# 1AC

### Advantage

#### The advantage is price hikes.

#### Pharma crisis now –drug prices are high and rising globally because of monopolies, and patents are at fault.

**Rajkumar 20** [Vincent Rajkumar, S. (Dr. S. Vincent Rajkumar is Editor in Chief of Blood Cancer Journal, and the Edward W. and Betty Knight Scripps Professor of Medicine at the Mayo Clinic, Rochester, Minnesota) The high cost of prescription drugs: causes and solutions. Blood Cancer J. 10, 71, June 23, 2020, <https://doi.org/10.1038/s41408-020-0338-x>] chsAK

Global spending on prescription drugs in 2020 is expected to be ~$1.3 trillion; the United States alone will spend ~$350 billion[1](https://www.nature.com/articles/s41408-020-0338-x#ref-CR1). These high spending rates are expected to increase at a rate of 3–6% annually worldwide. The magnitude of increase is even more alarming for cancer treatments that account for a large proportion of prescription drug costs. In 2018, global spending on cancer treatments was approximately 150 billion, and has increased by >10% in each of the past 5 years[2](https://www.nature.com/articles/s41408-020-0338-x#ref-CR2). The high cost of prescription drugs threatens healthcare budgets, and limits funding available for other areas in which public investment is needed. In countries without universal healthcare, the high cost of prescription drugs poses an additional threat: unaffordable out-of-pocket costs for individual patients. Approximately 25% of Americans find it difficult to afford prescription drugs due to high out-of-pocket costs[3](https://www.nature.com/articles/s41408-020-0338-x#ref-CR3). Drug companies cite high drug prices as being important for sustaining innovation. But the ability to charge high prices for every new drug possibly slows the pace of innovation. It is less risky to develop drugs that represent minor modifications of existing drugs (“me-too” drugs) and show incremental improvement in efficacy or safety, rather than investing in truly innovative drugs where there is a greater chance of failure. Seriousness of the disease High prescription drug prices are sustained by the fact that treatments for serious disease are not luxury items, but are needed by vulnerable patients who seek to improve the quality of life or to prolong life. A high price is not a barrier. For serious diseases, patients and their families are willing to pay any price in order to save or prolong life. High cost of development Drug development is a long and expensive endeavor: it takes about 12 years for a drug to move from preclinical testing to final approval. It is estimated that it costs approximately $3 billion to develop a new drug, taking into account the high failure rate, wherein only 10–20% of drugs tested are successful and reach the market[7](https://www.nature.com/articles/s41408-020-0338-x#ref-CR7). Although the high cost of drug development is a major issue that needs to be addressed, some experts consider these estimates to be vastly inflated[8](https://www.nature.com/articles/s41408-020-0338-x#ref-CR8),[9](https://www.nature.com/articles/s41408-020-0338-x#ref-CR9). Further, the costs of development are inversely proportional to the incremental benefit provided by the new drug, since it takes trials with a larger sample size, and a greater number of trials to secure regulatory approval. More importantly, we cannot ignore the fact that a considerable amount of public funding goes into the science behind most new drugs, and the public therefore does have a legitimate right in making sure that life-saving drugs are priced fairly. Lobbying power of pharmaceutical companies Individual pharmaceutical companies and their trade organization spent approximately $220 million in lobbying in the United States in 2018[10](https://www.nature.com/articles/s41408-020-0338-x#ref-CR10). Although nations recognize the major problems posed by high prescription drug prices, little has been accomplished in terms of regulatory or legislative reform because of the lobbying power of the pharmaceutical and healthcare industry. Causes for the high cost of prescription drugs Monopoly The most important reason for the high cost of prescription drugs is the existence of monopoly[4](https://www.nature.com/articles/s41408-020-0338-x#ref-CR4),[5](https://www.nature.com/articles/s41408-020-0338-x#ref-CR5). For many new drugs, there are no other alternatives. In the case of cancer, even when there are multiple drugs to treat a specific malignancy, there is still no real competition based on price because most cancers are incurable, and each drug must be used in sequence for a given patient. Patients will need each effective drug at some point during the course of their disease. There is seldom a question of whether a new drug will be needed, but only when it will be needed. Even some old drugs can remain as virtual monopolies. For example, in the United States, three companies, NovoNordisk, Sanofi-Aventis, and Eli Lilly control most of the market for insulin, contributing to high prices and lack of competition[6](https://www.nature.com/articles/s41408-020-0338-x#ref-CR6). Ideally, monopolies will be temporary because eventually generic competition should emerge as patents expire. Unfortunately, in cancers and chronic life-threatening diseases, this often does not happen. By the time a drug runs out of patent life, it is already considered obsolete (planned obsolescence) and is no longer the standard of care[4](https://www.nature.com/articles/s41408-020-0338-x#ref-CR4). A “new and improved version” with a fresh patent life and monopoly protection has already taken the stage. In the case of biologic drugs, cumbersome manufacturing and biosimilar approval processes are additional barriers that greatly limit the number of competitors that can enter the market. Clearly, all monopolies need to be regulated in order to protect citizens, and therefore most of the developed world uses some form of regulations to cap the launch prices of new prescription drugs. Unregulated monopolies pose major problems. Unregulated monopoly over an essential product can lead to unaffordable prices that threaten the life of citizens. This is the case in the United States, where there are no regulations to control prescription drug prices and no enforceable mechanisms for value-based pricing.

#### Patent’s cause evergreening which means little innovation and it keeps prices high forever by preventing generics from entering the market.

**Amin 21** [Tahir Amin, co-founder of nonprofit I-MAK.org. “The Problem with High Drug Prices Isn’t ‘Foreign Freeloading,’ It’s the Patent System.” CNBC, CNBC, 27 June 2018, [www.cnbc.com/2018/06/25/high-drug-prices-caused-by-us-patent-system.html](http://www.cnbc.com/2018/06/25/high-drug-prices-caused-by-us-patent-system.html) Accessed 4 Sept. 2021] chsAK

One in four Americans are unable to fill prescriptions due to high prices. Today’s drug patent monopolies are stronger than at any point in the last century, raising prescription prices. Until the U.S. patent system is reformed, the pharmaceutical industry will continue to deny competition, block incentives discoveries and promote ineffective drugs. Americans continue to suffer the highest prescription drug costs of anyone in the world. One in four are unable to fill prescriptions due to high prices, [according to a recent poll](https://www.kff.org/health-costs/poll-finding/kaiser-health-tracking-poll-august-2015/). And even though drug prices tripled over the last decade, analysts predict they will double again in the next ten years. We have a runaway problem on our hands, and while new proposals from Congress and the president seek to improve the drug pricing system, we will fail to reach lasting solutions unless we address a root factor in this national crisis: patents. Contrary to the [Trump administration’s](https://www.cnbc.com/id/105059550) recent claims, the source of our prescription drug problems is not “foreign freeloading” governments creating unfair pricing schemes—it’s the unfair pricing systems created right here in the U.S. Today’s drug patent monopolies are deeper, longer and stronger than at any point in the last century—and it’s costing Americans and people around the world. Before a prescription drug even enters the market—before pricing negotiations occur between payers, government agencies, insurers, and so on—the U.S. patent office awards exclusivity to drug makers for intellectual property claims that have a huge impact on the market. And unfortunately, while patenting is an important mechanism for incentivizing and rewarding invention, pharmaceutical companies have figured out how to game the system—prolonging monopolies, claiming newness where there often is none, and taking patients on a ride they can barely afford. In a recent study of every drug on the market between 2005 and 2015, a University of California School of Law professor found a “startling departure from the classic conceptualization of intellectual property protection for pharmaceuticals.” 'Evergreening' Instead of going to new medicines, the study finds that 74 percent of new patents during the decade went to drugs that already existed. It found that 80 percent of the nearly 100 best-selling drugs extended their exclusivity protections at least once, and 50 percent extended their patents more than once—with the effect of prolonging the time before generics could reach the market as drug prices continued to rise. The strategy is called “evergreening”: drug makers add on new patents to prolong a drug’s exclusivity, even when the additions aren’t fundamentally new, non-obvious, and useful as the law requires. One of the most expensive cancer drugs on the market, Revlimid®, is a case in point: priced at over $125,000 per year of treatment, [Celgene](https://www.cnbc.com/quotes/?symbol=CELG-CH) has sought 105 patents on Revlimid®, many of which have been granted, extending its monopoly until the end of 2036. That gives the Revlimid® patent portfolio a lifespan of 40 years, which is being used to block or deter generic competitors from entering the market. But [a recent I-MAK analysis](http://www.i-mak.org/americas-overspend/) finds that several of Celgene’s patents are mere add-ons—not fundamentally new to deserve a patent. And because of the thicket of patents around Revlimid®, payers are projected to spend $45 billion in excess costs on that drug alone as compared to what they could be paying if generic competitors were to enter when the first patent expires in 2019. Meanwhile, Celgene is also among the pharmaceuticals that have been recently scolded by the [FDA](https://www.cnbc.com/fda/) for refusing to share samples with generic makers so they can test their own products against the brands in order to attain FDA approval. In the absence of genuine competition in the U.S. prescription drug market, monopolies are yielding reckless pricing schemes and prohibitively expensive drugs for Americans (and people around the world) who need them. In 2015, for example, [U.S. Senators Wyden and Grassley found after an 18-month bipartisan investigation](https://www.wyden.senate.gov/news/press-releases/wyden-grassley-sovaldi-investigation-finds-revenue-driven-pricing-strategy-behind-84000-hepatitis-drug) that the notorious $84,000 price tag for the hepatitis C drug made by [Gilead](https://www.cnbc.com/quotes/?symbol=GILD) was based on “a pricing and marketing strategy designed to maximize revenue with little concern for access or affordability.” Gilead’s subsequent hepatitis C drug Harvoni® was introduced to the market at a still higher cost of $94,500. Who benefits when drugs are priced so high? Not the 85 percent of Americans with hepatitis C who are still not able to afford treatment. Few affordable solutions “Since the early 2000s, very few new drugs or indications have provided a tangible advance for patients,” the French medical journal Prescrire wrote in 2014. This is the problem with drug pricing today. Plenty of top-dollar drugs armored in patents, but too few solutions for patients that are genuinely affordable and helpful. Until our patent system is reformed, the pharmaceutical industry will continue to abuse it—denying real competition, blocking incentives for actual new drug discoveries and using clever marketing strategies around “new” products that do not improve health outcomes. For a free and competitive market that will actually help America’s patients, what we really need is to restore fairness to the patent system in the U.S. It may be convenient to blame foreign countries or insurance companies or any number of culprits for our high drug prices, but until we look at the heart of the problem and stop deflecting, patients in the U.S. and around the world will continue to lack treatments they can access and afford.

#### Disparities in access due to high costs reinforce global colonial hierarchies and worsen global inequalities.

**Sekalala et al. 21A** [Sharifah Sekalala, Lisa Forman, Timothy Hodgson, Moses Mulumba, Hadijah Namyalo-Ganafa, and Benjamin Mason Meier, (Sekalala: Warwick Law School, University of Warwick, Coventry, UK, Forman: Dalla Lana School of Public Health, University of Toronto, Toronto, Ontario, Canada)7-12-2021, accessed on 9-7-2021, BMJ Global Health , "Decolonising human rights: how intellectual property laws result in unequal access to the COVID-19 vaccine", https://gh.bmj.com/content/6/7/e006169] chsAK

Entrenching inequalities between countries The current global distribution of COVID-19 vaccines is largely dictated by power disparities and inequities in financial and other resources, with predominantly high-income countries contracting bilaterally with individual pharmaceutical companies (many in their own countries) for specific vaccines, leaving countries from the Global South facing inequitable vaccine access. Bilateral deals between states and pharmaceutical companies, whether completed by Global North or Global South states, significantly compromise the effectiveness and equity of the COVAX initiative, limited as it already is by the coercive influence, vested interests and participation of pharmaceutical companies and their host nations. The African Union, for example, endorsed the TRIPS waiver to relax WTO rules so that LMICs could create their own COVID-19 vaccines, but this collective effort across African countries faced resistance from Global North countries and pharmaceutical companies. The IP system appears to have pushed countries in the Global South that may prefer not to be dependent on the charitable model of the COVAX scheme to join high-income countries in engaging directly with manufacturers to purchase COVID-19 vaccines. This has included African countries, despite the African Union’s criticism of the inequities resulting from IP law protections. This process has reproduced colonially entrenched power dynamics, in which poorer countries lack the bargaining power to obtain competitive rates and, consequently, typically end up paying far more than the wealthier, developed countries. More broadly, countries in the Global South are pressured into participating in global systems of trade that result in the exploitation of their own populations by unjust global economic systems and IP laws.[39](https://gh.bmj.com/content/6/7/e006169#ref-39) The high cost of vaccines for countries from the Global South constitutes a large proportion of their health expenditure, and this comes at the expense of other health priorities. In many cases, the only way in which Global South countries can purchase vaccines is to move themselves further into debt. Given the detrimental neocolonial implications of debt, with a long history of loan conditionalities through structural adjustment programmes, increasing debt to service health needs contributes to the worsening of inequalities between the Global North and Global South.[40](https://gh.bmj.com/content/6/7/e006169#ref-40) These programmes may increase debt and undermine development in ways that limit the realisation of the right to health.[41](https://gh.bmj.com/content/6/7/e006169#ref-41) The World Bank has set aside US$12 billion and has already disbursed loans of US$500 million for vaccines in low-income and middle-income nations;[42](https://gh.bmj.com/content/6/7/e006169#ref-42) poorer nations, instead of servicing already depleted health systems, are forced to divert additional funds to servicing debt.

#### High costs fuel unequal structures by restricting access to those in power.

**Sekalala et al. 21 B** [Sharifah Sekalala, Lisa Forman, Timothy Hodgson, Moses Mulumba, Hadijah Namyalo-Ganafa, and Benjamin Mason Meier, (Sekalala: Warwick Law School, University of Warwick, Coventry, UK, Forman: Dalla Lana School of Public Health, University of Toronto, Toronto, Ontario, Canada)7-12-2021, accessed on 9-7-2021, BMJ Global Health , "Decolonising human rights: how intellectual property laws result in unequal access to the COVID-19 vaccine", https://gh.bmj.com/content/6/7/e006169] chsAK

The high costs of vaccines also propagate inequalities within nations, as desperate countries try to recoup some of the costs by charging their people for vaccine access or using complex arrangements that prioritise some people over others. Egypt, for instance, is charging for the COVID-19 vaccine, which is likely to exclude the poorest people, who have already been severely affected by the crisis.[43](https://gh.bmj.com/content/6/7/e006169#ref-43) In reality, it also means that wealthier individuals are prioritised, as they usually find it easier to pay for access. Those able to access vaccines in these countries, very often a small economic and political elite, are often in positions of power precisely along the lines of existing global inequalities and often to the prejudice of groups marginalised on the basis of gender, race and other grounds of discrimination prohibited under international human rights law. Facilitating vaccine access for more affluent members of society reinforces power structures at the expense of marginalised populations. In South Africa, conservative non-governmental organisations aligned closely with the interests of the white minority and elite corporate interests launched a court challenge in order to procure private supplies of vaccines, bypassing the nationwide mechanisms set up by the government to ensure equitable vaccine access. However, having faced opposition from human rights activists and the South African government, this litigation was ultimately withdrawn. (For more information on this litigation see ref [44 45](https://gh.bmj.com/content/6/7/e006169#ref-44).) Kenya has also prioritised diplomats for COVID-19 vaccination at the expense of health workers, and Indonesia has suggested that the ‘more productive’ members of society be vaccinated first.[46 47](https://gh.bmj.com/content/6/7/e006169#ref-46) In other countries, such as Peru, political elites and their families and friends were secretly vaccinated before the broader populations. (See as examples ref [48 49](https://gh.bmj.com/content/6/7/e006169#ref-48).) An important issue at the boundary of national and international concerns is the potential use of ‘vaccine passports’.[50](https://gh.bmj.com/content/6/7/e006169#ref-50) Free movement of goods is integral to one of the core objectives of the IHR, and yet many governments are proposing the use of COVID-19 vaccination passports as a mechanism for reopening their economies, which would discriminate against those who have not been vaccinated. The EU introduced vaccine passports in the summer of 2021 for entry into the eurozone and excluded vaccines that were made from the Serum Institute in India which is responsible for the majority of vaccines provided in the Global South.[51](https://gh.bmj.com/content/6/7/e006169#ref-51) Vaccination disparities both within and between countries mean that many people in LMICs are unlikely to be vaccinated until 2023; therefore, vaccine passports would only further exacerbate both national and global inequalities and disproportionately restrict the rights of large swathes of the global population from exercising their right to freedom of movement on an equal basis.

#### A million people on Medicare will die because they can’t afford medicine.

**Lagasse 20 [**Lagasse, Jeff. “More than 1.1 Million Deaths among Medicare Recipients Are due to the High Cost of Drugs.” Healthcare Finance News, 19 Nov. 2020, www.healthcarefinancenews.com/news/more-11-million-deaths-among-medicare-recipients-are-due-high-cost-drugs. Accessed 5 Sept. 2021] chsAK

‌ More than 1.1 million Medicare patients could die over the next decade because they can't afford to pay for their prescription medications, according to a new study released by the [West Health Policy Center](https://www.westhealth.org/what-we-do/policy-advocacy-2/), a nonprofit and nonpartisan policy research group. If current drug pricing trends continue, it's estimated that cost-related nonadherence to drug therapy will result in the premature deaths of 112,000 beneficiaries a year, making it a leading cause of death in the U.S. – ahead of diabetes, influenza, pneumonia and kidney disease. Millions more will suffer worsening health conditions and run up medical expenses that will cost Medicare an additional $177.4 billion by 2030, or $18 billion a year for the next 10 years. For the study, researchers developed a 10-year model representative of the majority of Medicare beneficiaries with chronic conditions. The model allows users to estimate how different levels of price reductions would lower the number of premature deaths and decrease Medicare spending on a sliding scale. Researchers also modeled what would happen if Medicare was allowed to bring down drug prices for its beneficiaries through direct negotiation with drug companies, as described in H.R. 3, the Elijah E. Cummings Lower Drug Costs Now Act, passed by the U.S. House of Representatives last year. They found Medicare negotiation could result in 94,000 fewer deaths annually. The model also found that the policy would reduce Medicare spending by $475.9 billion by 2030. WHAT'S THE IMPACT? Failing to take medications as prescribed is one of the biggest contributors to poor health, hospital admissions, higher healthcare costs and preventable deaths. And the report showed the issue is growing, a direct result of runaway drug prices and a lack of policies and regulations that make drugs more affordable. The price of prescription medications has skyrocketed in recent years. Between 2007 and 2018, list prices for branded pharmaceutical products increased by 159%, and there are few signs of it slowing. According to the Centers for Medicare and Medicaid Services, spending on prescription drugs will grow faster than any other major medical goods or services over the next several years. Under Medicare, beneficiaries must pay 25% of the cost of generic and brand-name medications. For many people with multiple chronic conditions, this could add up to thousands of dollars a year in [out-of-pocket](https://www.healthcarefinancenews.com/directory/out-pocket-payments) costs.

#### Millions die in Africa due to reliance on expensive foreign medicine.

**Pheage 17** [Pheage, Tefo. “Dying from Lack of Medicines.” Africa Renewal, Mar. 2017, www.un.org/africarenewal/magazine/december-2016-march-2017/dying-lack-medicines. Accessed 5 Sept. 2021] chsAK

Approximately 1.6 million Africans died of malaria, tuberculosis and HIV-related illnesses in 2015. These diseases can be prevented or treated with timely access to appropriate and affordable medicines, vaccines and other health services. But less than 2% of drugs consumed in Africa are produced on the continent, meaning that many sick patients do not have access to locally produced drugs and may not afford to buy the imported ones. Without access to medicines, Africans are susceptible to the three big killer diseases on the continent: malaria, tuberculosis and HIV/AIDS. Globally, 50% of children under five who die of pneumonia, diarrhea, measles, HIV, tuberculosis and malaria are in Africa, according to the World Health Organisation (WHO). The organisation defines having access to medicine as having medicines continuously available and affordable at health facilities that are within one hour’s walk of the population. In some parts of Zimbabwe, for example, some nurses give painkillers to sick patients as a “treat-all drug,” says Charles Ndlovu, a Zimbabwean living in Botswana. Some of his family members have been treated in hospitals in Zimbabwe. With most medicines unavailable, the nurses have little choice. Dave Puo, from Mpumalanga in South Africa, says that in his country, “when you seek medical attention, you are often informed that there is no medication and advised to go to the big hospitals,” which the majority of the poor cannot afford. “The system does not care about your [empty] pockets.” Inhibiting factors About 80% of Africans, mostly those in the middle-income bracket and below, rely on public health facilities, reported the World Bank in 2013. With public health facilities suffering chronic shortages of critical drugs, many patients die of easily curable diseases. Several factors inhibit access to medicines, but the major ones, according to the WHO, are the shortage of resources and the lack of skilled personnel. “Low-income countries experience poor availability of essential medicines in health facilities, substandard-quality treatments, frequent stock-outs and suboptimal prescription and use of medicines,” says the world health body. Africa’s inefficient and bureaucratic public sector supply system is often plagued by poor procurement practices that make drugs very costly or unavailable. Added to these are the poor transportation system, a lack of storage facilities for pharmaceutical products and a weak manufacturing capacity. Africa’s capacity for pharmaceutical research and development (R & D) and local drug production still has a long way to go, say experts. Only 37 out of 54 African states have some level of pharmaceutical production. Except South Africa, which boasts some active local pharmaceutical ingredients, most countries rely on imported ingredients. The result is that Africa imports 70% of its pharmaceutical products, with India alone accounting for nearly 18% of imports in 2011. Pharmaceutical imports in Africa include up to 80% of the antiretroviral drugs (ARVs) used to treat HIV/AIDS, according to trade data. “Many African governments spend a disproportionate amount of their scarce resources on procuring medicines,” writes Carlos Lopes, former executive secretary of the United Nations Economic Commission for Africa. To produce medicines, a country must abide by Current Good Manufacturing Practices (CGMP), which are enforced by the United States and other governments to ensure the quality of manufacturing processes and facilities. Many African countries do not have the technical, financial or human resources required for high-scale drug production. But Egypt, Morocco, South Africa and Tunisia have made progress in local pharmaceutical productions. Morocco is Africa’s second-largest pharmaceutical producer (after South Africa), and has 40 pharmaceutical manufacturing companies that supply 70% of products for local consumption and also exports to neighbouring countries. Countries such as Ghana, Kenya, Nigeria and Tanzania are currently developing production capacity. Suspicions Many African political leaders and development experts believe that the world’s biggest pharmaceutical companies are reluctant to offer technical support to African manufacturers. For example, in 2001, 39 international pharmaceutical companies dragged the South African government to court to challenge its plans to manufacture and import cheap, generic HIV/AIDS drugs. The companies claimed that South Africa’s plans breached their patent rights. Although they later withdrew the matter from court following pressure from groups that advocate for international access to medicines, South Africa’s late president Nelson Mandela accused the companies of exploiting the developing world by charging exorbitant fees for HIV/AIDS drugs. “That is completely wrong and must be condemned,” he said at the time. There is evidence, however, that local production improves access and brings down the cost of medicines. “Ever since the high-tech generic drug production [facility], Cinpharm-Cameroon, was set up, it is relatively easier for Cameroonians to have access to medicines,” says Mr. Lopes. “Now a low-wage earner can access a course of antibiotics at a lower price than a Kenyan counterpart.” Worth $24 million, Cinpharm-Cameroon produces 40 different drugs. The Trade Related Aspects of Intellectual Property Rights (TRIPS) regulation of the World Trade Organization (WTO), in force since 1986, curtails the right of companies to manufacture generic drugs, forcing countries to rely on brand-name products. However, the WTO in 2006 granted developing countries a 10-year waiver to manufacture generic drugs using the intellectual property rights of big pharmaceutical companies overseas. Despite US objections, the waiver, which expired this year, was extended until two-thirds of WTO members decide to remove it. Experts believe that is unlikely to happen, as the US appears to be the only big country insisting on its removal. WHO director-general Dr. Margaret Chan remarked in 2010 that the debate on access to medicine is often clouded by suspicions: “Suspicions that the rules governing international trade in pharmaceutical products are rigged to favour the rich and powerful; that economic interests will trump health concerns.” The debate, Dr. Chan added, is complicated by deep mistrust. “Countries unskilled in trade negotiations fear they will be tricked or duped. Countries fear that pharmaceutical companies will use unfair tactics, really, every trick in the book, to reduce competition from lower-priced generics.” Dr. Chan added that, while the ethical argument of not depriving people of access to life-saving medicines is a reasonable one, the for-profit pharmaceutical companies respond to market forces. “What incentives does this industry have to fix prices according to their affordability among the poor?”

#### High costs could push 100 million into extreme poverty annually .

**World Bank 17**[12-01-2017, accessed on 9-8-2021, The World Bank, "Tracking universal health coverage : 2017 global monitoring report", https://documents.worldbank.org/en/publication/documents-reports/documentdetail/640121513095868125/tracking-universal-health-coverage-2017-global-monitoring-report] chsAK

Ensuring that all people can access the health services they need – without facing ﬁnancial hardship – is key to improving the well-being of a country’s population. But universal health coverage is more than that: it is an investment in human capital and a foundational driver of inclusive and sustainable economic growth and development. It is a way to support people so they can reach their full potential and fulﬁl their aspirations. This is why we, as the leaders of the World Bank Group and the World Health Organization, have made the achievement of universal health coverage a priority for both our institutions. Part of that commitment is this joint 2017 UHC Global Monitoring Report. The report reveals that at least half the world’s population still lacks access to essential health services. Furthermore, some **800 million** people spend more than 10 per cent of their household budget on health care, and almost **100 million** people are pushed into extreme poverty each year because of out-of-pocket health expenses. This is unacceptable. But what gives us hope is that countries across the income spectrum are leading and driving progress towards UHC, recognizing that it is both the right and the smart thing to do. We are also encouraged that – although data availability and analysis are still a challenge – most countries are already generating credible and comparable data on health coverage. We would like to acknowledge the role of the Organisation for Economic Co-operation and Development (OECD) and the United Nations Children’s Fund (UNICEF) in making this happen. Our data have revealed major gaps. The more we know about those gaps – and how different countries are bridging them – the closer we come to identifying what we must do to improve health coverage. But if the world is serious about meeting its goal of achieving Universal Health Coverage by 2030, we all need to be far more ambitious. To this end, the World Bank Group and the World Health Organization are committed to working with countries to increase access to essential health services, ensure that people don’t fall into poverty because of health expenses, and move closer to our goal of Universal Health Coverage by 2030. That won’t be easy, but it’s possible. We are ready to make it happen.

#### There is functionally no escape from it.

**Guglielmi 17** [Giorgia Guglielmi, 7-25-2017, accessed on 9-8-2021, Science, "Why so much of the world is stuck in a ‘poverty trap'", https://www.science.org/news/2017/07/why-so-much-world-stuck-poverty-trap] chsAK

In a tiny village just a few kilometers outside of Dakar, farmers struggle to get by on the equivalent of $2 a day. They live off the milk of their cows, sell the wool of their sheep at local markets, and put their children to work tending the fields. Yet none of this is enough to raise them out of poverty. It's like filling a leaking bucket with water: No matter how much effort they put in, they never succeed in making enough to meet their daily needs. Now, for the first time, scientists have found a way to determine the root causes of this "poverty trap": Disease, whether of humans, animals, or crops, tends to rob the world's poorest people of their livelihood, keeping them destitute regardless of how hard they work or how much economic aid they get. But the study also suggests possible solutions. The work provides important insights and implications for future interventions, says Chris Desmond, an expert on social development at the Human Sciences Research Council in Dalbridge, South Africa, who was not involved in the research. "Policymakers need to look at the public health situation, the access to primary health care, the condition of biological pests in the environment," he says. "They need to look at all those things before they can decide what type of intervention to do." To conduct the research, scientists led by Calistus Ngonghala, a mathematician at the University of Florida in Gainesville, collected both economic and disease data from 83 of the most and least developed countries. The data included annual income per person and the impact of diseases in terms of financial cost, disease incidence, and mortality, which vary dramatically around the world. For example, the caterpillar of the armyworm moth destroys crops in places like Brazil and Zimbabwe, but can't survive in places with temperate climates like Romania. Similarly, human diseases like malaria and dengue fever abound in places like Kenya and Cambodia, where the tropical climate favors their spread, and these countries also happen to offer limited access to health care. The researchers used these and related data to "train" mathematical models to determine how economic and disease factors, as well as ecological factors such as the growth rate of fish populations and other natural resources, affected poverty. The models show that poor people who live in areas with limited human, animal, and crop disease might be able to lift themselves out of poverty either through their own means or with a bit of economic assistance, such as money to buy more crops and cattle. But in places of high disease and limited means of combating it, [people could be stuck in poverty](https://www.nature.com/articles/s41559-017-0221-8), no matter how much economic aid they receive, the team reports this month in Nature Ecology & Evolution. "If you're a subsistence farmer, infectious diseases not only affect your health, they also affect your earning, because you depend on your physical labor to get an income," Ngonghala says. "We were surprised when we realized that in some instances economic aid is not going to help at all." Considering that more than 10% of the world, or **about 800 million** people—live in extreme poverty, the study suggests that most of them will never escape it unless issues beyond mere income are addressed. One effective way to break poverty traps may be structural changes such as increasing access to health care by reducing health care costs, and preventing disease transmission through vaccine coverage. Once people are able to get well and safeguard their crops and livestock, they also might be able to dig themselves out of poverty, says study co-author Matthew Bonds, an economist at Harvard University. Bonds uses as an example Rwanda, a sub-Saharan country that succeeded in reducing extreme poverty and hunger as part of the Millennium Development Goals, a series of international development goals for the year 2015. "[Rwanda] has had a major investment in health infrastructure and health systems," he says. "Most people can get access to health insurance and to most forms of health care inexpensively." In addition, foreign businesses are investing in the country's energy and telecommunication sectors, helping to lift people out of poverty traps, he says. However, the study can't tell whether additional health interventions in Rwanda would result in more economic growth. To address that, the researchers would need a detailed survey of the country's pests, epidemics, and per person income. "Our models simply show theoretical possibilities, they do not provide conclusive evidence," Bonds says. Yet, he adds, the models predicted health interventions to be the most significant drivers of positive economic outcomes. "You can't lose with health care."

.

### Plan

#### Thus, I affirm: The member nations of the World Trade Organization ought to reduce intellectual property protections for medicines by implementing a one-and-done approach for patent protection.

#### The specifics are through Feldman’s plan, and it solves evergreening by only allowing a single patent.

Feldman 19A Robin Feldman 2-11-2019 "‘One-and-done’ for new drugs could cut patent thickets and boost generic competition" <https://www.statnews.com/2019/02/11/drug-patent-protection-one-done/> (Arthur J. Goldberg Distinguished Professor of Law, Albert Abramson ’54 Distinguished Professor of Law Chair, and Director of the Center for Innovation)//SidK + Elmer

* Feldman 19 is a plan advocate

I believe that one period of protection **should be enough**. We should make the legal changes necessary to prevent companies **from building patent walls** and piling up mountains of rights. This could be accomplished **by a “one-and-done” approach** for patent protection. Under it, a drug would receive just one period of exclusivity, and no more. The choice of which “one” could be left entirely in the hands of the pharmaceutical company, with the election made when the FDA approves the drug. Perhaps development of the drug went swiftly and smoothly, so the remaining life of one of the drug’s patents is of greatest value. Perhaps development languished, so designation as an orphan drug or some other benefit would bring greater reward. The choice would be up to the company itself, based on its own calculation of the maximum benefit. The result, however, is that a pharmaceutical company chooses whether its period of exclusivity would be a patent, an orphan drug designation, a period of data exclusivity (in which no generic is allowed to use the original drug’s safety and effectiveness data), or something else — but **not all of the above** and more. Consider Suboxone, a combination of buprenorphine and naloxone for treating opioid addiction. The drug’s maker has extended its protection cliff eight times, including obtaining an orphan drug designation, which is intended for drugs that serve only a small number of patients. The drug’s first period of exclusivity ended in 2005, but with the additions its protection now lasts until 2024. That makes almost two additional decades in which the public has borne the burden of monopoly pricing, and access to the medicine may have been constrained. Implementing a one-and-done approach in conjunction with FDA approval underscores the fact that these problems and solutions are designed for pharmaceuticals, not for all types of technologies. That way, one-and-done could be implemented through **legislative changes to the FDA’s drug approval system**, and would apply to patents granted going forward. One-and-done would apply to both patents and exclusivities. A more limited approach, a baby step if you will, would be to invigorate the existing patent obviousness doctrine as a way to cut back on patent tinkering. Obviousness, one of the five standards for patent eligibility, says that inventions that are obvious to an expert or the general public can’t be patented. Either by congressional clarification or judicial interpretation, many pile-on patents could be eliminated with a ruling that the core concept of the additional patent is nothing more than the original formulation. Anything else is merely an obvious adaptation of the core invention, modified with existing technology. As such, the patent would fail for being perfectly obvious. Even without congressional action, a more vigorous and robust application of the existing obviousness doctrine could significantly improve the problem of piled-up patents and patent walls. Pharmaceutical companies have become adept at maneuvering through the system of patent and non-patent rights to create mountains of rights that can be applied, one after another. This behavior lets drug companies keep competitors out of the market and beat them back when they get there. We shouldn’t be surprised at this. Pharmaceutical companies are profit-making entities, after all, that face pressure from their shareholders to produce ever-better results. If we want to change the system, we must change the incentives driving the system. And right now, the incentives for creating patent walls are just too great.

#### Reforming the Patent Process would lower Drug Prices and incentivize Pharma Innovation by revitalizing the Market.

Stanbrook 13, Matthew B. "Limiting “evergreening” for a better balance of drug innovation incentives." (2013): 939-939. (MD (University of Toronto) PhD (University of Toronto))//Elmer

At issue in the Indian case was “evergreening,” a now widespread practice by the pharmaceutical industry designed to extend the monopoly on an existing drug by modifying it and seeking new patents.2 Currently, half of all drugs patented in Canada have multiple subsequent patents, extending the lifetime of the original patent by about 8 years.3 Manufacturers, in defence of these practices, predictably tout the advantages of new versions of their products, which often represent more potent isomers or salts of the original drugs, longer-lasting formulations or improved delivery systems that make adherence easier or more convenient. But the new versions are by definition “**me too” drugs**, and demonstration that the resulting **incremental benefits** in efficacy and safety are clinically meaningful **is often lacking**. Moreover, the original drugs have often been “blockbusters” used for years to improve the health of millions of patients. It seems hard to argue convincingly why such beneficial drugs require an upgrade, often just before their patents expire. Rather than the marginal benefits accrued from tinkering with already effective agents, patients worldwide are in desperate need of new classes of pharmaceuticals for the great many health conditions for which treatments are presently inadequate or entirely lacking. But developing truly innovative drugs is undeniably a high-risk venture. It is important and necessary that pharmaceutical companies continue to take these risks, because they are usually the only entities with sufficient resources to do so. Therefore, companies must continue to perceive **sufficient incentives** to continue investing in innovation. Indeed, there is evidence that the prospect of future evergreening has become part of the incentive calculation for innovative drug development.4 But surely it is perverse to extend unpredictably a period of patent protection that the government intended to be clearly defined and predictable, and to maintain incentives that drive companies to divert their **drug-development resources away from innovation**. **Current patent legislation may not be optimal** for striking the right balance between encouraging innovation and facilitating profiteering. Given the broad societal importance of patent legislation, ongoing research to enable active governance of this issue should be a national priority. In the last decade, Canada’s laws have been among the friendliest toward evergreening in the world.5 We should now reflect on whether this is really in our national interest. Governments, including Canada’s, would do well to take inspiration from India’s example and tighten regulations that currently facilitate evergreening. This might involve **denying future patents for modifications** that currently would receive one. An overall reduction in the duration of all secondary patents on a therapy might also be considered. Globally, a more flexible and individualized approach to the length of drug patents might be a more effective strategy to align corporate incentives with population health needs. Limits on evergreening would likely reduce the **extensive patent litigation** that contributes to the **high prices of generic drugs** in Canada.3 Reducing economic pressure on generic drug companies may facilitate current provincial initiatives to lower generic drug prices. As opportunities to generate revenue from evergreening are eliminated, research-based pharmaceutical companies would be left with no choice but to invest more in innovative drug development to maintain their profits.

### Framing

#### Ideal theory is too abstract to motivate descriptive agents - it fails as a fundamental ethic. Only non-ideal theory that begins from lived, material experiences can guide action.

Mills 05 [Mills, Charles. W, Professor of Moral and Intellectual philosophy at Northwestern University, “Ideal Theory” as Ideology. Hypatia, Volume 20, Number 3, Summer 2005, pp. 165-184. <http://www.nsdupdate.com/assets/2017/02/Ideal-theory-as-ideology.pdf>] chsAK

I suggest that this spontaneous reaction, far from being philosophically naïve or jejune, is in fact the correct one. If we start from what is presumably the uncontroversial premise that the ultimate point of ethics is to guide our actions and make ourselves better people and the world a better place, then the framework above [ideal theory] will not only be unhelpful, but will in certain respects be deeply antithetical to the proper goal of theoretical ethics as an enterprise. In modeling humans, human capacities, human interaction, human institutions, and human society on ideal-as-idealized-models, in never exploring how deeply different this is from ideal-as-descriptive-models, we are abstracting away from realities crucial to our comprehension of the actual workings of injustice in human interactions and social institutions, and thereby guaranteeing that the ideal-as-idealized-model will never be achieved. It is no accident that historically subordinated groups have always been deeply skeptical of ideal theory, generally see its glittering ideals as remote and unhelpful, and are attracted to nonideal theory, or what significantly overlaps it, “naturalized” theory. In the same essay cited above, Jaggar identifies a “unity of feminist ethics in at least one dimension,” a naturalism “characteristic, though not definitive, of it” (Jaggar 2000, 453). Marxism no longer has the appeal it once did as a theory of oppression, but it was famous for emphasizing, as in The German Ideology, the importance of descending from the idealizing abstractions of the Young Hegelians to a focus on “real, active [people] men,” not “men as narrated, thought of, imagined, conceived,” but “as they actually are,” in (class) relations of domination (Marx and Engels 1976, 35–36). And certainly black Americans, and others of the racially oppressed, have always operated on the assumption that the natural and most illuminating starting point is the actual conditions of nonwhites, and the discrepancy between them and the vaunted American ideals. Thus Frederick Douglass’s classic 1852 speech, “What to the Slave Is the Fourth [of] July?” points out the obvious, that the inspiring principles of freedom and independence associated with the celebration are not equally extended to black slaves: “I am not included within the pale of this glorious anniversary! Your high independence only reveals the immeasurable distance between us. . . . The rich inheritance of justice, liberty, prosperity and independence, bequeathed by your fathers, is shared by you, not by me. . . . This Fourth July is yours, not mine. You may rejoice, I must mourn” (1996, 116, emphasis in original). So given this convergence gender, class, and race theory on the need to make theoretically central the existence and functioning of the actual non-ideal structures that obstruct the realization of the ideal, what defensible arguments for abstracting away from these realities could there be?

#### We can’t begin from “impartial” equality --- it ignores how certain individuals are actively denied participation in that starting point -- the society operates under an ethic that affirms the consequences of that exclusion.

#### And questions of structural violence come first because they determine the scope of morality.

Winter and Leighton 99[Deborah Du Nann Winter and Dana C. Leighton,  (Deborah Du Nann Winter is Professor of Psychology at Whitman College in Walla Walla, Washington, where she has taught for 26 years. She is the author of Ecological Psychology: Healing the Split Between Planet and Self (1996) as well as numerous articles on the psychology of peace and environmental issues. She serves as President of Psychologists for Social Responsibility, and is on the Editorial Board of Peace and Conflict: Journal of Peace Psychology., Dana Leighton is an undergraduate Psychology Major at Whitman College), 6-1-1999, accessed on 7-25-2020, Cpb-us-w2.wpmucdn, "Peace, Conflict, and Violence: Peace Psychology for the 21st Century.", http://sites.saumag.edu/danaleighton/wp-content/uploads/sites/11/2015/09/SVintro-2.pdf ] chsAK

Finally, to recognize the operation of structural violence forces us to ask questions about how and why we tolerate it, questions which often have painful answers for the privileged elite who unconsciously support it. A final question of this section is how and why we allow ourselves to be so oblivious to structural violence. Susan Opotow offers an intriguing set of answers, in her article Social Injustice. 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 tppressed, 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.

Thus, the standard is mitigating structural violence— it’s consequentialist. Prefer:

[1] Parameters—theoretical justifications come first since they frame an obligation constitutive to the judge whose role is an educator—prefer our framing:

(a) Inclusion – discussions of structural violence and material oppression allow for ALL underprivileged people to be in our calculus to make debate more inclusive . Outweighs since all voter assume people can access debate spaces.

#### (b) Advocacy Skills- shifting our frames to SV promotes good scholarship that creates advocates who care about those things in the real world, which is key in the context of the winter and leighton evidence.

#### (c) Education – Absent fighting oppression, lived experiences are ignored and marginalized debaters internalize self-hatred as being justified to stop other supposedly more important events.

### UV

#### [1] 1AR theory –

#### a) AFF gets it - otherwise neg can engage in infinite abuse

#### b) drop the debater – 1AR is too short for theory and substance so ballot implications are key to check abuse

#### c) no neg RVIs – they can stick me with 6min of answers to a short arg and make the 2AR impossible

#### d) competing interps – 1AR interps aren’t bidirectional and the neg should have to defend their norm since they have more time.

#### e) Highest layer first because it indicts the neg’s positions and skews my time allocation on other flows like T or the K

#### f) no 2nr theory, rvis or paradigm issues otherwise the neg gets 6 minutes to dump on this layer which is impossible for a 3 min 2ar

#### Fairness is a voter because debate’s a game that needs rules to evaluate it and education since it gives us portable skills for life like research and thinking.