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#### **Disease outbreaks are inevitable hurt minority populations but eliminating medical IP is key to socialize medicine which prevents the impact – their innovation DA doesn’t apply because it doesn’t work for pandemics and Cuba disproves**

**Attard 20** (Joe Attard, Writer for Socialist Revolution, 24 March 2020, “Pandemics, profiteering and big pharma: how capitalism plagues public health” <https://www.marxist.com/pandemics-profiteering-and-big-pharma-how-capitalism-plagues-public-health.htm>) [Twinz]

A perfect storm of private sector profiteering, reckless production practices, environmental destruction and underinvestment in medical research has made global pandemics more common, and undermined our capacity to deal with them. Capitalism not only gave rise to this invisible and deadly enemy – it is the biggest obstacle in our fight against it. While COVID-19 has taken governments worldover by surprise, it was an accident waiting to happen. Just as the economic and social chaos the pandemic has provoked was prepared in the last period, capitalism has long since laid the basis for a public health disaster on this scale. “You want a vaccine? Show me the money” Apologists for capitalism preach the superiority of the free market system over economic planning. But pharmaceutical production and R&D are totally hobbled by market forces. In the past two decades, there have been a number of international viral outbreaks that have claimed thousands of lives (Sars-CoV-1, Mers, Zika, Ebola etc.) To date, only one vaccine for these diseases has reached the market – for Ebola.[1] Coronavirus is not an unknown threat. SARS is part of the coronavirus family. The US government has spent more than £500m on coronavirus research over the past 20 years.[2] However, scientists are starting well behind the curve. Jason Schwartz, professor at the Yale School of Public Health, told the Atlantic earlier this month: “Had we not set the SARS vaccine research programme aside [in 2004], we would have had a lot more of this foundational work that we could apply to this new, closely related virus.”[3] The high-cost, high-reward business model of for-profit medical R&D doesn’t apply well to active pandemics, because the market immediately dries up when the crisis peters out, which means that funding is pulled and research is shelved.[4] Coronavirus SARS CoV 2 Image Felipe Esquivel Reed Research into treatments for the coronavirus are hampered by market forces / Image: Felipe Esquivel Reed However, it was recently announced that the US National Institute of Allergy and Infectious Diseases (NIAID) received the first candidate for a vaccine against COVID-19.[5] The vaccine has been produced by NIAID in partnership with a company called Moderna, based on research from various universities in the States, Britain and Australia.[6] The approval process is being fast tracked, meaning trials could begin as early as next month.[7] But it will be at least a year before such a vaccine could be mass produced, by which time the pandemic might have burned out – potentially taking millions of lives with it. And even then, NIAID will require another large pharmaceutical company to take on the task of manufacturing the vaccine. This is because the biggest such companies, like Pfizer, Novartis etc. have a stranglehold on the bulk of raw materials, and have consolidated patents on the manufacturing process for vaccines.[8] So far, there is little interest from these pharmaceutical fat cats. This is despite the fact that US Health and Human Services Secretary Alex Azar has stated that any private manufacturer would be allowed to set “reasonable” prices for their product. “We need the private sector to invest,” he said, “price controls won’t get us there.”[9] For millions of people, this vaccine could be a lifesaver – but the capitalists will not invest if there are no profits to be made. The market economy is leaving humanity to its fate. The majority of pharmaceutical R&D funding comes from the private sector, which accounted for 67 percent of a total $194.2bn invested in the US health sector in 2018, compared to 22 percent by federal bodies and 8 percent by academic and research institutes.[10] Pharmaceutical companies use these high R&D costs as justification for boosting prices of older and generic drugs, to the point that essential medicines like insulin can cost $25 to $100 a vial in the States.[11] In 2015, the president of Turing Pharmaceuticals, Martin Shkreli, caused a scandal by increasing the cost of Daraprim (a drug used in the treatment of AIDS-related conditions) from $13.50 to $750 per pill.[12] Despite the excuse that such windfalls are reinvested in drug development, the vast majority of new medicines are produced by state-funded or subsidised research: including the new candidate vaccine for COVID-19.[13] Rather than advancing medical research and innovation, private pharmaceutical companies mostly use their financial clout to amass patents on medicines developed with public money, flog derivatives of existing drugs at inflated prices and churn out lifestyle drugs like viagra.[14] By using these practices (and benefitting from a liberalisation of anti-monopoly laws in the 1990s), pharmaceuticals became the fastest-growing and highest-profit legitimate industry on earth by the turn of the millenium, raking in $1.2tn USD in 2018 alone.[15] With so much easy money flowing in, private pharmaceutical companies have little interest in developing new vaccines on their own initiative – especially for active epidemics. The mechanism by which viruses live and propagate is poorly understood by science. Diseases like coronavirus also mutate very quickly into new strains. Vaccine development is a difficult, expensive and time-consuming process, in which returns are never guaranteed. Trevor Jones, director of the Association of the British Pharmaceutical Industry, claimed that it costs $500 million to research and develop a new drug, and drug companies expect to earn back that investment within the first three to five years of sales.[16] The last “blockbuster vaccine” produced in the private sector was Merck’s Gardasil, for use against HPV, which came out in 2006 after a 20-year development cycle.[17] Forbes recently reported on the industry’s “innovation crisis”, outlining the main contradiction at the heart of this sector: profits are going up, but the number of new drugs and vaccines is going down: “Failing productivity seems like a strange problem in an industry that generates more cash than it can deploy, enjoys unlimited demand and wields monopolistic pricing power. But pharma is not a ‘normal’ business. Each new drug, each clinical trial is an experiment. Development is inherently unpredictable, as reflected in a success rate of 2%... [A] review of data on changes in the value of drugs and industry revenues between 1995 and 2014 did not show the predicted decline. The productivity problem stems not from constraints on opportunity [but] rising costs.”[18] In short, developing new medicines presents too high of a risk and not enough of an assured profit, meaning drugs companies are devoting their resources to more lucrative avenues, and doing very well. At the same time, private pharma uses its oligarchic power to hamper the development and manufacture of new drugs by anyone else, including the state. The result is that, while the capitalists are still raking it in, the market has left us ill-equipped to deal with crises like the COVID-19 outbreak. Contradictions and crisis With the private sector dragging its feet, many attempts have been made to build up state-run medical R&D. But while state research has received more funding in the advanced capitalist countries in recent years, it still only commands about 5 percent of total spending in the USA, for example. By contrast, military spending takes up 54 percent.[19] And the immense power of the pharmaceutical oligarchy means it can bend government bodies to its will if they conflict with the bottom line. The state doesn’t dictate to capital, but vice versa. The last time the US government approved a national vaccination programme was for swine flu in 1976. Four drug firms – Merck’s Sharp & Dohme, Merrell, Wyeth and Parke-Davis – refused to sell to the government the 100 million doses of the vaccine they had manufactured until they got full liability indemnity and a guaranteed profit.[20] And shortly before the COVID-19 outbreak, the Coalition for Epidemic Preparedness Innovations (CEPI) raised $750bn to expedite the development of vaccines to treat new epidemics, with support from countries like Japan, Germany, Canada etc. But private drugs companies on CEPI’s scientific advisory panel (including Johnson & Johnson, Pfizer and Takeda) forced the organisation to back down on the principle that “all countries would have equal and affordable access to CEPI-funded vaccines”.[21] This ensured the capitalists would still be able to turn a healthy profit on any vaccines developed through this fund, in any foreign market. Two of the biggest impediments to progress in the field of medical research are also the two biggest fetters on the development of capitalist society in general: the nation state and private property. The rise of protectionist tendencies worldwide also affects the drugs market, with nations jealously concealing the results of their latest pharmaceutical research – both state-funded and private. During this COVID-19 crisis, these tendencies have been accelerated. World leaders are hunkering down behind their borders, refusing to share essential resources to fight the pandemic. The Serbian president recently decried the “fairytale” of European solidarity, given the EU laws that prevent the movement of doctors and key medical supplies to non-Schengen countries. He then announced Serbia’s own borders closed to “foreigners”.[22] In truth, solidarity between the Schengen countries has also broken down, with Germany at first banning the export of desperately needed facemasks to countries like Italy.[23] 21 of the 26 Schengen nations have now closed their borders, posing an existential threat to the EU. This madness is the product of a senile system, which has descended into in-fighting precisely when unity is most needed. Viruses know no borders, and the lack of international coordination severely hampers our ability to respond to pandemics. Epidemiology lab 2020 Image Health mil Researching vaccines is financially risky / Image: Health mil Recently, students at the University of Sheffield sequenced whole genomes of the coronavirus from UK patients, and are set to make their research public.[24] This is a remarkable achievement that arose from state-subsidised academia. However, there is now a race to develop a vaccine based on such research, and by various governments to secure exclusivity. First into the dog pile was US President Donald Trump, who followed his ‘America First’ maxim by offering the German biopharmaceutical company CureVac “large sums of money” for exclusive rights to a COVID-19 vaccine and antiviral agents.[25] The German government has apparently met this move with a counter-offer. This could potentially set off a bidding war, which will force millions of people and state health services to buy vaccines at prices set by the winner. Under a planned world economy, all of the planet’s resources could be pooled into developing an effective treatment and vaccine for COVID-19. But the antagonised interests of capitalist nations prevent this. Attempts to overcome these antagonisms on a capitalist basis have met with little success. For instance, the WHO operates the Pandemic Influenza Preparedness (PIP) Framework, which facilitates the sharing of medical research between nations. But it only applies to influenza, not any other infectious disease with pandemic potential, due to pressure from the industry and governments.[26] Indeed, the WHO itself is a shadow of its lofty objectives. Its funding has been cut in half by the Trump administration, it is rife with rumours of corruption, and has been supplanted by the World Bank as the biggest financier of public health globally.[27] Similar bodies like the Centres of Disease Control and Prevention (CDC) have also seen their budgets slashed in recent years: casualties of the protectionist tendency in the world markets.[28] Furthermore, private-sector medical companies consider their products (whether they actually developed them, or merely purchased the patents) to be their private possessions: valuable only for their market potential, not their capacity to cure people. Recently, a private company threatened with legal action two volunteers who were 3D-printing valves for use in ventilators, selling them for $1 against a typical market price of $11,000.[29] This kind of private sector parsimony is replicated across the international pharmaceutical market. For example, the 1994 Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) guarantees IP protection for all companies, including pharmaceutical firms, when selling their products in any WTO country. This proves problematic in poorer countries, where essential drugs are the intellectual property of private companies, whose exorbitant prices are too high for these markets, and who resist attempts to produce cheaper derivatives domestically. In response to this problem, in 2001 (on the initiative of the WHO), the Doha Declaration on TRIPS and Public Health – agreed by all WTO Member States – affirmed that public health should always take precedence over the enforcement of intellectual property rights. However, according to Oxfam in 2019: “rich countries and pharmaceutical companies have ignored the Doha Declaration and pursued an aggressive agenda to subject the developing world to even stricter IP protection, through free-trade agreements and unilateral pressure.”[30] In short, powerful nations will always crush the weak, and the private property rights of the capitalists always trump human need. A recent statement by the British government inadvertently exposed the failure of the so-called free market to ameliorate this pandemic. The Tory administration has banned the parallel export of 80 drugs (including Aluvia, adrenaline and morphine), due to speculation by private companies, which were attempting to buy the drugs cheaply in Britain, then hoard and sell them at an inflated price abroad. This hasn’t been prohibited because it is ethically unacceptable, but because the government was afraid it would “aggravate supply problems”.[31] It has also transpired that the US firm Rising Pharmaceuticals increased the price of chloroquine (an antimalarial, which is being tested against COVID-19) on 23 January, when the scale of the outbreak in China became apparent. The drug price rose 97.86 per cent to $7.66 per 250mg pill and $19.88 per 500mg pill. Although the PR backlash led them to quickly return the cost to the ‘normal’ market rate, Rising has previously been fined for price fixing, and it is clear they intended to exploit the suffering of millions of people to score a windfall.[32] This won’t be the last time a company seeks to turn a quick buck on the coronavirus pandemic. Contrast this with Cuba’s production and distribution of Interferon alfa 2b: developed in 1986 by the state-run BioCubaFarma in collaboration with China. This drug, which can help stop some of the symptoms of coronavirus, has been tested with positive results on 1,500 coronavirus patients in China already. Cuba has shipped Interferon in large quantities to badly-affected countries like Italy. Teams of Cuban doctors have also been sent to dozens of countries to help fight outbreaks.[33] It is a clear testament to the superiority of a planned economy that a small Carribean Island can produce an effective treatment for a disease that resists the best efforts of the mightiest capitalist countries on earth, and freely send medical resources to those in need. Similarly, whereas for-profit pharmaceutical companies have dropped research into complex conditions like Alzheimer’s disease due to a lack of returns, Cuba’s state-run medical research has produced some exciting breakthroughs against both Alzheimer’s and HIV.[34] Needless to say, the trade embargoes imposed on Cuba by the US will be an obstacle to any of these potentially life-saving treatments reaching the people who need them, and there will be consequences for any US trade partners who accept them. The limitations of the capitalist system mean that medical R&D on vaccines for serious, life-threatening diseases have been basically stagnant since the 1960s. Humanity is increasingly vulnerable to global epidemics (for reasons I will explain), and our weapons to resist them are becoming obsolete. The pharmaceutical industry is privatising the profits of this essential sector, and socialising the risks. And capitalist governments are facilitating them. An infectious disease researcher interviewed in the New York Times recently opined: “What matters more to the drug companies? Keeping trade secrets and boosting the bottom line or taking a leading role in stemming the COVID-19 outbreak?”[35] The answer is clear as day. A crisis like the current pandemic offers no better argument for placing these unproductive parasites under democratic control so their immense resources can be put to good use. The poorest suffer most So far, COVID-19 has only just hit the least-developed countries. The first confirmed cases have recently been reported in Somalia and Tanzania.[36] Another was detected in the Gaza Strip.[37] The virus will inevitably spread, and when it does, the results will be catastrophic. How can a country like Somalia – which barely has a functioning government, and whose housing and sanitation are in a miserable state – carry out social distancing measures or subsidise lost wages? How will its medical infrastructure cope with thousands of infected patients? And aside from these poor countries, what happens when the thousands of Middle-Eastern refugees living in tents in European migrant camps become infected? The answer is obvious. There will be no containment, there will be no concerted medical response. People will be left to fend for themselves. This state of affairs is merely par for the course when it comes to disease prevention in underdeveloped nations. Less than 10 percent of global health research public spending is dedicated to diseases that affect the poorest 90 percent of the world population.[38] Deadly diseases like HIV/AIDS and tuberculosis thrive in poor countries. Neglected tropical diseases kill 500,000 people in the developing world every year.[39] And if private drugs companies see scant financial incentive in developing medicines for the advanced capitalist countries, they see none at all in the poorest nations. Dr. Harvey Bale Jr., head of the International Federation of Pharmaceutical Manufacturers, asserted that there was “no marketplace to speak of in the poor world”.[40] Dr. Bernard Pécoul of the Médecins Sans Frontières added that the push for profits “leaves you focused on 300 to 400 million people in rich countries.”[41] This is a very clear example of where production for profit is grossly misaligned with need. Aids is commons in Africa Image Jonrawlinson Disease has claimed millions of lives needlessly in the less-developed world. Capitalism is to blame / Image: Jonrawlinson To give an example, in the late ‘90s, the genome for tuberculosis was sequenced. TB causes terrible suffering in the poorest parts of the world. Despite the WHO organising a 1998 summit to gain the support of leading pharmaceutical companies to develop a vaccine and treatments, none of these companies was willing to commit to any project that would realistically yield profits of less that $350m a year or five years or more. That would have required a total cost of $11 USD per pill, per patient in sub-Saharan Africa, for instance, which at the time spent less than $10 USD per citizen, per year, on all healthcare needs. In short, private pharma refused to commit any of its resources to alleviating the suffering of poor nations unless they accomplished the impossible. The project was abandoned. And aside from a lack of investment in R&D, many private firms have abandoned production of existing, important drugs for the developing world, including five treatments for African sleeping sickness, aminosidine for the parasitic disease leishmaniasis and even the polio vaccine.[42] Far from advancing human society in the fight against illness, capitalism is actually taking us backwards. International bodies like the WHO and the G8 have attempted to incentivise private sector investment in the poor world with subsidies like Advanced Market Commitments (AMC), through which advanced capitalist countries agree to meet some of the costs of getting affordable vaccines to where they’re needed most.[43] Alternatively, the US Food and Drug Administration offers vouchers that can be exchanged for fast-tracked reviews of any future product to companies that develop effective medicines for neglected diseases.[44] But all of these rewards have failed, either because they don’t provide enough of an incentive, or because pharmaceutical companies have found ways to game the system and enrich themselves even further. For instance, by applying the aforementioned voucher to the anti-malarial medicine Coartem, Novartis accrued an additional profit of $321m solely for registering their product with the US FDA, even though the medicine is already in widespread use elsewhere.[45] The only value private pharma sees in the developing world is a testing lab to outsource its clinical trials, which represent the single-biggest cost of drug development.[46] This cost can be significantly off-set by exploiting test subjects in places like India, where clinical trials have created a thriving market. Better yet, these firms can often avoid disagreeable red tape like ethical standards and informed consent by moving these operations to countries where regulations are looser, and turning desperate people into their lab rats.[47] Some poorer countries have sought to offset rising drug costs by investing in their own pharmaceutical manufacture and distribution channels, at the cost of deepening their foriegn debt. However, these efforts have been frustrated by the Pharmaceutical Manufacturers’ Association (the industry’s main bosses’ organisation), which feels this represents an “infringement on their free market rights.”[48] From 2008 to 2018, an Intergovernmental Working Group on Public Health, Innovation and Intellectual Property Rights (IGWG) has sought to address the demands of developing countries for a global system of R&D that better reflects their needs. But its recommendations have been totally ignored by both imperialist countries and private pharma. The situation was summed up in a damning report by Oxfam: “The lack of medical innovation is a global problem which requires a significant increase in resources, applied in an effective and coordinated manner. The current system of R&D under-utilises the capacities, skills, and resources available in all countries. Efforts to improve R&D across the developing world are fragmented, unsustainable, and unlikely to lead to large-scale changes.” Despite the complaints of Oxfam and the IGWG, you can’t change the rules of capitalism by appealing to the capitalists’ better nature. If there’s no profitable market, they won’t invest. The reforms they propose would require a fundamental break with the current system. Naturally, research on life-saving treatments for illnesses that afflict the developing world would also have a positive impact on the development of vaccines and treatments in the advanced capitalist countries. But the market system only thinks about immediate returns. Human lives are small change. Disease also serves to keep the poor world poor. The HIV/AIDS crisis (the origins of which lie in primate-to-human transmission through the illegal bushmeat market, to which desperate populations resorted after successive famines) carved through the developing world like a scythe in the 1980s and 1990s. Up to 121m fewer people are alive today as a consequence of this pandemic.[49] The World Bank estimated in 1991 that HIV/AIDS commanded more than 4 percent of Tanzania’s health budget, 7 percent of Malawi’s, 9 percent of Rwanda’s, 10 percent of Burundi’s and 55 percent of Uganda’s.[50] Furthermore, epidemics in poor nations in Africa and the Americas have been exacerbated by the impact of war and coups, provoked by imperialist meddling, which crippled these countries’ already vulnerable health infrastructures.[51] Insulting attempts from the 1970s by the World Bank to “pressurise” poor countries to spend more on disease prevention and healthcare have been curtailed by their need to service immense debts to bodies like the IMF.[52] Imperialism has brought ruin to these nations, not only through colonialism, exploitation and war, but also illness. Now, they are practically defenceless against emergencies like the COVID-19 pandemic. Environmental destruction and intensive farming: rearing disease While its exact origins are unclear, COVID-19 is thought to have been introduced from animal to human populations at the end of last year in Wuhan, the capital of Hubei province in China, and subsequently spread through national and international travel during Chinese New Year.[53] This is similar to the 2003 SARS outbreaks, which resulted from transmission of a mutated strain of coronavirus at a live animal market in Guangdong province.[54] Neither of these outbreaks were ‘natural’ occurrences. Rather, they were the inevitable consequence of rapacious capitalist production, which is creating fertile ground for potentially lethal diseases to cultivate in animal populations and spread to human beings. The increased prevalence of pandemics in recent years can be partly explained by capitalist destruction of the environment. Since 1940, there have been hundreds of microbial pathogens appearing in new territory: including HIV and Ebola in Africa, Zika in the Americas and so on. More than two-thirds of these originate from wildlife, rather than domestic animals.[55] Deforestation through logging, urban expansion, road building and mining destroys wild species’ habitats and increases their contact with human settlements, which offers more opportunities for microbes that live harmlessly in their bodies to “spillover” into ours. Disease ecologist Thomas Gillespie, interviewed in Scientific American stated: “I am not at all surprised about the coronavirus outbreak. The majority of pathogens [in the bodies of wild animals] are still to be discovered. We are at the very tip of the iceberg.”[56] Deforestation Chris Cunning Environmental destruction plays a major role in the emergence of new pandemics worldwide / Image: Chris Cunning For example, the 2017 Ebola outbreaks originated from species of bats, who have been forced to roost in trees in farms and backyards due to deforestation. These animals become carriers for animal-to-human strains of viruses due to repeated contact, and either pass on pathogens through bites, fecal matter, or through being sold as food in informal “wet markets” – where species that would never naturally encounter one another are caged side by side.[57] These markets are an essential food source for poor people in Asia and Africa, however, according to Gillespie they are “a perfect storm for cross-species transmission of pathogens. Whenever you have novel interactions with a range of species in one place, whether that is in a natural environment like a forest or a wet market, you can have a spillover event.”[58] This is exactly what resulted in the mutant coronavirus that caused the SARS epidemic, and possibly COVID-19.[59] One hypothesis is that the virus was passed from a bat or pangolin at a wet market to its first human victim: a 55-year-old man.[60] However, this is only one scenario in which dangerous pathogens can arise from animals. In factory farms, hundreds of thousands of individuals are packed in cramped conditions, which creates an ideal environment for microbes to become lethal pathogens. Bird flu, for example, originated in wild waterfowl. But when the influenza reaches factory farms for chickens, it ravages the population and mutates quickly to become more virulent. This is what produced the feared H5N1 strain of avian influenza, which can infect and kill humans.[61] Moreover, attempts to maximise the production of particular animal products have resulted in the widespread emergence of monoculture farms – in which only one kind of animal is reared. This creates an ideal environment for the evolution of dangerous viruses.[62] Swine flu originated from monocultures of pigs, for example – although the hog farming industry lobbied the WHO to rename swine flu by its scientific name, H1N1, to divert attention from its origin.[63] It has been hypothesised by some scientists that pig monocultures may even have bred the novel coronavirus.[64] These issues affect agribusiness in all advanced capitalist countries, and food production operations in the US and Europe have served as ground zeroes for the H5N2 and H5Nx influenzas, both of which were downplayed by American public health officials.[65] However, it is no accident that a number of serious epidemics in the past several years have originated from China. Here, as well, capitalist production is to blame. The rapid development of China’s economy on a capitalist basis has erected an epidemiological house of cards in the country. Rob Wallace’s book, Big Farms Make Big Flu: Dispatches on Influenza, investigates the emergence of avian flu in China. He explains how, in the 1980s and ‘90s, the country modernised and consolidated its agribusiness in provinces like Guangdong, where the first H5N1 case was recorded in 1997. Foreign companies like Charoen Pokphand (CP) were invited to set up shop in Guangdong, introducing vertically integrated operations where the animals, their feed and processing plants were all provided by the same firm. This resulted in an explosion of the number of ducks and chickens produced annually. US-style intensive farming techniques (with even-more-relaxed regulation) were introduced to satisfy market demand and maximise profits, and the insurmountable competition devastated rural agricultural production by peasant communities, leading to a massive internal migration to these provinces.[66] This placed huge monocultures of poultry in close contact with densely packed human populations. Hubei is China’s sixth-largest poultry producing province, with a population of 58.5m.[67] No matter how COVID-19 originated, Hubei was always a ticking time-bomb for disease. Ducks in cages at wet market Shenzhen China Image Daniel Case Coronavirus likely originated in a "wet market" / Image: Daniel Case The immense economic power of companies like CP (which now produces 600m of China’s 2.2bn chickens annually sold) translates into huge political power in Asia, which comes in useful when their actions result in pandemics. For instance, CP was a major supporter of Telecommunications tycoon Thaksin Shinawatra, the prime minister of Thailand during the country’s first bird flu epidemic – whose promises to run the country “like a business” saw massive attacks on workers’ rights and aggressive liberalisation of the Thai economy.[68] When the outbreaks began in Thailand, Shinawatra played an active role in blocking efforts to stem the spread of bird flu. Chicken-processing plants actually intensified production, with trade unionists reporting that one factory was still churning out between 90,000 to 130,000 poultry daily, despite it being obvious the chickens were sick.[69] Shinawatra and his ministers went on TV eating chickens to show their confidence, but behind the scenes, CP and other big agribusinesses were colluding with the government to pay off contract farmers to keep quiet about their infected flocks. In return, the government was secretly supplying corporate farmers with vaccines, while poorer farmers were kept in the dark: putting themselves and their animals at risk.[70] When Japan banned poultry from China during the crisis, CP’s Thai factories picked up the slack, resulting in the company making even-greater profits from an epidemic largely of its own making![71] Another long-term threat posed by intensive farming (to which I will return later) is the cultivation of antibiotic resistant microbes. Shortly after the discovery of antibiotics revolutionised medical science, it was discovered that expensive livestock lived longer when dosed with them. Unfortunately, livestock undergoing these treatments place more than double the global selective pressure on bacterial populations to evolve and become resistant, which exacerbates an existing, and already extremely serious problem for public health.[72] In short, the massive pressure placed on animals and the environment by capitalist production has contributed to a very dangerous scenario, in which human-communicable pathogens are evolving and spreading at an accelerated rate. It recalls the words of Engels, writing in Dialectics of Nature: “Let us not...flatter ourselves overmuch on account of our human victories over nature. For each such victory nature takes its revenge on us. Each victory, it is true, in the first place brings about the results we expected, but in the second and third places, it has quite different, unforeseen effects which only too often cancel the first…”[73] Nowhere is this sentiment truer than in the pathogens that originate in factory farms. However, none of the problems outlined here are endemic to efficient food production. All of them stem from intensive farming techniques, designed to maximise profits above all, which are very cruel to the animals we eat, and potentially disastrous to public health. There is no reason that monocultures of animals, dosed on antibiotics, must be crammed cheek-by-jowl into hellish factories, and become breeding grounds for disease. Under a rationally planned economy, all of these processes could be made as efficient, humane and safe as possible, without having to satisfy the capitalists’ lust for profits. “Outbreaks are inevitable, pandemics are optional” In 1994, Pulitzer-winning journalist Laurie Garrett wrote The Coming Plague: Newly Emerging Diseases in a World Out of Balance. This was followed in 2001 by Betrayal of Trust: The Collapse of Global Public Health. Over these two books, she explained that “human disruption of the global environment, coupled with behaviors that readily spread microbes between people and from animals to humans, guaranteed a global surge in epidemics, even an enormous pandemic. [These] outbreaks were aided and abetted by inept health systems, human behavior, and the complete lack of consistent political and financial support for disease-fighting preparedness everywhere in the world.”[74] Though she didn’t put it in these terms, these books were a damning indictment of capitalism and its corrosive effects on public health. Garrett’s warnings were corroborated in a 2018 report by the Global Preparedness Monitoring Board, which warned that “there is a very real threat of a rapidly moving, highly lethal pandemic of a respiratory pathogen killing 50 to 80 million people and wiping out nearly 5% of the world’s economy”.[75] The report continues: “Between 2011 and 2018, WHO tracked 1,483 epidemic events in 172 countries. Epidemic-prone diseases such as influenza, severe acute respiratory syndrome (SARS), Middle East respiratory syndrome (MERS), Ebola, Zika, plague, yellow fever and others, are harbingers of a new era of high-impact, potentially fast-spreading outbreaks that are more frequently detected and increasingly difficult to manage… Any country without basic primary health care, public health services, health infrastructure and effective infection control mechanisms faces the greatest losses, including death, displacement and economic devastation.”[76] Coronavirus Tories Image Socialist Appeal COVID-19 has exposed the callousness and ineptitude of capitalist governments / Image: Socialist Appeal In other words, the current COVID-19 crisis is part of a new era in which pandemics will become more common, for the reasons I have described. The world is underprepared for this, and the poorest countries are going to suffer the most. Aside from the emergence of new pathogens, there are other threats on the horizon, including antibiotic-resistant strains of microbes like streptococcus and staphylococcus, cultivated in hospitals in the advanced capitalist countries, due to an over-reliance on antibiotics developed in the post-war period.[77] Illnesses of the 19th and 20th century, like TB, are returning with a vengeance in poor communities like Harlem in New York City – and developing antibiotic resistance.[78] In the 1990s, a forecast by the University of California predicted that by 2070 the world would have exhausted all antimicrobial drug options, as viruses, bacteria, parasites and fungi would have evolved complete resistance to the human pharmaceutical arsenal.[79] This apocalyptic scenario could be avoided, if more was invested in R&D for vaccines and alternative treatments. But as explained, this is not a profitable avenue for big pharma. Responding to the aforementioned GPMB report, Garrett was sceptical that any of its proposals (which amount to lobbying governments and private enterprise to cooperate more effectively on funding and research) would amount to anything. She wrote: “With no intention of degrading the GPMB’s effort, I must sadly say that this core message has been shouted from the rafters many times before, with little discernible impact on tone-deaf political leaders, financial enterprises, or multinational institutions. There’s no reason to think this time will be any different.”[80] Indeed, on a capitalist basis, it is unlikely that the situation will improve. These diseases have been conjured up by the system itself, and the living patterns of modern capitalist societies create ideal conditions for them to spread. Urbanisation has concentrated the vast majority of the planet’s 8bn people into dense populations, where disease can run rampant. And the dramatic increase in worldwide movement of people and goods (facilitated by modern transport, and exacerbated by war and climate change) creates viable channels for microbes to rage across the planet. It only took a matter of days before COVID-19 had spread from one end of the earth to the other. Such a global problem requires an international solution. But, as described, antagonism between different capitalist nations, the private property rights of the major pharmaceutical companies and the profit-based mode of production prevents the kind of coordinated response necessary to fight pandemics. The capitalist upswing in the postwar period was a period of great optimism for public health. Improved housing and sanitation, and the discovery of antibiotics, meant life expectancies increased sharply.[81] In the United Kingdom, the working class returned from a victorious war demanding reforms, amongst which was the National Health Service: providing complex medical aid freely at the point of use. In 1995, Dr. Jonas Salk’s polio vaccine successfully reduced cases of the illness in Western Europe and North America from 76,000 in 1955 to 1,000 in 1967.[82] In 1978, the WHO convened a meeting of health ministers from over 130 nations in Alma-Ata in the USSR, issuing a document (‘the Declaration of Alma-Ata’) that called for “the attainment by all peoples of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life,” defining health as “a state of complete physical, mental, and social well-being, not merely the absence of disease or infirmity,” and “a fundamental human right.”[83] But today, far from a human right, decent and affordable healthcare is denied to millions of people. Meanwhile, years of underinvestment and privatisation have brought progress on medical research to a near-halt, and the democratic gains of the post-war period have been curtailed. The ruling class has met this current crisis with a Malthusian cynicism worthy of Trevelyan, openly considering the “positive economic effects” of COVID-19 killing off “non-productive” layers of society.[84] The austerity that followed the 2008 crash has taken a heavy toll on public health, the consequences of which are now being ruthlessly exposed by the new coronavirus outbreak.[85] Everywhere, a lack of (privately manufactured) testing kits makes it impossible to gather accurate data on the extent of the coronavirus pandemic. Beds are in critically short supply. Retired health workers are being returned to service. Countries like Britain initially downplayed the risk posed by the virus, before u-turning and imposing a lockdown. The early talk of “mitigation” and “flattening the curve” rather than containment was partly to avoid disrupting business, but was also because the health service can’t take the burden of an outbreak that could reportedly last until 2021 and put 8m people in hospital.[86] Meanwhile, decentralisation and successive cuts to the Italian healthcare system over the last 30 years have led to major shortages of not just ventilators and beds, but even face masks and hand sanitiser, in one of the worst-affected countries.[87] Oversubscribed Italian hospitals have no choice but to choose who lives or dies based on age. Health workers are completely overstrained, with images of Italian nurses passed out from exhaustion testifying to the dire state of affairs.[88] Moreover, the bosses in one country after another are refusing to take appropriate safety measures or cease production until forced to by strike action. And even where bourgeois governments have agreed to underwrite wages and take ownership of certain sectors in order to save the capitalist system, the working class will inevitably be expected to foot the bill when the dust settles. Capitalism has not only made new outbreaks more likely, but has strip-mined public health to the point that it is unable to cope with them. As the epidemiologist Larry Brilliant, who led the fight against smallpox, once said: “outbreaks are inevitable, but pandemics are optional.”[89] None of this has to happen. Under a planned economy, all the ingenuity of humanity would be directed towards developing vaccines for the biggest killer diseases. Mass immunisation programmes would then be freely conducted in every country on earth – eradicating diseases like Ebola just like we did smallpox. The environmental crises and intensive farming techniques that create breeding grounds for pathogens could be replaced with production planned in harmony with nature, which prioritises human and animal welfare over profits. Any new viral outbreak could be met with a concerted, global response to prevent it from reaching pandemic levels. All research and resources for the treatment of infected cases could be shared and utilised on the basis of need. Rather than having to pay private pharmaceutical companies through the nose, their immense operations would be expropriated and managed on a democratic basis to produce vaccines and antigens as needed. Instead of wasting millions in public money to obtain hospital beds, these could be simply requisitioned. Testing and quarantine facilities could be erected to manage the emergency. And rather than antagonistic capitalist countries racing to hoard resources – and striving to keep business profitable at the expense of public health – federated socialist countries could present a united front against epidemics. Non-essential production could be halted and social distancing measures carried out whenever necessary, without any impact on pay. And logistics could be planned to ensure shelves were stocked, basic necessities were distributed and nobody felt the need to horde essentials. Modern medicine represents a phenomenal victory of human society over nature. At least in the advanced capitalist countries, it has doubled our life expectancy and massively improved our quality of life. Any modern society that cannot guarantee its population good health, and protection against preventable pandemics, cannot be considered civilised. Where the capitalists and their political cronies meet public health emergencies by shrugging their shoulders and informing the masses: “your loved ones will die”,[90] a socialist society would equip humanity with the weapons it needs in the battle against disease. The callous, inept response of capitalist governments to the COVID-19 pandemic, and the resulting social fallout, will provoke a leap forward in the consciousness of the masses. Already, there have been spontaneous strikes in Italy, Spain, Portugal, France, the USA, Canada and elsewhere against attempts by the bosses to force workers to choose between risking infection at their workplaces, or losing pay. This is only a harbinger of what is to come. We are entering into a new epoch of dramatic struggle against a terminally sick system.

#### **Iniequalities within capitalism exacerbate disease spread – it increases risk factors for the poor and diverts medical resources from minority communities**

**Pirtle 20** Laster Pirtle, Whitney N. [Dr. Whitney (Laster) Pirtle is currently an Assistant Professor of Sociology, Associated Faculty in Critical Race and Ethnic Studies, and Affiliated Faculty in Public Health at the University of California – Merced] “Racial Capitalism: A Fundamental Cause of Novel Coronavirus (COVID-19) Pandemic Inequities in the United States.” Health Education & Behavior, vol. 47, no. 4, Aug. 2020, pp. 504–508, doi:10.1177/1090198120922942.//mb

Abstract Racial capitalism is a fundamental cause of the racial and socioeconomic inequities within the novel coronavirus pandemic (COVID-19) in the United States. The overrepresentation of Black death reported in Detroit, Michigan is a case study for this argument. Racism and capitalism mutually construct harmful social conditions that fundamentally shape COVID-19 disease inequities because they (a) shape multiple diseases that interact with COVID-19 to influence poor health outcomes; (b) affect disease outcomes through increasing multiple risk factors for poor, people of color, including racial residential segregation, homelessness, and medical bias; (c) shape access to flexible resources, such as medical knowledge and freedom, which can be used to minimize both risks and the consequences of disease; and (d) replicate historical patterns of inequities within pandemics, despite newer intervening mechanisms thought to ameliorate health consequences. Interventions should address social inequality to achieve health equity across pandemics. Keywords capitalism, coronavirus, COVID-19, fundamental causes, health inequities, racism Racial capitalism is a fundamental cause of disease in the world and will be a root cause of the racial and socioeconomic inequities in COVID-19 that we will be left to sort out when the dust settles. What is a fundamental cause? In Link and Phelan’s widely cited (1995) theoretical article, they argued that a social condition is a basic, fundamental cause of disease disparities if it (a) influences multiple disease outcomes, (b) affects disease outcomes through multiple risk factors, (c) involves access to flexible resources that can be used to minimize both risks and the consequences of disease, and (d) is reproduced overtime through the continual replacement of intervening mechanisms. Sociological health research has since proven that both socioeconomic and racial social inequities are social conditions that fit the formula and contribute to socioeconomic and racial health inequities (i.e., Gee & Ford, 2011; Lutfey & Freese, 2005; Phelan & Link, 2015; Phelan et al., 2010; Sewell, 2016; Williams & Collins, 2001). I extend this conversation by arguing that the research is actually capturing how racial capitalism works to have a fundamental impact on health inequities, as Black radical thought traditions suggested as much decades ago. As introduced by Robinson (1983), racial capitalism is the idea that racialized exploitation and capital accumulation are mutually constitutive. Racial capitalism created the modern world system, through slavery, colonialism, and genocide because “the development, organization, and expansion of capitalist society pursued essentially racial directions, so too did social ideology” (Robinson, 1983, p. 2). Racially minoritized and economically deprived groups face capitalist and racist systems that continue to devalue and harm their lives, even within newer, supposedly deracialized neoliberal agendas (Clarno, 2017; Johnson, 2017). We have ample evidence of racial capitalism as a cause of health inequities in the United States though, collectively, scholarship has not always connected all the pieces. For instance, Pulido (2016) argues that racial capitalism is at the very core of the Flint, Michigan lead water crisis: The people of Flint are so devalued that their lives are subordinated to the goals of municipal fiscal solvency . . . this devaluation is based on both their blackness and their surplus status, with the two being mutually constituted. (p. 1) Additional research has found that exposure to the Flint water crisis has been linked to both physical (Sadler et al., 2017) and mental (Cuthbertson et al., 2016) health problems for poor and people of color and can be explained through multiple mechanisms, such as disinvested, racially segregated neighborhoods (Michigan Civil Rights Commission 2017). Travel just 70 miles down I-75 from Flint to Detroit, Michigan, and we are able to witness in real time the way racial capitalism is shaping COVID-19 health inequities. In a report by Michigan’s Health Department, as of April 3, 2020, Detroit City and surrounding counties have the largest number of cases in the state; as Nichols (2020) wrote for the New York Times, Detroit is already mourning. Detroit and its surrounding areas have large populations of people of color, most of whom are Black Americans and populations that are poor and working class (Nichols, 2020; Schulz et al., 2002). Even more striking than the incidence rates, however, is statistics that reveal that out of the direct deaths related to COVID-19, 40% of them are of Black residents in a state that has only 14% Black population. The clock is already ticking in Detroit on the racial time bomb in the coronavirus crisis (Blow, 2020), and data replicate these trends in major metros across the United States including Chicago, New Orleans, and New York (McCarthy, 2020). The overrepresentation in mortality among Black Americans, or death gap, is a result of structural violence (Ansell, 2017) as created through a racial capitalist system. In the sections that follow, I detail how racial capitalism acts as a fundamental cause of health inequities and COVID-19. A. Racial Capitalism Influences Multiple Disease Outcomes First, the people of Detroit already endure multiple health problems, such as high rates of diabetes (National Medical Association, 2015). An early report from Italy found that a large majority of COVID-19 fatalities occurred in those who had comorbidities, or additional illnesses like diabetes and asthma, that amplified COVID-19’s wear on the body (Ebhardt et al., 2020). To be clear, these racial differences in illnesses are not the result of biological or even behavioral differences in race but a result of racist, capitalist systems that structure people’s lives. B. Racial Capitalism Increases Multiple Disease Risk Factors Racism and capitalism have, for example, mutually constructed racial residential segregation, which refers to the physical separation of groups into residential contexts that are patterned by race (Rothstein, 2017). Racial residential segregation has been imposed by legislation, supported by major economic institutions, enshrined in the housing policies of the federal government, enforced by the judicial system, and legitimized by the ideology of white supremacy that was advocated by the church and other cultural institutions. (Williams & Collins, 2001, p. 405) Residents in deprived neighborhoods have less access to green spaces and healthy, affordable foods; thus, restricting healthy behaviors. Racial residential segregation means poor people of color are also forced to live near manufacturing and other harmful toxins and wastes. People restricted to these areas endure multiple exposures to harmful physical and social environments and increased stressful events, all of which demonstrate how multiple risk factors shape health, including COVID-19. A 2002 study by health researchers argued that racial and spatial relations were fundamental determinants of health in Detroit (Schulz et al., 2002). Not only is Detroit one of most segregated cities in America, as mapping data shows (Cable, 2013), but Detroit also ranks in the top 20 major cities in the United States with highest rates of homelessness (Frohlich, 2019), and the majority of those persons are Black. Homelessness is another way that racial capitalism puts the poor, older, and families of color at increased risk for consequences of COVID-19 (Torres, 2020). How can a person even shelter in place with no shelter? Given our capitalist, privatized insurance system in the United States, most homeless and unemployed have inadequate access to quality health care (Ansell, 2017). Though, to be clear, America’s exceptionally unequal, extreme neoliberal health care system puts the entire country at risk (Gaffney, 2020). Health care inequities are another risk factor; the coronavirus does not have to discriminate across race and class, our health care system does that work on its own. Racial and economic differences in testing and treatment rates (Farmer, 2020) is one mechanism that shapes disparities. In a recent interview on PBS News Hour, Dr. Uché Blackstock shared the implications of racial bias in medical encounters: when black and brown people interface with the health care system, they often encounter provider bias. So, we know, and it’s well-documented, that their pain is undertreated or their complaints are minimized. So, my concern is that, when these patients present to emergency departments and hospitals in their areas with COVID-19 symptoms, that their symptoms may be downplayed or they may not be taken seriously. And we do already have the data to support that trend continuing to happen. (Blackstock, 2020) C. Racial Capitalism Restricts Access to Flexible Resources That Buffer Negative Disease Outcomes Additionally, racial capitalism is a fundamental cause because it shapes access to flexible resources. For example, those with high socioeconomic status secure a superior set of knowledge, power, money, power, prestige, and beneficial social connections, all of which can alleviate the consequences of the disease (Link & Phelan, 1995). Think about who has access to up-to-date reports of COVID-19 that communicate important health education facts on protection. The wealthy can also afford to pay others to do their grocery shopping or order online, meanwhile part-time Amazon workers forced to be on the front line write pleas about having no paid time off (Guendelsberger, 2020). And, why don’t employers value and protect the workers doing the essential jobs? Jason Hargrove, a Black bus driver in Detroit, who was exposed to COVID-19 and lacked access to proper safety equipment wondered this himself shortly before passing away from the disease (Witsil, 2020). Racism also restricts those same crucial flexible resources, in addition to others even more racialized such as freedom. For instance, unfreedoms, or the lack of control Black Americans have over their lives in the United States, whether it be attributed to historical systems of slavery or mass incarceration today, puts them at heighted risks for mental and physical health problems (e.g., Alexander, 2020; Phelan & Link, 2018). The vulnerability and unfreedoms of detained populations at the border and in prisons, who are overwhelmingly Black and Brown and poor, increases their risk for harsh consequences of COVID-19 (Morse, 2020). Throughout Michigan’s prison system, as reported on April 3 by WXYZ Detroit, 184 incarcerated persons have already tested positive for COVID-19 (R. Jones, 2020). D. Racial Capitalism Shapes Disease Outcomes Overtime Despite Implementation of Intervening Mechanisms Finally, intervening mechanisms found to mitigate some health inequities, like increased public sanitation or health education interventions, cannot fully eradicate the relationship between racism, poverty, and health because they are replaced by other mechanisms, like gentrification and rent surges that leads to housing instability and homelessness. In fact, mechanisms that sustain racial capitalism present a “fundamental resilience in the face of changing proximate causes” (Seamster & Ray, 2018, p. 330). The resilience can be evidenced in the revert back to previously mitigated mechanisms that are once again contributing to disease disparities, such as poor water sanitization (look again no further than the Flint water crisis).

#### **Cap creates greater risk of disease spreads Pandemics**

**Pappas and Cozzarelli 20** (Mike is an activist and medical doctor working in New York City; Tatiana is a former middle school teacher and current Urban Education PhD student at CUNY, Left Voice, Capitalism is an Incubator for Pandemics. Socialism is the Solution., 3-9-2020, accessed 7-21-2020, https://www.leftvoice.org/capitalism-is-an-incubator-for-pandemics-socialism-is-the-solution) Kuchimanchi

Coronavirus in Capitalism

It is only going to get worse. The spread of the virus is impossible to stop — and this is due to social reasons more than biological ones. While doctors recommend that people stay home when they are feeling sick in order to reduce the possibility of spreading the virus, working-class people just can’t afford to stay home at the first sight of a cough.

Contrary to Donald Trump’s recent suggestions that many with COVID-19 should “even go to work,” the CDC recommends that those who are infected by the virus should be quarantined. This poses a problem under capitalism for members of the working class who cannot afford to simply take off work unannounced. New York City Mayor, Bill de Blasio recently suggested avoiding crowded subway cars or working from home if possible, but many rely on public transit. Suggestions from government leaders show their disconnect from the working class. 58% Americans have less than $1,000 in their savings and around 40% of Americans could not afford an unexpected bill of $400. So for many, staying home or not using public transit is simply not an option.

Even more people avoid the doctor when we get sick. With or without insurance, a trip to the hospital means racking up massive medical bills. The Guardian reports that 25% of Americans say they or a family member have delayed medical treatment due to the costs of care. In May 2019, The American Cancer Society found that 56% of adults report having at least one medical financial hardship. Medical debt remains the number one cause of bankruptcy in the country. One third of all donations on the fundraising site GoFundMe go to covering healthcare costs. That is the healthcare system of the wealthiest country in the world: GoFundMe.

Clearly, this is a very dangerous scenario. Already, people are being saddled with massive bills if they seek tests for the coronavirus. The Miami Herald wrote a story about Osmel Martinez Azcue who went to the hospital for flu-like symptoms after a work trip to China. While luckily it was found that he had the flu, the hospital visit cost $3,270, according to a notice from his insurance company. Business Insider made a chart of the possible costs associated with going to the hospital for COVID-19:

Of course, these costs will be no problem for some. The three richest Americans own more wealth than the bottom 50% of Americans. The concentration of wealth in the hands of fewer and fewer capitalists is part of capitalism’s DNA. But as Kate Pickett and Richard Wilkson highlight extensively in their book The Spirit Level: Why Greater Equality Makes Societies Stronger, people in more equal societies are healthier. They live longer, have lower infant mortality, and have high self-ratings of health. Inequality leads to poorer overall health.

So how does this relate to COVID-19? The main theory for these outcomes is that inequality of wealth and power in a society leads to a state of chronic stress. This wreaks havoc on bodily systems such as the cardiovascular system and the immune system, leaving individuals more susceptible to health problems. This means as societies become more and more unequal, we will see individuals more and more susceptible to infection. Capitalism’s inequality puts us all at greater risk as COVID-19 spreads.

#### **Any reform on IPR fails, capitalist nations maintain their dominance over the market and developing nation- TRIPS proves. Thus the advocacy is the member nations of the World Trade Organization ought to abolish all medical intellectual property protections.**

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These events – the corporate capture of the global pharmaceutical IP regime, state complicity and vaccine imperialism – are not new. Recall [Article 7 of TRIPS](https://www.wto.org/english/docs_e/legal_e/27-trips_01_e.htm), which states that the objective of the Agreement is the ‘protection and enforcement of intellectual property rights [to] contribute to the promotion of technological innovation and to the transfer and dissemination of technology’. In similar vein, Article 66(2) of TRIPS further calls on developed countries to ‘provide incentives to enterprises and institutions within their territories to promote and encourage technology transfer to least-developed country’. While the language of ‘transfer of technology’ might seem beneficial or benign, in actuality it is not. As I discussed in [my book](https://www.bloomsburyprofessional.com/uk/patent-games-in-the-global-south-9781509927401/), and as [Carmen Gonzalez](https://digitalcommons.law.seattleu.edu/cgi/viewcontent.cgi?referer=&httpsredir=1&article=1631&context=faculty) has also shown, when development objectives are incorporated into international legal instruments and institutions, they become embedded in structures that may constrain their transformative potential and reproduce North-South power imbalances. This is because these development objectives are circumscribed by capitalist imperialist structures, adapted to justify colonial practices and mobilized through racial differences. These structures are the essence of international law and its institutions even in the twenty-first century. They continue to animate broader socio-economic engagement with the global economy even in the present as well as in the legal and regulatory codes that support them. Thus, it is not surprising that even in current global health crisis, calls for this same transfer of technology in the form of a TRIPS waiver to scale up global vaccine production is being thwarted by the hegemony of developed states inevitably influenced by their respective pharmaceutical companies. The ‘emancipatory potential’ of TRIPS cannot be achieved if it was not created to be emancipatory in the first place. It also makes obvious the ways international IP law is not only unsuited to promote structural reform to enable the self-sufficiency and self-determination of the countries in the global south, but also produces asymmetries that perpetuate inequalities.

#### **The affirmative is a class-based critique of the system through a radical interrogation of the fundamental structures of capitalism—pedagogical spaces are the crucial staging ground for keeping socialism on the horizon. Thus, the role of the ballot is to vote for the best methodology to resist capitalism.**

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(Peter and Valerie, “Class Dismissed? Historical materialism and the politics of ‘difference’,” Educational Philosophy and Theory Vol. 36, Issue 2, p. 183-199)//RM

For well over two decades we have witnessed the jubilant liberal and conservative pronouncements of the demise of socialism. Concomitantly, history's presumed failure to defang existing capitalist relations has been read by many self-identified ‘radicals’ as an advertisement for capitalism's inevitability. As a result, the chorus refrain ‘There Is No Alternative’, sung by liberals and conservatives, has been buttressed by the symphony of post-Marxist voices recommending that we give socialism a decent burial and move on. Within this context, to speak of the promise of Marx and socialism may appear anachronistic, even naïve, especially since the post-al intellectual vanguard has presumably demonstrated the folly of doing so. Yet we stubbornly believe that the chants of T.I.N.A. must be combated for they offer as a fait accompli, something which progressive Leftists should **refuse to accept**—namely **the triumph of capitalism** and its political bedfellow neo-liberalism, which have worked together to naturalize suffering, undermine collective struggle, and obliterate hope. We concur with Amin (1998), who claims that such chants must be defied and revealed as absurd and criminal, and who puts the challenge we face in no uncertain terms: humanity may let itself be led by capitalism's logic to a **fate of collective suicide** or it may pave the way for an alternative humanist project of global socialism. The grosteque conditions that inspired Marx to pen his original critique of capitalism are present and flourishing. The inequalities of wealth and the gross imbalances of power that exist today are leading to abuses that exceed those encountered in Marx's day (Greider, 1998, p. 39). Global capitalism has paved the way for the obscene concentration of wealth in fewer and fewer hands and created a world increasingly divided between those who enjoy opulent affluence and those who languish in dehumanizing conditions and economic misery. In every corner of the globe, we are witnessing social disintegration as revealed by a rise in abject poverty and inequality. At the current historical juncture, the combined assets of the 225 richest people is roughly equal to the annual income of the poorest 47 percent of the world's population, while the combined assets of the three richest people exceed the combined GDP of the 48 poorest nations (CCPA, 2002, p. 3). Approximately 2.8 billion people—almost half of the world's population—struggle in desperation to live on less than two dollars a day (McQuaig, 2001, p. 27). As many as 250 million children are wage slaves and there are over a billion workers who are either un- or under-employed. These are the concrete realities of our time—realities that **require a vigorous class analysis**, an **unrelenting critique** of capitalism and an oppositional politics capable of confronting what Ahmad (1998, p. 2) refers to as ‘capitalist universality.’ They are realities that require something more than that which is offered by the prophets of ‘difference’ and post-Marxists who would have us relegate socialism to the scrapheap of history and mummify Marxism along with Lenin's corpse. Never before has a Marxian analysis of capitalism and class rule been so desperately needed. That is not to say that everything Marx said or anticipated has come true, for that is clearly not the case. Many critiques of Marx focus on his strategy for moving toward socialism, and with ample justification; nonetheless Marx did provide us with **fundamental insights** into class society that have held true to this day. Marx's enduring relevance lies in his indictment of capitalism which continues to wreak havoc in the lives of most. While capitalism's cheerleaders have attempted to hide its sordid underbelly, Marx's description of capitalism as the sorcerer's dark power is even more apt in light of contemporary historical and economic conditions. Rather than jettisoning Marx, decentering the role of capitalism, and discrediting class analysis, radical educators must continue to engage Marx's oeuvre and extrapolate from it that which is useful **pedagogically, theoretically, and**, most importantly, **politically** in light of the challenges that confront us. The urgency which animates Amin's call for a collective socialist vision necessitates, as we have argued, moving beyond the particularism and liberal pluralism that informs the ‘politics of difference.’ It also **requires** challenging the **questionable assumptions** that have come to constitute the core of contemporary ‘radical’ theory, **pedagogy** and politics. In terms of effecting change, what is needed is a cogent **understanding** of the systemic nature of exploitation and oppression based on the precepts of a radical political economy approach (outlined above) and one that incorporates Marx's notion of ‘unity in difference’ in which people share widely common material interests. Such an understanding extends far beyond the realm of theory, for the manner in which we choose to interpret and explore the social world, the **concepts and frameworks** we use to express our sociopolitical understandings, are more than just abstract categories. They imply intentions, organizational practices, and political agendas. Identifying class analysis as the basis for our understandings and class struggle as the basis for polistical transformation implies something **quite different** than constructing a sense of political agency around issues of race, ethnicity, gender, etc. Contrary to ‘Shakespeare's assertion that a rose by any other name would smell as sweet,’ it should be clear that this is not the case in political matters. Rather, in politics ‘the essence of the flower lies in the name by which it is called’ (Bannerji, 2000, p. 41). The task for progressives today is to seize the moment and plant the seeds for a political agenda that is grounded in historical possibilities and informed by a vision committed to overcoming exploitative conditions. These seeds, we would argue, must be derived from the tree of radical political economy. For the vast majority of people today—people of all ‘racial classifications or identities, all genders and sexual orientations’—the common frame of reference arcing across ‘difference’, the ‘concerns and aspirations that are most widely shared are those that are rooted in the common experience of everyday life shaped and constrained by political economy’ (Reed, 2000, p. xxvii). While post-Marxist advocates of the politics of ‘difference’ suggest that such a stance is outdated, we would argue that the categories which they have employed to analyze ‘the social’ are now losing their usefulness, particularly in light of actual contemporary ‘social movements.’ All over the globe, there are large anti-capitalist movements afoot. In February 2002, chants of ‘Another World Is Possible’ became the theme of protests in Porto Allegre. It seems that those people struggling in the streets haven’t read about T.I.N.A., the end of grand narratives of emancipation, or the decentering of capitalism. It seems as though the struggle for basic survival and some semblance of human dignity in the mean streets of the dystopian metropoles doesn’t permit much time or opportunity to read the heady proclamations emanating from seminar rooms. As E. P. Thompson (1978, p. 11) once remarked, sometimes ‘experience walks in without knocking at the door, and announces deaths, crises of subsistence, trench warfare, unemployment, inflation, genocide.’ This, of course, does not mean that socialism will inevitably come about, yet a sense of its nascent promise animates current social movements. Indeed, noted historian Howard Zinn (2000, p. 20) recently pointed out that after years of single-issue organizing (i.e. the politics of difference), the WTO and other anti-corporate capitalist protests signaled a turning point in the ‘history of movements of recent decades,’ for it was the issue of ‘class’ that more than anything ‘bound everyone together.’ History, to paraphrase Thompson (1978, p. 25) doesn’t seem to be following Theory's script. Our vision is informed by Marx's historical materialism and his revolutionary socialist humanism, which must not be conflated with liberal humanism. For left politics and pedagogy, a socialist humanist vision remains crucial, whose fundamental features include the creative potential of people to challenge collectively the circumstances that they inherit. This variant of humanism seeks to give expression to the pain, sorrow and degradation of the oppressed, those who labor under the ominous and ghastly cloak of ‘globalized’ capital. It calls for the transformation of those conditions that have prevented the bulk of humankind from fulfilling its potential. It vests its hope for change in the development of critical consciousness and social agents who make history, although not always in conditions of their choosing. The political goal of socialist humanism is, however, ‘not a resting in difference’ but rather ‘the emancipation of difference at the level of human mutuality and reciprocity.’ This would be a step forward for the ‘discovery or creation of our real differences which can only in the end be explored in reciprocal ways’ (Eagleton, 1996, p. 120). Above all else, the enduring relevance of a radical socialist pedagogy and politics is the **centrality** it accords to the interrogation of capitalism. We can no longer afford to remain indifferent to the horror and savagery committed by capitalist's barbaric machinations. We need to recognize that capitalist democracy is unrescuably contradictory in its own self-constitution. Capitalism and democracy cannot be translated into one another without profound efforts at manufacturing empty idealism. Committed Leftists must unrelentingly cultivate a democratic socialist vision that refuses to forget the ‘wretched of the earth,’ the children of the damned and the victims of the culture of silence—a task which requires more than abstruse convolutions and striking ironic poses in the agnostic arena of signifying practices. Leftists must illuminate the little shops of horror that lurk beneath ‘globalization’s’ shiny façade; they must challenge the true ‘evils’ that are manifest in the tentacles of global capitalism's reach. And, more than this, Leftists must search for the cracks in the edifice of globalized capitalism and shine light on those fissures that **give birth to alternatives.** Socialism today, undoubtedly, runs against the grain of received wisdom, but its vision of a vastly improved and freer arrangement of social relations beckons on the horizon. Its unwritten text is nascent in the present even as it exists among the fragments of history and the shards of distant memories. Its potential remains untapped and its promise needs to be redeemed.

#### **Large-scale threats of future suffering perpetuate capitalist violence and the hegemonic power of the elite, endlessly prolonging suffering. The only response is to interrupt the system, insisting that the urgent bodies across the globe cannot wait**

#### **Olson ‘15 (Elizabeth Olson, prof of geography @ UNC Chapel Hill ‘Geography and Ethics I: Waiting and Urgency,’ *Progress in Human Geography*, vol. 39 no. 4, pp. 517-526)//RM**

Though toileting might be thought of as a special case of bodily urgency, geographic research suggests that the body is increasingly set at odds with larger scale ethical concerns, especially **large-scale future events of forecasted suffering**. Emergency planning is a particularly good example in which the large-scale threats of future suffering can **distort moral reasoning**. Žižek (2006) lightly develops this point in the context of the war on terror, where in the presence of fictitious and real ticking clocks and warning systems, the urgent body must be **bypassed** because there are **bigger scales to worry about**:¶ What does this all-pervasive sense of urgency mean ethically? The pressure of events is so overbearing, the stakes are so high, that they nec essitate a suspension of ordinary ethical concerns. After all, displaying moral qualms when the lives of millions are at stake plays into the hands of the enemy. (Žižek, 2006)¶ In the presence of large-scale future emergency, the urgency to secure the state, the citizenry, the economy, or the climate creates new scales and new temporal orders of response (see Anderson, 2010; Baldwin, 2012; Dalby, 2013; Morrissey, 2012), many of which treat the urgent body as impulsive and thus requiring management. McDonald’s (2013) analysis of three interconnected discourses of ‘climate security’ illustrates how bodily urgency in climate change is also recast as a menacing impulse that might require exclusion from moral reckoning. The logics of climate security, especially those related to national security, ‘can encourage perverse political responses that not only fail to respond effectively to climate change but may present victims of it as a threat’ (McDonald, 2013: 49). **Bodies that are currently suffering cannot be urgent**, because they are **excluded from the potential collectivity** that could be **suffering everywhere in some future time**. Similar bypassing of existing bodily urgency is echoed in writing about violent securitization, such as drone warfare (Shaw and Akhter, 2012), and also in intimate scales like the street and the school, especially in relation to race (Mitchell, 2009; Young et al., 2014).¶ As large-scale urgent concerns are institutionalized, the urgent body is increasingly obscured through technical planning and coordination (Anderson and Adey, 2012). The predominant characteristic of this institutionalization of large-scale emergency is a ‘built-in bias for action’ (Wuthnow, 2010: 212) that circumvents contingencies. The urgent body is at best an assumed eventuality, one that will likely require another state of waiting, such as triage (e.g. Greatbach et al., 2005). Amin (2013) cautions that in much of the West, governmental need to provide evidence of laissez-faire governing on the one hand, and assurance of strength in facing a threatening future on the other, produces ‘just-in-case preparedness’ (Amin, 2013: 151) of neoliberal risk management policies. In the US, ‘personal ingenuity’ is built into emergency response at the expense of the poor and vulnerable for whom ‘[t]he difference between abjection and bearable survival’ (Amin, 2013: 153) will not be determined by emergency planning, but in the material infrastructure of the city.¶ In short, the urgencies of the body provide justifications for social exclusion of the most marginalized based on impulse and perceived threat, while large-scale future emergencies effectively absorb the deliberative power of urgency into the institutions of preparedness and risk avoidance. Žižek references Arendt’s (2006) analysis of the banality of evil to explain the current state of ethical reasoning under the war on terror, noting that people who perform morally reprehensible actions under the conditions of urgency assume a ‘tragic-ethic grandeur’ (Žižek, 2006) by sacrificing their own morality for the good of the state. But his analysis fails to note that bodies are today so rarely legitimate sites for claiming urgency. In the context of the **assumed priority of the large-scale future emergency**, the urgent body becomes **literally nonsense, a non sequitur** within societies, states and worlds that will **always be more urgent**.¶ If the important ethical work of urgency has been to identify that which must not wait, then the capture of the power and persuasiveness of urgency by large-scale future emergencies has consequences for the kinds of normative arguments we can raise on behalf of urgent bodies. How, then, might waiting compare as a normative description and critique in our own urgent time? Waiting can be categorized according to its purpose or outcome (see Corbridge, 2004; Gray, 2011), but it also modifies the place of the individual in society and her importance. As Ramdas (2012: 834) writes, ‘waiting … produces hierarchies which segregate people and places into those which matter and those which do not’. The segregation of waiting might produce effects that counteract suffering, however, and Jeffery (2008: 957) explains that though the ‘politics of waiting’ can be repressive, it can also engender creative political engagement. In his research with educated unemployed Jat youth who spend days and years waiting for desired employment, Jeffery finds that ‘the temporal suffering and sense of ambivalence experienced by young men can generate cultural and political experiments that, in turn, have marked social and spatial effects’ (Jeffery, 2010: 186). Though this is not the same as claiming normative neutrality for waiting, it does suggest that waiting is more ethically ambivalent and open than urgency.¶ In other contexts, however, our descriptions of waiting indicate a strong condemnation of its effects upon the subjects of study. Waiting can demobilize radical reform, **depoliticizing ‘the insurrectionary possibilities of the present by delaying the revolutionary imperative to a future moment that is forever drifting towards infinity’** (Springer, 2014: 407). Yonucu’s (2011) analysis of the self-destructive activities of disrespected working-class youth in Istanbul suggests that this sense of infinite waiting can lead not only to depoliticization, but also to a disbelief in the possibility of a future self of any value. Waiting, like urgency, can **undermine the possibility of self-care** two-fold, first by making people wait for essential needs, and again by reinforcing that waiting is ‘[s]omething to be ashamed of because it may be noted or taken as evidence of indolence or low status, seen as a symptom of rejection or a signal to exclude’ (Bauman, 2004: 109). This is why Auyero (2012) suggests that waiting creates an ideal state subject, providing ‘temporal processes in and through which political subordination is produced’ (Auyero, 2012: loc. 90; see also Secor, 2007). Furthermore, Auyero notes, it is not only political subordination, but the subjective effect of waiting that secures domination, as citizens and non-citizens find themselves ‘waiting hopefully and then frustratedly for others to make decisions, and in effect surrendering to the authority of others’ (Auyero, 2012: loc. 123).¶ Waiting can therefore function as a potentially important spatial technology of the elite and powerful, mobilized not only for the purpose of **governing individuals**, but also to **retain claims over moral urgency**. But there is **growing resistance** to the capture of claims of urgency by the elite, and it is important to note that even in cases where the material conditions of containment are currently impenetrable, arguments based on human value are at the forefront of **reclaiming urgency for the body**. In detention centers, clandestine prisons, state borders and refugee camps, geographers point to ongoing struggles against the ethical impossibility of bodily urgency and a rejection of states of waiting (see Conlon, 2011; Darling, 2009, 2011; Garmany, 2012; Mountz et al., 2013; Schuster, 2011). Ramakrishnan’s (2014) analysis of a Delhi resettlement colony and Shewly’s (2013) discussion of the enclave between India and Bangladesh describe people who refuse to give up their own status as legitimately urgent, even in the context of larger scale politics. Similarly, Tyler’s (2013) account of desperate female detainees stripping off their clothes to expose their humanness and suffering in the Yarl’s Wood Immigration Removal Centre in the UK suggests that demands for recognition are not just about politics, but also about the acknowledgement of humanness and the irrevocable possibility of being that which cannot wait. The continued existence of places like Yarl’s Wood and similar institutions in the USA nonetheless points to the challenge of exposing the urgent body as a moral priority when it is so easily hidden from view, and also reminds us that our research can help to explain the relationships between normative dimensions and the political and social conditions of struggle.¶ In closing, geographic depictions of waiting do seem to evocatively describe otherwise obscured suffering (e.g. Bennett, 2011), but it is striking how rarely these descriptions also use the language of urgency. Given the discussion above, what might be accomplished – and risked – by incorporating urgency more overtly and deliberately into our discussions of waiting, surplus and abandoned bodies? Urgency can clarify the implicit but understated ethical consequences and normativity associated with waiting, and encourage explicit discussion about harmful suffering. Waiting can be productive or unproductive for radical praxis, but urgency compels and requires response. Geographers could be instrumental in reclaiming the ethical work of urgency in ways that leave it open for critique, clarifying common spatial misunderstandings and representations. There is good reason to be thoughtful in this process, since moral outrage towards inhumanity can itself obscure differentiated experiences of being human, dividing up ‘those for whom we feel urgent unreasoned concern and those whose lives and deaths simply do not touch us, or do not appear as lives at all’ (Butler, 2009: 50). But when the urgent body is rendered as only waiting, both materially and discursively, it is just as easily cast as impulsive, disgusting, animalistic (see also McKittrick, 2006). Feminist theory insists that the urgent body, whose encounters of violence are ‘usually framed as **private, apolitical and mundane’** (Pain, 2014: 8), are as deeply **political, public, and exceptional** as other forms of violence (Phillips, 2008; Pratt, 2005). Insisting that **a suffering body, now, is that which cannot wait**, has the **ethical effect of drawing it into consideration alongside the political, public and exceptional scope of large-scale futures**. It may help us insist on the body, both as a single unit and a plurality, as a legitimate scale of normative priority and social care.¶ In this report, I have explored old and new reflections on the ethical work of urgency and waiting. Geographic research suggests a contemporary popular bias towards the urgency of large-scale futures, institutionalized in ways that further obscure and discredit the urgencies of the body. This bias also justifies the production of new waiting places in our material landscape, places like the detention center and the waiting room. In some cases, waiting is normatively neutral, even providing opportunities for alternative politics. In others, the technologies of waiting serve to manage potentially problematic bodies, leading to suspended suffering and even to extermination (e.g. Wright, 2013). One of my aims has been to suggest that **moral reasoning is important** both because it **exposes normative biases against subjugated people**, and because it potentially **provides routes toward struggle where claims to urgency seem to foreclose** the **possibilities** of alleviation of suffering. **Saving the world still should require a debate about whose world is being saved, when, and at what cost – and this requires a debate about what really cannot wait**. My next report will extend some of these concerns by reviewing how feelings of urgency, as well as hope, fear, and other emotions, have played a role in geography and ethical reasoning.¶ I conclude, however, by pulling together past and present. In 1972, Gilbert White asked why geographers were not engaging ‘the truly urgent questions’ (1972: 101) such as racial repression, decaying cities, economic inequality, and global environmental destruction. His question highlights just how much the discipline has changed, but it is also unnerving in its echoes of our contemporary problems. Since White’s writing, our moral reasoning has been stretched to consider the future body and the more-than-human, alongside the presently urgent body – topics and concerns that I have not taken up in this review but which will provide their own new possibilities for urgent concerns. My own hope presently is drawn from an acknowledgement that the **temporal characteristics of contemporary capitalism** can be interrupted in creative ways (Sharma, 2014), with the possibility of squaring the urgent body with our large-scale future concerns. **Temporal alternatives already exist in ongoing and emerging revolutions** and the disruption of claims of cycles and circular political processes (e.g. Lombard, 2013; Reyes, 2012). Though **calls for urgency will** certainly be used to obscure evasion of responsibility (e.g. Gilmore, 2008: 56, fn 6), they may also **serve as fertile ground for radical critique**, a truly fierce **urgency for now.**

# **CASE**

#### **Climate change is irreversible – prefer our date, credentials (UN), and their EV doesn’t consider oceans or permafrost Bodkin 19,**Henry Bodkin is a Health and Science Correspondent for the Telegraph, 9/25/19, “Climate change now irreversible due to warming oceans, UN body warns”, *The Telegraph,*Accessed 11/16/20, ZL https://www.telegraph.co.uk/science/2019/09/25/climate-change-now-irreversible-due-warming-oceans-un-body-warns

## Climate change is now irreversible, thanks to ocean warming crossing a “tipping point”, UN experts have warned. A new report predicts that, even with significant emission cuts, [sea levels will rise](https://www.telegraph.co.uk/news/2019/08/18/national-trust-asks-beach-goersto-post-pictures-instagram-help/) by the end of the century, with serious coastal flooding becoming hundreds of times more frequent. The planet has warmed to 1C above pre-industrial temperatures, and around 90 percent of that excess heat has been absorbed by the oceans, the Intergovernmental Panel on Climate Change said. It means rapidly melting ice in [Antarctica](https://www.telegraph.co.uk/news/2018/04/03/antarctic-ice-sheet-loses-area-size-london-base-say-scientists/) and Greenland is now pushing up sea levels by 3.6mm a year, at twice the rate of the Twentieth Century. Despite commitments by the UK, French, and other governments to achieve net-zero carbon emissions in coming decades, the analysis predicts that there is too much heat in the oceans to prevent disruption for hundreds of millions of people. Unveiling the latest report in Monaco on Wednesday, panel-member Valerie Masson-Delmotte, said: “Climate change is already irreversible due to the heat uptake in the ocean. “We can’t go back, whatever we do with our emissions.” According to the new forecasts, approximately 70 percent of the world’s permafrost will thaw if emissions continue to rise. This, in turn, could free up “tens to hundreds of billions of tonnes” of CO2 and methane into the atmosphere, further heating the planet. Sea levels could rise by around 30cm to 60cm by 2100 even if greenhouse gases are rapidly cut and global warming is kept to well below 2C above pre-industrial levels, but around 60-110 cm if emissions continue to increase, the analysis found. Meanwhile, annual coastal flood damages are projected to increase 100 to 1,000 times by 2100, and some island nations are "likely to become uninhabitable". Hans-Otto Portner, another IPCC expert, said: “There are large uncertainties about tipping points that may be ahead of us, but for some systems, especially biological evidence in the oceans, we have already evidence that the tipping point has been passed.” The warnings come as the UK government announced an international coalition to push for at least 30 percent of oceans to be in protected areas by 2030. Ministers say the move helps sensitive species such as seahorses, turtles, and corals to thrive, and can fight climate change by protecting key habitats for storing carbon such as mangrove forests and seagrass meadows. Historically the Antarctic Ocean has an ice-free September only once every 100 years or so, however, if global temperatures rise to two degrees above pre-industrial levels this would become as frequent as every three years, the panel said. The [2015 Paris accord](https://www.telegraph.co.uk/news/2019/09/23/russia-ratifies-paris-climate-accord-targets-critically-insufficient/) commits signatories to adopt policies intended to keep warming to within 1.5 degrees. However, Donald Trump has since withdrawn the US from the agreement. In one of her last acts as Prime Minister, Theresa May set a legally-binding target to cut greenhouse gasses to net-zero by 2050 in June. Last year a separate IPCC report called for 45 percent reductions in carbon emissions by 2030. "If we reduce emissions sharply, consequences for people and their livelihoods will still be challenging, but potentially more manageable for those who are most vulnerable," said Hoesung Lee, chair of the body, on Wednesday.” Professor Peter Wadhams, professor of ocean physics at the University of Cambridge, said the report had failed to mention the "very serious threat" of methane rising from the seabed of the Arctic continental shelf as its permafrost thaws, potentially contributing large amounts of extra greenhouse gas.

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## **AT Substandard Drugs**

#### **IP rules will not address substandard drugs because they are unrelated to criminal trademark infringement.**

**Oxfam International 11** (C. Oxfam International is a confederation of 13 like-minded organizations working together and with partners and allies around the world to bring about lasting change. It works directly with communities and seeks to influence the powerful to ensure that poor people can improve their lives with having a say in decisions that affect them. The principal belief is that people should have a respect for human rights and that will help alleviate poverty.) “Eye on the Ball.” Oxfam International, Oxfam International, 14 July 2014, www.oxfam.org/en/research/eye-ball.

Poor-quality, or ‘substandard’, medicines threaten patients and public health in developing countries. Prioritization of medicines regulation by developing-country governments, with the technical and financial support of rich countries, is badly needed. Under the guise of helping to address dangerous and ineffective medicines, rich countries are pushing for new **intellectual-property rules** and reliance on police – rather than health regulatory – action. This approach **will not ensure that medicines consistently meet quality standards**. Worse, new intellectual property rules **can undermine access to affordable** generic **medicines and damage public health**. Developing countries must improve medicines regulation – not expand intellectual-property enforcement – in order to ensure medicine quality. Summary Access to medicines at affordable prices is critical to the enjoyment of the human right to health. Lower prices require the implementation of pro -access policies that include the promotion of generic competition. However, medicines cannot be selected on the basis of price alone. To ensure that only safe, effective, and quality products are on the market, effective regulation is necessary. There is a significant difference between rich and poor countries in their ability to regulate the quality of medicines. In developed countries, national drug -regulatory authorities (DRAs) authorize medicines for use on the basis of their demonstrated safety, efficacy, and quality. Following authorization, or ‘registration’, health authorities monitor the market in order to detect and remove any poor -quality, falsified, or unregistered medicines. Rich countries expend significant resources on the protection of patients. In contrast, for many reasons, a large number of developing countries are not able to regulate medicines effectively. This is principally due to a lack of money, equipment, and trained personnel. The poorest countries are unable even to maintain a registry of medicines, and therefore cannot effectively monitor which products are on the market. The World Health Organization (WHO) estimates that approximately 30 per cent of countries fall into this category. In the absence of effective medicines regulation, poor -quality, or ‘substandard’, medicines, together with falsified, or fake and falsely labelled, medicines, may be widely traded and consumed. Although the prevalence of substandard and falsified medicines in developing - country markets is unknown, due to a lack of complete and reliable data, anecdotal evidence suggests that substandard medicines are widely available in some markets. The consumption of poor -quality or falsified medicines has devastating consequences for patients and for public health. Substandard medicines do not meet the scientific specifications for the product as laid down in the WHO standards. They may contain the wrong type or concentration of active ingredient, or they may have deteriorated during distribution in the supply chain and thus become ineffective or dangerous. Falsified medicines are intentionally misrepresented to consumers. They may be fake in terms of composition or they may be falsely labelled, meaning that the information provided about the product is inaccurate. In the interests of individual patient safety and public health in general, the capacity of developing -country DRAs to regulate medicines should be strengthened. A commitment to providing reliable and affordable medicines, together with the provision of universal health services and medicines , should be embedded in national policies and strategies to improve health -care infrastructure. The capacity of DRAs to properly enforce medicines regulations must be assured. 3 While many rich countries invest in this approach, a number of them are also pressuring developing countries to embrace **the flawed argument that stricter enforcement of intellectual property (IP) is the best remedy to protect patients from poor-quality medicines**. This argument **is based on the fact that one class of medicines that should be removed from the market (‘counterfeits’) is the result of a type of IP infringement: criminal trademark infringement**. Yet **evidence suggests that the vast majority of substandard and falsified medicines are unrelated to criminal trademark infringement. Stringent IP enforcement measures** only target counterfeit medicines, and **cannot be relied upon to ensure that** the much broader categories of **substandard** and falsified **medicines are removed from the market**. Rich countries and some members of the multinational pharmaceutical industry propose the enactment of additional **IP enforcement rules to fight broadly defined ‘counterfeit’ medicines**. These rules have been and will be introduced in developing countries through numerous channels, including the recently completed Anti-Counterfeiting Trade Agreement (ACTA), bilateral and regional trade agreements, and technical assistance. The proposed new rules would be implemented on the basis of expansive definitions of ‘counterfeit’ **which include medicines that do not infringe any IP**, including substandard medicines and also legitimate, quality generic medicines. In some jurisdictions, the term ‘counterfeit’ has been redefined such that governments are obligated to use both existing and proposed IP and law enforcement measures to restrict access to lawfully-available generics together with true counterfeit products. The new IP enforcement rules **threaten public health and access to medicines**. They **create new barriers to the production of and trade in quality generic medicines, which are a lifeline for millions of patients in poor countries**. The seizures of at least 19 shipments of generic medicines in transit through the EU, intended for patients in developing countries, provide a stark example of the consequences of these new IP enforcement measures. Developing-country governments are under pressure to emphasize IP enforcement in order to ensure that medicines are safe and of quality, rather than public-health measures that are most appropriate to this objective. A WHO-led initiative, the International Medical Products Anti-Counterfeiting Taskforce (IMPACT), is contributing to the confusion surrounding the definition of counterfeit medicines and what should be done about them. IMPACT proposes an expansive definition of counterfeit medicines that confuses counterfeits and generic medicines, and overemphasizes police action to ensure the safety and efficacy of medicines. At the same time, the multinational pharmaceutical industry has exerted pressure on individual countries, such as Kenya and Thailand, to change their national laws and law enforcement priorities in ways that endanger access to generic medicines**. Instead of expanding IP enforcement, developing countries should remain focused on public-health measures to ensure that all medicines within their borders meet acceptable standards of quality**. In addition to the long-term goal of building competent national DRAs that can 4 effectively develop and enforce medicines regulations, governments should consider (depending on national circumstances): regional information sharing, harmonizing aspects of regulation and registration, and continuing a reliance on WHO prequalification, as well as co-operation with more advanced country regulators. The WHO Good Governance for Medicines (GGM) anti-corruption task force has a part to play, and the Medicines Transparency Alliance, a new multi-stakeholder initiative, shows promise. Such efforts bear no relationship to IP and, in fact, efforts to improve public health can be undermined by inappropriate **IP enforcement policies** that **reduce generic competition and** therefore **drive up the price of medicines**. High medicine prices are often a key factor that pushes low-income households to buy medicines from unregulated outlets, where they may be cheaper but of inadequate quality or falsified.