# 1NC-round4-valley

## 1

#### Interpretation: intellectual property protections is a generic bare plural. The aff may not defend that member nations of the World Trade Organization reduce a subset of intellectual property protections for medicines.

Nebel 19 Jake Nebel [Jake Nebel is an assistant professor of philosophy at the University of Southern California and executive director of Victory Briefs.] , 8-12-2019, "Genericity on the Standardized Tests Resolution," Briefly, https://www.vbriefly.com/2019/08/12/genericity-on-the-standardized-tests-resolution/ SM

Both distinctions are important. Generic resolutions can’t be affirmed by specifying particular instances. But, since generics tolerate exceptions, plan-inclusive counterplans (PICs) do not negate generic resolutions. Bare plurals are typically used to express generic generalizations. But there are two important things to keep in mind. First, generic generalizations are also often expressed via other means (e.g., definite singulars, indefinite singulars, and bare singulars). Second, and more importantly for present purposes, bare plurals can also be used to express existential generalizations. For example, “Birds are singing outside my window” is true just in case there are some birds singing outside my window; it doesn’t require birds in general to be singing outside my window. So, what about “colleges and universities,” “standardized tests,” and “undergraduate admissions decisions”? Are they generic or existential bare plurals? On other topics I have taken great pains to point out that their bare plurals are generic—because, well, they are. On this topic, though, I think the answer is a bit more nuanced. Let’s see why. 1.1 “Colleges and Universities” “Colleges and universities” is a generic bare plural. I don’t think this claim should require any argument, when you think about it, but here are a few reasons. First, ask yourself, honestly, whether the following speech sounds good to you: “Eight colleges and universities—namely, those in the Ivy League—ought not consider standardized tests in undergraduate admissions decisions. Maybe other colleges and universities ought to consider them, but not the Ivies. Therefore, in the United States, colleges and universities ought not consider standardized tests in undergraduate admissions decisions.” That is obviously not a valid argument: the conclusion does not follow. Anyone who sincerely believes that it is valid argument is, to be charitable, deeply confused. But the inference above would be good if “colleges and universities” in the resolution were existential. By way of contrast: “Eight birds are singing outside my window. Maybe lots of birds aren’t singing outside my window, but eight birds are. Therefore, birds are singing outside my window.” Since the bare plural “birds” in the conclusion gets an existential reading, the conclusion follows from the premise that eight birds are singing outside my window: “eight” entails “some.” If the resolution were existential with respect to “colleges and universities,” then the Ivy League argument above would be a valid inference. Since it’s not a valid inference, “colleges and universities” must be a generic bare plural. Second, “colleges and universities” fails the upward-entailment test for existential uses of bare plurals. Consider the sentence, “Lima beans are on my plate.” This sentence expresses an existential statement that is true just in case there are some lima beans on my plate. One test of this is that it entails the more general sentence, “Beans are on my plate.” Now consider the sentence, “Colleges and universities ought not consider the SAT.” (To isolate “colleges and universities,” I’ve eliminated the other bare plurals in the resolution; it cannot plausibly be generic in the isolated case but existential in the resolution.) This sentence does not entail the more general statement that educational institutions ought not consider the SAT. This shows that “colleges and universities” is generic, because it fails the upward-entailment test for existential bare plurals. Third, “colleges and universities” fails the adverb of quantification test for existential bare plurals. Consider the sentence, “Dogs are barking outside my window.” This sentence expresses an existential statement that is true just in case there are some dogs barking outside my window. One test of this appeals to the drastic change of meaning caused by inserting any adverb of quantification (e.g., always, sometimes, generally, often, seldom, never, ever). You cannot add any such adverb into the sentence without drastically changing its meaning. To apply this test to the resolution, let’s again isolate the bare plural subject: “Colleges and universities ought not consider the SAT.” Adding generally (“Colleges and universities generally ought not consider the SAT”) or ever (“Colleges and universities ought not ever consider the SAT”) result in comparatively minor changes of meaning. (Note that this test doesn’t require there to be no change of meaning and doesn’t have to work for every adverb of quantification.) This strongly suggests what we already know: that “colleges and universities” is generic rather than existential in the resolution. Fourth, it is extremely unlikely that the topic committee would have written the resolution with the existential interpretation of “colleges and universities” in mind. If they intended the existential interpretation, they would have added explicit existential quantifiers like “some.” No such addition would be necessary or expected for the generic interpretation since generics lack explicit quantifiers by default. The topic committee’s likely intentions are not decisive, but they strongly suggest that the generic interpretation is correct, since it’s prima facie unlikely that a committee charged with writing a sentence to be debated would be so badly mistaken about what their sentence means (which they would be if they intended the existential interpretation). The committee, moreover, does not write resolutions for the 0.1 percent of debaters who debate on the national circuit; they write resolutions, at least in large part, to be debated by the vast majority of students on the vast majority of circuits, who would take the resolution to be (pretty obviously, I’d imagine) generic with respect to “colleges and universities,” given its face-value meaning and standard expectations about what LD resolutions tend to mean.

#### It applies to IP protections:

#### Upward entailment test – spec fails the upward entailment test because saying that nations ought to reduce one type of IPP does not entail that those nations ought to reduce all kinds of IPP

#### Adverb test – adding “usually” to the res doesn’t substantially change its meaning because a reduction is universal and permanent

#### Vote neg:

#### Semantics outweigh:

#### T is a constitutive rule of the activity and a basic aff burden – they agreed to debate the topic when they came here

#### Jurisdiction – you can’t vote aff if they haven’t affirmed the resolution

#### It’s the only stasis point we know before the round so it controls the internal link to engagement – there’s no way to use ground if debaters aren’t prepared to defend it

#### Limits – there are countless affs accounting for every kind of intellectual property protections, like tertiary patents, provisional patents, and design patents – unlimited topics incentivize obscure affs that negs won’t have prep on – limits are key to reciprocal prep burden – potential abuse doesn’t justify foregoing the topic and 1AR theory checks PICs

#### Ground – spec guts core generics like innovation that rely on reducing all kinds of IP for all medicines because individual types of IP don’t substantially affect the pharmaceutical industry – also means there is no universal DA to spec affs

#### TVA solves – read as an advantage to whole rez

#### Paradigm issues:

#### Drop the debater – their abusive advocacy skewed the debate from the start

#### Comes before 1AR theory – NC abuse is responsive to them not being topical

#### No RVIs – fairness and education are a priori burdens – and encourages baiting – outweighs because if T is frivolous, they can beat it quickly

#### Fairness is a voter ­– necessary to determine the better debater

#### Education is a voter – why schools fund debate

## 2

#### The member nations of the World Trade Organization should integrate centralized medical records and genetic information with machine learning technology and make data commercially available for biotechnology and pharmaceutical companies.

#### Combining centralized records with genetic info shifts research to a genotype first approach---both are key for synching gene variants with their medical effects. Excluding people from coverage ensures bottlenecks that undermine research.

Broad 14. (The Eli and Edythe L. Broad Institute of MIT and Harvard, often referred to as the Broad Institute, is a biomedical and genomic research center located in Cambridge, Massachusetts. Innovative “genotype first” approach uncovers protective factor for heart disease. June 31, 2014.https://www.broadinstitute.org/news/innovative-“genotype-first”-approach-uncovers-protective-factor-heart-disease)

**Extensive sequencing of DNA from thousands of individuals** in Finland has **unearthed scores of mutations that** destroy gene function **and are found at unusually high frequencies**. Among these are two mutations in a gene called LPA that may reduce a person’s risk of heart disease. **These findings are an exciting** proof-of-concept **for a new “**genotype first**” approach to identifying** rare genetic variants **associated with, or protecting from, disease followed by** extensive medical review **of carriers**. The new study by researchers from the Broad Institute, Massachusetts General Hospital (MGH), the University of Helsinki, and an international team of collaborators appears in a paper published online July 31 in PLOS Genetics. The **researchers** studied exomes — the portions of the genome that correspond to protein-coding genes — from 3,000 Finns and compared them to those of 3,000 non-Finnish Europeans. They identified 83 gene-deactivating variants that were at least twice as prevalent in Finns and went on to study these variants in over 35,000 Finns. Recent examples in heart disease, HIV, type 2 diabetes and Crohn’s disease have demonstrated that such mutations – known as “loss-of-function” mutations – in some cases protect from, rather than cause, disease and thereby **suggest** new paths **toward** therapeutics. **Geneticists have known that** Mendelian, **recessive genetic diseases** – such as Tay-Sachs or cystic fibrosis that **are caused by a single, mutated gene** – are **more common in** isolated populations **because of a phenomenon known as “**bottlenecking**.”** When a small population is isolated for tens to hundreds of generations, the population’s genetic diversity becomes restricted, and occasional rare genetic variations can by chance become much more common. While this has long been recognized as the source of the unique rare disease patterns seen in isolated populations, this paper demonstrates that the same principles can help researchers identify rare, loss-of-function variants in genome-wide association studies on these isolated populations. In the current study, researchers chose to study modern Finns – a population that descended from a well-documented bottleneck that occurred around 4,000 years ago. Comparing Finns with their non-Finnish European counterparts gave the researchers strong, empirical data. The LPA gene encodes Lipoprotein(a), a type of lipoprotein, first identified in 1963 and a known risk factor for heart disease. The variants described in this paper reduced levels of LPA gene expression causing lower levels of Lipoprotein(a) in the blood. The research team examined Finnish medical records and found that the loss-of-function variants were not associated with other health problems, making blocking LPA expression a potentially exciting therapeutic approach. **The availability of** centralized medical records **available in Finland enabled the researchers to** shift the paradigm **of** medical genetics **to a “genotype first” approach**. “**This new approach could significantly change how researchers analyze rare variants for complex diseases**. **It gives us a** window **into the** genetics of complex diseases **that we haven’t had before**,” said co-senior author Mark Daly, co-director of the Program in Medical and Population Genetics at the Broad Institute and chief of the Analytic and Translational Genetics Unit for the Center for Human Genetic Research at MGH. “By combining the information from detailed medical records with the information contained in the genomes of a bottlenecked population, we’re uncovering rare variants that contribute to complex diseases.” Heart disease is a leading killer globally. The World Health Organization reports that cardiovascular disease was responsible for 30 percent of all global deaths, or 17.3 million people in 2008. Therapeutics able to specifically address this risk by targeting LPA could have a global impact on medical outcomes. This work highlights the potential for using rare variant analysis in isolated populations to study complex diseases, an approach that had previously been largely limited to Mendelian traits. **The approach can now be applied to other complex diseases that have many contributing genetic factors.** “We’ve illustrated the validity of this approach by identifying rare, loss-of-function variants with promising therapeutic potential for the treatment of heart disease, but **this work also represents a** reproducible approachthat can be used to increase our understanding of other complex diseases as well,” said co-senior author Aarno Palotie (Broad Institute, Massachusetts General Hospital, Harvard Medical School, Institute for Molecular Medicine Finland FIMM, University of Helsinki).

#### Only data integration solves pharma collapse---the plan saves the industry

**Shaywit**[**z**](https://www.forbes.com/sites/davidshaywitz/)**13** (David, Medicine reporter for Forbes, “What's Holding Back Cures? Our Collective Ignorance (And No, Not A Pharma Conspiracy)” <https://www.forbes.com/sites/davidshaywitz/2013/05/10/whats-holding-back-cures-our-collective-ignorance-and-no-not-a-pharma-conspiracy/#eda1100236fd>)

The unfortunate truth is that drug companies really want to cure disease, but rarely know how. [Medical science simply isn’t up to the challenge](http://www.forbes.com/sites/davidshaywitz/2011/12/02/biopharmas-dirty-secret-revealed-science-is-fragile-forecasting-is-unreliable-now-deal-with-it-2/). Most diseases aren’t well enough understood to enable the rational development of truly transformative treatments. When high-profile pharma studies fail – such as the slew of recent Phase 3 Alzheimer’s Disease trials – it’s fashionable to characterize them as yet another industry failure. There’s some truth to this: the proximal cause may well be a poor decision to continue the development of a questionable drug. But the root cause is likely insufficient understanding of disease pathophysiology. We should also be careful about dismissing the value of incremental advances– a reflex I know I still have, although I’ve [recognized](http://www.nytimes.com/2002/07/16/health/improved-drug-regimens-help-patients-take-their-medicine.html) the value of seemingly small tweaks from the time I was a resident. Even today, when I critique (as derivative) formulation plays like liquid Ritalin, I’m glad to be [reminded](https://twitter.com/kevintoshio/status/312306291261448192) of the kids who stand to benefit from just such a medication. What’s Next? As the healthcare system looks more critically at value – demanding more evidence of effectiveness from providers and products alike – drug companies will be faced with two options. The best choice, of course, would be to figure out how to come up with truly revolutionary treatments. Perhaps unexpected insights will emerge from big data and the [integration](http://www.forbes.com/sites/davidshaywitz/2012/12/30/turning-information-into-impact-digital-healths-long-road-ahead/) of phenotypic and genotypic information, in the [framework of system biology](http://www.nature.com/nrd/journal/v8/n4/abs/nrd2826.html); maybe a new therapeutic modality will arrive on the scene. It’s possible intensified [collaboration](http://www.forbes.com/sites/davidshaywitz/2012/03/29/youre-welcome-the-vital-role-companies-play-in-pressure-testing-academic-medical-research/) between academic and industry researchers will eventually yield something useful, or that [open-data approaches](http://www.sagebase.org/philosophy/) (as championed by organizations like [Sage Bionetworks](http://www.sagebase.org/)[disclosure: I served as a founding advisor]) will achieve critical mass, and deliver impactful insights. But unless something substantial changes, progress is likely to remain slow and stochastic, and truly game-changing novel therapeutics will continue to be the exceptions rather than the rule. Given the ongoing challenges of creating transformative medications, there’s likely to be intensified focus on capturing, in a more granular fashion, the benefits of incrementally improved drugs; such assessments will not be a “nice to have” but a “must have,” table stakes for consideration by payors, and (to the extent these measures are used to demonstrate efficacy) regulators as well. I also suspect pharmas will increasingly look to offer “solutions” (e.g. associated app or access to an online community) not just pills, to deliver value, though it’s unclear whether such approaches will either prove effective or represent an attractive value proportion for the relevant stakeholders.

## 3

#### Drug price reform coming now – fight is ramping up but Biden has the opportunity

Cancryn 9/9 Cancryn, Adam. Adam Cancryn is a health care reporter for POLITICO Pro, graduate of Washington & Lee University."Biden admin backs direct government drug price negotiations." POLITICO, 9 Sept. 2021, www.politico.com/news/2021/09/09/biden-drug-price-negotiations-510828.

A new Biden administration plan aimed at lowering prescription drug prices endorses giving the government sweeping power to directly negotiate the cost of medicines, calling it one of the key steps Congress could take to make drugs “more affordable and equitable” for all Americans.

The plan — developed by the Department of Health and Human Services and released on Thursday — largely backs Democrats’ ongoing efforts to lower drug prices as part of a $3.5 trillion reconciliation proposal, and mirrors a range of legislative options that both House and Senate lawmakers have floated in recent years.

Those include capping out-of-pocket costs in Medicare Part D, limiting how quickly pharmaceutical companies can hike prices on existing drugs and banning so-called pay-for-delay agreements aimed at blocking generic competition to brand-name drugs.

But the HHS report’s embrace of broad price negotiation is the administration’s latest signal that it’s siding with progressives who have pushed for a far more aggressive approach to slashing pharmaceutical costs.

Under the HHS plan, the government would directly negotiate prices for drugs in Medicare parts B and D, with those prices also being available to private insurance plans and any employers who want to participate.

House Democrats passed a similar provision as part of a major drug pricing bill in 2019. But it never made it into law, and some in the party’s centrist wing have since vowed to oppose drug price negotiation.

Notably, the plan stops short of supporting the use of “march-in rights” that progressives argue empower the government to pull patent rights from a drug that is deemed too expensive. Sen. Elizabeth Warren has long advocated for the approach, and urged HHS to utilize it in an August letter with Sen. Amy Klobuchar and Rep. Lloyd Doggett.

“The Biden Administration has the opportunity to lower the prices of key drugs using these authorities,” the lawmakers wrote to HHS Secretary Xavier Becerra.

The department in its report acknowledged that it has been petitioned to use march-in rights, saying only that it would give them “due consideration.”

The HHS plan also lays out a series of administration actions that the department could take to fulfill what it identified as three “guiding principles:” making drugs more affordable, improving competition within the industry and encouraging innovation.

Those options included testing value-based payment models and boosting cost-sharing support to certain low-income Medicare beneficiaries. It also suggests that improved data collection from insurers and pharmacy benefit managers could give the government better insight into drug pricing, as well as rebates and out-of-pocket spending on prescription medications.

HHS developed the report in response to an executive order that President Joe Biden issued earlier this year aimed at improving competition across a range of industries, including the drug sector.

#### Biden’s PC is key to wrangle democrats and counter pharma lobbying

Johnson 8/12 Johnson, Jake, writer for Alternet . "Joe Biden throws support behind bold reforms to slash drug prices." Alternet, August 12, 2021, www.alternet.org/2021/08/biden-medicare-negotiate-prices.

The powerful industry's public and behind-closed-doors lobbying push is likely to grow more aggressive as congressional Democrats' reconciliation package begins to take shape.

On Wednesday, the Senate approved a $3.5 trillion budget resolution setting the boundaries for the package, and the House is expected to take up and pass the resolution later this month. Once both chambers have passed an identical resolution, congressional committees will begin crafting legislative text.

"We will save taxpayers hundreds of billions by requiring that Medicare negotiate prescription drug prices with the pharmaceutical industry and we will use those savings to expand Medicare by covering the dental care, hearing aids, and eyeglasses that seniors desperately need," Sen. Bernie Sanders (I-Vt.), the chief architect of the budget resolution, said in a statement earlier this week.

But it's far from certain that a Medicare negotiation provision will survive the process of developing the final reconciliation bill, particularly given that a number of Big Pharma-backed House Democrats—including Reps. Scott Peters (D-Calif.) and Jake Auchincloss (D-Mass.)—have recently voiced skepticism about the proposal.

With Republicans unanimously opposed to the reconciliation package, Democrats can afford just a handful of defections in the House and none in the Senate.

Larry Levitt, executive vice president for health policy at the Kaiser Family Foundation, told HuffPost on Thursday that "it's not yet clear how the Democratic leadership will corral the necessary votes for a drug pricing plan, but there's no sign they're backing off."

"An epic battle with the pharmaceutical industry is coming," said Levitt.

In a series of tweets responding to Biden's prescription drug agenda, Levitt wrote that while the president's "proposal doesn't break new policy ground," it "is significant in that he is now using his political capital to push for congressional action at a pivotal moment in the debate."

#### WTO waiver takes time, energy, and political capital away from domestic legislation – big pharma and EU allies

Bhadrakumar 5/9 M K Bhadrakumar is a former Indian diplomat. "Biden’s talk of vaccine IP waiver is political theater." Asia Times, May 9, 2021, asiatimes.com/2021/05/bidens-talk-of-vaccine-ip-waiver-is-political-theater.

On the other hand, Biden, whose political life of half a century was largely spent in the US Congress, is well aware of the awesome clout of the pharmaceutical companies in American politics. From that lobby’s perspective, the patent waiver “amounts to the expropriation of the property of the pharmaceutical companies whose innovation and financial investments made the development of Covid-19 vaccines possible in the first place,” as a senior scholar at the Johns Hopkins Center for Health Security puts it. The US pharmaceutical industry and congressional Republicans have already gone on the offensive blasting Biden’s announcement, saying it undermines incentives for American innovation. Besides, the argument goes, even with the patent waiver, vaccine manufacturing is a complex process and is not like simply flipping a switch. Senator Richard Burr, the top Republican on the US Senate Health Committee, denounced Biden’s decision. “Intellectual property protections are part of the reason we have these life-saving products,” he said. “Stripping these protections only ensures we won’t have the vaccines or treatments we need when the next pandemic occurs.” The Republican senators backed by Republican Study Committee chairman Jim Banks propose to introduce legislation to block the move. Clearly, Biden would rather spend his political capital on getting the necessary legislation through Congress to advance his domestic reform agenda rather than spend time and energy to take on the pharmaceutical industry to burnish his image as a good Samaritan on the world stage. Conceivably, Biden could be counting on the “text-based negotiations” at the WTO dragging on for months, if not years, without reaching anywhere. The US support for the waiver could even be a tactic to persuade pharmaceutical firms to back less drastic steps like sharing technology and expanding joint ventures to boost global production quickly. So far Covid-19 vaccines have been distributed primarily to the wealthy countries that developed them, while the pandemic sweeps through poorer ones such as India, and the real goal is, after all, expanded vaccine distribution. Biden is well aware that there will be huge opposition to the TRIPS waiver from the United States’ European allies as well. The British press has reported that the UK has been in closed-door talks at the World Trade Organization in recent months along with the likes of Australia, Canada, Japan, Norway, Singapore, the European Union and the US, who all opposed the idea.

#### Drug price controls massively reduce healthcare costs across the board – even assuming conservative models

Gamba 6/9 Gamba, Tyler. Author at the AJMC. "Adoption of the Lower Drug Costs Now Act May Lead to Billions in Savings." AJMC, 9 June 2021, www.ajmc.com/view/adoption-of-the-lower-drug-costs-now-act-may-lead-to-billions-in-savings.

H.R.3, the Elijah E. Cummings Lower Drug Costs Now Act would improve efficiency and produce billions in savings for the commercial health care market’s employers and end consumers if fully implemented, according to a new study from Milliman commissioned by the West Health Policy Center.

Among its goals, the act’s provisions seek to reduce prescription drug costs, increase drug price transparency, lower member out-of-pocket spending, and increase potential coverage eligibility. Costs for the most expensive brand drugs in the United States would be negotiated between the manufacturers and the HHS secretary. Significant drug cost increases over the rate of inflation would need to be issued back as rebates to CMS.

To predict the effects of such reforms, the Milliman study sought quantitative estimates for the scope of these changes. Milliman’s models incorporated several variables, including current trends and projected spending based on different percentage adjustments to drug prices, rebates, and public vs private cost rates from 2023 through 2029.

The study estimates 46% of drug spending would be subject to negotiation under the legislation’s Title I by 2026, with an average 2.5% reduction in total commercial market claims by 2029.Overall, successful implementation of H.R. 3 means employers may reduce their health care expenditures by $195 billion while employees would save $61 billion. Of this latter amount, reduced premiums would account for $53 billion and out-of-pocket costs, $8 billion.

Overall, the market covered by the Affordable Care Act (ACA) could see savings of $58 billion, comprising $34 billon in reduced beneficiary premiums, $21 billion in federal savings by reduced Advance-Premium Tax Credits, and $2 billion in lower cost-sharing.

The estimates assume manufacturers could make such increases to the prices at a faster rate than the current yearly trends. This possibility still leads to stronger total savings via H.R. 3’s Title I. The study does not factor in further limitations on increases by plan sponsors and pharmacy benefit managers, which could improve savings for employers and employees, because it mainly applies to Medicare.

Under the most conservative pricing model—where manufacturers hypothetically increase supply costs to unprecedented highs to minimize revenue loses—$250 billion in lower costs are still passed on to employers and employees.

Additionally, the study notes that although end consumers are generally responsible for most of their plan premiums, and thus would get most of the savings, the federal government also would save on the significant portion it pays toward member premiums in the individual marketplaces.

#### Collapses the economy

Howrigon, 16 — Ron Howrigon, M.S. in Economics with a focus on Health Economics from North Carolina State University, President and Founder of Fulcrum Strategies, 18 Years of Experience in Healthcare, 12-30-2016, “Flatlining: How Healthcare Could Kill the U.S. Economy,” Greenbranch Publishing, 1st Edition, Accessed via Minnesota Libraries, Date Accessed: 8-10

Ok, let’s shift from looking at individuals to looking at the big picture—from micro- to macroeconomics. It’s important to understand where healthcare **fits into the big picture** when it comes to the economy at large. Most people who don’t work in the industry don’t clearly understand how much of the U.S. economy healthcare makes up. In fact, given the size of the economy, healthcare in the U.S. can be impactful on the ***world* economy**. This is important to understand because future changes in healthcare not only affect ow we get care and how much we pay for it, but could also significantly affect things like **unemployment**, the **national debt**, and **interest rates**. The influences on the U.S. economy will have **a ripple effect** on other countries around the world. In 1960, healthcare as a market accounted for only 5% of the U.S. economy. For every dollar transacted, only 5 cents were spent for healthcare. The entire U.S. economy was $543 billion, and healthcare accounted for about $27 billion. By itself, in 1960, the U.S. healthcare market would rank as the 15th largest world economy, putting it just in front of the GDP (Gross Domestic Product) of Australia and just behind the GDP of Italy. Think about that for a minute: the U.S., **spent more money on healthcare** than the Australians did on everything! To put this further into perspective, in 1960, the U.S. Department of Defense was twice as large as healthcare. The Defense Department consumed 10% of the U.S. economy, which means it would rank as the 11th largest world economy just in front of Japan and just behind China. Now fast-forward 50 years. In 2010, the United States GDP was $15 trillion. The total healthcare expenditures in the United States for 2010 were $2.6 trillion. At $2.6 trillion, the U.S. healthcare market has moved up from 15th and now ranks as the **5th largest world economy**, just behind Germany and just ahead of both France and the United Kingdom. That means that while healthcare was only 5% of GDP in 1960, it has risen to over 17% of GDP in only 50 years. Over that same time, the Defense Department has gone from 10% of GDP to less than 5% of GDP. This means that in terms in terms of its portion of the U.S. economy, defense spending has been reduced by half while healthcare spending has more than tripled. If **healthcare** continues to trend at the same pace it has for the last 50 years, it will consume more than **50% of the U.S. economy** by the year 2060. Every economist worth their salt will tell you that health-care will never reach 50% of the economy. It’s simply not possible because of **all the other things** it would have to **crowd out to reach** that point. So, if we know healthcare can’t grow to 50% of our economy, **where is the breaking point?** **At what point does healthcare consume so much of the economy that it breaks the bank**, so to speak? This is the big question when it comes to healthcare. If something doesn’t happen to reverse the 50-year trend we’ve been riding, when will the healthcare bubble burst? How bad will it be and how exactly will it happen? While no one knows the **exact answers** to those questions, economists and healthcare experts agree that something needs to **happen**, because we simply **can’t continue on this trend** forever. Another way to look at healthcare is to study its impact on the federal budget and the national debt. In 1998, federal healthcare spending accounted for 19% of the revenue taken in by the government. Just eight years later, in 2006, healthcare spending had increased to 24% of federal revenue. In 2010, the Affordable Healthcare Act passed and significantly increased federal spending accounted for almost one-third of all revenue received by the government and surpassed Social Security as the largest single budget category. What makes this trend even more alarming is the fact that revenue to the federal government double from 1998 to 2016. That means healthcare spending by the federal government has almost quadrupled in terms of actual dollars in that same time period. If this trend continues for the next 20 years, healthcare spending will account for over half the revenue received by the government by the year 2035. Again, the simply can’t happen without causing significant issue for the financial wellbeing of out country. In recent history, the U.S. economy has experienced the near catastrophic failure of two major market segments. The first was the auto industry and the second was the housing industry. While each of these reached their breaking point for different reasons, they both required a significant government bailout to keep them from completely melting down. What is also true about both of **those market failures** is that, looking back, it’s easy to see the warning signs. What happens if health care is the next industry to suffer a major failure and collapse? It’s safe to say that a **health care meltdown** would make both the **auto**motive and **housing** industries’ experiences **seem minor** in comparison. While that may be hard to believe, it becomes clear if you look at the numbers. The **auto industry** contributes around 3.5 percent of this country’s GDP and employs 1.7 million people. This industry was deemed **“too big to fail”** which is the rationale the U.S. government used to finance its bail out. From 2009 through 2014, the federal government invested around $80 billion in the U.S. auto industry to keep it from collapsing. Health care is five times larger than the auto industry in terms of its percentage of GDP, and is ten times larger than the auto industry in terms of the number of people it employs. The construction industry (which includes all construction, not just housing) contributes about 6 percent of our country’s GDP and employs 6.1 million people. Again, the health care market dwarfs this industry. It’s **three times larger** in terms of GDP production and, with 18 million people employed in the health care sector, it’s three times larger than construction in this area, too. These comparisons give you an idea of just how significant a portion health care comprises of the U.S. economy. It also begins to help us understand the impact it would have on the economy if health care melted down like the auto and housing industries did. So, let’s continue the comparison and use our experience with the auto and housing industries to suggest to what order of magnitude the impact a failure in the health care market would cause our economy. The bailout in the auto industry cost the federal government $80 billion over five years. Imagine a similar failure in health care that prompted the federal government to propose a similar bailout program. Let’s imagine the government felt the need to inject cash into hospital systems and doctors’ offices to keep them afloat like they did with General Motors. Since health care is five times the size of the auto industry, a similar bailout could easily cost in excess of $400 billion. That’s about the same amount of money the federal government spends on welfare programs. To pay for a bailout of the health care industry, we’d have to eliminate all welfare programs in this country. Can you imagine the impact it would have on the economy if there were suddenly none of the assistance programs so many have come to rely upon? When the housing market crashed, it caused the loss of about 3 million jobs from its peak employment level of 7.4 million in 1996. Again, if we transfer that experience to the health care market, we come up with a truly frightening scenario. If health care lost 40 percent of its jobs like housing did, it would mean 7.2 million jobs lost. That’s more than four times the number of people who are employed by the entire auto industry — an industry that was considered too big to be allowed to fail. The loss of **7.2 million jobs** would increase the unemployment rate by 5 percent. That means we could easily top the **all-time high unemployment rate** for our country. OK, now it’s time to take a deep breath. I’m not convinced that health care is fated to **unavoidable failure** and economic catastrophe. That’s a worst-case scenario. The problem is that at even a fraction the severity of the auto or housing industry crises we’ve already faced, a health care collapse would still be devastating. Health care **can’t be allowed** to continue its current inflationary trending. I believe we are on the verge of some major changes in health care, and that how they’re **implemented** will determine their impact on the overall **economic picture** in this country and around the world. Continued failure to recognize the truth about health care will only cause the resulting market corrections to be worse than they need to be. I don’t want to diminish the pain and anguish that many people caught up in the housing crash experienced. I think an argument can be made, though, that if the health care market crashes and millions of people end up with no health care, the resulting fallout could be could be much worse than even the housing crisis.

#### Economic decline causes nuclear war

Tønnesson, 15 — Stein Tønnesson, Leader of East Asia Peace program at Uppsala University, Research Professor at the Peace Research Institute Oslo, “Deterrence, Interdependence and Sino–US Peace” International Area Studies Review, Review Essay, Volume 18, Issue 3, Pages 297-311, SAGE Journals, Minnesota Libraries, Date Accessed: 8-4

Several recent works on China and Sino–US relations have made substantial contributions to the current understanding of how and under what circumstances a combination of nuclear deterrence and economic interdependence may reduce the risk of war between major powers. At least four conclusions can be drawn from the review above: first, those who say that interdependence may **both inhibit and drive conflict** are right. Interdependence raises the **cost of conflict** for all sides but asymmetrical or unbalanced dependencies and **negative trade expectations** may generate tensions leading to trade wars among inter-dependent states that in turn increase the risk of military conflict (Copeland, 2015: 1, 14, 437; Roach, 2014). The risk may increase if one of the interdependent countries is governed by an inward-looking socio-economic coalition (Solingen, 2015); second, the risk of war between China and the US should not just be analysed bilaterally but include their allies and partners. Third party countries could drag China or the US into confrontation; third, in this context it is of some comfort that the three main economic powers in Northeast Asia (China, Japan and South Korea) are all deeply integrated economically through production networks within a global system of trade and finance (Ravenhill, 2014; Yoshimatsu, 2014: 576); and fourth, decisions for war and peace are taken by very few people, who act on the basis of their future expectations. International relations theory must be supplemented by foreign policy analysis in order to assess the value attributed by national decision-makers to economic development and their assessments of risks and opportunities. If leaders on either side of the Atlantic begin to seriously fear or **anticipate their own nation’s decline** then they may blame this on **external dependence**, appeal to anti-foreign sentiments, contemplate the use of force to gain respect or credibility, adopt protectionist policies, and ultimately **refuse to be deterred by** either **nuclear arms** or prospects of socioeconomic calamities. Such a dangerous shift could happen **abruptly**, i.e. under the instigation of actions by a third party – or against a third party.

Yet as long as there is both nuclear deterrence and interdependence, the tensions in East Asia are unlikely to escalate to war. As Chan (2013) says, all states in the region are aware that they cannot count on support from either China or the US if they make provocative moves. The greatest risk is **not** that **a territorial dispute** leads to war under present circumstances but that **changes in the world economy** alter those circumstances in ways that render **inter-state peace** more precarious. If China and the US fail to rebalance their financial and trading relations (Roach, 2014) then a trade war could result, interrupting transnational production networks, provoking social distress, and exacerbating nationalist emotions. This could have **unforeseen consequences** in the field of security, with nuclear deterrence remaining the only factor to **protect the world from Armageddon**, and **unreliably so**. Deterrence could **lose its credibility**: one of the two great powers might gamble that the other yield in a cyber-war or conventional limited war, or third-party countries might engage in conflict with each other, with a view to obliging Washington or Beijing to **intervene**.

## Case

### Underview

#### Overview- err neg on all 1ar theory-

#### 1] 2nr has to split between substance and over-cover theory b/c of the 7/6, 2 speech aff advantage and they get 2ar collapse and persuasiveness advantage and no 3nr to check

#### 2] Responses to the counter-interp will inevitably be new- implications-

#### A] Evaluate the theory debate after the 2nr- means you have to draw a strict line between 1ar and 2ar args- if they didn’t do the weighing, it’s their fault since it should’ve been in the 1ar

#### B] If intervention happens on theory, intervene to reduce theory and just vote on substance

#### 3] Reasonability- good is good enough- they create a race to the top of blippy theory debate which crowds out substance and internal link turns their education offense- potential abuse isn’t a voter- that’s infinitely regressive

### Advantage

#### Vague standards for new patents are unenforceable and explode costs – the link alone turns case because the plan is unenforceable

Madigan & O'Connor 19 [Kevin Madigan joined CPIP in January of 2016. As Deputy Director, Kevin works closely with CPIP scholars in their research and promotion of comprehensive intellectual property law and policy. Before joining CPIP, Kevin worked as an intellectual property Research Associate at Finnegan Henderson Farabow Garrett & Dunner and also interned at the Recording Industry Association of America. Sean O’Connor, noted innovation law scholar, is a Professor of Law and Faculty Director of the Center for Intellectual Property x Innovation Policy (C-IP2) at George Mason University, Antonin Scalia Law School. "“No Combination Drug Patents Act” Stalls, but Threats to Innovation Remain." https://cip2.gmu.edu/2019/06/27/no-combination-drug-patents-act-stalls-but-threats-to-innovation-remain/]

While the amendment provided for a rebuttal to the presumption of obviousness, the language was ambiguous and likely to render the patent system even more unreliable than it already is. The proposed statute said that an applicant may rebut the presumption of obviousness if the covered claimed invention “results in a statistically significant increase in the efficacy of the drug or biological product that the covered claimed invention contains or uses.” It is unclear what would qualify as “statistically significant,” and proving this vague standard would be nearly impossible.

In order to show a “statistically significant increase in efficacy,” long and costly head-to-head clinical trials would be necessary. To be clear, this is not a standard required by the FDA for new drug approval, let alone patentability.

#### Eliminating evergreening ends the pharmaceutical industry – incremental developments are key to global breakthroughs on emerging pathogens

Madigan & O'Connor 19 [Kevin Madigan joined CPIP in January of 2016. As Deputy Director, Kevin works closely with CPIP scholars in their research and promotion of comprehensive intellectual property law and policy. Before joining CPIP, Kevin worked as an intellectual property Research Associate at Finnegan Henderson Farabow Garrett & Dunner and also interned at the Recording Industry Association of America. Sean O’Connor, noted innovation law scholar, is a Professor of Law and Faculty Director of the Center for Intellectual Property x Innovation Policy (C-IP2) at George Mason University, Antonin Scalia Law School. "“No Combination Drug Patents Act” Stalls, but Threats to Innovation Remain." https://cip2.gmu.edu/2019/06/27/no-combination-drug-patents-act-stalls-but-threats-to-innovation-remain/]

Like most forms of innovation, the development of medicines and therapeutics is a process by which one builds and improves upon previous discoveries and breakthroughs. Sometimes those improvements are major advancements, but often they are incremental steps forward. In the pharmaceutical field, incremental or follow-on innovation frequently results in new therapeutic uses for existing drugs, which address serious challenges related to adverse effects, delivery systems, and dosing schedules. While they might not sound like medical breakthroughs on par with the discovery of penicillin, these advancements in the administration and use of pharmaceuticals improve public health and save lives.

Additionally, follow-on innovations are—and should remain—subject to the same patentability standards as any other technologies. Patents reward advancements that are novel, useful, and nonobvious, and our patent system has long recognized that patent claims are to be presumed patentable and nonobvious. The Graham amendment would have turned this established standard on its head, creating a separate and ill-defined hurdle for certain advancements in medicine.

The benefits of incremental innovation to public health and patients cannot be overstated. New formulations of malaria drugs, dosing regimens and delivery systems for AIDS patients, more efficient administrations of insulin for the treatment of diabetes, and developments in the treatment of cognitive heart disease have all been possible because of incremental innovation.

Imposing unjustified restrictions on the patentability of advancements like these would be disastrous for drug development, as the incentives that come with patent protection would be all but eliminated. Without the assurance that their innovative labor would be supported by intellectual property protection, pioneering drug developers would shift resources away from improving drug formulations and uses. The development of more effective treatments of some of the most devastating diseases would stall, as innovators would be unable to commercialize their products, recoup losses, or fund future research and development.

As critics continue to target myopically the patent system for a broader issue of drug prices in the American health care system, it’s likely not the last time that language like this will be proposed. In order to avoid the implementation of such ill-conceived standards into our patent laws, understanding what’s at stake is critical. The future of medical innovation depends on it.

#### It tips the entire industry into insolvency

Globerman & Lybecker 14 [Steven Globerman is Resident Scholar and Addington Chair in Measurement at the Fraser Institute as well as Professor Emeritus at Western Washington University. Kristina M.L. Acri, née Lybecker – Chair of the Department of Economics and Business, Colorado College. "The Benefits of Incremental Innovation FOCUS ON THE PHARMACEUTICAL INDUSTRY The Benefits of Incremental Innovation FOCUS ON THE PHARMACEUTICAL INDUSTRY." https://www.fraserinstitute.org/sites/default/files/benefits-of-incremental-innovation.pdf]

Incremental innovation is a financial necessity for high-tech industries such as biotechnology and pharmaceuticals. Given the paucity and unpredictability of radical innovation, incremental advances sustain the industry financially, for no mature industry can do so from income derived from breakthrough innovation alone. As described by Wertheimer, Levy, and O’Connor, “[t]he pharmaceutical industry must generate revenue based predominantly on incremental innovations, which characterize the majority of products and contribute the majority of revenue” (Wertheimer, Levy, and O’Connor, 2001: 108–109). Evidence of the prevalence of breakthrough relative to incremental innovations is shown in figure 2.2 below. Over the entire period, products based on incremental innovations outnumber breakthrough products. In addition, it is essential to recognize the importance of risk management. Any technology portfolio will comprise projects of differing risk levels. In the case of the pharmaceutical industry, incremental innovation projects are an essential—and significant—component of this portfolio. The incremental innovation projects will be characterized by lower risk and a greater probability of reaching the market (Wertheimer, Levy, and O’Connor, 2001: 110).

#### Weakening IP encourages imitation, not innovation – it removes the financial incentive to invent

Globerman & Lybecker 14 [Steven Globerman is Resident Scholar and Addington Chair in Measurement at the Fraser Institute as well as Professor Emeritus at Western Washington University. Kristina M.L. Acri, née Lybecker – Chair of the Department of Economics and Business, Colorado College. "The Benefits of Incremental Innovation FOCUS ON THE PHARMACEUTICAL INDUSTRY The Benefits of Incremental Innovation FOCUS ON THE PHARMACEUTICAL INDUSTRY." https://www.fraserinstitute.org/sites/default/files/benefits-of-incremental-innovation.pdf]

Finally, protecting innovation fosters economic growth and development, and that includes incremental innovation. A growing body of empirical evidence demonstrates that increasingly robust intellectual property protections, in combination with other policies, increase economic development, foreign direct investment (FDI), and innovation.5 A 2006 report from the United Nations Industrial Development Organization (UNIDO) studied the role of intellectual property rights in advanced nations in technology transfer and economic growth, concluding that protecting innovation creates benefits for countries at all levels of development. For developing countries, strengthening intellectual property rights encourages growth. For middle-income countries, evidence indicates that domestic innovation and diffusion of technology can lead to growth and that strengthening IPRs can encourage industries to shift from imitation to innovation. For advanced economies, stronger IPRs increase innovation and raise growth (Falvy, Foster, and Memedovic, 2006). Moreover, enforcing intellectual property rights and protecting innovation also drives research on cures. This is true of the diseases of both industrialized and developing nations. A recent study by Kyle and McGahan (2012) finds evidence of more research on diseases in nations with TRIPS-compliant IP provisions, as their patent provisions were put into place and implemented, than on diseases prevalent in non-TRIPS-compliant nations, controlling for the level of economic development and other factors.6

## 2nr

CP  
Only the CP solves pharmaceutical innovation – peak pharma is here, and evergreening is a non-factor. Bottleknecks in development come from a shortage of drugs and siloed medical information that prevents effective industrial testing and population-level health science. The CP solves:

1. It integrated everyone’s medical records into a large-scale anonymous database available to commercial developers – that allows firms to access far more info when designing drugs

2. It harmonizes genetic information – that’s key to tracking demographic vulnerabilities to next-gen pathogens and keep pace with emerging diseases

3. It uses machine learning to identify population – level vulnerabilities in biotech – that’s key, humans are structurally incapable of continuing pharma innovation at pace with glboaliztion – only the CP solves –

#### **Clinical access is the deciding factor for biomedical research --- diversity programs alone can’t consolidate or exchange genomic details efficiently.**