# 1AC – WTO IPP

## COVID-19

#### **There’s a huge and dangerous inequality in vaccination rates.**

Lynch, 21

Lynch, David J. “Poor Countries’ Struggles amid Vaccines Shortfall Threaten Greater Instability, Migration and Disease.” Washington Post, The Washington Post, 29 June 2021, www.washingtonpost.com/us-policy/2021/06/29/global-economy-pandemic/. Accessed 9 July 2021.

Even as millions of Americans enjoy a post-pandemic boom, fresh covid-19 outbreaks in the developing world are undermining economic recovery and fueling political unrest. Sluggish vaccination campaigns stand between the world’s poorest nations and the resumption of normal life, casting a shadow over a global rebound that is otherwise shaping up as the most impressive in 80 years, according to the World Bank. The United States and other rich nations have promised to deliver 1 billion vaccines to governments in Africa, Asia and Latin America. But 18 months after the pandemic began, there is no agreed plan or timetable for inoculating perhaps half of the people on the planet. Now, amid the spread of the highly infectious delta variant, and as finance ministers from the Group of 20 prepare to meet next week, the issue is gaining new urgency. In Africa, which is suffering the world’s fastest-rising covid caseload, less than 1 percent of the adult population has been vaccinated and South Africa, Rwanda and Uganda all have reimposed restrictions on activity. Latin America is reeling as covid deaths soar in Brazil, Argentina and Colombia. And in South Asia, India’s nearly 1.4 billion people will not reach herd immunity until October 2022, says Bank of America Merrill Lynch. A failure to accelerate vaccinations could allow the virus to mutate into more deadly forms, leaving lasting wounds on dozens of economies, preventing for years a complete restoration of global travel and ultimately threatening Americans’ health. By aggravating societal cleavages, disparities in the pandemic response between rich and poor nations also could spur political instability and unauthorized migration, including along the southern U.S. border, experts warn. “The virus is still raging across the planet, and we don’t have the vaccines. This is the greatest priority right now,” said Achim Steiner, administrator of the United Nations Development Program. “ … If this economic crisis paralyzes the ability of state institutions to stand up crisis response, organize vaccination supply chains and provide recovery stimulus packages that can help the economies to recover, we will actually see a political crisis on the back of the economic crisis.”

#### LICs don’t have enough vaccines; they’re forced to import vaccines due to IP protections.

Nature, 21

“A Patent Waiver on COVID Vaccines Is Right and Fair.” Nature, vol. 593, no. 7860, 25 May 2021, pp. 478–478, www.nature.com/articles/d41586-021-01242-1, 10.1038/d41586-021-01242-1.

The core problem is that vaccine manufacturing, research and development is too heavily concentrated in a small group of high- and middle-income countries. Companies in these countries, which are also the main IP holders, have sold the majority of available vaccine doses to their own governments, and to governments of other high-income nations. Some 6 billion doses out of the 8.6 billion confirmed purchases so far have been pre-ordered by governments in high- and middle-income countries. According to pharmaceutical-industry data, the industry expects to have made a total of about ten billion vaccine doses by the end of 2021. But on the basis of current trends, this is unlikely to happen, according to researchers at the International Monetary Fund in Washington DC. In a paper published on 19 May, they report that the industry is likely to have produced around six billion doses by the end of 2021 (see go.nature.com/2tchn13). This potential shortfall increases the risk that people in low-income countries will need to wait even longer for their first doses. As Nature went to press, the number of vaccines given so far in Africa amounted to little more than one dose per person for some 2% of Africa’s 1.2 billion people. This is, among other factors, because the continent currently imports 99% of its vaccines, and because African countries lack the pre-order purchasing capacity of richer nations. It is why the African Union has announced a plan for 60% of Africa’s vaccines to be manufactured on the continent by 2040. At the Global Health Summit in Rome last week, ahead of this week’s World Health Assembly in Geneva, Switzerland, European nations promised to share more vaccine doses with low- and middle-income countries. European Commission president Ursula von der Leyen is also proposing to ‘clarify and simplify’ the existing ways in which countries can implement compulsory licensing. And there is a strong possibility that the G7 group of the world’s biggest economies will pledge more funding for vaccination when member countries meet in the United Kingdom next month. These commitments are crucial in the race to end the pandemic. But they do not deal with the systemic issue — countries backing the IP waiver are not asking for charity, but for the right to develop and make their own vaccines, free from the worry that they will be sued by patent holders. Those backing the COVID IP waiver understand this core principle. The leaders of countries that are not currently in favour of the patent waiver must recognize it, too. As John Nkengasong, director of the Africa Centres for Disease Control and Prevention, says: they need to be on the right side when the history of the pandemic comes to be written.

#### **Factories are ready to make hundreds of millions of vaccines, but patents won’t allow them to—patents are causing inequality in vaccine distribution.**

Cheng and Hinnant, 21

Cheng, Maria and Hinnant, Lori. “Countries Urge Drug Companies to Share Vaccine Know-How.” AP NEWS, Associated Press, 20 Apr. 2021, apnews.com/article/drug-companies-called-share-vaccine-info-22d92afbc3ea9ed519be007f8887bcf6.

In an industrial neighborhood on the outskirts of Bangladesh’s largest city lies a factory with gleaming new equipment imported from Germany, its immaculate hallways lined with hermetically sealed rooms. It is operating at just a quarter of its capacity. It is one of three factories that The Associated Press found on three continents whose owners say they could start producing hundreds of millions of COVID-19 vaccines on short notice if only they had the blueprints and technical know-how. But that knowledge belongs to the large pharmaceutical companies who have produced the first three vaccines authorized by countries including Britain, the European Union and the U.S. — Pfizer, Moderna and AstraZeneca. The factories are all still awaiting responses. Across Africa and Southeast Asia, governments and aid groups, as well as the World Health Organization, are calling on pharmaceutical companies to share their patent information more broadly to meet a yawning global shortfall in a pandemic that already has claimed over 2.5 million lives. Pharmaceutical companies that took taxpayer money from the U.S. or Europe to develop inoculations at unprecedented speed say they are negotiating contracts and exclusive licensing deals with producers on a case-by-case basis because they need to protect their intellectual property and ensure safety. Critics say this piecemeal approach is too slow at a time of urgent need to stop the virus before it mutates into even deadlier forms. WHO called for vaccine manufacturers to share their know-how to “dramatically increase the global supply.” “If that can be done, then immediately overnight every continent will have dozens of companies who would be able to produce these vaccines,” said Abdul Muktadir, whose Incepta plant in Bangladesh already makes vaccines against hepatitis, flu, meningitis, rabies, tetanus and measles. All over the world, the supply of coronavirus vaccines is falling far short of demand, and the limited amount available is going to rich countries. Nearly 80% of the vaccines so far have been administered in just 10 countries, according to WHO. More than 210 countries and territories with 2.5 billion people hadn’t received a single shot as of last week. The deal-by-deal approach also means that some poorer countries end up paying more for the same vaccine than richer countries. South Africa, Mexico, Brazil and Uganda all pay different amounts per dose for the AstraZeneca vaccine — and more than governments in the European Union, according to studies and publicly available documents. AstraZeneca said the price of the vaccine will differ depending on local production costs and how much countries order. “What we see today is a stampede, a survival of the fittest approach, where those with the deepest pockets, with the sharpest elbows are grabbing what is there and leaving others to die,” said Winnie Byanyima, executive director of UNAIDS. In South Africa, home to the world’s most worrisome COVID-19 variant, the Biovac factory has said for weeks that it’s in negotiations with an unnamed manufacturer with no contract to show for it. And in Denmark, the Bavarian Nordic factory has capacity to spare and the ability to make more than 200 million doses but is also waiting for word from the producer of a licensed coronavirus vaccine. Governments and health experts offer two potential solutions to the vaccine shortage: One, supported by WHO, is a patent pool modeled after a platform set up for HIV, tuberculosis and hepatitis treatments for voluntary sharing of technology, intellectual property and data. But no company has offered to share its data. The other, a proposal to suspend intellectual property rights during the pandemic, has been blocked in the World Trade Organization by the United States and Europe, home to the companies responsible for creating coronavirus vaccines. That drive has the support of at least 119 countries and the African Union but is adamantly opposed by vaccine makers. Advocates of sharing vaccine blueprints argue that, unlike with most drugs, taxpayers paid billions to develop vaccines that could help end the world’s biggest public health emergency in living memory. “People are literally dying because we cannot agree on intellectual property rights,” said Mustaqeem De Gama, a South African diplomat involved in the WTO discussions. Paul Fehlner, the chief legal officer for biotech company Axcella and a supporter of the WHO patent pool board, said governments that poured billions of dollars into developing vaccines and treatments should have demanded more from the companies they were financing from the beginning. “A condition of taking taxpayer money is not treating them as dupes,” he said. Last month, Dr. Anthony Fauci, the leading pandemic expert in the United States, said all options need to be on the table, including improving production capacity in the developing world and working with pharmaceuticals to relax their patents. “Rich countries, ourselves included, have a moral responsibility when you have a global outbreak like this,” Fauci said. “We’ve got to get the entire world vaccinated, not just our own country.” It’s hard to know exactly how much more vaccine could be made worldwide if intellectual property restrictions were lifted. But Suhaib Siddiqi, former director of chemistry at Moderna, said with the blueprint and technical advice, a modern factory should be able to get vaccine production going in at most three to four months. “In my opinion, the vaccine belongs to the public,” said Siddiqi. “Any company which has experience synthesizing molecules should be able to do it.”

#### Reducing IP protections is vital to reduce vaccine inequality—empirics disprove all pro-patent arguments.

Kumar, 21

(Rajeesh, Associate Fellow Manohar Parrikar Institute for Defence Studies and Analysis, https://www.idsa.in/issuebrief/wto-trips-waiver-covid-vaccine-rkumar-120721)

In October 2020, India and South Africa had submitted a proposal to the World Trade Organization (WTO), suggesting a waiver of certain provisions of the Trade-Related Aspects of Intellectual Property Rights (TRIPS) Agreement for the “prevention, containment and treatment of COVID-19”. The proposal seeks the waiver of “the implementation, application, and enforcement of sections 1, 4, 5 and 7 of part II of the TRIPS agreement”, which are stipulations referring to copyright, industrial design, patents, and undisclosed information (trade secrets).1 The proponents of the proposal argue that a waiver will enable timely and equitable access to affordable health products and technologies, including vaccines. Though many member countries had supported and co-sponsored the proposal, a small but influential group of countries, mainly Australia, Canada, the European Union (EU), Japan, the United Kingdom (UK) and the United States (US), opposed it. They argued that existing exceptions under the TRIPS Agreement are sufficient to address the concerns mentioned in the proposal. This resulted in sidelining of the waiver proposal for months. However, on 5 May 2021, the Joseph Biden administration announced its support for waiving intellectual property protections for COVID-19 vaccines.2 It was a significant step towards breaking the seven-month gridlock, and led to many more countries modifying their position on the waiver proposal. On 25 May 2021, the co-sponsors of the waiver proposal submitted a revised proposal that specified the scope of the waiver as applying to “health products and technologies” and also added a section on the proposed duration of the waiver, i.e., three years.3 At present, more than 100 countries, including the US and China support this proposal. The principal opponent of the waiver is the EU and in June 2021, it submitted an alternative proposal to the TRIPS Council, which requested to keep TRIPS’ provisions intact and focused on compulsory licensing and removing vaccine export restrictions to address the concerns raised by India and South Africa.4 The EU proposal also stated that the TRIPS Agreement does not prevent countries from taking measures to protect public health.5 At the meeting of the TRIPS Council on 8–9 June 2021, the member states agreed to text-based negotiations focusing on two proposals tabled by members. The members also decided to hold a series of meetings till the end of July 2021 to take stock of the text-based negotiations. However, the latest developments show that the waiver discussions hit a hurdle due to a split between the developed and developing countries over the negotiation text. This brief discusses how TRIPS becomes a barrier to the equitable access of COVID-19 vaccines. It also examines how a waiver will help India in its fight against COVID-19 at home and abroad. TRIPS and its Exceptions TRIPS, a comprehensive multilateral agreement on Intellectual Property (IP), was an outcome of the Uruguay Round (1986–94) of negotiations of the General Agreement on Tariffs and Trade (GATT). The Agreement came into force on 1 January 1995 and offers a minimum standard of protection for Intellectual Property Rights (IPR).6 In WTO, IPR are divided into two main categories. First, copyright and related rights (Articles 9 to 14, Part II of the TRIPS Agreement). Second, industrial property that includes trademarks, geographical indications, industrial designs, patents, integrated circuit layout designs, and undisclosed information (Articles 15 to 38, Part II of the TRIPS Agreement).7 Article IX.3 and IX.4 of the Marrakesh Agreement Establishing the WTO deals with TRIPS waivers. Article IX.3 says that in “exceptional circumstances” the Ministerial Conference may waive off an obligation imposed on WTO member countries.8 Such a decision requires the support of three-fourths of the WTO membership. According to Article IX.4, any waiver granted for more than one year will be reviewed by the Ministerial Conference. Based on the annual review, the Conference may extend, modify, or terminate the waiver. The TRIPS Agreement provides some flexibility primarily in the form of compulsory licensing and research exceptions through Articles 30 and 31. While Article 30 permits WTO members to make limited exceptions to patent rights, Article 31 provides a detailed exception, provided certain conditions are met. Compulsory licensing is the process of granting a license by a government to use a patent without the patent holder's consent. Article 31 permits granting compulsory license under circumstances such as “national emergencies”, “other circumstances of extreme urgency”, “public noncommercial use”, or against “anti-competitive” practices.9 In addition to these original waivers, the Declaration on the TRIPS Agreement and Public Health, adopted at the 2001 Doha Ministerial Meeting, also recognises some exceptions, for instance, in situations of a public health emergency, member countries have the freedom to determine the grounds upon which compulsory licenses are granted. Similarly, under Article 66.1, the least developed countries (LDCs) are given waivers for implementing TRIPS on pharmaceuticals till 1 January 2033. COVID-19 and TRIPS Waiver Two significant factors rekindled the debate on TRIPS waiver for essential medical products—first, vaccine inequity, and second, the insufficiency of existing waiver provisions in fighting the COVID-19 pandemic. COVID-19 is an exceptional circumstance, and equitable global access to the vaccine is necessary to bring the pandemic under control. However, the world is witnessing quite the reverse, i.e., vaccine nationalism. Vaccine nationalism is “my nation first” approach to securing and stockpiling vaccines before making them available in other countries. A TRIPS waiver would be instrumental in addressing the growing inequality in the production, distribution, and pricing of the COVID-19 vaccines. Vaccine Inequity According to Duke Global Health Innovation Center, which monitors COVID-19 vaccine purchases, rich nations representing just 14 per cent of the world population have bought up to 53 per cent of the most promising vaccines so far. As of 4 July 2021, the high-income countries (HICs) purchased more than half (6.16 billion) vaccine doses sold globally. At the same time, the low-income countries (LICs) received only 0.3 per cent of the vaccines produced. The low and middle-income countries (LMICs), which account for 81 per cent of the global adult population, purchased 33 per cent, and COVAX (COVID-19 Vaccines Global Access) has received 13 per cent.10 Many HICs bought enough doses to vaccinate their populations several times over. For instance, Canada procured 10.45 doses per person, while the UK, EU and the US procured 8.18, 6.89, and 4.60 doses per inhabitant, respectively.11 Source:“Tracking COVID-19 Vaccine Purchases Across the Globe”, Duke Global Health Innovation Center, Updated 9 July 2021. Consequently, there is a significant disparity between HICs and LICs in vaccine administration as well. As of 8 July 2021, 3.32 billion vaccine doses had been administered globally.12 Nonetheless, only one per cent of people in LICs have been given at least one dose. While in HICs almost one in four people have received the vaccine, in LICs, it is one in more than 500. The World Health Organization (WHO) notes that about 90 per cent of African countries will miss the September target to vaccinate at least 10 per cent of their populations as a third wave looms on the continent.13 South Africa, the most affected African country, for instance, has vaccinated less than two per cent of its population of about 59 million. This is in contrast with the US where almost 47.5 per cent of the population of more than 330 million has been fully vaccinated. In Sub-Saharan Africa, vaccine rollout remains the slowest in the world. According to the International Monetary Fund (IMF), at current rates, by the end of 2021, a massive global inequity will continue to exist, with Africa still experiencing meagre vaccination rates while other parts of the world move much closer to complete vaccination.14 This vaccine inequity is not only morally indefensible but also clinically counter-productive. If this situation prevails, LICs could be waiting until 2025 for vaccinating half of their people. Allowing most of the world’s population to go unvaccinated will also spawn new virus mutations, more contagious viruses leading to a steep rise in COVID-19 cases. Such a scenario could cause twice as many deaths as against distributing them globally, on a priority basis. Preventing this humanitarian catastrophe requires removing all barriers to the production and distribution of vaccines. TRIPS is one such barrier that prevents vaccine production in LMICs and hence its equitable distribution. TRIPS: Barrier to Equitable Health Care Access The opponents of the waiver proposal argue that IPR are not a significant barrier to equitable access to health care, and existing TRIPS flexibilities are sufficient to address the COVID-19 pandemic. However, history suggests the contrary. For instance, when South Africa passed the Medicines and Related Substances Act of 1997 to address the HIV/AIDS public health crisis, nearly 40 of world’s largest and influential pharma companies took the South African government to court over the violation of TRIPS. The Act, which invoked the compulsory licensing provision, allowed South Africa to produce affordable generic drugs.15 The Big Pharma also lobbied developed countries, particularly the US, to put bilateral trade sanctions against South Africa.16 Similarly, when Indian company Cipla decided to provide generic antiretrovirals (ARVs) to the African market at a lower cost, Big Pharma retaliated through patent litigations in Indian and international trade courts and branded Indian drug companies as thieves.17 Another instance was when Swiss company Roche initiated patent infringement proceedings against Cipla’s decision to launch a generic version of cancer drug, “erlotinib”. Though the Delhi High Court initially dismissed Roche's appeal by citing “public interest” and “affordability of medicines,” the continued to pressure the generic pharma companies over IPR. 18 Likewise, Pfizer’s aggressive patenting strategy prevented South Korea in developing pneumonia vaccines for children.19 A recent document by Médecins Sans Frontières (MSF), or Doctors Without Borders, highlights various instances of how IP hinders manufacturing and supply of diagnostics, medical equipment, treatments and vaccines during the COVID-19 pandemic. For instance, during the peak of the COVID-19 first wave in Europe, Roche rejected a request from the Netherlands to release the recipe of key chemical reagents needed to increase the production of diagnostic kits. Another example was patent holders threatening producers of 3D printing ventilators with patent infringement lawsuits in Italy.20 The MSF also found that patents pose a severe threat to access to affordable versions of newer vaccines.21 Source:“COVID-19 Vaccine R&D Investments”, Global Health Centre, Graduate Institute, Geneva, Updated 9 July 2021. The opponents of the TRIPS waiver also argue that IP is the incentive for innovation and if it is undermined, future innovation will suffer. However, most of the COVID-19 medical innovations, particularly vaccines, are developed with public financing assistance. Governments spent billions of dollars for COVID-19 vaccine research. Notably, out of $6.1 billion in investment tracked up to July 2021, 98.12 per cent was public funding.22 The US and Germany are the largest investors in vaccine R&D with $2.2 billion and $1.5 billion funding. Source:“COVID-19 Vaccine R&D Investments”, Global Health Centre, Graduate Institute, Geneva, Updated 9 July 2021. Private companies received 94.6 per cent of this funding; Moderna received the highest $956.3 million and Janssen $910.6 million. Moreover, governments also invested $50.9 billion for advance purchase agreements (APAs) as an incentive for vaccine development. A recent IMF working paper also notes that public research institutions were a key driver of the COVID-19 R&D effort—accounting for 70 per cent of all COVID-19 clinical trials globally.23 The argument is that vaccines are developed with the support of substantial public financing, hence there is a public right to the scientific achievements. Moreover, private companies reaped billions in profits from COVID-19 vaccines. Source: Katharina Buchholz, “COVID-19 Vaccines Lift Pharma Company Profits”, Statista, 17 May 2021. One could argue that since the US, Germany and other HICs are spending money, their citizens are entitled to get vaccines first, hence vaccine nationalism is morally defensible. Nonetheless, it is not the case. The TRIPS Agreement includes several provisions which mandates promotion of technology transfer from developed countries to LDCs. For instance, Article 7 states that "the protection and enforcement of IP rights should contribute to the promotion of technological innovation and the transfer and dissemination of technology, to the mutual advantage of producers and users of technical knowledge and in a manner conducive to social and economic welfare, and to a balance of rights and obligations."24 Similarly, Article 66.2 also mandates the developed countries to transfer technologies to LDCs to enable them to create a sound and viable technological base. The LMICs opened their markets and amended domestic patent laws favouring developing countries’ products against this promise of technology transfer. Another argument against the proposed TRIPS waiver is that a waiver would not increase the manufacturing of COVID-19 vaccines. Indeed, one of the significant factors contributing to vaccine inequity is the lack of manufacturing capacity in the global south. Further, a TRIPS waiver will not automatically translate into improved manufacturing capacity. However, a waiver would be the first but essential step to increase manufacturing capacity worldwide. For instance, to export COVID-19 vaccine-related products, countries need to ensure that there are no IP restrictions at both ends – exporting and importing. The market for vaccine materials includes consumables, single-use reactors bags, filters, culture media, and vaccine ingredients. Export blockages on raw materials, equipment and finished products harm the overall output of the vaccine supply chain. If there is no TRIPS restriction, more governments and companies will invest in repurposing their facilities. Similarly, the arguments such as that no other manufacturers can carry out the complex manufacturing process of COVID-19 vaccines and generic manufacturing as that would jeopardise quality, have also been proven wrong in the past. For instance, in the early 1990s, when Indian company Shantha Biotechnics approached a Western firm for a technology transfer of Hepatitis B vaccine, the firm responded that “India cannot afford such high technology vaccines… And even if you can afford to buy the technology, your scientists cannot understand recombinant technology in the least.”25 Later, Shantha Biotechnics developed its own vaccine at $1 per dose, and the UNICEF (United Nations Children’s Emergency Fund) mass inoculation programme uses this vaccine against Hepatitis B. In 2009, Shantha sold over 120 million doses of vaccines globally. India also produces high-quality generic drugs for HIV/AIDS and cancer treatment and markets them across the globe. Now, a couple of Indian companies are in the last stage of producing mRNA (Messenger RNA) vaccines.26 Similarly, Bangladesh and Indonesia claimed that they could manufacture millions of COVID-19 vaccine doses a year if pharmaceutical companies share the know-how.27 Recently, Vietnam also said that the country could satisfy COVID-19 vaccine production requirements once it obtains vaccine patents.28 Countries like the United Arab Emirates (UAE), Turkey, Cuba, Brazil, Argentina and South Korea have the capacity to produce high-quality vaccines but lack technologies and know-how. However, Africa, Egypt, Morocco, Senegal, South Africa and Tunisia have limited manufacturing capacities, which could also produce COVID-19 vaccines after repurposing. Moreover, COVID-19 vaccine IPR runs across the entire value chain – vaccine development, production, use, etc. A mere patent waiver may not be enough to address the issues related to its production and distribution. What is more important here is to share the technical know-how and information such as trade secrets. Therefore, the existing TRIPS flexibilities, such as compulsory and voluntary licensing, are insufficient to address this crisis. Further, compulsory licensing and the domestic legal procedures it requires is cumbersome and not expedient in a public health crisis like the COVID-19 pandemic.

#### To end the pandemic, people in poor countries need to be vaccinated. If we don’t fix the vaccine inequality, millions more will die.

Clendaniel, 21

Clendaniel, Morgan. “Why Global Herd Immunity Is out of Reach: 99% of People in Poor Countries Are Unvaccinated.” Fast Company, Fast Company, 5 July 2021, www.fastcompany.com/90652213/why-global-herd-immunity-is-out-of-reach-99-of-people-in-poor-countries-are-unvaccinated.

Public health experts estimate that approximately 70% of the world’s 7.9 billion people must be fully vaccinated to end the COVID-19 pandemic. As of June 21, 2021, 10.04% of the global population had been fully vaccinated, nearly all of them in rich countries. Only 0.9% of people in low-income countries have received at least one dose. I am a scholar of global health who specializes in health care inequities. Using a data set on vaccine distribution compiled by the Global Health Innovation Center’s Launch and Scale Speedometer at Duke University in the United States, I analyzed what the global vaccine access gap means for the world. Supply is not the main reason some countries are able to vaccinate their populations while others experience severe disease outbreaks—distribution is. Many rich countries pursued a strategy of overbuying COVID-19 vaccine doses in advance. My analyses demonstrate that the U.S., for example, has procured 1.2 billion COVID-19 vaccine doses, or 3.7 doses per person. Canada has ordered 381 million doses; every Canadian could be vaccinated five times over with the two doses needed. Overall, countries representing just one-seventh of the world’s population had reserved more than half of all vaccines available by June 2021. That has made it very difficult for the remaining countries to procure doses, either directly or through COVAX, the global initiative created to enable low- to middle-income countries equitable access to COVID-19 vaccines. Last year, researchers at Northeastern University modeled two vaccine rollout strategies. Their numerical simulations found that 61% of deaths worldwide would have been averted if countries cooperated to implement an equitable global vaccine distribution plan, compared with only 33% if high-income countries got the vaccines first. Put briefly, when countries cooperate, COVID-19 deaths drop by approximately in half. Vaccine access is inequitable within countries, too—especially in countries where severe inequality already exists. In Latin America, for example, a disproportionate number of the tiny minority of people who’ve been vaccinated are elites: political leaders, business tycoons and those with the means to travel abroad to get vaccinated. This entrenches wider health and social inequities. The result, for now, is two separate and unequal societies in which only the wealthy are protected from a devastating disease that continues to ravage those who are not able to access the vaccine. This is a familiar story from the HIV era. In the 1990s, the development of effective antiretroviral drugs for HIV/AIDS saved millions of lives in high-income countries. However, about 90% of the global poor who were living with HIV had no access to these lifesaving drugs. Concerned about undercutting their markets in high-income countries, the pharmaceutical companies that produced antiretrovirals, such as Burroughs Wellcome, adopted internationally consistent prices. Azidothymidine, the first drug to fight HIV, cost about $8,000 a year – over $19,000 in today’s dollars. That effectively placed effective HIV/AIDS drugs out of reach for people in poor nations – including countries in sub-Saharan Africa, the epidemic’s epicenter. By the year 2000, 22 million people in sub-Saharan Africa were living with HIV, and AIDS was the region’s leading cause of death. The crisis over inequitable access to AIDS treatment began dominating international news headlines, and the rich world’s obligation to respond became too great to ignore.

#### **The virus is still deadly—the pandemic needs to end. The world needs to be vaccinated.**

Cunningham, 21

Cunningham, Erin. “Coronavirus World Updates: WHO Sounds Alarm as Global Deaths Top 4 Million, Delta Spreads to 100 Countries.” Washington Post, The Washington Post, 8 July 2021, www.washingtonpost.com/world/2021/07/08/covid-19-global-updates-who-sounds-alarm-global-deaths-top-4-million-delta-spreads-100-countries/.

World Health Organization officials issued stern warnings to nations planning to relax coronavirus restrictions as global deaths from the virus topped 4 million and the more virulent delta variant was spotted in more than 100 countries, including those with high vaccination rates. Speaking at a briefing Wednesday, the officials cautioned that more contagious variants were “currently winning the race against vaccines,” as most of the world’s population has yet to be immunized. Even the delta variant, which was first identified in India and is now tearing through unvaccinated populations around the world, “is itself mutating and will continue to do so,” said Maria Van Kerkhove, technical lead at the WHO’s Health Emergencies Program. “There are more than two dozen countries that have epidemic curves that are almost vertical right now,” she said. “We’re not in a good place.”

## Future Pandemics

#### The plan creates a new goldilocks patent law that exempts pandemics.

Lindsey, 21

(Brink, <https://www.brookings.edu/blog/up-front/2021/06/03/why-intellectual-property-and-pandemics-dont-mix/>, 6-3)

Waiving patent protections is certainly no panacea. What is needed most urgently is a massive drive of technology transfer, capacity expansion, and supply line coordination to bring vaccine supply in line with global demand. Dispensing with patents in no way obviates the need for governments to fund and oversee this effort. Although focusing on these immediate constraints is vital, we cannot confine our attention to the short term. First of all, the COVID-19 pandemic is far from over. Although Americans can now see the light at the end of the tunnel thanks to the rapid rollout of vaccines, most of the world isn’t so lucky. The virus is currently raging in India and throughout South America, overwhelming health care systems and inflicting suffering and loss on a horrific scale. And consider the fact that Australia, which has been successful in suppressing the virus, recently announced it was sticking to plans to keep its borders closed until mid-2022. Criticisms of the TRIPS waiver that focus only on the next few months are therefore short-sighted: this pandemic could well drag on long enough for elimination of patent restrictions to enable new vaccine producers to make a positive difference. Furthermore, and probably even more important, this is almost certainly not the last pandemic we will face. Urbanization, the spread of factory-farming methods, and globalization all combine to increase the odds that a new virus will make the jump from animals to humans and then spread rapidly around the world. Prior to the current pandemic, the 21st century already saw outbreaks of SARS, H1N1, MERS, and Ebola. Everything we do and learn in the current crisis should be viewed from the perspective of getting ready for next time. THE NATURE OF THE PATENT BARGAIN When we take the longer view, we can see a fundamental mismatch between the policy design of intellectual property protection and the policy requirements of effective pandemic response. Although patent law, properly restrained, constitutes one important element of a well-designed national innovation system, the way it goes about encouraging technological progress is singularly ill-suited to the emergency conditions of a pandemic or other public health crisis. Securing a TRIPS waiver for COVID-19 vaccines and treatments would thus establish a salutary precedent that, in emergencies of this kind, governments should employ other, more direct means to incentivize the development of new drugs.

#### Another pandemic WILL happen.

MacKenzie, 21

Published on September 7, 2021, “Stopping the Next Pandemic: How Covid-19 Can Help Us Save Humanity,” by Debora MacKenzie. Debora MacKenzie has been covering emerging diseases for more than 30 years as a science journalist for outlets like New Scientist magazine. She has been reporting on COVID-19 from the start, and she was among the first journalists to suggest that it could become a pandemic. From SARs to rabies and Ebola to AIDs, she's been on the frontline in reporting on how pandemics form, why they spread, and how to stop them throughout her career. In addition to infectious disease, she also specializes in reporting on the science of complexity and social organization. Before becoming a journalist, she worked as a biomedical researcher.

Second, this pandemic won’t be the last one. There are simply too many potentially pandemic germs out there to predict which will emerge next. But before Covid-19 happened, we knew coronaviruses were among the leading possibilities: they were on a WHO watch list. Even with such warnings, we didn’t do enough preparatory work on drugs and vaccines for coronaviruses like Covid-19 to allow us to easily adapt and produce them now—and we still haven’t for many other viruses that pose a threat, including some real nightmares we will meet in Chapter 2. We need to do that now. We also need to do some serious pandemic planning for when the next one happens. The Center for Health Security at the Johns Hopkins Bloomberg School of Public Health was among the institutions already trying to do that before Covid. Among other efforts, they were running computer simulations of hypothetical pandemics as a training exercise for public officials. A month before the first clusters of unusual pneumonia were recognized in Wuhan, they ran one called Event 201, starring a fictitious virus that was nearly a dead ringer for Covid-19. I can think of few better illustrations of how we knew this was coming. Let me emphasize that this was a total coincidence: this was a what-if scenario playing out in a computer model of US society, featuring a made- up virus. They chose a coronavirus for the simulation because we knew these viruses were a threat, and also to show how disruptive even a relatively mild virus can be. They succeeded. The result of the simulation was what we started living out just a few months later: overwhelmed health care, disrupted global supply chains, needless death, economic dislocation. And a table full of officials from government and industry sitting there, saying*, If this were to happen, there’s not much my sector/department/office could do.* Turned out many of them were right. And the people who wrote that simulation were going easy on the officials—maybe so they’d sit through the entire afternoon and not be so horrified that they’d quietly slip out at the coffee break, trying to forget what they’d seen. There are much worse viruses out there that could trigger a pandemic that would kill more people at younger ages. It will not be much comfort to those who have lost or will lose loved ones to Covid-19, but so far, believe it or not, we’ve been lucky. In addition, what almost no one realized before Covid-19 happened—I don’t know how many realize it now—was what a pandemic could do to our complex, just in-time society, and that economic domino effects would cascade through our tightly coupled global support networks. What we need to remember, though, is that we will have another pandemic. And it could be worse. So we have to do better—and we can. The hard-earned good news is that Covid-19 has shown us what we need to do. We cannot let a virus catch our interconnected global community this stupidly flat-footed again. We cannot let it break those interconnections either, at least not all of them. If this pandemic teaches us anything, it is that up against a contagious disease, we are all in this together. One big early lesson was that no country can really seal off their borders anymore or go it alone. Our society is global; our risk is global; our response and our cooperation must be global.

#### A temporary TRIPS waiver creates a precedent for early action and for LICs to be able to produce their own medicines—saving lives.

Berger, 21

Berger, Miriam. “Global Vaccine Inequality Runs Deep. Some Countries Say Intellectual Property Rights Are Part of the Problem.” Washington Post, The Washington Post, 20 Feb. 2021, www.washingtonpost.com/world/2021/02/20/poor-countries-arent-getting-vaccines-waiving-intellectual-property-rights-could-help/.

On the other side are South Africa and India, leading the charge on behalf of the vast number of countries without any — or a limited supply of — vaccine doses and other equipment for fighting the virus. They argue that the rest of the world cannot keep waiting for the lifesaving shots, which Western countries have monopolized by buying up existing supplies and pre-purchasing future rounds. Given the gravity of the global public health crisis, the latter camp wants to resort to an emergency waiver mechanism, whereby the intellectual property rights for making vaccines and related medical supplies would be temporarily suspended, which in theory would lead to production and distribution ramping up more equitably in factories worldwide. It’s a hyper-technical issue — turning on interpretation of TRIPS, the WTO’s Agreement on Trade-Related Aspects of Intellectual Property Rights — and it’s heavy in symbolism for developing countries increasingly alarmed by a race to vaccinate that is stacked against them. In the immediate term, waiving intellectual property rights alone cannot fix the problem of vaccine inequities and shortages. But, drawing on lessons learned during the HIV/AIDS crisis, experts said it could have far-reaching implications by preventing subsequent scarcities and sending a signal now about the imperative of collective action. “Developing countries are already fed up with what they perceive as the selfishness of the West buying up all of the demand and [that] they’ve got to get to the back to the queue,” said David Fidler, adjunct senior fellow for cybersecurity and global health at the Council on Foreign Relations. Now, he said, “they are having these sort of ridiculous conversations at the WTO about how to deal with this debacle for humanity.” Meanwhile, he added, “inequitable vaccine access is just going to get worse.” Anthony S. Fauci, President Biden’s chief medical adviser on the coronavirus, told a virtual World Health Organization briefing Monday that the impasse is “a very sensitive issue but an issue that I think really does need to be addressed.” Citing compromises that countries and companies reached during the AIDS epidemic, he expressed support for similar action but not for any specific proposal. “I’m not sure exactly what the model will be, but I think at least we do have some precedent that you can make arrangements with companies that would allow them both to maintain a considerable amount of profit at the same time that areas of the world that don’t have resources can share in a way that would be lifesaving to literally millions of people,” he said. When the WTO was formed in 1995, public health experts worried that many of the global agency’s agreements would empower private companies and ultimately harm public health. Over time, various sides largely worked out their differences, Fidler said, except when it came to intellectual property, which he called a “a festering sore.” That sore proved lethal during the HIV/AIDS crisis. By the 1990s, antiviral drugs were available to combat infections, but restrictions on production because of patent rules kept them far too expensive for most infected people in sub-Saharan Africa to access. In 2001, a deal was finally reached. Called the Doha Declaration, it clarified “that the TRIPS Agreement does not and should not prevent member governments from acting to protect public health,” according to the WTO. The amendments specified that countries could seek compulsory licensing — a way for a government to waive intellectual property rights without the patent owner’s consent — in cases of national or other extreme emergencies. It also laid out mechanisms for the companies to still receive compensation. The Doha Declaration helped lower the cost of lifesaving HIV/AIDS medications for the hardest-hit victims. Along with the President’s Emergency Plan for AIDS Relief (PEPFAR), a U.S. program that was passed in 2003, these collective actions started to turn the tide on a treatable disease upending the lives of millions of people in less wealthy countries. The WTO’s action set a precedent, said Yuan Qiong Hu, legal adviser for the Doctors Without Borders Access Campaign, which is advocating for the WTO coronavirus waiver. But countries with the power to enact change acted too late for too many, dragging their feet on lowering prices. “If they took action earlier, it could have been even better. We could have maybe saved more lives,” she said. “It’s purely a matter of political will to recognize the challenges.” The coronavirus pandemic, unlike the AIDS epidemic, is not centered in low-income countries. Rather, it’s affecting all countries simultaneously scrambling for the same resources. That’s why Mustaqeem De Gama, an intellectual property expert and South Africa’s WTO representative, said it’s time for the global trade agency to act to ensure that “inappropriate use of intellectual property” doesn’t lead to “an artificial scarcity of supply.” TRIPS, he said, recognizes that every country has the right “to ensure that its citizens have access to necessary medicines, equipment and technology that will address covid-19.” He said a WTO waiver would reinforce that principle and allow countries to prepare to start their own production rather than having to wait until richer countries fill their vaccine orders first. “The ability to pay shouldn’t be the determinant for access,” Hu said. WTO action instead could “allow countries to prepare to produce and share resources.”

## Plan

#### Member nations of the World Trade Organization ought to reduce intellectual property protections for medicines by implementing a waiver from certain provisions of the TRIPS Agreement for the prevention, containment, and treatment of COVID-19.

#### The aff plan is to implement the patent waiver proposed by India and South Africa.

#### Communication from India and South Africa to the WTO, 20

(WAIVER FROM CERTAIN PROVISIONS OF THE TRIPS AGREEMENT FOR THE PREVENTION, CONTAINMENT AND TREATMENT OF COVID-19 <https://docs.wto.org/dol2fe/Pages/SS/directdoc.aspx?filename=q:/IP/C/W669.pdf&Open=True>, 10-2)

An effective response to COVID-19 pandemic requires rapid access to affordable medical products including diagnostic kits, medical masks, other personal protective equipment and ventilators, as well as vaccines and medicines for the prevention and treatment of patients in dire need. 6. The outbreak has led to a swift increase in global demand with many countries facing acute shortages, constraining the ability to effectively respond to the outbreak. Shortages of these products has put the lives of health and other essential workers at risk and led to many avoidable deaths. It is also threatening to prolong the COVID-19 pandemic. The longer the current global crisis persist, the greater the socio-economic fallout, making it imperative and urgent to collaborate internationally to rapidly contain the outbreak. 7. As new diagnostics, therapeutics and vaccines for COVID-19 are developed, there are significant concerns, how these will be made available promptly, in sufficient quantities and at affordable price to meet global demand. Critical shortages in medical products have also put at grave risk patients suffering from other communicable and non-communicable diseases. 8. To meet the growing supply-demand gap, several countries have initiated domestic production of medical products and/or are modifying existing medical products for the treatment of COVID-19 patients. The rapid scaling up of manufacturing globally is an obvious crucial solution to address the timely availability and affordability of medical products to all countries in need. 9. There are several reports about intellectual property rights hindering or potentially hindering timely provisioning of affordable medical products to the patients.3 It is also reported that some WTO Members have carried out urgent legal amendments to their national patent laws to expedite the process of issuing compulsory/government use licenses. 10. Beyond patents, other intellectual property rights may also pose a barrier, with limited options to overcome those barriers. In addition, many countries especially developing countries may face institutional and legal difficulties when using flexibilities available in the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS Agreement). A particular concern for countries with insufficient or no manufacturing capacity are the requirements of Article 31bis and consequently the cumbersome and lengthy process for the import and export of pharmaceutical products. 11. Internationally, there is an urgent call for global solidarity, and the unhindered global sharing of technology and know-how in order that rapid responses for the handling of COVID-19 can be put in place on a real time basis. 12. In these exceptional circumstances, we request that the Council for TRIPS recommends, as early as possible, to the General Council a waiver from the implementation, application and enforcement of Sections 1, 4, 5, and 7 of Part II of the TRIPS Agreement in relation to prevention, containment or treatment of COVID-19. 13. The waiver should continue until widespread vaccination is in place globally, and the majority of the world's population has developed immunity hence we propose an initial duration of [x] years from the date of the adoption of the waiver. 14. We request that the Council for TRIPS urgently recommends to the General Council adoption of the annexed decision text.

The entire waiver proposal: <https://docs.wto.org/dol2fe/Pages/SS/directdoc.aspx?filename=q:/IP/C/W669R1.pdf&Open=True>

## Framework - Util

#### The standard is maximizing expected well-being.

**My Value for the debate is utilitarianism. Util is a moral system where the rightness or wrongness of an action is judged by the outcome it produces. This is the best system for debating government actions for 3 reasons:**

**1. State actor—states are not moral individuals so they can’t have Kantian intent.**

**2. Topic specific- debates about the WTO and patents inevitably regress to consequences—the patents are moral or immoral because of their ability to help or hurt the world.**

**3. Relational wording- Member nations in the resolution is plural, this implies we are debating about how the international community should be shaped and not what an individual’s moral obligations may be.**

#### Governments must use util since they can’t focus on every individual rights violation

Goodin, 95

Robert, 1995, Philosopher of Political Theory, Public Policy, and Applied Ethics. Utilitarianism as a Public Philosophy, Cambridge University Press, pg. 26-27

The great advantage of utilitarianism as a guide to public conduct is that it avoids gratuitous sacrifices, it ensures as best we are able to ensure in the uncertain world of public policy-making that policies are sensitive to people’s interests or desires or preferences. The great failing of more deontological theories, applied to those realms, is that they fixate upon duties done for the sake of duty rather than for the sake of any good that is done by doing one’s duty. Perhaps it is permissible (perhaps it is even proper) for private individuals in the course of their personal affairs to fetishize duties done for their own sake. It would be a mistake for public officials to do likewise, not least because it is impossible. The fixation on motives makes absolutely no sense in the public realm, and might make precious little sense in the private one even, as Chapter 3 shows. The reason public action is required at all arises from the inability of uncoordinated individual action to achieve certain morally desirable ends. Individuals are rightly excused from pursuing those ends. The inability is real; the excuses, perfectly valid. But libertarians are right in their diagnosis, wrong in their prescription. That is the message of Chapter 2. The same thing that makes those excuses valid at the individual level – the same thing that relieves individuals of responsibility – makes it morally incumbent upon individuals to organize themselves into collective units that are capable of acting where they as isolated individuals are not. When they organize themselves into these collective units, those collective deliberations inevitably take place under very different circumstances and their conclusions inevitably take very different forms. Individuals are morally required to operate in that collective manner, in certain crucial respects. But they are practically circumscribed in how they can operate, in their collective mode. And those special constraints characterizing the public sphere of decision-making give rise to the special circumstances that make utilitarianism peculiarly apt for public policy-making, in ways set out more fully in Chapter 4. Government house utilitarianism thus understood is, I would argue, a uniquely defensible public philosophy.