## Resolved

### I affirm the resolution: The Member Nations of the World trade organization ought to reduce intellectual property protections for medicines. ,

**The value is Justice, defined as giving each their due, because the only reason to value anything else is because humans value it. This would concede that humans are valuable and deserving of what they need, thus affirming justice.**

**To ensure a just system, we must first ensure the system is all-inclusive and provides equal treatment for all parties involved. Thus, I provide the criterion of Minimizing Structural Oppression.**

**Winter and Leighton 99** (Deborah DuNann Winter and Dana C. Leighton. Winter: Psychologist that specializes in Social Psych, Counseling Psych, Historical and Contemporary Issues, Peace Psychology. Leighton: PhD graduate student in the Psychology Department at the University of Arkansas. Knowledgable in the fields of social psychology, peace psychology, and justice and intergroup responses to transgressions of justice) (Peace, conflict, and violence: Peace psychology in the 21st century.  Pg 4-5)

She argues that our normal perceptual cognitive processes divide people into in-groups and out-groups. Those outside our group lie outside our scope of justice. Injustice that would be instantaneously confronted if it occurred to someone we love or know is barely noticed if it occurs to strangers or those who are invisible or irrelevant. We do not seem to be able to open our minds and our hearts to everyone, so we draw conceptual lines between those who are in and out of our moral circle. Those who fall outside are morally excluded, and become either invisible, or demeaned in some way so that we do not have to acknowledge the injustice they suffer. Moral exclusion is a human failing, but Opotow argues convincingly that it is an outcome of everyday social cognition. To reduce its nefarious effects, we must be vigilant in noticing and listening to oppressed, invisible, outsiders. Inclusionary thinking can be fostered by relationships, communication, and appreciation of diversity. Like Opotow, all the authors in this section point out that structural violence is not inevitable if we become aware of its operation, and build systematic ways to mitigate its effects. Learning about structural violence may be discouraging, overwhelming, or maddening, but these papers encourage us to step beyond guilt and anger, and begin to think about how to reduce structural violence. All the authors in this section note that the same structures (such as global communication and normal social cognition) which feed structural violence, can also be used to empower citizens to reduce it. In the long run, reducing structural violence by reclaiming neighborhoods, demanding social justice and living wages, providing prenatal care, alleviating sexism, and celebrating local cultures, will be our most surefooted path to building lasting peace

**Prefer my criterion for three reasons:**

**[1] Combatting structural oppression is a prerequisite to all other theories, as there must be total moral inclusion before a theory can be deemed legitimate.**

**[2] Prioritizing oppressed peoples allows us to focus action on those who need it, as opposed to generally pursuing goods for all.**

**[3] Ignoring structural oppression in pursuit of abstract theories legitimizes oppression by prioritizing the pursuit of arbitrary moral goods over real world consequences.**

**Definitions available upon request.**

**Member** - one of the individuals composing a group. (Merriam-Webster)

**Nations** - a community of people composed of one or more [nationalities](https://www.merriam-webster.com/dictionary/nationalities) and possessing a more or less defined territory and government. (Merriam-Webster)

Topicality Arg - Carlson ‘77 explains “the English ‘bare plural’ (an NP with plural head that lacks a determiner), in spite of its apparently diverse possibilities of interpretation, is optimally represented in the grammar as a unified phenomenon.” This means that the usage of “nations” without giving an exact quantity to rely on should be assumed a “unified phenomenon,” or all-inclusive. Because of this, we are debating over all member nations of the WTO.

**World Trade Organization** - an international body founded in 1995 to promote international trade and economic development by reducing tariffs and other restrictions. (Oxford Dictionary)

**Ought** - Used to express obligation; a natural expectation. (Merriam-Webster)

Moral Obligation Counter - The definition of a “moral obligation” you are referring to is the definition of the noun form of ought on Merriam-Webster. The usage of ought in this prompt is as an auxiliary verb, so my definition is correct.

**Reduce** - to diminish in size, amount, extent, or number. (Merriam-Webster)

**Intellectual Property Protections** - protection for inventions, literary and artistic works, symbols, names, and images created by the mind. Learn how you can protect your intellectual property by using: [Examples are] Patents, Trademarks, Trade Secrets, and Copyrights. (Upcounsel)

**Medicines** - a substance or preparation used in treating disease. (Merriam-Webster)

**Price Gouging -** when the seller increases the prices of goods to a level much higher than is considered reasonable or fair.

### Contention 1: Price Gouging

#### Price Gouging is a healthcare catastrophe that must be solved, as it targets vulnerable groups that cannot avoid buying medicines.

<https://www.ncsl.org/research/financial-services-and-commerce/price-gouging-state-statutes.aspx>

### Subpoint A: Insulin

#### The Status Quo is killing thousands.

#### Insulin is priced horrifically high, forcing poor families into debt when it costs very little to make. The high cost forces people to even use it after expiration putting the patients in danger.

**Magee 20**

Erinne Magee. [Magee is an expert writer for the boston globe with multiple books exposing horrific corporate schemes]. February 24th, 2020. “Big pharma’s unconscionable insulin racket endangers people with diabetes”. Accessed 8/30/21. <https://www.bostonglobe.com/2020/02/24/magazine/big-pharmas-unconscionable-insulin-racket-endangers-people-with-diabetes/> // js69

Some diseases kill because they’re so aggressive, or medicine simply doesn’t work. But other diseases — like the type 1 diabetes my 10-year-old daughter was diagnosed with three years ago — can be 100 percent effectively managed by medicine. Yet people are still dying from type 1 diabetes because insulin, the drug they need to survive, is so expensive. Just before Lexi was diagnosed, we noticed she was experiencing an unquenchable thirst, frequent trips to the bathroom, weight loss, and extreme hunger. She also looked tired and lacked energy. When I called the doctor, I was told to immediately pick her up from school and bring her to a walk-in care facility. That day, my daughter unwillingly joined the ranks of about 1.25 million other Americans with type 1 diabetes—one more among the 40,000 diagnoses made each year, according to estimates by the nonprofit organization BeyondType1.Org. A vial of insulin costs just a few dollars to manufacture. Depending on the body’s sensitivity to insulin, a person may need several vials each month. My daughter, who is 80 pounds soaking wet, uses just over one vial per month. The cost of insulin is highest in Maine, where my family lives, analysis by the nonprofit Health Care Cost Institute found. In 2016 a 40-day supply ran $865; in California, it was less than half that. My family is “lucky” — we’ve made personal and professional choices, some that we question every day, so that we have access to insulin for our daughter and don’t have to ration it. But 1 in 4 US patients rations insulin because of cost, according to T1International, a nonprofit advocacy organization [PDF]. Some parents have to work more than one job — they post on Twitter about becoming drivers for Lyft, Uber, or DoorDash on nights and weekends; some even consider selling their homes to cover the costs of medication for their children. Others will go bankrupt. “No matter how many jobs you have, the credit card debt for the annual expense of $12,000 for just insulin, is absurd,” says Nathan Loewy, a father in Minnesota who, along with his son, has type 1 diabetes. “Between holding multiple jobs, working side jobs, maxing out credit cards, and, at times, relying on the black market to make it to the next month, we have survived. However, we are not unscathed,” he told me via e-mail. Loewy’s wife has type 2 diabetes. After paying their $5,000 deductible, the family still has insulin bills for about $7,000 out of pocket for the remainder of the year. Other necessary items not covered include blood glucose test strips, continuous glucose monitors, and insulin pump supplies. Patients are told to discard opened insulin after 30 days because it loses potency. Of course, when you’re dealing with liquid gold, not everyone abides by the expiration date. More people in the United States ration their insulin than in other countries, The Boston Globe reported. Some survive this constant experiment; some don’t. They can land in the emergency room if they’ve waited too long and their blood is already becoming acidic. Not only is this life-threatening, it also takes up beds and doctors’ time solely to get insulin. This is a real fear for parents, especially as children become adults and need their own health insurance. “Having to reassure a child that they will not end up having to ration their insulin is heart-breaking,” says Loewy, “especially when I cannot guarantee that to be true, as **big pharma** has made it clear that they **value[s] profits over patients**.”

**Understand that**

<https://www.liebertpub.com/doi/10.1089/dia.2018.0101#:~:text=Thus%2C%20cumulatively%20we%20have%20about,people%20requiring%20insulin%20therapy%20worldwide>.

150–200 million people require insulin therapy worldwide.

### Impact: The Aff Solves with lower prices

#### Patents allow a “government sanctioned monopoly” on insulin – looser IP laws would substantially decrease the cost of insulin – research and manufacturing costs are very low now

**Johnson 18** [Judith A. Johnson, Specialist in Biomedical Science Policy at Congressional Research Service with an MS in molecular biology from Yale, 11-19-2018, “Insulin Products and the Cost of Diabetes Treatment,” Congressional Research Service, https://fas.org/sgp/crs/misc/IF11026.pdf]/

Insulin is a hormone that regulates the storage and use of sugar (glucose) by cells in the body. When the pancreas does not make enough insulin (type 1 diabetes) or it cannot be used effectively (type 2 diabetes), sugar builds up in the blood. This may lead to serious complications, such as heart disease, stroke, blindness, kidney failure, amputation of toes, feet, or limbs. Prior to the discovery of insulin treatment, type 1 diabetics usually died from this disease. There were 23.1 million diagnosed cases of diabetes in the United States in 2015 according to the Centers for Disease Control and Prevention (CDC). Adding an estimated 7.2 million undiagnosed cases brings the total to 30.3 million (9.4% of U.S. population). People with type 1 diabetes, about 5% of U.S. cases, must have insulin injections to survive. For those with type 2 diabetes, about 95% of cases, many can control their blood glucose by following a healthy diet, losing weight, maintaining regular physical activity, and taking oral medications, but some require insulin injections to control their blood glucose levels. Data collected in the 2010-2012 National Health Interview Survey from diabetics aged 18 or older indicate that 14% are treated with insulin alone, 14.7% are treated with both insulin and oral medication, 56.9% are treated with oral medication alone (not insulin), and 14.4% are not treated with either medication. The price of various insulin products has risen significantly. From 2001 to 2015, the price of one type of insulin (insulin lispro) increased 585% (from $35 to $234 per vial). One vial might last a patient less than two weeks. Given the number of Americans dependent on insulin, Congress may be interested in considering whether consumers have access at a reasonable cost. Insulin Discovery and Development Insulin was discovered nearly a century ago, in 1921, by researchers at the University of Toronto; their U.S. patent was later sold to the university for $1. Manufacturing challenges resulted in collaboration with Eli Lilly in 1923 in order to make enough insulin for the North American market. They also licensed the right to produce insulin to other firms including a Danish company which eventually became Novo Nordisk. Insulin is a small protein composed of 51 amino acids. Because it is made from a living organism, it is considered to be a biologic, or biological product. Like many other biologics (such as drugs or vaccines), insulin was obtained in the past by extraction from animals. Production has changed over the years as researchers have made alterations to insulin, easing its use by the patient. The ideal treatment regimen for diabetics would closely mimic the way insulin secretion occurs in the body. This would involve a consistent insulin level between meals combined with a mealtime level of insulin that has a rapid onset and duration of action to match the glucose peak that occurs after a meal. The original insulin, also called regular insulin, is a short-acting type of product with a duration of action of about 8 hours, making it less suitable for providing 24-hour coverage. In the late 1930s through the 1950s, regular insulin was altered by adding substances (protamine and zinc) to gain longer action; these are called intermediate-acting insulins. One such advance (neutral protamine Hagedorn, or NPH) was patented in 1946 and is still in use today. It allowed for the combination of two types of insulin in premixed vials (intermediate-acting and regular insulin), making a single daily injection possible for some patients. In 1982, recombinant DNA technology allowed for the replacement of animal insulin extracted from cattle and pig pancreases by human insulin (Humulin R) made in a laboratory fermentation process using microorganisms. These advances still did not mirror the normal release of insulin. Over the past few decades, slight modifications of the insulin molecule—called insulin analogs—have been developed. This has resulted in five types of insulin products on the market: long-acting, rapid-acting, intermediate-acting, short-acting (regular insulin), and premixed. In the early 2000s, the long-acting insulin analogs, Lantus (insulin glargine) and Levemir (insulin detemir), entered the market. In addition, the rapid-acting insulin analogs Humalog (insulin lispro) and Novalog (insulin aspart) were developed to allow for quicker absorption and shorter duration of action at mealtime. The insulin analogs more closely replicate normal insulin patterns in the body and resulted in a greater number of patients using these new products. In 2000, of privately insured adults with type 2 diabetes using insulin, 19% were using analog insulins; by 2010, 96% were using these products. Studies indicate that the more expensive [insulin] analogs does] not seem to provide any advantage over regular insulin in controlling glucose levels or preventing diabetes-related complications, but they are more convenient for the patient. Insulin Regulation and Production In the past, all biologics, including insulin, were regulated by the National Institutes of Health (or its precursors) under the Public Health Service Act (PHSA). In 1941, Congress gave the Food and Drug Administration (FDA) authority over the marketing of insulin. As a result, insulin has been regulated as a drug under the Federal Food, Drug, and Cosmetic Act (FFDCA) rather than as a biologic under the PHSA. In the United States “generic” insulin products are referred to by FDA as “follow-on” products and are not called biosimilars (which are regulated under the PHSA). However, under a provision of the Biologics Price Competition and Innovation Act (BPCIA) of 2009, biologics approved as drugs under the FFDCA will transition to biological licenses under the PHSA in March 2020. BPCIA was enacted as Title VII of the Patient Protection and Affordable Care Act (ACA, P.L. 111-148). Currently, [Recognize that] three firms—Eli Lilly, Novo Nordisk, Sanofi Aventis—account for over 90% of the **global** insulin market and produce the entire insulin supply for diabetic patients in the United States. For the most part, insulins produced by these companies are brand-name drugs. In general, brandname drugs cost more because the drug manufacturer has free reign in setting the drug price due to a government sanctioned monopoly for a defined period of time. Branddrugs are protected from market competition by (1) patents issued by the U.S. Patent Office and (2) a regulatory exclusivity period granted by FDA under the Drug Price Competition and Patent Term Restoration Act of 1984 (P.L. 98-417), also called the Hatch-Waxman Act. According to some analysts, lack of price competition in the U.S. insulin market is a contributor to the high cost of this vital drug. The price of a drug is directly affected by the number of different manufacturers marketing the drug. According to an FDA analysis of generic chemical drugs, “the first generic competitor prices its product only slightly lower than the brand-name manufacturer. However, the appearance of a second generic manufacturer reduces the average generic price to nearly half the brand name price. As additional generic manufacturers market the product, the prices continue to fall, but more slowly. For products that attract a large number of generic manufacturers, the average generic price falls to 20% of the branded price and lower.” One “generic” insulin product—or what FDA calls a “follow-on” product—is being marketed in the United States. Eli Lilly received tentative approval for Basaglar from FDA in August 2014. Final approval occurred in December 2015 following resolution of patent issues with Sanofi-Aventis, maker of the brand product, Lantus (insulin glargine). The Basaglar application was submitted to FDA under Section 505(b)(2) of the FFDCA and relied on the FDA’s finding of safety and effectiveness for Lantus. Eli Lilly began marketing Basaglar in the United States in December 2016; by the end of December 2017, Basaglar had captured about 17% of the U.S. Lantus volume share. Because three firms manufacture all the insulin used in this country, the market behaves differently from the usual case in pharmaceutical markets where generic competition results in price reductions following patent expiration and the end of the exclusivity period granted by FDA under Hatch-Waxman. Basaglar, the only follow-on insulin available in the United States, is made by one of the three insulin-making firms, Eli Lilly. Basaglar’s approval has not resulted in a new insulin manufacturer on the U.S. market. Industry observers believe that as other pharmaceutical companies enter the insulin market, price reductions may begin to occur. In July 2017, FDA granted tentative approval to a second insulin glargine product, Lusduna Nexvue, made by Merck. However, in October 2018 Merck announced that it is discontinuing Lusduna. Some industry analysts believe Merck’s decision was due to the drug rebates offered by the three manufacturers of insulin products. For drugs such as insulin with a high list price, manufacturers may use a high rebate to gain placement on an insurance company formulary. This results in making the drug more affordable for insurance plans, but the drug remains expensive for the uninsured, as well as for those with high cost-sharing insurance plans. Price of Insulin, Cost of Manufacture, and Profit The price of a drug often has very little basis in the cost of manufacturing a drug. Also, it is very rare to find data on manufacturing costs; this is considered to be proprietary information. However, a 1995 paper in Biotechnology and Bioengineering focused on the process used by Eli Lilly in the commercial production of insulin using E. coli bacteria. The authors found that [This is good as] the total cost involved in making enough insulin to treat one patient per year is $33.60. This amount would be altered by inflation, but would be offset by process improvements. Most of the manufacturing cost (94.2%) is associated with the recovery and purification of insulin; the remainder (5.8%) is the fermentation process using E. coli. The economic analysis includes the cost of raw materials, product separation materials, facility overhead (depreciation and maintenance of the facility), treatment and disposal of waste materials, and labor of plant operators and laboratory scientists who perform analysis of the process and product (quality control/quality assurance). It does not account for other costs, such as the cost of vialing and quality assurance of vialing, distribution costs, promotion and advertising costs, and briefly mentions research and development cost recapture. In the case of insulin, however, much of the initial basic research—original drug discovery and patient trials—was performed 100 years ago. Other more recent costs, such as developing the recombinant DNA fermentation process (over 35 years ago) and the creation of insulin analogs (about 20 years ago) may account for some portion of the current price of insulin products, but exactly how much is known only by the manufacturers. The pricing of insulin could also reflect accounting for research costs of other drug products, both the past costs of drugs that were not successful as well as future products that are currently under development. A September 2018 study published in BMJ Global Health calculates that a year’s supply of human insulin could be $48 to $71 per person and between $78 and $133 for analog insulins; this amount would cover production costs and still deliver a profit to the manufacturer. How much profit is fair is another piece of the drug pricing puzzle. A November 2017 Government Accountability Office (GAO) report found that the average profit margin was 20% in 2015 for the largest 25 drug companies, compared with 6.7% for the largest 500 companies in general. The three insulin manufacturers are among the largest 25 drug companies.

**Reducing IPR can save or improve the lives of every single diabetic in the US, as Furst ‘20 explains** <https://newsnetwork.mayoclinic.org/discussion/high-cost-of-insulin-has-life-or-death-implications-for-diabetic-patients/>Mayo Clinic is medical news so it’s very reliable for this /// Seq WL

The commentary by [S. Vincent Rajkumar, M.D.](https://www.mayo.edu/research/faculty/rajkumar-s-vincent-m-d/bio-00085953), a Mayo Clinic physician, describes the cost of insulin as an urgent public health issue. "There are 30 million patients with diabetes in the United States, and about 25%, or 7.4 million Americans, need insulin. For the 1.3 million patients with Type 1 diabetes, insulin is as vital as air and water. Some patients are rationing insulin or switching to cheaper forms without proper supervision. We cannot wait to act." The commentary appears in the January issue of Mayo Clinic Proceedings, which focuses on diabetes and the discovery of insulin in 1921. The use of insulin to treat diabetes has transformed the lives of millions of people, but the sharp cost increase in recent years has threatened patient care. Insulin is a naturally occurring hormone that helps regulate blood sugar levels. [Insulin therapy](https://www.mayoclinic.org/diseases-conditions/diabetes/in-depth/insulin/art-20050970) is vital for people with [Type 1 diabetes](https://www.mayoclinic.org/diseases-conditions/type-1-diabetes/symptoms-causes/syc-20353011) and for many patients with [Type 2 diabetes](https://www.mayoclinic.org/diseases-conditions/type-2-diabetes/symptoms-causes/syc-20351193). Type 1 diabetes is a chronic condition where the pancreas produces little or no insulin. With Type 2 diabetes, the body resists the effects of insulin or doesn't produce enough to maintain normal glucose levels. Long-term complications can be debilitating and life-threatening. "There have been many recent reports of deaths in patients with Type 1 diabetes because of the lack of affordable insulin," Dr. Rajkumar says. "The high prevalence of diabetes, the chronic lifelong nature of [diabetes] the disease, and the fact that patients with Type 1 diabetes will die without access to insulin make[s] this an urgent problem that must be solved expeditiously." "The No. 1 reason for the high cost of insulin is the presence of a vulnerable population that needs insulin to survive," he says. "This population is willing to pay almost anything to have access to a lifesaving drug, and manufacturers know it.

<https://www.who.int/news-room/fact-sheets/detail/diabetes#:~:text=In%202019%2C%20an%20estimated%201.5,high%20blood%20glucose%20in%202012>.

In 2019, an estimated 1.5 million deaths were directly caused by diabetes

### Subpoint B: Hepatitis

#### The treatment of Harvoni costs more than any infected Hepatitis C victim can pay, especially when it is most common in poorer areas. due to it spreading mostly through unclean medical instruments according to director of Global Health Law at Georgetown Gian Burci in 2017 writes,

Burci, G. L. [Gian Luca Burci is Adjunct Professor of international law at the Graduate Institute of International and Development Studies, Geneva since 2012. He is also the Director of the joint LLM on Global Health Law and Governance between the Graduate Institute and Georgetown Law School, as well as Academic Adviser in the Global Health Centre of the Graduate Institute.] [(2017). Privatized Pharmaceutical Innovation vs Access to Essential Medicines: A Global Framework for Equitable Sharing of Benefits. JAMA: Journal of the American Medical Association, 317(5), 473–474. [https://doi.org/10.1001/jama.2016.17994 //](https://doi.org/10.1001/jama.2016.17994%20//) js69

The effect of the current privatized model of pharmaceutical innovation on the development and affordability of lifesaving vaccines and medicines has been an enduring source of conflict. The need to promote and reward the development of new drugs and devices through patent protection—and the high prices this promotion and protection generate[s]—seem to adversely affect equitable access to essential medicines and the right to health. Throughout the world, even in the United States, the high cost of pharmaceuticals provokes controversy, as is evident with the pricing of the epinephrine injection (EpiPen) and ledipasvir/sofosbuvir (Harvoni). The global landscape on innovation and access to medicines is fragmented and inequitable. The price of antiretroviral agents to treat human immunodeficiency virus/AIDS, for example, has declined precipitously, but equally important medicines cost far too much for health care systems. For example, in the United States, the price of a standard nondiscounted [a] 12-week course of Harvoni to treat hepatitis C is $84 000 [84 thousand dollars]. The [status quo] privatized model for pharmaceutical innovation also is not producing treatments for neglected diseases such as dengue [fever] and leishmaniasis, vaccines for diseases with pandemic potential such as Ebola, and new antimicrobials to address the growing problem of drug resistance. On September 14, the United Nations Secretary-General’s High-Level Panel on Access to Medicines sought to close the gap between privatized innovation and affordability of pharmaceuticals.1 Intense disagreements between public interest organizations and industry—between high- and lower-income countries—revealed the entrenched economic and social interests at stake, with the outcome potentially affecting millions of lives. The disagreements became evident on November 8, when the World Trade Organization (WTO), the international organization managing the global rules of trade and adjudicating trade disputes, discussed the high-level report. The findings of the report were also considered, and generated disagreement and heated discussions, in the UN General Assembly and the Programme Coordinating Board of UNAIDS, the UN Joint Programme on HIV/AIDS. The report has also been proposed for discussion in the World Health Organization (WHO) Executive Board at the end of January 2017. In this Viewpoint we offer a global framework to foster coherence, enhancing incentives for innovation while ensuring equitable access. Promoting Innovation: What Will It Take? Reform proposals to promote innovation for development of products for treating neglected diseases while increasing affordability seek to delink pharmaceutical prices from research and development (R&D), thus reducing industry’s dependence on high prices based on patent monopolies to recoup R&D costs. First, governments could offer public investments, tax breaks, or both, for basic R&D or financial rewards for discoveries that save the most lives. Second, public-private development partnerships, such as the Medicine for Malaria Venture,2 expend public and philanthropic funds to engage industry and academia in undertaking R&D to develop products for treatment of neglected diseases. Third, donors could offer advance market commitments, guaranteeing manufacturers a market by purchasing vaccine production at a high fixed price in return for their commitment to offer doses to lower-income countries at a low price.3

### Impact: The Aff solves for Harvoni’s inaccessibility

**CDC ‘21 states** <https://www.cdc.gov/hepatitis/global/index.htm> it’s the CDC, it’s qualified /// Seq WL

296 million people worldwide are living with hepatitis B

58 million people worldwide are living with [have] hepatitis C

1.5 million people were newly infected with chronic hepatitis B

1.5 million people were newly infected with chronic hepatitis C

Both hepatitis B and hepatitis C can lead to lifelong infection. [The] WHO estimates that 1.1 million deaths occurred in 2019 due to these [hepatitis] infections and their effects including liver cancer, cirrhosis, and other conditions caused by chronic viral hepatitis ([1](https://www.cdc.gov/hepatitis/global/index.htm#ref01)).

#### Solvency: Harvoni becoming accessible under the Aff is proven with the expiration of the Truvada patent as Highleyman 21 says,

Highleyman, Liz. “Cheaper Generic Prep Now Available in the United States.” POZ, 21 May 2021, w[ww.poz.com/article/cheaper-generic-prep-now-available](http://www.poz.com/article/cheaper-generic-prep-now-available). // js69

Multiple generic formulations of tenofovir disoproxil fumarate/emtricitabine—the equivalent of Truvada—are now available in the United States for HIV treatment and prevention, leading to a dramatic drop in the price of [pre-exposure prophylaxis (PrEP)](https://www.poz.com/tag/prep). The Food and Drug Administration approved Gilead Sciences’ Truvada for HIV treatment in 2004 and for prevention in 2012. But the coformulation of tenofovir disoproxil fumarate (TDF) and emtricitabine was protected by patents, and the brand-name cost [was] has been around $1,600 to [$21,600 a year] $1,800 per month. Under pressure from [advocates](https://www.poz.com/article/cdc-patent-prep-advocates-find) and the [U.S. government](https://www.poz.com/article/new-twist-gilead-patent-lawsuit-truvada-descovy-prevent-hiv), Gilead reached an agreement with Teva Pharmaceuticals to allow the Israeli company exclusive rights to sell a generic version of Truvada in the United States a year before the patent on emtricitabine was set to expire. Teva’s generic product [hit the U.S. market](https://www.poz.com/article/first-generic-truvada-now-available-united-states) in October 2020, but at about $1,455 a month, it undercut the cost of brand-name Truvada by only a couple of hundred dollars. “Historically, when there’s only one generic manufacturer in the field, the price difference is a minuscule 10% to 15%,” Tim Horn, the director of medication access and pricing at NASTAD told POZ. “The real savings for all purchasers and payers won’t begin until there’s robust generic competition.” That time has now arrived. Teva’s six-month window of exclusivity expired in March, and [at least eight additional](https://www.drugs.com/availability/generic-truvada.html) generic TDF/emtricitabine products— [were] made by companies including Aurobindo, Cipla and Mylan—are currently available. Generic drugs are tested for pharmacological equivalence, and they are [just] as safe and effective[.] as their brand-name counterparts. As expected, the increased competition has led to a steep decline in prices. According to drug price comparison sites, such as [GoodRx.com](https://www.goodrx.com/truvada) and [RxSaver.com](https://www.rxsaver.com/drugs/emtricitabine-tenofovir-disoproxil-fumarate/coupons), generic Truvada can be purchased for as little as [is $828 a year] $69 per month with discount coupons.

#### Vote Aff on this contention because accessibility to treatments is removed from people of lower income. Only Aff offers a way to save people with neglected diseases like Hep. C, ultimately alleviating structural violence.

### Contention 2: Poor Countries

#### Viruses place everyone at risk - resource disparities threaten communities with less access to medicine according to UNICEF in 2021

, UNICEF. [UNICEF, also known as the United Nations Children’s Fund, is` a United Nations agency responsible for providing humanitarian and developmental aid to children worldwide. The agency is among the most Compulsory licensing is a death warrant for thousands of people.

Rathod & Barot 21, Manvi Rathod is a final year law student studying at Pravin Gandhi College of Law, Mumbai

(India). She is keenly interested in Intellectual Property Rights, International Human Rights, and International Relations &

Keiya Barot is a final year law student studying at Pravin Gandhi College of Law, Mumbai (India). She is keenly interested

in Intellectual Property Rights, International Human Rights, and International Relations, “India and South Africa’s COVID

Vaccine Proposal to the WTO: Why Patent Waiver Must Be Considered Over Compulsory Licensing,” IP Watchdog, January

2, 2021, https://www.ipwatchdog.com/2021/01/02/india-south-africas-covid-vaccine-proposal-wto-patent-waiver-must-

considered-compulsory-licensing/id=128652/

Another reason cited for opposing the proposal was that the TRIPS Agreement already has flexibility protocols to combat

public health emergencies, such as compulsory licensing. Compulsory licensing ensures the use of a

patent without authorization from the patent holder in cases of national emergency

and for public non-commercial use, thus allowing governments to make generic versions of

medications without the patent holder’s consent. However, while the developing countries tout

compulsory licensing as the solution to the problem of procurement, this solution will be an ineffective one for more than

one reason. TRIPS allows for “adequate remuneration” to be paid to the patent holder in accordance with the economic

value of the authorization. However, TRIPS does not provide the exact definition of what is “adequate” and how to compute

the “economic value” of the authorization. Not only this, manufacturers can only produce predefined

quantities in each compulsory license, limiting large-scale production and mass-

inoculation. The ability of the patent holders and their governments to fix a high remuneration based on the high

economic value of the COVID-19 vaccine could widen the gap between the least developed nations and their ability to access

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the vaccines. World Bank Chief Economist Joseph Stiglitz rightly described TRIPS as

“a death warrant for thousands of people in the poorest countries of the world.”

This means that the most discussed alternative to affirming, compulsory licensing, will

result in the deaths of thousands, if not millions. Affirming may not be a panacea but it is

a step in the right to direction to saving these lives and so we must affirm.

widespread and recognizable social welfare organizations in the world, with a presence in 192 countries and territories.] "COVID-19 Vaccines: 5 Reasons Why Dose Donations Are Essential." UNICEF. 2021. Web. August 18, 2021. <https://www.unicef.org/coronavirus/covid-19-vaccines-whydose- donations-are-essential>. // js69

COVID-19 doesn’t discriminate, and the dangerous surges in infection rates and the emergence of new variants in some countries places everyone at risk. The development of safe and effective COVID-19 vaccines is a huge step forward in the global effort to end the pandemic and to get back to doing more of the things we enjoy with the people we love. But there is currently a limited number of vaccines, so it’s critical to prioritize vaccinations to save lives and to protect public health services in all countries. The COVAX Facility – the global COVID vaccine equity scheme – represents a pathway toward addressing the imbalance in vaccine access between high and low-income countries. [However,] COVAX is undersupplied.

#### Countries such as India are suffering from an economic crisis due to the IPR as Pai 21 says,

Pai, Madhukar, and Manu Prakash. “Opinion | India's Covid-19 Crisis Is a Dire Warning for All Countries.” The Washington Post, WP Company, 30 Apr. 2021, www.washingtonpost.com/opinions/2021/04/30/indias-covid-19-crisis-is-dire-warning-all-countries/. [Madhukar Pai is a professor of epidemiology and global health at McGill University. Manu Prakash is an associate professor of bioengineering at Stanford University’s Center for Innovation in Global Health. ] // js69

The covid-19 crisis in India is a massive setback for the entire world. The scale of the nation’s surge is a warning not only for its neighboring countries, which are also experiencing sharp increases in cases, but also for countries around the globe. If we do not heed this warning and work on vaccine equity, we risk a forever pandemic with long-term cycles of lockdowns, economic damage and constant fear. India is reporting more than 380,000 cases and 3,500 deaths daily. Both are underestimates. The Indian health-care system is completelyoverwhelmed. It is impossible to find hospital beds. Supplies such as oxygen are incredibly scarce, and there is a huge backlog with diagnostic testing. Many people with sick family members and friends in India — including us — are checking in on them. This time around, younger people are sick and, as is always the case, the poor are hit the hardest. The devastating second wave in India is the [as the] result of a perfect storm: a failure to plan for a second wave; premature relaxation of public health measures; large gatherings; insufficient vaccination. coverage; and newer variants such as B.1.1.7 and B.1.617 that are highly transmissible and potentially more severe. India has 95,000 intensive care beds and 48,000 ventilators. By mid-May, it is projected that the country will need 340,000 beds and more than 700,000 ventilators. Rural India has few of these and is already hit hard. India needs the global community’s support to survive this crisis. Even as India struggles to get the second wave under control, cases are surging among India’s neighbors;, including Nepal, Pakistan, Bangladesh and Sri Lanka. While the exact variant driving the new surges among India’s neighbors is unclear, the B.1.617 variant has already spread to more than 18 countries. Other countries in South Asia have far less resources and medical infrastructure compared with India. Nepal, for example, has 1,486 ICU beds and 634 ventilators , and Nepal’s health ministry is anticipating a need to treat 15,000 ICU patients by July. Bangladesh, home to 163 million people, has only 1,134 covid-19 ICU beds. Pakistan, the fifth-largest country in the world, has fewer than 4,000 ventilators. India’s neighbors can ill afford the kind of devastation India is experiencing. Vaccination coverage in these countries is too low to prevent surges. Pakistan, Bangladesh and Nepal have vaccinated 1 percent, 3.5 percent and 7 percent of their populations, respectively, with a single dose. And vaccination numbers are not likely to ramp up soon, given that India is now prioritizing domestic vaccination efforts. India’s vaccine supply to Covax, the World Health Organization’s initiative to send vaccines to developing countries, is now in jeopardy. Another truly frightening scenario is the [we will deal with] spread of the more transmissible and lethal variants. to low-income countries, especially on the South American and African continents. The uncontrolled outbreak in Brazil (driven by the aggressive P.1 variant) has already posed a threat for many South American countries. Most countries in Africa have limited health infrastructure and cannot possibly deal with the severe disease typical of the newer variants. As the variant that emerged in South Africa has shown, the continent has limited capacity for such surges. It is estimated that there are fewer than 2,000 ventilators across 41 African countries. Ten African countries have none at all. Only about 2 percent of the vaccine doses administered to date globally have been in Africa, and poorer countries might not be vaccinated until 2024. The entire continent is therefore highly vulnerable to the newer variants that are causing havoc in Asia and South America. If African leaders and the general public give up on public health measures, they might see the kind of devastating surge that South Asia is experiencing. No country is safe. It has become painfully clear that newer variants of the virus have transformed the nature of this pandemic. We cannot just vaccinate rich countries and hope that we will be safe. The only way to end this pandemic is to end it everywhere. Otherwise, we will forever play whack-a-mole with a constantly mutating virus. History will not be kind to us if we do not ensure global access to covid-19 vaccines. The rollout of highly effective vaccines in record time is one of the greatest triumphs of science. But the [we are facing the] hoarding of vaccines and roadblocks around sharing raw materials. and information on how to make these vaccines globally will be seen as our biggest strategic mistake. Global leaders must collaborate, waive intellectual property rights, share technology, and allow and support more countries to manufacture vaccines. Sharing of the mRNA vaccine recipe is critical, since these vaccines can be quickly redesigned to keep up with the newer variants. India is a cautionary tale for the world. It is proof that we cannot fight this pandemic country by country. By the time we put out one fire, we will have to fight another. World leaders must think beyond their borders and do the right thing for all of humanity.

#### Worldwide COVID deaths aren’t slowing down and government reports are horrifically inaccurate due to a lack of testing in poorer areas which have the highest impact of COVID, totalling to 7 million but very likely higher as Sullivan 21 writes,

Sullivan, Becky. “New Study Estimates More than 900,000 People Have Died of COVID-19 In U.S.” NPR, NPR, 6 May 2021, [www.npr.org/sections/coronavirus-live-updates/2021/05/06/994287048/new-study-estimates-more-than-900-000-people-have-died-of-covid-19-in-u-s. //](http://www.npr.org/sections/coronavirus-live-updates/2021/05/06/994287048/new-study-estimates-more-than-900-000-people-have-died-of-covid-19-in-u-s.%20//) js69

A new study estimates that the number of people who have died of COVID-19 in the U.S. is more than 900,000, a number 57% higher than official figures. Worldwide, the study's authors say, the COVID-19 death count is nearing 7 million, more than double the reported number of 3.24 million. The analysis comes from researchers at the University of Washington's Institute for Health Metrics and Evaluation, who looked at excess mortality from March 2020 through May 3, 2021, compared it with what would be expected in a typical nonpandemic year, then adjusted those figures to account for a handful of other pandemic-related factors. The final count only estimates deaths "caused directly by the SARS-CoV-2 virus," according to the study's authors. SARS-CoV-2 is the virus that causes COVID-19. Researchers estimated dramatic undercounts in countries such as India, Mexico and Russia, where they said the official death counts are some 400,000 too low in each country. In some countries — including Japan, Egypt and several Central Asian nations — the Institute for Health Metrics and Evaluation's death toll estimate is more than 10 times higher than reported totals. "The analysis just shows how [it is] challenging it has been during the pandemic to accurately track the deaths — and actually, transmission — of COVID. And by focusing in on the total COVID death rate, I think we bring to light just how much greater the impact of COVID has been already and may be in the future," said Dr. Christopher Murray, who heads the Institute for Health Metrics and Evaluation. The group reached its estimates by calculating excess mortality based on a variety of sources, including official death statistics from various countries, as well as academic studies of other locations. Then, it examined other mortality factors influenced by the pandemic. For example, some of the extra deaths were caused by increased opioid overdoses or deferred health care. On the other hand, the dramatic reduction in flu cases last winter and a modest drop in deaths caused by injury resulted in lower mortality in those categories than usual. Researchers at UW ultimately concluded that the extra deaths not directly caused by COVID-19 were effectively offset by the other reductions in death rates, leaving them to attribute all of the net excess deaths to the coronavirus. "When you put all that together, we conclude that the best way, the closest estimate, for the true COVID death is still excess mortality, because some of those things are on the positive side, other factors are on the negative side," Murray said.

#### And in India the death toll is drastically rising and is likely to stay that way Kapur 21 writes,

Kapur, Manavi. “A New Estimate of Covid-19 Deaths in India Could DOUBLE 2021's Global Toll.” Quartz, Quartz, 29 July 2021, qz.com/india/2039756/indias-actual-covid-19-death-toll-could-be-eight-times-higher/. // js69

If India was to accurately account for all the Covid-19 deaths in the country, it would likely double the confirmed global death toll. for 2021. The country may have undercounted its pandemic fatalities by seven or eight times., A [new study](https://doi.org/10.1101/2021.07.20.21260872) conducted by researchers in India, Canada, and the US has found. This would take India’s Covid-19 mortality from [the official 422,022](https://www.mohfw.gov.in/) to between 3.1 and 3.4 million. To date, the World Health Organization (WHO) estimates [4.18 million people](https://covid19.who.int/) have died of Covid-19, of which about 2 million were in 2021. During India’s brutal second wave of Covid-19 in the months between April and June, public health experts, human rights activists, and the international community blamed the Narendra Modi government [for undercounting deaths](https://qz.com/india/2008973/why-is-india-undercounting-its-covid-19-deaths/). The sense was that several deaths were not being attributed to [Covid-19](https://qz.com/re/covid-19/), while the country’s crematoriums and makeshift riverside graveyards [revealed a ghastly side](https://qz.com/india/2009723/how-journalists-are-exposing-indias-true-covid-19-death-toll/) of India’s Covid crisis. “We recognise that multiple challenges lead to underreporting of Covid-19 fatalities including deaths that occur outside of hospitals that either are not captured or incur a lag, deaths that are classified under comorbid illnesses, deaths that are attributable to low access to quality healthcare or a shortage of healthcare resources, and deaths that are undetected as a result of an inadequate COVID-19 testing programme,” researchers, including noted epidemiologists Giridhara R Babu and Bhramar Mukherjee, [wrote in the American Journal of Public Health](https://doi.org/10.2105/AJPH.2021.306419) (AJPH) on July 27. “Our review of the existing evidence suggests that the problem is particularly acute for India, where a large number of deaths (especially ones happening outside a healthcare facility or in rural areas) routinely remain medically unreported,” they said.

#### However, the Aff increases vaccine production in India which helps solve the spread. Thrasher in 21 writes,

Thrasher, Rachel. “How Will Everyone Benefit If WTO Members Sign the TRIPS COVID-19 Waiver?” Open Access Government, 15 Feb. 2021, [www.openaccessgovernment.org/trips-covid-19-waiver/103738/](http://www.openaccessgovernment.org/trips-covid-19-waiver/103738/). [researcher with the Boston University Global Development Policy Center. She works on policy issues related to trade and investment agreements, trade law and development, economic relations between developing countries, and multilateral environmental agreements. She is the author of Constraining Development: The Shrinking of Policy Space in the International Trade Regime (Anthem, forthcoming, July 2021).] // js69

\*Brackets in original article

At the informal meeting of the Council for the Agreement of Trade-Related Aspects of Intellectual Property (TRIPS) on February 4, the United States, together with the European Union, United Kingdom, Japan and Australia continued to block the initiative to waive certain World Trade Organization (WTO) provisions that potentially constrain manufacture and disbursal of COVID-19 medicines, diagnostics, medical equipment, and vaccines. What is the TRIPS COVID-19 waiver? This narrow waiver, proposed initially by South Africa and India, would temporarily waive patent rights over these products to facilitate increased production volume and more widespread manufacturing worldwide. Nevertheless, while the US and the EU push for more discussion about the facts of the current situation, South Africa, India, and others are seeking to negotiate the text of the proposed waiver. At the moment, the talks are at an impasse. At the moment, the talks are at an impasse. But evidence is mounting that signing the TRIPS waiver would not only be good for the current supporters of the initiative, but for the whole world, and maybe especially for the developed countries who are currently opposed to it. The financial costs to all countries during the pandemic goes far beyond paying for the research and development, treatments and vaccines to manage COVID-19 cases. Economic impacts will be felt across the global economy through supply chain disruptions rooted in growing inequality within and between countries, likely costing around $9.2 trillion dollars, half of which would be borne by a handful of developed [develops an] economies. Economic impacts […] likely costing around $9.2 trillion dollars The projected timeline for vaccinations exacerbates the financial costs. Initial predictions for vaccine rollout all over the world have proven optimistic at best and current projections suggest that many will have to wait at least three, and up to seven, years for substantial global immunity through vaccines, leaving low-income countries hopelessly behind. The lack of manufacturing capacity by drugmakers One of the main reasons the vaccines have not become as widely available as initially hoped is the lack of production capacity by key firms. For obvious reasons, a small handful of corporations cannot produce enough vaccines for the whole world population. Producing enough will depend heavily on licensing and transferring technology to more manufacturers. This reality is highlighted by a recent case in which a vaccine innovator company (Inovio) sued its own contracted biologics manufacturer (VGXI) because they refused to release their own trade secrets to other potential producers in order to ramp up capacity. These same supply capacity issues afflict other more well-known companies as well – including Novavax and Moderna. Pharmaceutical companies would prefer to rely on voluntary licensing [by corporations] agreements (VLAs) to increase production. These VLAs allow the patent holder to control who is producing their patented good and where they are able to sell the product. Gilead’s VLA to produce remdesivir is the most widely known example of such a process. While initially applauded for increasing access and to a potentially life-saving treatment for COVID-19 at affordable prices, further research showed that the agreement excluded 70 countries who would have to purchase the drug at the monopoly price. Given that cautionary tale, it is unlikely that VLAs would be enough to ensure widespread access. The rigid reality of the TRIPS Agreement Many countries who push back against a TRIPS waiversuggest that the TRIPS Agreement is already flexible in its allowance of compulsory licensing to facilitate generic manufacture of patented vaccines. The agreement allows member states to authorise compulsory licenses (CLs) under their own domestic law in cases of extreme urgency, as long as the scope and duration of the license is narrowly circumscribed. In ordinary circumstances, countries can impose a CL if they are unable to negotiate a voluntary license within a reasonable period of time. In both cases, the innovator is due “adequate remuneration” (Art. 31). Certainly, there has never been a case of extreme urgency like this one, and WTO members theoretically may have recourse to this provision. However, previous CLs issued by member states have met with both public and private opposition. The United States has repeatedly put pressure on India for its CL on an expensive cancer drug, claiming that India is “diluting” intellectual property rights and violating the TRIPS Agreement. Private pharmaceutical companies and U.S. lawmakers have even taken action to threaten sanctions against India through its Special 301 Report, a trade watch-list of sorts. Colombia faced similar backlash when they took the first steps toward issuing a CL for a leukemia treatment – Glivec. Both the Swiss government and Novartis, the patent holder, argued forcefully that CLs are “tantamount to expropriation” – code for exercising a sort of eminent domain through regulation. More recently, Malaysia attempted to use a CL to increase affordability of a Hepatitis C medication and once more the United States, together with its pharmaceutical industry, threatened to wield the power of sanctions through a Special 301 Report. As a result of these and other instances, countries have, understandably, been reluctant to develop more flexible domestic CL policies and are certainly out of practice in using them. A TRIPS COVID-19 waiver opens up global production Given the challenges of imposing compulsory licenses and the limits of voluntary ones, the TRIPS waiver offers another way for vaccine producers around the world to ramp up global production without the risks of contending with domestic and international IP disputes. the TRIPS waiver offers another way for vaccine producers around the world to ramp up global production In the first place, they argue, intellectual property protection is [what made these vaccines possible](https://insidetrade.com/daily-news/us-others-defend-ip-rights-waiver-backers-push-text-based-talks) to begin with – undermining those rights, then could undercut the potential for future lifesaving products. The protection of intellectual property is [certainly aimed at increasing innovation](https://www.journals.uchicago.edu/doi/full/10.1086/669706?casa_token=rONrWfPIP7EAAAAA%3AY7UnTSWbe2rI79fnx2KlCZ2CxOcuy9zeKeh9cPdCjfMyhoSC1g1NC-eL9KUTCKRmsZTknURuOP8&), and some studies have shown that [innovation does increase with greater protection](https://journals.sagepub.com/doi/pdf/10.1177/0976399616686860?casa_token=LEX4uDS6wnAAAAAA:CHAWXha9-HMEVK8xeAMM1Gy39L6QscB22M4TfpvxKHstG9LIKXexoUfAO6C7w8ebS_wCAvZFkSXG). At the same time, other research suggests that strong IP protection could [actually discourage subsequent innovation](https://www.journals.uchicago.edu/doi/full/10.1086/669706?casa_token=rONrWfPIP7EAAAAA%3AY7UnTSWbe2rI79fnx2KlCZ2CxOcuy9zeKeh9cPdCjfMyhoSC1g1NC-eL9KUTCKRmsZTknURuOP8&). Even without disregarding the valuable role of intellectual property protection, however, the TRIPS waiver would not dismantle our current system of innovation incentives. Rather it is a narrow, time-limited waiver aimed only at facilitating global access to COVID-19 related products. Most of the vaccine developers have already received [ample](https://grants.nih.gov/policy/natural-disasters/corona-virus.htm) [government](https://ec.europa.eu/info/live-work-travel-eu/coronavirus-response/public-health/coronavirus-vaccines-strategy_en) [support](https://www.fiercepharma.com/pharma/after-nearly-1b-research-funding-moderna-takes-1-5b-coronavirus-vaccine-order-from-u-s) for the research and development stage – diminishing the need for patent monopolies (which are supposed to make up for large up-front capital expenditure). The second argument put forward by opponents of the TRIPS waiver points out that intellectual property rights are not the real bottleneck preventing more rapid global production, at least in the case of vaccines. Rather, the manufacturing capacity of most of the world’s countries is simply [not advanced enough](https://insidetrade.com/daily-news/us-others-defend-ip-rights-waiver-backers-push-text-based-talks) to make these types of vaccines. But this argument seems to run up against the vein of the previous contention – if intellectual property rights are not the issue, if no vaccine manufacturers are going to be able to ramp up production to make any kind of real difference in distribution, then there’s no point in being concerned about temporarily waiving those rights. The current producers will still effectively benefit from their patent monopolies. The current producers will still effectively benefit from their patent monopolies. On the other hand, there is growing evidence that perhaps qualified [producers around the world stand ready](https://www.oxfam.org/en/press-releases/monopolies-causing-artificial-rationing-covid-19-crisis-3-biggest-global-vaccine) to contribute to the production of more vaccines. Despite an unknown timeline, there is a real possibility that the TRIPS waiver may make it possible for a huge increase in vaccine production, not to mention the production of other COVID-19 treatments and equipment.

### My third contention is future pandemics.

#### Our current patent system can’t sustain pandemics, especially ones worse than COVID as Lindsey writes in 21

Lindsey 21

Lindsey, Brink. [Brink Lindsey is Vice President and Director of the Open Society Project at the Niskanen Center. Previously he was the Cato Institute's vice president for research.] “Why Intellectual Property and Pandemics Don't Mix.” Brookings, Brookings, 3 June 2021, www.brookings.edu/blog/up-front/2021/06/03/why-intellectual-property-and-pandemics-dont-mix/. // js69

Unfortunately, the U.S. **patent system** at present **is out of balance**. Over the past few decades, **the expansion of patentability** to include software and business methods as well as a general relaxation of patenting requirements have led to wildly excessive growth in these temporary monopolies: the number of patents granted annually has [skyrocketed roughly fivefold](https://www.uspto.gov/web/offices/ac/ido/oeip/taf/us_stat.htm) since the early 1980s. One unfortunate result has been **the rise of** “non-practicing entities,” better known as **patent trolls**: firms that make nothing themselves but buy up patent portfolios and monetize them through aggressive litigation. As a result, a law that is supposed to encourage innovation has **turned into** a [legal minefield](https://scholarship.law.cornell.edu/cgi/viewcontent.cgi?article=4620&context=clr) for many would-be innovators. In the pharmaceutical industry, firms have abused the law by piling up patents for trivial, therapeutically irrelevant “innovations” that allow them to [extend their monopolies](https://www.i-mak.org/wp-content/uploads/2018/08/I-MAK-Overpatented-Overpriced-Report.pdf) and keep raising prices long beyond the statutorily contemplated 20 years. Patent law is creating these unintended consequences because policymakers have been caught in an ideological fog that [conflates “intellectual property” with actual property rights](https://www.niskanencenter.org/wp-content/uploads/2019/09/LT_IPMisnomer-2-1.pdf) over physical objects. Enveloped in that fog, they regard any attempts to put limits on patent monopolies as attacks on private property and view ongoing expansions of patent privileges as necessary to keep innovation from grinding to a halt. In fact, patent law is a tool of regulatory policy with the usual tradeoffs between costs and benefits; like all tools, it can be misused, and as with all tools there are some jobs for which other tools are better suited. A well-designed patent system, in which benefits are maximized and costs kept to a minimum, is just one of various policy options that governments can employ to stimulate technological advance—including tax credits for R&D, prizes for targeted inventions, and direct government support. PUBLIC HEALTH EMERGENCIES AND DIRECT GOVERNMENT SUPPORT **For pandemics** and other public health emergencies, **patents’** mix of **costs and benefits is misaligned** with what is needed **for** an **effective policy response**. The basic patent bargain, even when well struck, is to pay for more innovation down the road with slower diffusion of innovation today. **In** the context of a **pandemic**, that bargain is a bad one and should be rejected entirely. Here the imperative is to accelerate the diffusion of vaccines and other treatments, not slow it down. Giving **drug companies** the power to **hold things up** by **blocking competitors and raising prices** pushes in the completely wrong direction. What approach to encouraging innovation should we take instead? How do we incentivize drug makers to undertake the hefty R&D costs to develop new vaccines without giving them exclusive rights over their production and sale? The most effective approach during a public health crisis is direct government support: public funding of R&D, advance purchase commitments by the government to buy large numbers of doses at set prices, and other, related payouts. And when we pay drug makers, we should not hesitate to pay generously, even extravagantly: we want to offer drug companies big profits so that they prioritize this work above everything else, and so that they are ready and eager to come to the rescue again the next time there’s a crisis. It was direct support via Operation Warp Speed that made possible the astonishingly rapid development of COVID-19 vaccines and then facilitated a relatively rapid rollout of vaccine distribution (relative, that is, to most of the rest of the world). And it’s worth noting that a major reason for the faster rollout here and in the United Kingdom compared to the European Union was the latter’s [misguided penny-pinching](https://www.nytimes.com/2021/05/17/opinion/europe-vaccines-commission.html?smid=tw-share). The EU bargained hard with firms to keep vaccine prices low, and as a result their citizens ended up in the back of the queue as various supply line kinks were being ironed out. This is particularly ironic since the Pfizer-BioNTech vaccine was developed in Germany. As this fact underscores, the chief advantage of direct support isn’t to “get tough” with drug firms and keep a lid on their profits. Instead, it is to accelerate the end of the public health emergency by making sure drug makers profit handsomely from doing the right thing. Patent law and direct support should be seen not as either-or alternatives but as complements that apply different incentives to different circumstances and time horizons. Patent law provides a decentralized system for encouraging innovation. The government doesn’t presume to tell the industry which new drugs are needed; it simply incentivizes the development of whatever new drugs that pharmaceutical firms can come up with by offering them a temporary monopoly. It is important to note that patent law’s incentives offer no commercial guarantees. Yes, you can block other competitors for a number of years, but that still doesn’t ensure enough consumer demand for the new product to make it profitable. DIRECT SUPPORT MAKES PATENTS REDUNDANT The situation is different in a pandemic. Here the government knows exactly what it wants to incentivize: the creation of vaccines to prevent the spread of a specific virus and other drugs to treat that virus. Under these circumstances, the decentralized approach isn’t good enough. There is no time to sit back and let drug makers take the initiative on their own timeline. Instead, the government needs to be more involved to incentivize specific innovations now. As recompense for letting it call the shots (pardon the pun), the government sweetens the deal for drug companies by insulating them from commercial risk. If pharmaceutical firms develop effective vaccines and therapies, the government will buy large, predetermined quantities at prices set high enough to guarantee a healthy return. For the pharmaceutical industry, it is useful to conceive of patent law as the default regime for innovation promotion. It improves pharmaceutical companies’ incentives to develop new drugs while leaving them free to decide which new drugs to pursue – and also leaving them to bear all commercial risk. In a pandemic or other emergency, however, it is appropriate to shift to the direct support regime, in which the government focuses efforts on one disease. In this regime, it is important to note, the government provides qualitatively superior incentives to those offered under patent law. Not only does it offer public funding to cover the up-front costs of drug development, but it also provides advance purchase commitments that guarantee a healthy return. It should therefore be clear that the pharmaceutical industry has no legitimate basis for objecting to a TRIPS waiver. Since, because of the public health crisis, drug makers now qualify for the superior benefits of direct government support, they no longer need the default benefits of patent support. Arguments that a TRIPS waiver would deprive drug makers of the incentives they need to keep developing new drugs, when they are presently receiving the most favorable incentives available, can be dismissed as the worst sort of special pleading.

#### Pandemics hit the poor worst according to the Brooking Institute in 17 writes,

Oppenheim, Ben, and Gavin Yamey. “Pandemics and the Poor.” Brookings, Brookings, 19 June 2017, www.brookings.edu/blog/future-development/2017/06/19/pandemics-and-the-poor/. // js69

**When** epidemics or **pandemics hit**, **they** usually **hit the poor first and worst**. We have known this for a while. The German pathologist Rudolf Virchow described this link between poverty and vulnerability to outbreaks in his [1848 study of a typhus epidemic in Upper Silesia](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1698167/): For there can now no longer be any doubt that such an epidemic dissemination of **typhus had only been possible under** the wretched conditions of life that **poverty** and lack of culture had created in Upper Silesia. What we have not known, until recently, is how best to help the poor protect themselves from pandemics. To understand why the poor are more vulnerable to epidemics and pandemics and what protections are required, we need to consider how **outbreaks** first start, how they **spread, and** how they **affect** individuals and **societies**. Recently, we’ve been studying pandemics—outbreaks that spread across international boundaries, potentially **wreaking enormous health, social, and economic damage. Pandemics are becoming more frequent, not less**: [Emily Chan and colleagues](http://www.pnas.org/content/107/50/21701.abstract) have shown that the likelihood of pandemics has risen over the last century due to environmental, ecological, and social factors.

**Developing nations cannot keep up with COVID and voluntary licensing by corporations has proven ineffective. Affirming can alleviate the struggles of marginalized nations, giving yet another route to minimize structural violence.**

**Thus, because future pandemics, price gouging and the COVID crisis can both be solved in an Aff world, which saves millions, I urge a strong Aff ballot.**