of Medicare in 1965—without the prescription drug benefit—didn’t increase drug use among the elderly or induce significant pharmaceutical innovation,202 though it did increase medical-equipment patenting.)203 True, increases in R&D alone do not necessarily enhance patient welfare. Subsequent work focused on biologics found a similar incentive effect from Part D implementation, but also concluded that “most of this effect is concentrated among products aimed at diseases that already have multiple existing treatments,”204 and the net welfare impact of such drugs is ambiguous. Even though the size of the Medicare subsidy is large, its net innovation benefit might be relatively modest. The United States offers a huge array of innovation incentives in the pharmaceutical industry already, including not just patents but also direct research funding through grants and national laboratories, prizes, tax incentives, regulatory exclusivities, data exclusivities, and special incentives for orphan drugs and pediatric research.205 Pharmaceutical “lifecycle management” through secondary patents and regulatory gaming mean that companies keep market power for years and even decades after initial patent expiration.206 For at least some drugs, patent-owner returns for pharmaceuticals seem to far exceed the risk-adjusted R&D costs.207 Greatly increasing this innovation subsidy through expansion of government insurance may thus lead to limited innovation gains— although, as discussed in the following Section, existing incentives appear to be insufficient for at least some kinds of socially valuable innovation. Even so, perhaps we should celebrate the expansion of patent owner profits above the baseline monopoly level, since it seems to spur at least some additional R&D investment. If Medicare Part D is justified solely for the access benefits it provides for the elderly, the fact that there is also an innovation subsidy that leads to the production of even some new drugs is an extra benefit for the world. It is found money. And more drugs to treat diseases for no extra cost seems like an unambiguously good thing.

#### Single-payer is affordable

Galvani et al. 20 [Alison P Galvani, PhD, Alyssa S Parpia, MPH, Eric M Foster, Burton H Singer, PhD, and Meagan C Fitzpatrick, PhD, 02-15-2020, “Improving the prognosis of health care in the USA,” Lancet, https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(19)33019-3/fulltext#%20]/Kankee

The bottom line of Medicare for All Through the mechanisms detailed previously, we predict that a single-payer health-care system would require $3·034 trillion annually (figure 3; appendix p 5), $458 billion less than national health-care expenditure in 2017.40 Even after accounting for the increased costs of coverage expansion, our data-driven base case includes $59 billion savings on hospital care, $23 billion on physician and clinical services, $217 billion on overheads, and $177 billion on prescription drugs (figure 3; appendix p 11). Consequently, annual expenditure per capita would decrease from $10 7396 to $9330, equivalent to a 13·1% reduction. The expectation of savings is robust and remains following variation in the input parameters. For example, if overhead costs only dropped to 6% of total health expenditure—rather than Medicare’s current 2·2%—the Medicare for All Act would still reduce costs by 10·3%. Conversely, savings would increase beyond our base case if our model overestimates the unfulfilled demand in people who do not have insurance or are underinsured. Given that $2261 billion is

## 2

#### Congress won’t withdraw the US from the WTO now, but more unfair trade practices abroad causes widespread backlash that ends involvement

Johnson 20 [Keith Johnson, a senior staff writer at Foreign Policy, 05-07-2020, “U.S. Effort to Depart WTO Gathers Momentum,” Foreign Policy, https://foreignpolicy.com/2020/05/27/world-trade-organization-united-states-departure-china/]/Kankee

Frustration with hyperglobalization, China’s “economic imperialism,” and a seemingly broken world trading system is boiling over into serious calls for the United States to withdraw from the World Trade Organization (WTO)—which would have potentially disastrous implications for the country if carried out. For the first time since 2005, lawmakers from both parties and both houses of Congress are pushing to pull the United States out of the trading body it helped create and which was the culmination of decades of postwar efforts to boost free trade and economic integration. By law, the United States has a chance to vote every five years on staying inside the WTO, but staying on board was such a no-brainer in recent years that no such resolution was even presented. But this year—powered by a rise in economic nationalism, growing concern about China, and frustration with two decades of paralysis at the WTO—the knives on Capitol Hill are out, to the delight of some of the trade hard-liners in the White House. “The WTO has been a disaster for the United States,” said Rep. Peter DeFazio, an Oregon Democrat, who introduced House legislation to withdraw this month. “No trade regime can last when it no longer serves the people of the countries who are part of it,” said Sen. Josh Hawley, a Missouri Republican, in a recent Senate floor speech after introducing his own resolution to leave. “Our interests and those of the WTO diverged long ago.” It’s doubtful that the measures could secure enough votes for passage in either chamber, and a tight legislative calendar makes the push for withdrawal doubly hard to pull off. But the rush for the exit is still a serious indication of deep and growing dissatisfaction with how global trade has evolved, highlighted by the vulnerability of cross-border supply chains that have begun to come apart under the stress of the COVID-19 pandemic. If the United States were to pull out of the system it helped build, the implications would be dire. Other countries would be able to discriminate against U.S. goods and services with no limits. Tariffs would almost certainly rise and export markets shrink. Meanwhile, others like China and the European Union would increasingly be in a position to write the rules of the future economy, from data protection and privacy to intellectual property and state subsidies. “We’d have no rights, and we’d lose a seat at the table,” said Wendy Cutler, a former U.S. trade negotiator now at the Asia Society. Why the big push now? For years, different aspects of the global trading system have stirred concern and at times anger in the United States and other countries; the WTO has essentially been stuck in place since the collapse of its last big negotiating round in 2008. For years, economists have debated the impact of the so-called “China shock” on U.S. jobs and manufacturing, and some evidence has shown that the competition from low-wage Chinese labor and the rapid movement of U.S. companies offshore hit the U.S. middle class harder than many economists expected. For years, Republicans have railed against international organizations—from the WTO to the International Criminal Court—that they see as encroaching on U.S. sovereignty. Now, all those forces have come together in a kind of imperfect storm.

#### A major country operating outside WTO consensus wrecks global trade norms

Bacchus 20 [James Bacchus, member of the Herbert A. Stiefel Center for Trade Policy Studies, the Distinguished University Professor of Global Affairs and director of the Center for Global Economic and Environmental Opportunity at the University of Central Florida, 12-16-2020, "An Unnecessary Proposal: A WTO Waiver of Intellectual Property Rights for COVID-19 Vaccines," Cato Institute, [https://www.cato.org/free-trade-bulletin/unnecessary-proposal-wto-waiver-intellectual-property-rights-covid-19-vaccines]/Kankee](https://www.cato.org/free-trade-bulletin/unnecessary-proposal-wto-waiver-intellectual-property-rights-covid-19-vaccines%5d/Kankee)

In a sign of their increasing frustration with global efforts to ensure that all people everywhere will have access to COVID-19 vaccines, several developing countries have asked other members of the World Trade Organization (WTO) to join them in a sweeping waiver of the intellectual property (IP) rights relating to those vaccines. Their waiver request raises anew the recurring debate within the WTO over the right balance between the protection of IP rights and access in poorer countries to urgently needed medicines. But the last thing the WTO needs is another debate over perceived trade obstacles to public health. Unless WTO members reach a consensus, the multilateral trading system may be further complicated by a delay like that in resolving the two‐​decades‐​old dispute between developed and developing countries over the compulsory licensing and generic distribution of HIV/AIDS drugs. A new and contentious “North‐​South” political struggle definitely would not be in the interest of the developed countries, the developing countries, the pharmaceutical companies, or the WTO. Certainly it would not be in the interest of the victims and potential victims of COVID-19. Background In early October 2020, India and South Africa asked the members of the WTO to waive protections in WTO rules for patents, copyrights, industrial designs, and undisclosed information (trade secrets) in relation to the “prevention, containment or treatment of COVID-19 … until widespread vaccination is in place globally, and the majority of the world’s population has developed immunity.”1 India and South Africa want to give all WTO members freedom to refuse to grant or enforce patents and other IP rights relating to COVID-19 vaccines, drugs, diagnostics, and other technologies for the duration of the pandemic. In requesting the waiver, India and South Africa have argued that “an effective response to the COVID-19 pandemic requires rapid access to affordable medical products including diagnostic kits, medical masks, other personal protective equipment and ventilators, as well as vaccines and medicines for the prevention and treatment of patients in dire need.” They have said that “as new diagnostics, therapeutics and vaccines for COVID-19 are developed, there are significant concerns, how these will be made available promptly, in sufficient quantities and at affordable prices to meet global demand.”2 Later in October, the members of the WTO failed to muster the required consensus to move forward with the proposed waiver. The European Union, the United States, the United Kingdom, and other developed countries opposed the waiver request.3 One WTO delegate, from the United Kingdom, described it as “an extreme measure to address an unproven problem.”4 A spokesperson for the European Union explained, “There is no evidence that intellectual property rights are a genuine barrier for accessibility of COVID‐​19‐​related medicines and technologies.”5 In the absence of a consensus, WTO members have decided to postpone further discussion of the proposed waiver until early 2021. Balancing IP Rights and Access to Medicines Not New to WTO This waiver controversy comes nearly two decades after the end of the long battle in the multilateral trading system over access to HIV/AIDS drugs. At the height of the HIV/AIDS crisis at the turn of the century, numerous countries, including especially those from sub‐​Saharan Africa, could not afford the high‐​priced HIV/AIDS drugs patented by pharmaceutical companies in developed countries. Having spent billions of dollars on developing the drugs, the patent holders resisted lowering their prices. The credibility of the companies, the countries that supported them, and the WTO itself were all damaged by an extended controversy over whether patent rights should take precedence over providing affordable medicines for people afflicted by a lethal disease. Article 8 of the WTO Agreement on the Trade‐​Related Aspects of Intellectual Property Rights (the TRIPS Agreement) provides that WTO members “may, in formulating or amending their laws and regulations, adopt measures necessary to protect public health … provided that such measures are consistent with the provisions of this Agreement.” In similar vein, Article 7 of the TRIPS Agreement provides that the “protection and enforcement of intellectual property rights” shall be “in a manner conducive to social and economic welfare.”6 It can be maintained that these two WTO IP rules are significantly capacious to include any reasonable health measures that a WTO member may take during a health emergency, such as a pandemic. Yet there was doubt among the members during the HIV/AIDS crisis about the precise reach of these provisions. As Jennifer Hillman of the Council on Foreign Relations observed, ordinarily the “inherent tension between the protection of intellectual property and the need to make and distribute affordable medicines” is “resolved through licensing, which allows a patent holder to permit others to make or trade the protected product—usually at a price and with some supervision from the patent holder to ensure control.”7 But, in public health emergencies, it may be impossible to obtain a license. In such cases, “compulsory licenses” can be issued to local manufacturers, authorizing them to make patented products or use patented processes even though they do not have the permission of the patent holders.8

#### US withdrawal from the WTO collapses global trade and causes WWIII

Hopewell and Horton 08-03 [Kristen Hopewell Associate Professor and Canada Research Chair in Global Policy at the University of British Columbia, and Ben Horton, Communications Manager; Project Lead, Common Futures Conversations, 08-03-2021, "Lessons from Trump’s assault on the World Trade Organization," Chatham House – International Affairs Think Tank, https://www.chathamhouse.org/2021/08/lessons-trumps-assault-world-trade-organization]/Kankee

What has this episode revealed about the strength of multilateral institutions such as the WTO, in the face of spoiling tactics from major powers? The WTO is unique amongst international institutions because it has a powerful enforcement mechanism – the dispute settlement system. However, the fundamental vulnerability is that if powerful states like the US and others won’t participate in the system and be bound by its rules, they quickly risk becoming irrelevant. And that’s the situation we’re in right now with the appellate body crisis, where, without a functioning mechanism to ensure that WTO rules are enforced, the entire system of global trade rules risk collapsing. Ironically, the United States has been the leader of the liberal trading order for the past 70 years, but since Trump, it has become its leading saboteur. What are the implications of a permanent collapse of the international trading system? The very real danger from such a breakdown is a return to what we saw in the 1930s. In response to the outbreak of the Great Depression, you had countries imposing trade barriers, blocking imports from other state, and a general escalation of tit-for-tat protectionism. This response wound up not only exacerbating the effects of the depression itself but has also been credited by some as paving the way for the outbreak of the second world war. The reason why institutions like the WTO were created in the first place was to prevent a recurrence of the 1930s protectionist trade spiral. The danger now – if those rules become meaningless and unenforceable – is the institutional foundations of postwar economic prosperity could unravel, throwing us back into economic chaos and potentially political disorder. What does the WTO’s future look like under new director-general Dr Okonjo-Iweala?

### 3

Judge, the Aff has made a serious violation in today’s debate. Normally, it is custom for all debaters to have a page on the High School LD Wiki page. This page is set up so that we are able to contact one another and exchange cases prior. Additionally, after rounds, we all post our documents that we read on the Wiki. Yet, my opponent not only has none of their documents on the Wiki, they do not have a page yet. This can be bad for a couple of reasons. First, this disclosure incentives good research because many debaters take inspiration from others. Second, since I have all of my documents on the Wiki, they are able to completely see what I have read in the past and prep me out. Now normally, this is a good thing if both debaters can do it since it encourages more clash and smarter debate, but since my opponent has no page, it is completely one sided, only they can prep me out and not the other way. Judge, my opponent today has broken this widespread norm that is quintessential in our debate community. So, what can we do? In order to set a norm that debaters should disclose ALL of their docs, you ought to vote neg for this violation by the aff.

## 4- case

Their case is extremely abusive. Judge, the topic for this Tournament is “Member nations of the WTO ought to reduce patent protections for medicine.” Yet, they constantly bring up the WHO, which is not mentioned in the resolution AT ALL.