# Speech 1AC Loyola Rd 2 vs Harvard Westlake 9-4 11AM

#### Theory after phil

### FW

#### Perspectivism is true –

#### 1] Opacity – we can never access another person’s perspective because we can never fully understand who someone else is or what they think. Every truth I create cannot be universalized because I can’t guarantee that they will create the same truth because they do what they want.

#### 2] Resolvability – Centuries of moral debate proves we can’t come to an objectively correct answer so it has to be indexed to individual subjects. High school debaters can’t come to a correct conclusion on their own and moral dilemmas are too complicated to “solve” in 45 minutes, so you should prefer a perspectivist account.

#### 3] Subjectivity only has meaning when it interacts with other machines – there are no intrinsic values and a failure to recognize that stratifies subjects and reifies violence.

**Malins 04** [Brackets Original. Peta Malins (Program Manager of the Bachelor of Legal and Dispute Studies and a Lecturer in Criminology and Justice Studies @ RMIT University). “Machinic Assemblages: Deleuze, Guattari and an Ethico-Aesthetics of Drug Use”. The University of Melbourne. 2004. Accessed 2/19/21. http://janushead.org/wp-content/uploads/2020/06/Malins.pdf //Xu]

As an assemblage, a [drug using body] has only itself, in connection with other assemblages and in relation to other bodies without organs. We will never ask what a [drug using body] means, as signified or signifier; we will not look for anything to understand in it. We will ask what it functions with, in connection with what other things it does or does not transmit intensities, in which other multiplicities its own are inserted and metamorphosed, and with what bodies without organs it makes its own converge. A [drug using body] exists only through the outside and on the outside. A [drug using body] itself is a little machine (Deleuze and Guattari, 1988: 4)1 The work of Deleuze and Guattari is perhaps best conceived of as a ‘tool box’2 –as a collection of machinic concepts that can be plugged into other machines or concepts and made to work. This is how I approach their writing, and why–despite initial misgivings–I have transformed the above excerpt (surreptitiously replacing the concept ‘book’ with ‘drug using body’) to suit the purposes of this paper. In making this transformation, I soon discovered that it became a perfect little language-machine: not only articulating where I want to take the concept of drug use, but also [through its parentheses] expressing the open applicability of Deleuze and Guattari’s work. Insert body of choice: a sexual body; a bicycle, a language; a body of art; a film–the excerpt works for them all. In this openly mutating state the passage introduces some of the key concepts in Deleuze and Guattari’s philosophical project: becomings, rhizomatic connections, and multiplicities. It also, more explicitly, outlines their project to take thought (and ethics) away from internal meanings, causes, and essences, and toward surface effects, intensities and flows. However it is the particular concept of the body activated by the excerpt–the concept of the body as machinic assemblage–that I find most useful to the task of rethinking drug use. It is a concept that unravels the modern fantasy of the body as a stable, unified, bounded entity, and gives a language to the multitude of connections that bodies form with other bodies (human and otherwise). A body’s function or potential or ‘meaning’ becomes entirely dependent on which other bodies or machines it forms an assemblage with. Colebrook’s (2002) example of the bicycle is useful here: a bicycle is a machine that doesn’t begin to work or have a particular meaning until it connects up with another machine. When it connects up with a cyclist, it becomes a vehicle; when is placed in a gallery, it becomes an artwork. A cigarette is similarly multiple: when smoked it becomes a drug; when held seductively at the end of ones fingertips it becomes an object of beauty; when shown in a film it becomes a plot device (Klein, 1993). And a drug using body is no different: when it connects up to bicycle, it becomes a cyclist; to a cigarette, a smoker; to LSD, a tripper. The drug using body is multiple. While numerous writers have begun to make movements toward rethinking drug use via Deleuze and Guattari3 , very few have explored this intersection in detail4 . In this paper I will map out some of the specific implications of rethinking the drug using body in this way. I will begin by exploring what happens to the subject (the ‘drug user’, the ‘addict’) when the body becomes a multiplicity. Like Deleuze and Guattari: I will not ask what a drug using body ‘means’ or signifies; but rather, what affects its assemblages produce and what flows of desire they cut off (its components and affects). I will then explore Deleuze and Guattari’s own particularly bleak conception of drug-use, arguing that the pessimism it engenders can be strategically sidestepped using Deleuze and Guattari’s other philosophical tools. I will explore how we might productively approach drug use via a Deleuzian ethics, and will argue for a specific ethical rethinking of drug use according to the concepts of the machinic assemblage and rhizomatic multiplicities. A strategy with implications not only for social policy, but also for how we understand ourselves. And who we might become. Subjectivity and the drug using body Bodies that fall prey to transcendence are reduced to what seems to persist across their alterations. Their very corporeality is stripped from them, in favor of a supposed substrate–soul, subjectivity, personality, identity–which in fact is no foundation at all, but an end effect, the infolding of a forcibly regularized outside. (Massumi, 1992: 112) For Deleuze and Guattari a body (human, animal, social, chemical) has no interior truth or meaning; it exists only through its external connections and affects. They write: We know nothing about a body until we know what it can do, in other words, what its affects are, how they can or cannot enter into composition with other affects, with the affects of another body. (ATP5 : 257) So where does this leave the subject? And identity? If we are to talk only of the drug using body and its multiplicities–where does the ‘drug user’ or ‘addict’ disappear to? For Deleuze and Guattari the subject is nothing more (and nothing less) than a particular way in which bodies have become organised and stratified in the post-Enlightenment social world. In order to comprehend the ‘human’ body, the social world (or socius) reduces the complexity and chaos of an ever-changing multiplicity of bodily flux to discrete categories of meaning and constancy. Bodies become ordered and delimited according to hierarchical binary presuppositions: human/animal, man/woman, healthy/unhealthy, lawful/criminal, hetero/gay, clean/junkie. Binaries that bodies never fully correspond to: No real body ever entirely coincides with either category. A body only approaches its assigned category as a limit: it becomes more or less “feminine” or more or less “masculine” depending on the degree to which it conforms to the connections and trajectories laid out for it by society… “Man” and “Woman” as such have no reality other than that of logical abstraction. (Massumi, 1992: 86) Yet when bodies fall outside these binaries, or try to claim a different identity, they are rarely granted anything outside a third term (‘bi-sexual’, ‘reformedsmoker’) that remains reliant upon, and limited to, those binary relations. Multiplicities reduced to binaries and trinities. Manifold potential reduced to a discrete set of bodily possibilities. You will be a boy or a girl; a smoker or a non-smoker; a civilized human being (with all bodily parts fulfilling civilized ‘human’ functions)’ or an animal. Your choice. You will subscribe to modern selfhood (and all its bodily and linguistic demands) or you’ll be rejected: You will be organized, you will be an organism, you will articulate your body–otherwise you’re just depraved. You will be signifier and signified, interpreter and interpreted–otherwise you’re just a deviant. You will be a subject, nailed down as one, a subject of the enunciation recoiled into a subject of the statement–otherwise you’re just a tramp. (ATP: 159)

**This commits us to practical deliberation as the method of moral inquiry   
Serra 09**Juan Pablo Serra. What Is and What Should Pragmatic Ethics Be? Some Remarks on Recent Scholarship*.* EUROPEAN JOURNAL OF PRAGMATISM AND AMERICAN PHILOSOPHY. 2009. Francisco de Vitoria College, Humanities Department, Faculty member. https://journals.openedition.org/ejpap/905

This separation of theory and practice runs parallel to another split, namely, that of ethics and morals or, better put, of ethical theory and moral practice. Peirce denies that morality is subject to rationality and thinks that ethics is valuable as a science in a broad sense. But he also regards ethics as a science which bears on human conduct only indirectly, through the examination of past actions and the self-correction of the self in view of future action. In addition, ethics would be a normative knowledge only in so far as it analyzes the adjustment of actions to ends and in so far as it studies the general way in which a good life can be lived. In morals Peirce appeals to instinct and sentiment, and in ethics he recommends the use of logical thinking —just as scientists do. However, even within the framework of his system, it’s not obvious that scientists may so easily set aside their instincts —in fact, instinct (or ‘rational instinct’ as he called it in 1908) plays a significant role in the economy of re- search. Moreover, the statement that in moral issues there may be no possibility of carrying out an inquiry that is truth-oriented is not an uncontroversial one. After all, moral inquiry is performed in a deliberative way, weighing up argumentations, beliefs and principles, and comparing them either with their probable or conceivable consequences or with lived as well as possible experiences that can be forceful or impinge upon the deliberative subject in such a way as to acquire the compulsory resistance due to reality. As Misak puts it succint- ly, “the practice of moral deliberation is responsive to experience, reason, argument, and thought experiments... Such responsiveness is part of what it is to make a moral decision and part of what it is to try to live a moral life” (2000: 52)3. Likewise, this same deliberative activity implies an effort to acquire habits, beliefs and principles that contribute to a truly free deliberation which, in turn, can result in creative conclusions. For Peirce, as you get more habit-governed, you become more creative and free, and your selfhood acquires plas- ticity and receptiveness to experience4. Vincent Colapietro has referred to Peirce’s description of human reason in terms of a deliberative rationality (1999: 24). Also, in another place he has explained that deliberation for Peirce is a process of preparation for future action which has to do with the checking of previous acts, the rehearsal in imagination of different roads to be followed by possible conduct and the nurturing of ideals (Colapietro 1997: 270, 281). It is precisely this experi- ment carried out within imagination that generates habits, because, as Peirce says in “A Survey of Pragmaticism”, “it is not the muscular action but the accompanying inward ef- forts, the acts of imagination, that produce the habit” (CP 5.479, 1907). Habits are regular ways of thinking, perceiving and interpreting that generate actions. As such, habits have a huge influence on human behavior, manifest themselves in the con- crete things we do and, at the same time, are formed within those same activities. Even more, according to Peirce, the activity takes the form of experimentation in the inner world; and the conclusion (if it comes to a definite conclusion), is that under given conditions, the interpreter will have formed the habit of acting in a given way whenever he may desire a given kind of result. The real and living logical conclusion is that habit (CP 5.491, 1907). Much more evidence could be given to support the view that habits are virtually decided (CP 2.435, c.1893) and also that intelligence comprises inward or potential actions that in- fluence the formation of habits (CP 6.286, 1893). Suffice it to say that, according to Peirce, deliberation is a function of the imagination, and that imagination is in itself an experiment which may have unexpected consequences that impose themselves upon the deliberative subject.

#### Thus, the standard is consistency with pragmatic deliberation.

#### Impact Calc – deliberation is procedural, which means that agents ought to act in a deliberative fashion by employing the pragmatic procedure of deliberation, not the substance or conditions where deliberation can arise. To clarify, consequences are a sequencing question.

#### 1] Pluralistic Materialism – other theories rely on minimalistic criteria; our framework understands knowledge as changing and uses experience to base social change and revise ideas. Glaude 7Eddie S. (Eddie S. Glaude Jr. is the African-American chair of the Center for African-American Studies and the William S. Tod Professor of Religion and African-American Studies at Princeton University.) In a Shade of Blue : Pragmatism and the Politics of Black America. University of Chicago Press, 2007. EBSCOhost. (5-7)

In a Shade of Blue is my contribution to the tradition I have just sketched. My aim is to think through some of the more pressing conceptual problems confronting African American political life, and I do so as a Deweyan prag-matist. I should say a bit about what I mean by this self-description. John Dewey thought of philosophy as a form of cultural and social criticism. He held the view that philosophy, properly understood as a mode of wis-dom, ought to aid us in our efforts to overcome problematic situations and worrisome circumstances. The principal charge of the philosopher, then, is to deal with the problems of human beings, not simply with the problems of philosophers. For Dewey, over the course of his long career, this involved bridging the divide between science, broadly understood, and morals—a divide he traced to a conception of experience that has led philosophers over the centuries to tilt after windmills. Dewey declared, “The problem of restoring integration and co-operation between man’s beliefs about the world in which he lives and his beliefs about values and purposes that should direct his conduct is the deepest problem of any philosophy that is not isolated from life.”9Dewey bases this conclusion on several features of his philosophy: (1) anti foundationalism, (2) experimentalism, (3) contextualism, and (4) soli-darity.10 Antifoundationalism, of course, is the rejection of foundations of knowledge that are beyond question. Dewey, by contrast, understands knowledge to be the fruit of our undertakings as we seek “the enrichment of our immediate experience through the control over action it exercises.”11He insists that we turn our attention from supposed givens to actual consequences, pursuing a future fundamentally grounded in values shaped by experience and realized in our actions. This view makes clear the experimental function of knowledge. Dewey emphasized that knowledge entails efforts to control and select future experience and that we are always con-fronted with the possibility of error when we act. We experiment or tinker, with the understanding that all facts are fallible and, as such, occasionally afford us the opportunity for revision.12Contextualism refers to an understanding of beliefs, choices, and actions as historically conditioned. Dewey held the view that inquiry, or the pursuit of knowledge, is value-laden, in the sense that we come to problems with interests and habits that orient us one way or another, and that such pursuits are also situational, in the sense that “knowledge is pursued and produced somewhere, some when, and by someone.”13Finally, solidarity captures the associational and cooperative dimensions of Dewey’s thinking. Dewey conceives of his pragmatism as “an instrument of social improvement” aimed principally at expanding democratic life and broadening the ground of individual self-development.14Democracy, for him, constitutes more than a body of formal procedures; it is a form of life that requires constant attention if we are to secure the ideals that purportedly animate it. Individuality is understood as developing one’s unique capacities within the context of one’s social relations and one’s community. The formation of the democratic character so important to our form of associated living involves, then, a caring disposition toward the plight of our fellows and a watchful concern for the well-being of our democratic life.

#### 2] Best studies prove pluralistic tendencies are inevitable

Polzler 19[Thomas Pölzler and Jennifer Cole Wright- “Empirical research on folk moral objectivism” <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6686698/> NCBI. Published July 5th 2019]

Examining these studies' results more closely, however, makes it less clear whether this interpretation is appropriate (Pölzler, 2018b). Take again Goodwin and Darley's study. In this study, almost 30% of subjects' responses to the disagreement measure and almost 50% of their responses to the truth‐aptness measure fell on the option that the researchers took to be indicative of subjectivism (Goodwin & Darley, 2008, pp. 1347, 1351). Moreover, while some moral statements were dominantly classified as objective (e.g., the above statement about robbery), many others were dominantly classified as nonobjective (e.g., the stem cell research statement). This suggests that subjects in Goodwin and Darley's study may have actually favored what Wright, Grandjean, and McWhite (2013) called “metaethical pluralism,” i.e., they sometimes sided with objectivism and other times with nonobjectivism. More recent studies have by and large confirmed this hypothesis of folk metaethical pluralism. Wright et al. (2013) and Wright, McWhite, and Grandjean (2014), for example, replicated Goodwin and Darley's results, using the exact same measures, but letting subjects classify the presented statements as moral and nonmoral themselves. Objectivity ratings for statements that were dominantly self‐classified as moral varied between as little as 5% and as much as 85%. Research based on different measures yielded high proportions of intrapersonal variation as well (e.g., Beebe, 2014; Beebe, Qiaoan, Wysocki, & Endara, 2015; Beebe & Sackris, 2016; Fisher, Knobe, Strickland, & Keil, 2017; Goodwin & Darley, 2012; Heiphetz & Young, 2017; Wright, 2018; Zijlstra, forthcoming‐a).2

#### 3] **Rule Following Paradox-** There is nothing inherent to a rule that tells us how we ought to follow it, which proves no internal motivation or direction to follow a particular rule, regardless of how correct the rule is. Since only our interpretation can tell us how to follow the rule, there can be no incorrect application. Only deliberation accounts for the diversity of interpretations of our norms.

#### 4] Performativity- when you enter debate, you presume that you can discuss the topic because of deliberation. This means denial of my framework is impossible and all objections should be ignored on face because responding to my framework requires my framework to do so.

### Affirm

#### IP laws prioritize uniformity and predictability as a method of homogenizing knowledge and refusing experimentation.

Wu 14 [Tim Wu (Julius Silver Professor of Law, Science and Technology at Columbia University). “Intellectual Property Experimentalism By Way of Competition Law”. Columbia Law School. 2014. Accessed 8/16/21. <https://scholarship.law.columbia.edu/cgi/viewcontent.cgi?article=2843&context=faculty_scholarship> //Xu]

The goals of uniformity and predictability has had its clearest implications at the international level. Unlike competition law, which varies significantly between OECD nations, over the last several decades all of the IP laws have become subject to a much stronger and geographically broader web of harmonizing international agreements, on multinational, regional and bilateral levels. The general aim of these treaties is to homogenize the world’s IP regimes, reducing or eliminating geographical variation. All of the major laws are the subject of longstanding global treaties specifying minimum protections (The Berne and Paris conventions), which were fortified in 1994 by the addition of an intellectual property agreement to the World Trade Organization, and further strengthened by numerous bilateral treaties since then. And of course the World Trade Organization, unlike the informal organizations common to competition law, has the power to punish deviations from the intellectual property treaties with serious trade sanctions. The pattern can also be observed at the national level. Both in Europe and the United States the last few decades have witnessed many important measures taken to create uniformity. In the United States, a single appeals court, the Federal Circuit, has heard the nation’s appeals in patent cases since 1982 in an effort to bring greater uniformity to the patent law. Though proposals for constructing a uniform patent court akin to the Federal Circuit in the European Union have been unsuccessful so far,26 the European Patent Convention, founded in 1973, provides a common application for the prosecution of patents in each of the member states.27 In short, stronger protection of uniform rights has been the clear trajectory of the intellectual property laws over the last few decades. That tendency is sharply at odds with the predispositions of the competition laws. The dichotomy I am suggesting here is, of course, not absolute. In certain areas of the competition law, one can sense the influence of a vested rights theory, in, for example, the resistance to breakups of dominant terms, even if the economic case for doing so might be quite strong. And there are areas in IP law, like the American fair use doctrine (a judicial and scholarly favorite), which have, in fact, served as important outlets for judicial tinkering in the face of changing conditions. For example the famous Sony decision, blessing the VCR, broke with prevalent copyright doctrine, arguably as a reaction to perceived technological necessity.28 Similarly, following a decade of bad press, Congress, the courts, and the American Patent Office have begun to make adjustments with American patent law. An example is the new post-grant review process, which includes a particular provision targeted at business method patents. Nonetheless it would be hard to describe the intellectual culture of either the intellectual property laws as truly committed to experimental improvement of the law. It would be even harder to describe competition law as devoted to the protection of fundamental rights. We are left with a divergence in intellectual cultures with broad implications for just about every advanced economy in the world. IV. USING ANTITRUST FOR PATENT EXPERIMENTALISM AT THE UNITED STATES SUPREME COURT I believe there is a need for a more experimentalist approach to the intellectual property laws, and particularly to the patent laws. The law, I believe, needs better mechanisms not simply to celebrate its successes, but to correct its errors, both specific and general. One way this might be achieved is to act within the structure and institutions of the laws themselves; as just discussed, this is a project underway in certain respects. But the other path is to rely on the competition laws as a kind of oversight and adjustment mechanism for the intellectual property laws.

#### The law is necessarily fallible and constrained by imperfection which requires constant experimentation to reconstruct “foundational” truths.

Wu 2 [Tim Wu (Julius Silver Professor of Law, Science and Technology at Columbia University). “Intellectual Property Experimentalism By Way of Competition Law”. Columbia Law School. 2014. Accessed 8/16/21. <https://scholarship.law.columbia.edu/cgi/viewcontent.cgi?article=2843&context=faculty_scholarship> //Xu]

Experimentalism is not a word that attorneys use very often. At its most general, the idea of legal experimentalism is to apply the scientific method of hypothesis, experiment, and observation of consequence to challenging legal and policy problems. It is, as such, closely related to a “pragmatist” legal philosophy.5 John Dewey is usually credited with laying a philosophical foundation for policy experimentalism in his writings in the 1910s and 1920s. Dewey, whose background was in education, believed that a successful democracy needed the capacity to learn and improve itself. The key to learning, he believed, was the processing of experiences, or in his words the “reconstruction or reorganization of experience which adds to the meaning of experience and which increases ability to direct the course of subsequent experience.”6 As relevant to the legal system, Dewey thought policy and “proposals for social action” should be subject to the experimental method. Policy-making, he said, should be a constant process of learning from experience, rather than relying on rigid or foundational truths. “Policies,” Dewey argued, should be “experimental in the sense that they will be entertained subject to constant and well-equipped observation of the consequences they entail when acted upon, and subject to ready and flexible revision in the light of observed consequences.”7 As understood here we can describe legal experimentalism as comprising three main principles. First, for the experimentalist, laws are simply instruments meant to achieve some end and useful only to the extent they do so. A law has no intrinsic value, and its existence should not necessarily count in favor of its retention. Second, every law should be thought of as an ongoing experiment. That is to say, every enactment, regu- lation or judicial opinion must be seen as that moment’s best guess as to what a rule should be, in light of imperfect information and human fallibility. Borrowing Dewey’s language, policies should be thought of as a “working hypothesis, not as programs to be rigidly adhered to and executed.”8 Given the imperfect nature of law-making, policy should be subject to revision when faced with new information or changed conditions. The law must also be able to learn and improve itself based on observation of consequences, intended or otherwise.

### Method

#### 1] 1AR theory is legit – anything else means infinite abuse

#### – drop the debater – 1AR is too short to make up for the time trade-off

#### – no RVIs – 6 min 2NR means they can brute force me every time

#### – competing interps – reasonability narrows the theory debate to one issue of brightline, making it easy for the Neg to collapse to the issue in the long 2NR

#### – 1AR theory is the highest layer – the NC has 7 minutes to be abusive and 6 minutes to leverage the abuse against 1A theory in the 2N, making checking abuse lexically impossible

#### 2] Give me new weighing in the 2AR for 1AR shells – I don’t know what arguments will be read in the 2NR so 1AR weighing is impossible as I don’t know what to weigh against.

#### 3] Affirm if I win offense to a counterinterp

#### A] Timeskew – 6 Minute 2NR with collapse to whatever I undercover means that you can win theory and substance, but I need to go for both in half the time and split it between the 2 layers.

#### B] Reciprocity – you get T and theory so I should get theory and an RVI to make the burden reciprocal.

#### 4] Procedural fairness is a voter and outweighs a] it’s an intrinsic good – debate is fundamentally a game and some level of competitive equity is necessary to sustain the activity, b] probability – debate can’t alter subjectivity, but it can rectify skews which means the only impact to a ballot is fairness and deciding who wins, c] it internal link turns every impact – a limited debate promotes in-depth research and engagement which is necessary to access all of their education.

#### 5] Presumption and permissibility affirm –

#### a) logic – if its permissible to do P, then you don’t have an obligation to do not P by definition.

Paraphrasing McNamara[Paul McNamara (Associate Professor of Philosophy @ the University of New Hampshire). “Deontic Logic.” Stanford Encyclopedia of Philosophy. First published Tue Feb 7, 2006; substantive revision Wed Apr 21, 2010. Accessed 11/16/19. <https://plato.stanford.edu/entries/logic-deontic//> Xu]

The five normative statuses of the Traditional Scheme are:[[4](https://plato.stanford.edu/entries/logic-deontic/notes.html#4)] it is obligatory that (OB) it is permissible that (PE) it is impermissible that (IM) it is omissible that (OM) it is optional that (OP) The first three are familiar, but the fourth is widely ignored, and the fifth has regularly been conflated with “it is a matter of *indifference* that p” (by being defined in terms of one of the first three), which is not really part of the traditional scheme (more below). Typically, one of the first two is taken as basic, and the others defined in terms of it, but any of the first four can play the same sort of purported defining role. The most prevalent approach is to take the first as basic, and define the rest as follows: PEp ↔ ~OB~p IM*p* ↔ OB~*p* OM*p* ↔ ~OB*p* OP*p* ↔ (~OB*p* & ~OB~*p*).

#### Thus, if you do not have an obligation to do not P, then you have an obligation to do P by the Law of Double Negation.

#### b) empirics

**Shah 19,**[Shah, Sachin. “A STATISTICAL ANALYSIS OF SIDE-BIAS ON THE 2019 JANUARY-FEBRUARY LINCOLN-DOUGLAS DEBATE TOPIC.” NSD Update, National Symposium of Debate, 16 Feb. 2019, <http://nsdupdate.com/2019/a-statistical-analysis-of-side-bias-on-the-2019-january-february-lincoln-douglas-debate-topic/> ]//LHPSS accessed 9/4/19

As a final note, it is also interesting to look at the trend over multiple topics. In the rounds **from** 93 TOC bid distributing tournaments (**2017 – 2019** YTD), **the neg**ative **won 52.99% of ballots** (**p-value < 0.0001)** and 54.63% of upset rounds (p-value < 0.0001). **This suggests the bias might be structural, and not topic specific, as this data spans six different topics.**

#### c] what the neg reads doesn’t prove the resolution false but challenges an assumption of it. statements which make assumptions like the resolution should be read as a tacit conditional which is an if p then q statement. for all conditionals, if the antecedent is false, then the conditional as a whole is true.

### Advantage

#### Plan – The member nations of the World Trade Organization ought to reduce intellectual property protections for medicines by implementing a one-and-done approach.

#### We are in an innovation crisis – new drugs are not being developed in favor of re-purposing old drugs to infinitely extend patent expiration.

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

Drug companies **have brought great innovations** to market. Society rewards innovation with patents, or with non-patent exclusivities that can be obtained for activities such as testing drugs in children, undertaking new clinical studies, or developing orphan drugs. The rights provided by patents or non-patent exclusivities provide a defined time period of protection so companies can recoup their investments by charging monopoly prices. When patents end, lower-priced competitors should be able to jump into the market and drive down the price. **But that’s not happening**. Instead, drug companies build massive patent walls around their products, extending the protection **over and over again**. Some modern drugs have an avalanche of U.S. patents, with expiration dates **staggered across time**. For example, the rheumatoid arthritis drug Humira is **protected by more than 100 patents**. Walls like that **are insurmountable**. Rather than rewarding innovation, our patent system is now largely repurposing drugs. Between 2005 and 2015, **more than three-quarters** of the drugs associated with new patents **were not new ones** coming on the market but existing ones. In other words, we are mostly churning and recycling. Particularly troubling, new patents can be **obtained on minor tweaks** such as adjustments to dosage or delivery systems — a once-a-day pill instead of a twice-a-day one; a capsule rather than a tablet. Tinkering like this may have some value to some patients, but it nowhere near justifies the rewards we lavish on companies for doing it. From society’s standpoint, incentives should drive scientists back to the lab to look for new things, not to recycle existing drugs for minimal benefit.

#### The only major study confirms our Internal Link – Evergreening decimates competition by resulting in functional monopolies

Arnold Ventures 20 9-24-2020 "'Evergreening' Stunts Competition, Costs Consumers and Taxpayers" <https://www.arnoldventures.org/stories/evergreening-stunts-competition-costs-consumers-and-taxpayers/> (Arnold Ventures is focused on evidence-based giving in a wide range of categories including: criminal justice, education, health care, and public finance)//Elmer

In 2011, Elsa Dixler was diagnosed with multiple myeloma. That August, she was prescribed Revlimid, a drug that had come on the market six years earlier. By January 2012, she went into full remission, where she has remained since. So long as Revlimid retains its effectiveness, she will take it for the rest of her life. “I was able to go back to work, see my daughter receive her Ph.D, and have a pretty normal life,” said Dixler, a Brooklyn resident who is now 74. “So, on the one hand, I feel enormously grateful.” But Dixler’s normal life has come at a steep financial cost to her family and to taxpayers. Revlimid typically costs nearly $800 per capsule, and Dixler takes one capsule per day for 21 days, then seven days off, and then resumes her daily dose, requiring 273 capsules a year. Since retiring from The New York Times at the end of 2017, she has been on Medicare. Dixler entered the Part D coverage gap (known as the donut hole) “within minutes,” she said. She estimates that adding her deductible, her copayment of $12,000, and what her Part D insurance provider pays totals approximately $197,500 a year. Revlimid should have **been subject to competition** from generic drug makers starting in 2009, bringing down its cost by many orders of magnitude. But by obtaining **27 additional patents**, eight orphan drug exclusivities and 91 total additional protections from the U.S. Food and Drug Administration (FDA) since Revlimid’s introduction in 2005, its manufacturer, Celgene, has extended the drug’s **monopoly** **period** **by 18 years** — through March 8, 2028. “I cannot fathom the immorality of a business that relies on **squeezing people with cancer**,” Dixler said, noting her astonishment that Revlimid has obtained orphan drug protections when it treats a disease that is not rare and does not serve a very limited population. She also observed that Revlimid’s underlying drug is thalidomide, which has been around for decades. “They didn’t invent a new drug, rather, they found a new use for it,” she said. “The cost of Revlimid has imposed constraints on our retirement,” Dixler said, “but when I hear other people’s stories, I feel very lucky. A lot of people have been devastated financially.” Revlimid is a case study in a process known as “evergreening” — artificially sustaining a monopoly for years and even decades by manipulating intellectual property laws and regulations. Evergreening is most commonly used with blockbuster drugs generating the highest prices and profits. **Of the roughly 100 best-selling drugs, more than 70 percent have extended their protection** from competition at least once. More than half have extended the protection cliff multiple times. The true scope and cost of evergreening has been brought into sharper focus by a groundbreaking, publicly available, comprehensive database released Thursday by the Center for Innovation at the University of California Hastings College of Law and supported by Arnold Ventures. **The Evergreen Drug Patent Search is the first database to exhaustively track the patent protections filed by pharmaceutical companies**. Using data from 2005 to 2018 on brand-name drugs listed in the FDA’s Orange Book — a listing of relevant patents for brand name, small molecule drugs — it demonstrates the full extent of how evergreening has been used by Big Pharma to prolong patents and delay the entry of generic, lower-cost competition. “Competition is the backbone of the U.S. economy,” said Professor Robin Feldman, Director of the UC Hastings Center for Innovation, who spearheaded the database’s creation. “But it’s not what we’re seeing in the drug industry. “With evergreening, pharmaceutical companies repeatedly make slight, often trivial, modifications to drugs, dosage levels, delivery systems or other aspects to obtain new protections,” she said. “They pile these protections on over and over again — so often that 78 percent of the drugs associated with new patents were not new drugs coming on the market, but existing drugs.” Competition is the backbone of the U.S. economy. But it’s not what we’re **seeing in the drug industry**. Professor Robin Feldman Director of the UC Hastings Center for Innovation In recent decades, evergreening has systematically undermined the Drug Price Competition and Patent Term Restoration Act of 1984, which created the generic drug industry. Commonly known as the Hatch-Waxman Act, it established a new patent and market exclusivity regime in which new drugs are protected from competition for a specified period of time sufficient to allow manufacturers to recoup their investments and earn a reasonable profit. When that protection expires, generic drug makers are incentivized to enter the market through a streamlined regulatory and judicial process. Drug prices typically drop by as much as 20 percent when the first generic enters the market**, and with more than one generic manufacturer, prices can plummet by 80 to 85 percent**. “Hatch-Waxman created an innovation/reward/competition cycle, but it’s been distorted into an innovation/reward/more reward cycle,” Feldman said. “To paraphrase something a former FDA commissioner once said, the greatest creativity in Big Pharma should come from the research and development departments, not from the legal and marketing departments.” Feldman led the development of the Evergreen Drug Patent Search in response to repeated requests from Congressional committees, members of Congress, state regulators and journalists for information about specific drugs and companies. “We want to make it so anyone can have the question about drug protections at their fingertips whenever they want,” Feldman said. “It’s designed to be easy and user-friendly, and to enhance public understanding about how competition may be limited rather than enhanced through the drug patent system.” The **database** was **created through** a painstaking process of **combing** through **160,000 data points** **to examine every instance where a pharmaceutical company added a new drug patent or exclusivity**. “Most of it was done by hand,” Feldman said, “with multiple people reviewing it at every stage. And along the way we repeatedly made conservative choices. **We erred on the side of underrepresenting the evergreen gain** to be sure we were as fair and reasonable as possible.” Among the 2,065 drugs covered in Evergreen Drug Patent Search, there are many examples of the evergreening strategy used by pharma to delay the entry of competition, especially generics, often for widely prescribed drugs, including those used to treat heartburn, chronic pain, and opioid addiction. Nexium Before Nexium, there was Prilosec, a popular drug to treat gastroesophageal reflux disease (GERD). But its patent exclusivity was due to expire in April 2001. In the late 1990s, with a precipitous drop in revenue looming, Prilosec’s manufacturer, AstraZeneca, decided to develop a replacement drug. Using “one-half of the Prilosec molecule — an isomer of it,” the result was Nexium, which received approval in February 2001. Essentially an evergreened version of Prilosec, Nexium’s exclusivity was then extended by more than 15 years, as AstraZeneca received 97 protections stemming from 16 patents. These included revised dosages, compounds, and formulations. Feldman said that tinkering changes such as Nexium’s do not involve the substantial research and development required for a new drug, nor do they constitute true innovations, yet for a decade and a half, patients and taxpayers were forced to pay far more than was warranted for GERD relief. In fact, in 2016 — one year after patent exclusivity expired — Nexium still topped all drugs in Medicare Part D spending, totaling $1.06 billion. Suboxone Use of this combination of buprenorphine and naloxone for treating opioid addiction has exploded in the wake of the opioid epidemic. Since its approval, Suboxone’s manufacturer, Reckitt Benckiser (now operating as Indivior), extended its protection cliff eight times, gaining nearly two extra decades of exclusivity through early 2030. The drug maker gained six patents for creating a film version of the drug — notably around the time protection was expiring for its tablet version. (The therapeutic benefits of the film and tablet are identical.) An earlier version of Suboxone also obtained an orphan drug designation, despite an opioid epidemic that has expanded Suboxone’s customer base to millions of potential customers. Suboxone generates more than $1 billion in annual revenue and ranks among the 40 top-selling drugs in the U.S. Truvada When Truvada, commonly referred to as PrEP, was approved in 2004, this HIV-prevention drug was a breakthrough. But 16 years later — and 14 years after its original exclusivity was to expire — it retains its monopoly status. Truvada’s manufacturer, Gilead, has received 15 patents and 120 protections since it came on the market, extending its exclusivity for more than 17 years, until July 3, 2024. In countries where generic Truvada is available, PrEP costs $100 or less per month, compared to $1,600 to $2,000 in the U.S. As a result, Truvada is unaffordable to many people **who need protection from HIV**. Barred from access, they are left vulnerable to infection. “We’re establishing a precedent that a pharmaceutical company can charge whatever it wants even as it allows an epidemic to continue, and the government refuses to intervene,” said James Krellenstein, co-founder of the group PrEP4All. “That should scare every American. If it’s HIV today, it will be another disease tomorrow.” EpiPen First approved in 1987, the EpiPen has saved the lives of countless numbers of people with deadly allergies. But it is protected from competition until 2025 — 38 years after its introduction — because its owner, Mylan, has filed five patents, four since 2010, all involving tweaks to the automatic injector. The actual medication used, epinephrine, has existed for more than a century — the innovation here is in the delivery device. Because these small changes to the injector have maintained its monopoly for so long, the cost of an EpiPen package (containing two injectors) has risen from $94 when Mylan purchased the device to between $650 and $700 today. For many people, especially parents of children with severe reactions to common allergens like peanuts, EpiPen’s increasing price tag imposes an onerous financial burden. What Can Be Done As the Evergreen Drug Patent Search makes clear, the positive impact of Hatch-Waxman has been steadily and severely eroded by a regulatory system vulnerable to increasingly sophisticated forms of manipulation. “You might say that the patent and regulatory system has been weaponized,” Feldman said. “When billions of dollars are at stake, there’s a lot of money available to look for ways to exploit the legal system. And companies have become adept at this, as our work has found.” There are several key steps that Congress could take to restore the balance between innovation and competition that is the key to a successful prescription drug regulatory process. These may include: Imposing restrictions on the number of patents that prescription drug manufacturers can defend in court to discourage the use of anticompetitive patent thickets. Limiting the patentability of so-called secondary patents — which don’t improve the safety or efficacy of a drug — through patent and exclusivity reform. Reforming the 180-day generic exclusivity, which can currently be abused to block other competitive therapies. “**The Evergreen Drug Patent Search provides the publicly available, evidence-based foundation that defines the extent of the problem**, and it can be used to develop policies that solve the problem of anti-competitive patent abuses,” said Kristi Martin, VP of Drug Pricing at Arnold Ventures. “Our incentives have gotten out of whack,” Martin said. “The luxury of monopoly protection should only be provided to innovations that provide meaningful benefits in saving lives, curing illnesses, or improving the quality of people’s lives. It should not be provided to those gaming the system. If we can change that, we can save consumers, employers, and taxpayers many billions of dollars while increasing the incentives for pharmaceutical companies to achieve breakthroughs."

#### Only innovation now solves AMR super-bugs -- timeframe’s key.

Sobti 19 [Dr. Navjot Kaur Sobti is an internal medicine resident physician at Dartmouth-Hitchcock-Medical Center/Dartmouth School of Medicine and a member of the ABC News Medical Unit. May 1, 2019. “Amid superbug crisis, scientists urge innovation”. <https://abcnews.go.com/Health/amidst-superbug-crisis-scientists-urge-innovation/story?id=62763415>] Dhruv

[The United Nations](https://abcnews.go.com/Politics/amal-clooney-angelina-jolie-speak-us-weighed-vetoing/story?id=62574726) has called antimicrobial resistance a “global crisis.” With the [rise in superbugs](https://abcnews.go.com/Health/superbug-fungus-global-health-threat-600-us-infected/story?id=62297532) across the globe, common infections are becoming harder to treat, and lifesaving procedures riskier to perform. Drug-resistant infections result in about 700,000 deaths per year, with at least 230,000 of those deaths due to multidrug resistant tuberculosis, [according to a groundbreaking report from the World Health Organization (WHO).](https://www.who.int/antimicrobial-resistance/interagency-coordination-group/IACG_final_report_EN.pdf?ua=1) Given that antibiotic resistance is present in every country, antimicrobial resistance (AMR) now represents a global health crisis, according to the UN, which has urged immediate, coordinated and global action to prevent a potentially devastating health and financial crisis. With the rising rates of AMR -- including antivirals, antibiotics, and antifungals -- estimates from the WHO show that AMR may cause 10 million deaths every year by 2050, send 24 million people into extreme poverty by 2030, and lead to a financial crisis as severe as the on the U.S. experienced in 2008. Antimicrobial resistance develops when germs like bacteria and fungi are able to “defeat the drugs designed to kill them,” according to the Centers for Disease Control and Prevention. Through a biologic “survival of the fittest,” germs that are not killed by antimicrobials and continue to grow. WHO explains that “poor infection control, inadequate sanitary conditions and inappropriate food handling encourage the spread” of AMR, which can lead to “superbugs.” Those superbugs require powerful and oftentimes more expensive antimicrobials to treat. Examples of superbugs are far and wide, and can range from drug-resistant bacteria like Pseudomonas aeruginosa and Staphylococcus aureus to fungi like Candida. These bugs can cause illnesses that range from pneumonia to urinary tract and sexually transmitted infections. According to the WHO, AMR has caused complications for nearly 500,000 people with tuberculosis, and a number of people with HIV and malaria. The people at the [highest risk for AMR](https://www.who.int/news-room/detail/27-02-2017-who-publishes-list-of-bacteria-for-which-new-antibiotics-are-urgently-needed) are those with chronic diseases, people living in nursing homes, hospitalized in the ICU or undergoing life-saving treatments such as organ transplantation and cancer therapy. These people often develop infections, which can become antimicrobial-resistant, rendering them difficult, if not impossible, to treat. [(MORE: Melissa Rivers talks about her father's suicide with Dr. Jennifer Ashton)](https://abcnews.go.com/Health/melissa-rivers-talks-fathers-suicide-dr-jennifer-ashton/story?id=62733179&cid=clicksource_26_null_headlines_hed) The CDC notes that “antibiotic resistance has the potential to affect people at any stage of life,” including the “healthcare, veterinary, and agriculture industries, making it one of the world’s most urgent public health problems." AMR can cause prolonged hospital stays, billions of dollars in healthcare costs, disability, and potentially, death. “The most important thing is to understand and embrace the interconnectedness of all of this,” said Dr. Robert Redfield, director of the CDC, in a recent interview with ABC News’ Dr. Jennifer Ashton. It’s not just our countries that are connected.” Research has shown that superbugs like Candida auris “came from multiple places, at the same time. It wasn’t just one organism that [evolved]” in a single location, Redfield added. Given longstanding concerns about antimicrobial misuse leading to AMR, physicians have embraced a medical approach called antibiotic stewardship. This encourages physicians to carefully evaluate which antibiotic is most appropriate for their patient, and discontinue it once it is no longer medically needed. WHO has also highlighted that the inappropriate use of antimicrobials in agriculture -- such as on farms and in animals -- may be an underappreciated cause of AMR. Noting these trends, the WHO has urged for “coordinated action...to minimize the emergence and spread of antimicrobial resistance.” It urges all countries to make national action plans, with a focus on the development of new antimicrobial medications, vaccines, and careful antimicrobial use. Redfield emphasized the importance of vaccination during the global superbug crisis, stating that “the only way we have to eliminate an infection is vaccination.” He added that investing in innovation is key to solving the crisis. While WHO continues to advocate for superbug awareness, they warn that AMR has reversed “a century of progress in health.” The WHO added that “the challenges of antimicrobial resistance” are “not insurmountable,” and that coordinated action will “help to save millions of lives, preserve antimicrobials for generations to come and secure the future from drug-resistant diseases.”

#### Extinction - generic defense doesn’t apply.

Srivatsa 17 Kadiyali Srivatsa 1-12-2017 “Superbug Pandemics and How to Prevent Them” <https://www.the-american-interest.com/2017/01/12/superbug-pandemics-and-how-to-prevent-them/> (doctor, inventor, and publisher. He worked in acute and intensive pediatric care in British hospitals)//Elmer

It is by now no secret that the human species is locked in a race of its own making with “superbugs.” Indeed, if popular science fiction is a measure of awareness, the theme has pervaded English-language literature from Michael Crichton’s 1969 Andromeda Strain all the way to Emily St. John Mandel’s 2014 Station Eleven and beyond. By a combination of massive inadvertence and what can only be called stupidity, we must now invent new and effective antibiotics faster than deadly bacteria evolve—and regrettably, they are rapidly doing so with our help. I do not exclude the possibility that bad actors might deliberately engineer deadly superbugs.1 But even if that does not happen, humanity faces an existential threat largely of its own making in the absence of malign intentions. As threats go, this one is entirely predictable. The concept of a “black swan,” Nassim Nicholas Taleb’s term for low-probability but high-impact events, has become widely known in recent years. Taleb did not invent the concept; he only gave it a catchy name to help mainly business executives who know little of statistics or probability. Many have embraced the “black swan” label the way children embrace holiday gifts, which are often bobbles of little value, except to them. But the threat of inadvertent pandemics is not a “black swan” because its probability is not low. If one likes catchy labels, it better fits the term “gray rhino,” which, explains Michele Wucker, is a high-probability, high-impact event that people manage to ignore anyway for a raft of social-psychological reasons.2 A pandemic is a quintessential gray rhino, for it is no longer a matter of if but of when it will challenge us—and of how prepared we are to deal with it when it happens. We have certainly been warned. The curse we have created was understood as a possibility from the very outset, when seventy years ago Sir Alexander Fleming, the discoverer of penicillin, predicted antibiotic resistance. When interviewed for a 2015 article, “The Most Predictable Disaster in the History of the Human Race, ” Bill Gates pointed out that one of the costliest disasters of the 20th century, worse even than World War I, was the Spanish Flu pandemic of 1918-19. As the author of the article, Ezra Klein, put it: “No one can say we weren’t warned. And warned. And warned. A pandemic disease is the most predictable catastrophe in the history of the human race, if only because it has happened to the human race so many, many times before.”3 Even with effective new medicines, if we can devise them, we must contain outbreaks of bacterial disease fast, lest they get out of control. In other words, we have a social-organizational challenge before us as well as a strictly medical one. That means getting sufficient amounts of medicine into the right hands and in the right places, but it also means educating people and enabling them to communicate with each other to prevent any outbreak from spreading widely. Responsible governments and cooperative organizations have options in that regard, but even individuals can contribute something. To that end, as a medical doctor I have created a computer app that promises to be useful in that regard—of which more in a moment. But first let us review the situation, for while it has become well known to many people, there is a general resistance to acknowledging the severity and imminence of the danger. What Are the Problems? Bacteria are among the oldest living things on the planet. They are masters of survival and can be found everywhere. Billions of them live on and in every one of us, many of them helping our bodies to run smoothly and stay healthy. Most bacteria that are not helpful to us are at least harmless, but some are not. They invade our cells, spread quickly, and cause havoc that we refer to generically as disease. Millions of people used to die every year as a result of bacterial infections, until we developed antibiotics. These wonder drugs revolutionized medicine, but one can have too much of a good thing. Doctors have used antibiotics recklessly, prescribing them for just about everything, and in the process helped to create strains of bacteria that are resistant to the medicines we have. We even give antibiotics to cattle that are not sick and use them to fatten chickens. Companies large and small still mindlessly market antimicrobial products for hands and home, claiming that they kill bacteria and viruses. They do more harm than good because the low concentrations of antimicrobials that these products contain tend to kill friendly bacteria (not viruses at all), and so clear the way for the mass multiplication of surviving unfriendly bacteria. Perhaps even worse, hospitals have deployed antimicrobial products on an industrial scale for a long time now, the result being a sharp rise in iatrogenic bacterial illnesses. Overuse of antibiotics and commercial products containing them has helped superbugs to evolve. We now increasingly face microorganisms that cannot be killed by antibiotics, antifungals, antivirals, or any other chemical weapon we throw at them. Pandemics are the major risk we run as a result, but it is not the only one. Overuse of antibiotics by doctors, homemakers, and hospital managers could mean that, in the not-too-distant future, something as simple as a minor cut could again become life-threatening if it becomes infected. Few non-medical professionals are aware that antibiotics are the foundation on which nearly all of modern medicine rests. Cancer therapy, organ transplants, surgeries minor and major, and even childbirth all rely on antibiotics to prevent infections. If infections become untreatable we stand to lose most of the medical advances we have made over the past fifty years. And the problem is already here. In the summer of 2011, a 43-year-old woman with complications from a lung transplant was transferred from a New York City hospital to the Clinical Center at the National Institutes of Health (NIH), in Bethesda, Maryland. She had a highly resistant superbug known as Klebsiella pneumoniae carbapenemase (KPC). The patient was treated and eventually discharged after doctors concluded that they had contained the infection. A few weeks later, a 34-year-old man with a tumor and no known link to the woman contracted KPC while at the hospital. During the course of the next few months, several more NIH patients presented with KPC. Doctors attacked the outbreak with combinations of antibiotics, including a supposedly powerful experimental drug. A separate intensive care unit for KPC patients was set up and robots disinfected empty rooms, but the infection still spread beyond the intensive care area. Several patients died and then suddenly all was silent on the KPC front, with doctors convinced they had seen the last of the dangerous bacterium. They couldn’t have been more mistaken. A year later, a young man with complications from a bone marrow transplant arrived at NIH. He became infected with KPC and died. This superbug is now present in hospitals in most, if not all U.S. states. This is not good. This past year an outbreak of CRE (carbapenem-resistant enterobacteriaceae) linked to contaminated medical equipment infected 11 patients and killed two in Los Angeles area hospitals. This family of bacteria has evolved resistance to all antibiotics, including the powerful carbapenem antibiotics that are often used as a last resort against serious infections. They are now so resilient that it is virtually impossible to remove them from medical tools such as catheters and breathing tubes placed into the body, even after cleaning. Then we have gonorrhea, chlamydia, and other sexually transmitted diseases that we cannot treat and that are spreading all over the world. Anyone who has sex can catch these infections, and because most people may not exhibit any symptoms they spread infections without anyone knowing about it. Sexually transmitted diseases used to be treatable with antibiotics, but in recent years we have witnessed the rise of multi-drug resistant STDs. Untreated gonorrhea can lead to infertility in men and women and blindness and other congenital defect in babies. As is well known, too, we have witnessed many cases of drug-resistant pneumonia. These problems have arisen in part because of simple mistakes healthcare professionals repeatedly make. Let me explain. Neither superbugs nor common bacterial infections produce any special symptoms indicative of their cause. Rashes, fevers, sneezing, runny noses, ear pain, diarrhea, vomiting, coughing, fatigue, and weakness are signs of common and minor illnesses as well as uncommonly deadly ones. Therefore, the major problem for clinicians is to identify a common symptom that may potentially be an early sign of a major infection that could result in an epidemic. We know that dangerous infections in any given geographical area do not start at the same time. They start with one victim and gradually spread. But that victim is only one among hundreds of patients a doctor will typically see, so many doctors will miss patients presenting with infections that are serious. They will probably identify diseases that kill fast, but slow-spreading infections such as skin infections that can lead to septicemia are rarely diagnosed early. In addition, I have seen doctors treating eczema with antibiotic cream, even though they know that bacteria are resistant to the majority of these drugs. This sort of action encourages simple infections to spread locally, because patients are therefore not instructed to take other, more useful precautions. On top of that, some people are frivolous about infections and assume doctors are exaggerating the threat. And some people are selfish. Once I was called to see a passenger during a flight who had symptoms consistent with infection. He boarded the plane with these symptoms, but began to feel much worse during the flight. I was scared, knowing how infections such as Ebola can spread. This made me think about a way to screen passengers before they board a flight. Airlines could refund a traveler’s ticket, or issue a replacement, in case of sickness—which is not the policy now. We currently have no method to block infectious travelers from boarding flights, and there are no changes in the incentive system to enable conscientious passengers to avoid losing their money if they responsibly miss a flight because of illness. Speaking of selfishness, I once saw a mother drop her daughter off at school with a serious bout of impetigo on her face. When I asked her why she had brought her daughter to school with a contagious infection, she said she could not spare the time to keep her at home or take her to the doctor. By allowing this child to contact other children, a simple infection can become a major threat. Fortunately, I could see the rash on the girl’s face, but other kids in schools may have rashes we cannot see. Incorrect diagnosis of skin problems and mistaken use of antibiotics to treat them is common all over the world, and so we are continually creating superbugs in our communities. Similarly, chest infections, sore throats, and illnesses diagnosed as colds that unnecessarily treated with antibiotics are also a major threat. By prescribing antibiotics for viral infections, we are not only helping bacteria develop resistance, but we are also polluting the environment when these drugs are passed in urine and feces. All of this helps resistant bacteria to spread in the community and become an epidemic. Ebola is very difficult to transmit because people who are contagious have visible and unusual symptoms. However, the emerging infections and pandemics of the future may not have visible symptoms, and they could break out in highly populous countries such as India and China that send thousands of travelers all over the world every day. When a person is infected with a contagious disease, he or she can expect to pass the illness on to an average of two people. This is called the “reproduction number.” Two is not that high a number as these things go; some diseases have far greater rates of infection. The SARS virus had a reproduction number of four. Measles has a reproduction number of 18. One person traveling as an airplane passenger and carrying an infection similar to Ebola can infect three to five people sitting nearby, ten if he or she walks to the toilet. The study that highlighted this was published in a medical journal a few years ago, but the airline industry has not implemented any changes or introduced screening to prevent the spread of infections by air travel passengers, a major vehicle for the rapid spread of disease. It is scary to think that nobody knows what will happen when the world faces a lethal disease we’re not used to, perhaps with a reproduction number of five or eight or even ten. What if it starts in a megacity? What if, unlike Ebola, it’s contagious before patients show obvious symptoms? Past experience isn’t comforting. In 2009, H1N1 flu spread around the world before we even knew it existed. The Questions Remains Why do seemingly intelligent people repeatedly do such collectively stupid things? How did we allow this to happen? The answer is disarmingly simple. It is because people are incentivized to prioritize short-term benefits over long-term considerations. It is what social scientists have called a “logic of collective action” problem. Everyone has his or her specialized niche interest: doctors their patients’ approval, business and airline executives their shareholders’ earnings, hospitals their reputations for best-practice hygienics, homemakers their obligation to keep their own families from illness. But no one owns the longer-term consequences for hundreds of millions of people who are irrelevant to satisfying these short-term concerns. Here is an example. At a recent Superbug Super Drug conference in London that I attended, scientists, health agencies, and pharmaceutical companies were vastly more concerned with investing millions of dollars in efforts to invent another antibiotic, claiming that this has to be the way forward. Money was the most pressing issue because, as everyone at the conference knew, for many years pharmaceutical companies have been pulling back from antibiotics research because they can’t see a profit in it. Development costs run into billions of dollars, yet there is no guarantee that any new drug will successfully fight infections. At the same conference Dr. Lloyd Czaplewski spoke about alternatives to antibiotics, in case we cannot come up with new ones fast enough to outrun superbug evolution. But he omitted mention of preventive strategies that use the internet or communication software to help reduce the spread of infections among families, communities, and countries. It is madness that we don’t have a concrete second-best alternative to new antibiotics, because we need them and we need them quickly. Of course, this is why we have governments, which have been known occasionally in the past as commonwealths. Governments are supposed to look out for the wider, common interests of society that niche-interested professionals take no responsibility for, and that includes public health. It is why nearly every nation’s government has an official who is analogous to the U.S. Surgeon General, and nearly every one has a public health service of some kind. Alas, national governments do not always function as they should. Several years ago physician and former Republican Senator Bill Frist submitted a proposal to the Senate for a U.S. Medical Expeditionary Corps. This would have been a specialized organization that could coordinate and execute rapid responses to global health emergencies such as Ebola. Nothing came of it, because Dr. Frist’s fellow politicians were either too shortsighted or too dimwitted to understand why it was a good idea. Or perhaps they simply realized that they could not benefit politically from supporting it. Plenty of mistakes continue to be made. In 2015, a particularly infectious form of bird flu ripped through 14 U.S. states, leading farmers to preventively slaughter nearly 40 million birds. The result of such callous and unnecessary acts is that, instead of exhausting themselves in the host population of birds, the viruses quickly find alternative hosts in which to survive, and could therefore easily mutate into a form that can infect humans. Earlier, during the 1980s, AIDS garnered more public attention because a handful of rich and famous people were infected, and because the campaign to eradicate it dovetailed with and boosted the political campaign on behalf of homosexual rights. Methicillin resistant Staphylococcus aureus (MRSA) in hospitals, by far the bigger threat at the time, was virtually ignored. Some doctors knew that MRSA would bring us to our knees and kill millions of people worldwide, but pharmaceutical companies and device and equipment manufacturers ignored these doctors and the thousands of patients dying in hospitals as a result of MRSA. They prioritized the wrong thing, and government did not correct the error. And that is partly how antibiotic-resistant infection went from an obscure hospital problem to an incipient global pandemic. Politics well outside the United States plays several other roles in the budding problem that we are confronting. Countries often will not admit they have a problem and request help because of the possible financial implications in terms of investment and travel. Guinea did not declare the Ebola epidemic early on and Chinese leaders, worried about trade and tourism, lied for months in 2002 about the presence of the SARS virus. In 2004, when avian influenza first surfaced in Thailand, officials there displayed a similar reluctance to release information. Hospitals in some countries, including India, are managed and often owned by doctors. They refuse to share information about existing infections and often categorically deny they have a problem. Reporting infections to public health authorities is not mandatory, and so hospitals that fail to say anything are not penalized. Even now, the WHO and the CDC do not have accurate and up-to-date information about the spread of E. coli or other infections, and part of the reason is that for-profit hospitals are reluctant to do anything to diminish their bottom line. Syria and Yemen are among those countries that are so weak and fragmented that they cannot effectively coordinate public healthcare. But their governments are also hostile to external organizations that offer relief. Part of the reason is xenophobia, but part is that this makes the government look bad. Relatedly, most poor-nation governments do not trust the efficacy of international institutions, and think that cooperating with them amounts to a re-importation of imperialism. They would rather their own people suffer and die than ask for needed help. That brings us to the level of international public health governance. Alas, sometimes poor-country governments estimate the efficacy of international institutions accurately. The WHO’s Ebola response in 2014-15 was a disaster. The organization was slow to declare a public health emergency even after public warnings from Médecins Sans Frontières, some of whose doctors had already died on the front line. The outbreak killed more than 28,000 people, far more than would have been the case had it been quickly identified. This isn’t just an issue of bureaucratic incompetence. The WHO is under-resourced for the problems it is meant to solve. Funding comes from voluntary donations, and there is no mechanism by which it can quickly scale up its efforts during an emergency. The result is that its response to the next major disease outbreak is likely to be as inadequate as were its responses to Ebola, H1N1, and SARS. Stakeholders admit that we need another mechanism, and most experts agree that the world needs some kind of emergency response team for dangerous diseases. But no one knows how to set one up amid the dysfunctional global governance structures that presently exist. Maybe they should turn to Bill Frist, whose basic concept was sound; if the U.S. government will not act, perhaps some other governments will, and use the UN system to do so. But as things stand, we lack a health equivalent of the military reserve. Neither government leaders nor doctors can mobilize a team of experts to contain infections. People who want to volunteer, whether for government or NGO efforts, are not paid and the rules, if any, are sketchy about what we do with them when they return from a mission. Are employers going to take them back? What are the quarantine rules? It is all completely ad hoc, meaning that humanity lacks the tools it needs to protect itself. And note, by the way, the contrast between how governments prepare for facing pandemics and how they prepare for making war. War is not more deadly to the human race than pandemics, but national defense against armed aggression is much better planned for than defense against threats to public health. There is a wealth of rules regarding it, too. Human beings study and plan for war, which kills people both deliberately and accidentally, but they do not invest comparable effort planning for pandemics, which are liable to kill orders of magnitude more people. To the mind of a medical doctor, this is strange. Creating Conditions for Infections to Spread Superbug infections spread for several interlocking reasons. Some are medical-epidemiological. Most of the infections of the past thirty years have started in one place and in one family. As already noted, they spread because many infectious diseases are highly contagious before the onset of symptoms, and because it is difficult to prevent patients who know they are sick from going to hospitals, work, and school, or from traveling further afield. But again, one reason for the problem is political, not medical. Many governments have no strategies in place to prevent pandemics because they are unwilling to tell their people how infections spread. They don’t want to worry people with such talk; it will make them, they fear, unpopular. So governments may have mountains of bureaucracy with great heaps of rules and regulations concerning public health, but they are generally unwilling to trust their own citizens to use common sense on their own behalf. This, too, seems very strange. Until now, no one has come forward to help us develop strategies to educate people how to identify and prevent the spread of infection to their families and communities. The majority of stakeholders have also been oblivious to the use of new technologies to help reduce the spread of these infections. There are some exceptions. In a fun blog post called Preparedness 101: Zombie Apocalypse, the CDC uses the threat of a zombie outbreak as a metaphor to encourage people to prepare for emergencies, including pandemics. It is well meaning and insightful, yet when my colleagues and I try to discuss ways of scaling up the CDC’s example with doctors and nurses, they shut down. Nobody plans for an actual crisis partly because it is too scary and hence paralyzing to think about. But it is also because it is not most health professionals’ job; it is not what they are trained and paid to do. It is always someone else’s job, except that it has turned out to be nobody’s job. Worse, the situation is not static. While we sit paralyzed, superbugs are evolving. Epidemiological models now predict how an algorithmic process of disease spread will move through the modern world. All urban centers around the entire globe can become infected within sixty days because we move around and cross borders much more than our ancestors did, thanks to air travel. A new pandemic could start crossing borders before we even know it exists. A flu-like disease could kill more than 33 million people in 250 days.3

#### Expanding breadth of Pharma Innovation into neglected diseases results in global linkages that revitalizes global health diplomacy.

Hotez 16, Peter J. Blue marble health: an innovative plan to fight diseases of the poor amid wealth. JHU Press, 2016. (Sabin Vaccine Institute and Texas Children’s Hospital Center for Vaccine Development, Departments of Pediatrics and Molecular Virology and Microbiology)//Elmer

We also need to better understand how these NTDs are actually transmitted within US borders, and I think it is extremely important to learn more about the links between these diseases and poverty. As I noted earlier, a drive through Houston’s Fifth Ward provides some insights, as one can quickly identify predisposing risk factors, including stray animals, dilapidated houses without window screens, standing water and discarded tires, and other evi- dence of environmental degradation, but we need to conduct careful epidemiological studies to really understand the links between poverty and NTDs, as well as animal reservoirs for illnesses such as Chagas disease and others. All of this presents an important research and development agenda for the NTDs in the United States. There are no point-of-care diagnostic tests available for most of the NTDs endemic to the nation, so blood from pa- tients must be sent to the CD С or other specialty research laboratories in order to establish a diagnosis for these conditions. As I sometimes point out to general audiences, when you go to your physician and get blood work done, there is no box to check off for toxocariasis or Chagas disease as there is for blood chemistries or other routine tests. We need diagnostic tests that are easily accessible to physicians and nurses. We also need new and improved treatments and vaccines. Because the NTDs are poverty-related diseases, they often fly below the radar screen of the major pharmaceutical companies and are not prioritized. Thus, the drugs used to treat these illnesses are not widely available, so typically the CDC has to be contacted in order to access them. In addition, many of these medicines were developed decades ago and produce a lot of side effects. For instance, the two medicines for Chagas disease—benznidazole and nifurtimox—cause skin rashes, diarrhea, and other unpleasant or even dangerous symptoms and illnesses. Patients using these medications have to interrupt their treatments up to 20% of the time. Moreover, these drugs cannot be used by pregnant women. Currently, new innovations for NTDs like Chagas dis- multinational ease still rely on nonprofit PDPs. The Geneva-based Drugs pharmaceutical for Neglected Diseases Initiative is leading efforts to de- companies have velop new and safer Chagas disease medicines [60], while shown little or modest at our National School of Tropical Medicine the Sab in interest in American Vaccine Institute and Texas Childrens Hospital Center for NTDs. As a result, new Vaccine Development (Sabin PDP) is working to develop products are being a therapeutic vaccine that could be used alongside exist- developed in the ing treatments [61]. These efforts rely on major philan- nonprofit sector. thropic donors. In our case at the Sabin PDP, they include the Kleberg Foundation, the Carlos Slim Foundation, the Southwest Electronic Energy Medical Research Institute, and Texas Childrens Hospital. Summary Points 1. In the United States, 45.3 million people live below the poverty line, roughly the same number of impoverished Americans alive during the early 1960s when Michael Harrington wrote The Other America. Approximately 20 million Americans now live in extreme poverty at one-half the US poverty level, and approximately 5 million are living on less than $2 per day 2. American poverty concentrates in specific areas, especially in southern states, with Texas having the largest numbers who live in poverty Important areas in the South include the Gulf Coast, border areas with Mexico, the Mississippi Delta, and Appalachia. 3. Approximately 12 million Americans are infected with NTDs, led by toxocariasis and trichomoniasis—which disproportionately affect African Americans—and Chagas disease (American trypanosomiasis) and cysticercosis—which disproportionately affect people of Hispanic origin. Toxoplasmosis is another important NTD. Toxocariasis, cysticercosis, and toxocariasis exert important mental health effects on impoverished Americans. Many of these NTDs are transmitted within US borders (autochthonous infections). 4. Arboviral infections are also important NTDs, led by dengue fever in Gulf Coastal areas and West Nile virus infection. WNV can cause chronic, persistent viral infections linked to chronic neurologic and renal disease. 5. There is an urgent need to promote awareness about the NTDs, especially for physicians and other health-care providers. 6. New policies are needed to expand surveillance for the NTDs affecting the United States. New legislation has been adopted in Texas, while additional bills are being introduced in the US Congress. Epidemiological studies are also needed to better understand how these diseases are transmitted and how they are linked to extreme poverty in the American South and elsewhere. 7. There is an urgent need for new “control tools” for American NTDs, including point-of-care diagnostics, antiparasitic and antiviral drugs, and vaccines. Many of these products are being developed by nonprofit PDPs rather than pharmaceutical companies. he G20 "A Theory of Justice" In his landmark 1971 book A Theory of Justice, the Harvard political philosopher John Rawls articulates two overriding principles of a just and fair society, namely, (1) “equality in the assignment of basic rights and duties” and (2) allowance of some social and economic inequalities, but only if they ultimately benefit “the least advantaged members of society” [1]. In terms of Rawls’s worldview, I believe that finding widespread NTDs among the extreme poor (and least-advantaged) who live amidst wealth—the central tenet of blue marble health—might represent one of the most jarring affronts to what he terms “justice as fairness” Because NTDs are now widespread among the leastadvantaged members of the worlds wealthiest economies, and they represent a major basis for thwarting their future growth, it is urgent for these nations, especially the G20 countries, to adopt strong internal policies to combat these diseases. I envision a three-pronged strategy to best address the G20 s (and Nigeria’s) poorest citizens afflicted by NTDs: 1. Each of the G20 nations and Nigeria has the capacity to fully understand the extent of these diseases within their own borders and then provide their own impoverished populations access to essential medicines used in mass drug administration to target helminth infections, in addition to trachoma, leprosy, yaws and scabies, and to provide treatments for other high-disease burden NTDs, including leishmaniasis and Chagas disease. The G20 countries and Nigeria Three major steps are required to effectively address blue marble health. 141 142 Blue Marble Health need to allocate resources and implement programs to achieve universal coverage for these diseases. 2. Each of the G20 nations and Nigeria has the capacity to conduct research and development for new NTD biotechnologies; they need to allocate resources toward this goal. 3. Both activities should be conducted within an overall framework of health system strengthening. Mass Drug Administration in the G20 A good place to revisit MDA among the G20 countries is to more closely examine the six G20 countries with positive worm indices—Brazil, China, India, Indonesia, Mexico, and South Africa—in addition to Nigeria. Together these countries account for one-half of the worlds helminth infections [2]. An analysis of WHO s PCT database reveals that most of these nations are severely underachieving when it comes to providing MDA for people who require regular and periodic treatment for their intestinal helminth infections, schistosomiasis, and LF. Shown in table 11.1 is WHO’s estimate of the percentage that received treatment in 2013 [3-5]. Overall, the G20 nations affected by helminth infections and Nigeria perform poorly when it comes to treating their affected populations through MDA. In terms of specific countries in Latin America, Brazil is reaching only approximately one-third of its children and population at risk. And although Mexico provides complete coverage for intestinal worms, it—as previously mentioned—neither diagnoses nor treats hundreds of thousands (and possibly millions) of people with Chagas disease. In Africa, Nigeria’s MDA reaches less than 25% of its children at risk for helminth infections, and there is no information about schistosomiasis coverage in South Africa forthcoming from WHO. However, as Dr. Eyrun Kjetland (who works extensively in South Africa) has pointed out, female genital schistosomiasis remains widespread there, in part because praziquantel has been mostly unavailable in the country, owing to its drug importation laws. Schistosomiasis and other NTDs are still found among the poor in the Kingdom of Saudi Arabia. The entire MENA region severely underdiagnoses most of its NTDs, including leishmaniasis. In Asia, Indonesia largely does not promote widespread deworming for its children, and only a small percentage of its population receives treatment for LF, while India does only marginally better. Indonesia also suffers from high rates of yaws, which can also be targeted by MDA using the antibiotic azithromycin. Similarly in India, the vast majority of its children do not have access to regular and periodic deworming, and only about one-half of the population receives MDA for LF. India also has the worlds largest numbers of leprosy cases. This disease can also be attacked through MDA using a multidrug therapy regimen. WHO does not present information on China, either because it has not been determined or is unavailable. However, China has made great strides in reducing its schistosomiasis prevalence since 1949, and it has eliminated LF. Similarly, Japan and South Korea have achieved significant success both in economic development and in reducing or eliminating its NTDs. 144 Blue Marble Health Key common factors for poor performance in meeting MDA targets are vast geographies, decentralization of health care, inadequate resource allocation, and lack of political will. Overall, the six G20 countries with positive worm indices, together with Nigeria, have the means and capacity to eliminate LF within their own borders, while greatly reducing the disease burdens of their intestinal helminth infections and schistosomiasis through MDA. Some of the key common factors for poor performance in meeting MDA targets are vast geographies, decentralization of health care that results in fragmentation of drug delivery, inadequate resource allocation, and lack of political will and commitment. What about G20 countries affected by NTDs but without a positive worm index? In the United States, the 12 million Americans infected and living with NTDs are largely unrecognized, undiagnosed, and untreated. The United States also does very little in terms of conducting active surveillance for Chagas disease (and other major NTDs), and only a tiny percentage of its population receives access to diagnosis and treatment—the same is true for Argentina. In both North America and Europe, toxocariasis and other parasitic zoonotic infections are seldom diagnosed and treated. Minimal information is available on eastern ------------------- Europeans, Turks, and Russians with intestinal worms or zoonotic NTDs or their access to diagnosis and treatment. NTDs remain widespread among Aboriginal Australians, including intestinal helminth infections and scabies—both of which can be targeted through MDA. Thus, the current status of access to essential medicines for people living in poverty and with NTDs among the G20 countries and Nigeria can be summarized as abysmal. The fact that so few are being treated through MDA programs is especially sad, given its low costs. As previ- ------------------- ously mentioned, there are approximately 1.07 billion treatments required among the populations at greatest risk in the G20 countries and Nigeria. At a cost of 50 cents per person per year, approximately $500 million would be required—that is, a dollar amount representing a tiny percentage (<0.001%) of the $65 trillion combined economy of these countries. The bottom line is that each of these nations has the internal capacity to provide these low-cost treatments to its impoverished populations. WHO has now launched a Universal Health Coverage (UHC) initiative that builds on its 1978 “Health for All” Alma-Ata declaration and the MillenThe current status of access to essential medicines for people living in poverty and with NTDs among the G20 countries and Nigeria can be summarized as abysmal. The G20 145 nium Development Goals, with a focus on protecting the health of the worlds most economically vulnerable populations. The activities highlighted here clearly fall within WHO s UHC mandate. Research and Development for New Control Tools and Biotechnologies For many of the leading NTDs—including vector-borne diseases such as dengue, leishmaniasis, Chagas disease, African sleeping sickness, and malaria, and also some helminth infections such as hookworm, schistosomiasis, onchocerciasis, and foodborne trematodiases—there are equally urgent needs to develop new drugs, diagnostics, and vaccines. Each year, the Australian policy group known as Policy Cures publishes an annual G-FINDER Report that measures the global investment in new technologies for neglected diseases, defining them broadly to include both the NTDs and the “big three” diseases: HIV/ AIDS, ТВ, and malaria [6]. For the year 2014, G-FINDER determined that approximately $3.37 billion was invested globally in neglected disease R&D technology, with most of that support going toward the big three diseases [6]. A look at total government support for neglected disease R&D, almost all of it from G20 countries, is also interesting. The public sector provided 64% of the total funding, and the United States provided two-thirds of that funding, mostly from the US National Institutes of Health [6]. In all, 71% of the total government funding for neglected diseases comes from the United States, European Commission, and United Kingdom. However, as the G-FINDER Report points out, these absolute numbers do not consider the GDPs of these nations. In terms of public funding relative to GDP ratios, countries such as Ireland, Denmark, Norway, and Argentina do particularly well in this regard [6]. Shown in table 11.2 are selected estimates from G-FINDER of the percentage of their GDP that various governments have devoted to R&D on Of government funding for neglected diseases R&D, a whopping 71% comes from the United States, European Commission, and United Kingdom. We need greater involvement and support from the remainder of the G20 countries, including positive worm index G20 countries— Brazil, China, India, Indonesia, Mexico, and South Africa, in addition to Nigeria. 146 Blue Marble Health Although NTDs and other poverty-related diseases account for almost 14% of the global disease burden, they receive only a bit more than 1% of the global health-related R&D funds. neglected diseases. Using data from the G-FINDER Report combined with GDP information, I calculate that the world spends approximately 0.0028% of its GDP on neglected diseases R&D. Only three G20 countries—United States, United Kingdom, and Australia—match or exceed that percentage, ------------------- although India and France come close to it. The worstperforming countries were China and Japan. However, in 2013 the Japanese government, together with Japans major pharmaceutical companies and the Bill & Melinda Gates Foundation, formed a partnership known as the Global Health Innovative Technology (GHIT) Fund for supporting PDPs and other entities to develop and shape new biotechnologies for neglected diseases, with an emphasis on NTDs [7, 8]. China is a different matter. The New York Times has reported that China paid out $86.3 billion in foreign investments in the year 2013 [9], with much of that spent in fragile nations where health systems are broken and NTDs are widespread. Clearly, China needs to allocate some of those funds to neglected diseases, either for MDA or new technologies. In addition, the nation of Brazil could easily increase its global contribution to NTD technologies by ю -fold in order to match higher-performing nations in this regard. Germany is now looking at supporting NTD technologies as part of an overarching G7 initiative on NTDs. In 2011, the German government launched a policy roadmap for neglected and poverty-related diseases [10]. Indeed, a recent analysis conducted by German investigators has found although NTDs ------------------- and other poverty-related diseases account for almost 14% of the global disease burden, they receive only a bit more than 1% of the global health-related R&D funds [11]. As shown in figure 11.1, by presenting R&D expenditures for a particular disease divided by the disability adjusted life years (DALYs) it is possible to get a sense of ------------------- diseases that are especially underfunded—even compared with other NTDS—such as the intestinal helminth infections and other neglected enteric diseases, as well as rheumatic fever [11]. Such data argue for the great urgency needed in addressing these health disparities by increasing R&D funding and support. Recently, the Dutch and German governments and the European Union (EU) have established important initiatives to support NTD R&D. The Dutch Ministry of Foreign Affairs, for instance, has been a major partner in our human hookworm vaccine initiative, while the EU has an important Frameworks Program 7 (FP7) for supporting new technologies [12], including a HOOKVAC Consortium of partners organized through the Amster dam Institute of Global Health and Development [13]. Most recently, the EU has established an ambitious Horizon 2020 program for expanding R&D in Europe, including NTD R&D activities [14], on top of a European and Developing Countries Clinical Trials Partnership (EDCTP) for clinically evaluating new NTD technologies [15]. New German government funding for NTD R&D funding was just announced. These Dutch, German, and EU initiatives represent an important advance for shaping the next generation of products to treat and prevent NTDs. Yet another aspect of blue marble health is the rise in comorbid conditions between the NTDs, the big three diseases, and the noncommunicable diseases. Impoverished and neglected populations in the G20 countries and Nigeria are facing a double hit resulting from the convergence of NTDs and NCDs. For instance, in Texas, Mexico, and India (but presumably elsewhere) they include both ТВ and diabetes interactions and, lately, dengue and diabetes interactions. In South Africa, HIV/AIDS now flourishes amidst the high prevalence of female genital schistosomiasis. Studying the pathogenesis and epidemiology of these comorbid interactions will also be an important theme in the coming years. Shaping a Policy for the G20 The G20 began meeting in 2008 in response to that years global recession and have since convened in a summit each year to discuss the major policy issues of the day [16]. At the 2015 G20 Summit held in Turkey, the major areas of broad emphasis included strengthening the global recovery and enhancing resilience, while ensuring sustainability [17]. Clearly, lifting the bottom segments of their populations out of poverty through NTD control and elimination could fall within the G20 remit. It is imperative that the six member nations with positive worm indices commit to providing total MDA coverage for their populations affected by the major helminth infections, and also that the four Western Hemispheric countries step up surveillance, diagnosis, and treatment for Chagas disease. Leishmaniasis, both kala-azar and the cutaneous form, also represent major NTDs affecting the G20, and these diseases need to be targeted for control and elimination. The US, Dutch, German, and Japanese governments, along with the EU, stand out for their contributions toward supporting product development to counter NTDs, 150 Blue Marble Health Equally important is the R&D agenda. There are some obvious underachievers among the G20 countries that must step up and contribute to R&D for new drug, diagnostic, and vaccine products to fight the neglected diseases [18]. Toward that aim, several investigators have proposed the establishment of R&D funds to support neglected disease research. They include a global vaccine development fund [19] and a general biomedical R&D fund focused on antimicrobial resistance, emerging infectious diseases, and neglected diseases [20]. Both proposals are thoughtful, have a lot of merit, and need to be considered, but I offer an alternative or complementary solution. In 2013, the World Health Assembly passed a resolution (66.22) that proposes a “strategic work plan” to achieve sustainable funding for health R&D that could emphasize NTDs. The plan commits the director-general of the World Health Organization to establish a global “observatory” in order to identify gaps and opportunities for health R&D related to neglected diseases [21]. Through a pooled fund managed by WHO-TDR (a special program on tropical disease research and training), several pilot projects are now being supported [22]. Given that todays neglected disease R&D support comes mostly from the United States—and indeed mostly from a single agency, the National Institutes of Health—it is difficult to envision how such a fund would be created without calling on the NIH yet again. Realistically, it is unlikely the NIH leadership or the well-established community of US scientists would be willing to cede control of NIH budgets to an international body. Instead, I think it is worth considering the possibility of having each of the G20 countries establish its own version of the Japanese GHIT Fund, which builds on indigenous scientists and academic institutions and their own pharmaceutical industries. A Chinese or South Korean version of GHIT for example could become a vital and important institution. Creating twenty separate innovation funds could achieve the same goals as a global fund, while simultaneously ensuring national ownership and capacity building for indigenous academic and industrial institutions. Many of them could develop and shape new biotechnologies in collaboration with the 16 international PDPs. This approach would be especially useful for the less developed G20 countries, including Brazil, Global funds for R&D are an option. An attractive alternative is to create national funds for product development R&D in each of the G20 countries and Nigeria—ones that resemble those put forward by the Dutch and Japanese governments. The G20 151 India, Indonesia, and Mexico. These nations have indigenous vaccine manufacturers, which are represented by the Developing Country Vaccine Manufacturers Network, and therefore have a level of sophistication for producing next-generation NTD vaccines. Still another option is for smaller groups of G20 countries to come together to support R&D investments. The EU’s programs for new NTD technologies highlighted above represent important examples. In addition, if institutions from China and India (both rivals and neighbors) collaborated in the area of neglected diseases [23], some important NTD problems affecting Asia could be solved in the coming years. The United States has potential to extend its outreach on NTDs by collaborating with other G20 nations in the Americas or other countries [24]. As a UN agency, WHO could certainly partner with one or more of these G20 NTD R&D investment funds, especially through its global health R&D observatory mechanism. Another key United Nations agency might include WIPO—the World Intellectual Property Organization. Through the Patent Cooperation Treaty mechanism, the Geneva-based WIPO represents one of the few revenue-generating UN agencies. In 2011, in collaboration with BIO Ventures for Global Health, it established WIPO Re:Search to facilitate the development of products to combat NTDs by bringing together major pharmaceutical companies and academic investigators working on these diseases [25]. As a revenue-generating UN agency under the charismatic leadership of Francis Gurry, WIPO has the potential to expand this remit to support NTD product R&D. Looking beyond the G20 The major NTDs linked to wealthy countries and blue marble health could also be addressed by nongovernmental organizations, including faith-based groups. For example, in 2011 the Pew Research Centers Forum on Religion and Public Life reported that the center of the worlds Christian-majority countries has shifted from Europe and North America to the Global South, meaning Africa, Asia, and Central and South America [26]. Thus, countries such as Brazil, Philippines, Angola, Democratic Republic of Congo, and Papua New Guinea now have some of the highest percentages of Christian populations. As shown in table 11.3, from an analysis published in PLOS NTDs I found that almost all of the world s Chagas disease cases and African trypanosomiasis (sleeping sickness) can be found in Christian-majority countries, in addition to almost one-half of the schistosomiasis cases [26]. These findings suggest the possibility of bringing in new actors to combat NTDs. They could include the Vatican and Pope Francis, especially given the new popes renewed commitment to impoverished populations [19]. The Orthodox Christian Church also has opportunities to highlight NTDs in countries such as Ethiopia or those in the Middle East, as do many Christian faith-based organizations and universities. The G20 153 Summary Points 1. The six G20 countries with positive worm indices—Brazil, China, India, Indonesia, Mexico, and South Africa, together with Nigeria, have the means and capacity to eliminate LF within their own borders, while greatly reducing the disease burdens of their intestinal helminth infections and schistosomiasis through MDA. 2. G20 countries without classical worm indices, including the United States, also need to find mechanisms for promoting surveillance and access to essential medicine options for the poor living with NTDs within their own borders. 3. The G20 countries also have important biotechnology capabilities, which have yet to be adequately tapped for producing new NTD diagnostics, drugs, and vaccines. Beyond the United States, European nations, Australia, and Japan, they also include Brazil, China, India, Indonesia, Mexico, Russian Federation, Saudi Arabia, South Africa, and South Korea. 4. Yet another aspect of blue marble health is the rise in comorbid conditions between the NTDs, the big three diseases, and the NCDs. 5. The EU and the Dutch and German governments have launched important NTD technology initiatives, as has the Japanese government and its partners through a new GHIT Fund. These activities support PDPs committed to NTDs as well as indigenous academic institutions and industrial organizations. 6. Large G20 economies such as Brazil and China must increase their global commitment to support new NTD technologies and R&D. 7. There are opportunities to link these new investments with parallel activities ongoing at two UN agencies, namely, WHO and WIPO. 8. These topics should be highlighted at future G20 summits. 9. Faith-based organizations could have a future role. For instance, the Vatican and related entities have opportunities to expand commitments to control those NTDs that are found to be prevalent among Christian-majority countries. Central to the blue marble health concept is that each of the G20 nations and Nigeria need to take greater responsibility for their own neglected diseases and neglected populations. Doing so could result in the control or elimination of one-half or more of the planets NTDs, with substantial gains made against HIV/AIDS, ТВ, and malaria. Thus, while programs of overseas development assistance devoted to health, such as PEPFAR, GFATM, PMI, and USAID’s NTD Program, in which the worlds richest countries provide support to the poorest nations for their neglected diseases, must continue and should even expand, we need increasingly to recognize the hidden burden of neglected diseases among the poor living in wealthy countries. As a first step, we must expand initiatives that raise awareness about the problem of NTDs within each of the G20 countries and Nigeria. The Global Network for NTDs linked to the Sabin Vaccine Institute has been working closely with the governments of India and Nigeria, respectively, in order to explain the opportunity for mass drug administration and its potential impact on health and economic development. MDA coverage rates are disappointingly low in these nations, especially for intestinal helminth infections and LF, as well as for schistosomiasis in the case of Nigeria. An extraordinary finding is that at least three nations with positive worm indices—India, Pakistan, and China—also maintain nuclear stockpiles [1]. Could the scientific horsepower of these nuclear states be partly redirected toward reducing endemic NTDs at home? 154 A Framework for Science and Vaccine Diplomacy 155 Outside of India and Nigeria, there is a need to promote NTD awareness in each of the G20 countries. For example, in the United States, our National School of Tropical Medicine has been highlighting the plight of some 12 million Americans living with NTDs. We have now worked with the Texas Legislature to enact a bill for NTD surveillance in suspected high-prevalence areas. However, similar initiatives need to be enacted across the G20 nations, including the European Union. In addition, international cooperation between the different G20 nations and Nigeria could be critical in achieving higher population coverage for MDA. For instance, China, despite its billions of dollars of business investments in sub-Saharan Africa, has not yet promoted NTD control efforts there. Yet China has tre- mendous expertise in MDA for NTDs and could provide Africa with valuable advice in this area. China was the first country to eliminate LF and has achieved successes in re- ducing its burden of schistosomiasis more than ю -fold since the 1949 revolution. China could also share its best practices with neighboring India, where NTDs remain practically ubiquitous [ 2]. Similarly, Japan and South Korea have made great gains toward eliminating intestinal helminth infections, while the former has also successfully eliminated LF and schistosomiasis. International cooperation between these three East Asian nations and Nigeria, or with the G20 countries with positive worm indices, especially India, Indonesia, and Brazil (where they are the highest), could result in important, positive health and economic gains. Each of these activities represents examples of what some refer to as global health diplomacy. Global Health Diplomacy My former colleague at Yale University, Ilona Kickbusch, currently the director of the Global Health Programme at the Graduate Institute of International and Development Studies in Geneva, has provided several working definitions of global health diplomacy, including efforts to “position health in foreign policy negotiations,” together with the establishment of global health governance initiatives [3]. Indeed, the creation of the GAVI Alliance, GFATM, UN AIDS, and other Geneva-based organizations might be considered vital examples of organizations created under the auspices of global health diplomacy, with the first two created following the 2000 Millennial Development Goals. The MDGs themselves represent an important framework for global health diplomacy, and arguably the most successful. Since 2005, several global health diplomacy initiatives have been enacted that could facilitate NTD activities among the G20 and Nigeria, although most of these actions are more focused on emerging viral infections of pandemic potential rather than the widespread chronic and debilitating NTDs. The International Health Regulations (IHR) were enacted in 2005 as a binding legal mechanism for all member states of WHO and focused on responses to acute public health emergencies [4]. IHR demands that countries report outbreaks and other public health events, while WHO responds with measures to uphold and enforce global health security [4]. IHR also establishes an emergency committee that advises the WHO director-general on whether an unexpected event should be considered a public health emergency. It also provides recommendations on initial steps for travel restrictions, surveillance, and infection control. With the possible exception of dengue fever, it is not clear how IHR will substantively address the NTDs or other blue marble health conditions. Moreover, even with IHR in place, the global response to the 2014 emergence of Ebola in West Africa was slow and inadequate and led to a catastrophic outbreak in the fall of that year [5]. This failure may require future revisions in the IHR, as recently recommended in a 2015 Lancet article by Lawrence Gostin and his colleagues at Georgetown University [6]. The Global Health Security Agenda (GHSA) is an interagency initiative of the US government conducted in partnership with other nations and international organizations, including WHO [7]. GHSA is also focused on preventing or reducing the impact of epidemics and outbreaks of pandemic potential, such as H7N9 influenza virus or MERS coronavirus, as well as detecting emerging threats and implementing rapid and effective responses. In some respects, GHSA represents the US component or response to IHR. It also covers intentional or accidental releases of dangerous infectious disease pathogens. Global Health 203s and The Lancet Commission were launched in 2013, coinciding with the twentieth anniversary of a landmark 1993 World Development Report that helped to ignite international efforts to link investments in health with economic development [8]. The Lancet Commission identifies four key messages and actions: (1) the substantial economic return on investing in health, which can be as much as 24% in low- and middle-income countries; (2) implementation of a “grand convergence” in global health through scale-up of health technologies and strengthening health systems by the year 2035; (3) fiscal policies such as taxation of tobacco and reduction of subsidies for fossil fuels, which represent powerful forces or “levers” for elected leaders; and (4) universal health coverage as an efficient mechanism to improve health as well as to provide “financial protection” [8]. The Addis Ababa Action Agenda (AAAA) is the product of the first of three international meetings for implementing the UN s 2015 Sustainable Development Goals. However, health is at present only a minor component of the AAAA. Indeed, the SDGs have been criticized because health is now only 1 of the 17 goals, whereas it was front and center among the 2000 MDGs. So far, the AAAAs recommendations have included the promotion of the health systems strengthening component of the GFATM and GAVI Alliance and the establishment of a Global Financing Facility (GFF) for womens and childrens health that would go hand-inhand with the UN secretary generals new Global Strategy for Every Woman Every Child [9]. The emphasis of these initiatives is to reduce preventable maternal, child, and adolescent deaths by 2030. Despite the evidence that hookworm infection and Chagas disease rank among the leading complications of pregnancy among women living in poverty in low- and middle-income countries, while female genital schistosomiasis is among sub-Saharan Africa’s most common gynecologic condition, there is not yet a specific mention of NTDs in the AAAA or GFF. Ultimately, the G20 nations can identify ways to address blue marble health disparities under the auspices of the SDGs or the global health diplomacy initiatives highlighted above. However, at present there is no specific mandate for them to do so. Vaccine Science Diplomacy Concurrently, the G20 nations have opportunities to collaborate in scientific activities leading to the development of new drugs, diagnostics, and vaccines. I have used the term “vaccine science diplomacy” to refer to inter- national scientific codevelopment of lifesaving vaccines between scientists of different nations, but particularly from nations with strained or evenly openly contentious international relations. The best historical example of vaccine science diplomacy is the codevelopment of the oral polio vaccine, led on the American side by Dr. Albert B. Sabin, and his Soviet virologist counterparts, including Dr. Mikhail Petrovich Chumakov [3]. In modern times there is potential interest in explor ing vaccine science diplomacy opportunities between the United States and some of the worlds Muslim-majority nations belonging to the Organisation of Islamic Cooperation [10,11]. OIC countries include most of the Middle East and North Africa, as well as some highly populated Southeast Asian nations, including Bangladesh, Indonesia, and Malaysia, as well as most of central Asia. New estimates that we published in PLOS NTDs in 2015 indicate that the 30 most-populated OIC countries account for 35% of the worlds helminth infections comprising the global Worm Index, including 50% of the worlds children who require MDA for schistosomiasis [11]. Given that approximately 1.5 billion people live in OIC countries, or about 20% of the global population, helminth infections appear to disproportionately affect the health and economic development of Muslim-majority countries, as does leishmaniasis, trachoma, and possibly other NTDs [11]. As shown in figure 12.1, there is also tight inverse association between the worm index and human development index in the Muslim world [11]. OIC nations with strong infrastructures in science and biotechnology are potentially attractive candidates to pursue joint vaccine science diplomacy initiatives with the United States. Here the idea would be to promote scientific collaborations between US scientists and scientists from selected OIC countries in order to create new NTD technologies for some of the worst-off Muslim-majority countries. The “worst-off” might include OIC countries at the high end of the worm index, including Mali, Cote d’Ivoire, Mozambique, Cameroon, Burkina Faso, and Niger, as well as Nigeria [11].

#### Solves hotspot escalation

Nang and Martin 17, Roberto N., and Keith Martin. "Global health diplomacy: A new strategic defense pillar." Military medicine 182.1-2 (2017): 1456-1460. (MC, Global Health Division, Uniformed Services University of the Health Sciences)//Elmer

INTRODUCTION: FORCE IF NECESSARY BUT NOT NECESSARILY FORCE The world appears unhinged. Instability from the Middle East, Caucasus, Africa, and Central America to Asia abound. The Study of Terrorism and Response to Terrorism database identified fewer than 300 major terrorist incidents between 1998 and 2004 in the Middle East and North Africa. In 2013, they listed 4,650 such incidents.1 Quieter cracks tear at the fabric of South America and parts of Asia. Although geographically distinct, many of these areas of instability share underlying causes that give rise to threats to the United States and the global community. Human-generated causes include corruption, poor governance, absence of the rule of law, violence, gross human rights abuses, climate change, environmental degradation, a weak civil society, and a lack of professional capabilities across skill sets within the government departments needed to effectively manage the operations of a well-run state.2 Natural causes include disasters, disease, demographic changes, and limited access to the resources essential for life. When these human or natural causes create conditions that result in poor provision of, or unequal access to essential services, such as water, food, shelter, health services, education, and economic opportunity, people lose confidence in government and hope for their children and their future. They become restless, demonstrate, can become violent and overthrow their governments (such as the self-immolation of Mohamed Bouazizi, the Tunisian cart vendor, which sparked 35 more selfimmolations by extralegal businessmen and started the Arab Spring), or can result in mass migrations.3 Desperate human security, conditions create desperate people undermining stability and creating even more demands from host nation governments and governments in neighboring states. Although force and counter terrorism programs are sometimes needed to address security threats, enormous opportunities are available to use nonkinetic capabilities within the Department of Defense (DoD), Department of State, U.S. Agency for International Development, other U.S. Government agencies, and civilian organizations to address the underlying causes of instability. Global health diplomacy is an underutilized strategic asset to do this. At a far lower cost, it will save lives, decrease economic losses, reduce the need for kinetic military operations, increase security cooperation, improve diplomatic relations, encourage trade, and create the foundations for longterm stability. HEALTH IS A NATIONAL SECURITY IMPERATIVE—DISTANT HEALTH THREATS ARE GLOBAL THREATS Health is a national security imperative. The second- and thirdorder effects of a strategic health or global health issue that severely impacts and overwhelms the stability of a far-distant nation can have broad and multiplying effects that transcend boundaries and can become regional and global security threats. When human immunodeficiency virus/acquired immunodeficiency syndrome first started to be seen in the United States, there were U.S. leaders that were not too concerned about its impact on the general public, alluding to the fact that it was a disease that mostly affected the four H’s: homosexuals, heroin addicts, hemophiliacs, and Haitians.4 From its first known cases in 1981 up to 2013, human immunodeficiency virus has infected almost 78 million people and killed about 39 million.5 The Chernobyl power plant accident that occurred on October 26, 1986, was a catastrophic nuclear accident. Several studies have been done to estimate the increase in health effects and cancer-related morbidity and mortality in Europe.6 Communicable diseases can be easily carried from a distant area of the world to a teeming metropolis within 24 hours because of the ease and affordability of plane travel. The interconnectedness of countries as a result of trade has its drawbacks— biological or chemical contamination of food or products commonly occur across oceans and continents.7 Noncommunicable diseases are also affecting not just high income countries but also low-to-middle income countries. Ubiquitous exports of fast-food meals, high-fructose drinks, and salty, fried foods have contributed to a tremendous increase in obesity and hypertension.8 Obese and sedentary populations negatively impact the workforce of a nation and its productivity. The offices of military personnel and readiness cite obesity as the number one disqualifying reason for new recruits.9 Twenty seven percent of the U.S. young adults are not fit to serve in the military.10 Addiction to illegal drugs is an important global health threat. The problems created by the manufacture of opium in Afghanistan, methamphetamine in Mexico, and cocaine in Peru and Columbia create tremendous and devastating health effects, loss of productivity, social disruptions, breed corruption in a nation’s military and police forces, and create turbulent violence all along its wake, both in the countries manufacturing the drugs and the countries importing them. Weather forecasters often discuss the multiplying effects that the fluttering of a butterfly’s wings in one country may have on the regional weather of another distant country. Global health professionals and more and more of our military and political leaders are now concerned that the disease that we see in a child in Africa or a pig in Asia may have tremendous impacts on the public health, economic productivity, military readiness, and strategic security interests of their nation. In addition, a weak health and political system anywhere can be a threat everywhere. LINKAGES: GLOBAL HEALTH, SECURITY, AND STRATEGIC CHALLENGES Global health encompasses the basic needs required for human security: respect for people’s universal rights, personal protection, the rule of law, access to food, water, health care, education, basic infrastructure, and shelter.11 Their absence leaves populations vulnerable to the depredations of insurgent groups and corrupt, venal cabals that can hijack a region or state for the benefit of themselves and a select group of people. This creates an environment of the privileged and abused, the included and excluded, and an environment ripe for insecurity and conflict.12 For a nation to provide the environment where people’s basic needs can be met requires capabilities within their governing infrastructure and communities. This includes management, finance, education, social sciences, law,medicine, public health, engineering, veterinary medicine, agronomy, and more. Their absence [undermines] ~~cripples~~ a nation’s ability to support a foundation for human security and stability, inhibits its ability to thrive in good times, and respond effectively to natural and man-made threats in bad times. It breeds corruption, poverty, poor health outcomes, spread of lethal diseases, gross human rights abuses and conflict. This we have seen played out with grim efficiency in Afghanistan, Pakistan, Iraq, Syria, Sudan, Democratic Republic of the Congo, Central African Republic, Libya, Yemen, Somalia, Nigeria, Honduras, and beyond. All have had disastrous regional effects, many have created direct threats to U.S. interests. Islamic State in Iraq and Syria was borne out of the brutal kleptocracy of Assad’s Syria and a destructive government in Iraq. Al-Shabaab was created in the failed state of Somalia. Boko Haram grew in the destitute and neglected regions of northern Nigeria. Al Qaeda and the Taliban secured a haven in the lawless western regions of Pakistan. Weak governments in Central America created a fertile ground for organized criminal gangs to terrorize the populace and profiteer off the illegal drug trade that destroys lives, and drives people to desperately flee northward into the United States. Insurgencies, terrorist organizations, and other nonstate actors thrive in the presence of an incompetent or abusive state government that violates segments of its citizenry and fails to provide an environment where peoples’ rights are protected and their basic needs met. These groups divine counter narratives that take advantage of people’s lack of hope and fears. They create a refuge and an outlet for people’s rage. Such messages and place of belonging can be a powerfulmagnet for youths, the poor, and the disenfranchised,who see little hope in the future. Security threats are not only manmade but also can come from nature. The international community’s failure to dramatically reduce our carbon footprint leaves us vulnerable to an increasing number of extreme weather events that threaten everything from coastal communities to food and water security. This will amplify existing tensions over natural resources and could result in the forced migrations of massive numbers of vulnerable people. The world’s population is expected to reach 9 billion by 2030. The growth will primarily occur in cities in the developing world most of which already have fractured or nonexistent infrastructure. Climate change will have a dramatic effect on densely populated poor urban areas, especially those in arid zones and in littoral areas. This is a recipe for disaster. Environmental degradation is also increasing the spread of infectious diseases and facilitating zoonoses to jump the species barrier and infect humans. The Ebola outbreak, like severe acute respiratory syndrome and H1N1 before it, is part of a long list of diseases that have infected humans from an animal reservoir with devastating impact. Many zoonoses exist and more will come. Using history’s guide, the next pandemic will likely be a zoonotic agent. Recognizing this, the United States last year led the creation of the Global Health Security Agenda to prevent, detect, and respond to deadly disease outbreaks.13 Though accepted by many countries, it has been implemented by few. No amount of force can resolve these challenges. However, global health diplomacy, exercised through civil-military and military-military programs, is a promising strategic tool that should be employed to address these wicked strategic or global health problems and improve domestic and international security. AN OPPORTUNITY TO ACT Despite a growing level of interest in academia and government agencies, there is little agreement on how to define “global health diplomacy.”14 Michaud defined it as “international diplomatic activities that (directly or indirectly) address issues of global health importance, and is concerned with how and why global health issues play out in a foreign policy context.”14 The World Health Organization (WHO) states that it “brings together the disciplines of public health, international affairs, management, law, and economics, and focuses on negotiations that shape and manage the global policy environment for health.”15 We summarize global health diplomacy as the application of a broad range of skill sets to cooperatively improve human security throughout the world. A vital area of focus must be to strengthen public service, governance capabilities, and civil society in unstable regions. Doing so will enable nations to create an environment where their citizens’ basic needs can be met, universal rights respected, and the ability to hold a government to account, secure. This includes building and retaining capabilities to manage effective, noncorrupt, justice, finance, health, education, defense, public works, and environmental departments. The absence of these structures cripples a country’s ability to govern itself and leaves it vulnerable to the causes of instability, both human and natural. The United States, by virtue of its strengths across diplomacy, defense, development, trade, and its inherent domestic civilian capabilities, has an opportunity to exercise its leadership and mobilize these assets. Using global health diplomacy to comprehensively strengthen public service and governance capabilities has been chronically neglected by the international development community. It needs a leader to start this process and the United States has the ability and authority to do so in the national and international interest.

#### The Plan solves Evergreening.

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

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