# Medical Apartheid AFF

### Cost-Accessibility

#### Black and Brown bodies pay the price: not only through experimentation, but accessibility.

**BP-Weeks**, Maurice, **2020,** Racial Health Disparities Are Fueled by Big Pharma's Patent Monopolies [Op-Ed]**,**

Time after time, Black and Brown people pay the price—either with our lives or through pain and suffering—because of systemic racial discrimination and the continued extraction of dollars from us. Nothing illustrates this truth more than COVID-19, which has been killing Black, Latinx and Indigenous people disproportionately because of lack of access to healthcare, safe housing and overrepresentation in what is now recognized as “essential work.” As researchers race to find potential cures for COVID-19, it’s already becoming clear that yet again, only certain people will have access to them. Before it even hits the market, Gilead Science set a heinous price for proposed COVID-19 treatment Remdesivir—over $3,000 per patient. This is just one example of the myriad of life-saving medication which Black and Brown people are denied via pricing. A new report, “Poi$on,” shows that Black folks have twice the rate of hypertension, and twice the mortality rate for diabetes compared to white people. Additionally, Latinx people also have twice the rate of diabetes and are more likely to experience preventable diabetes-related kidney failure and vision loss. On top of this already glaring health disparity, the report finds that Black and Latinx people are more likely to ration medication due to cost, which causes a slew of other issues including heart disease, strokes, and kidney disease. Often, diabetic patients who ration medication have to undergo amputations that are completely preventable with reliable access to affordable medication, leading to what ProPublica has deemed an “epidemic of amputations” in Black communities. The high cost of medication is not a coincidence. It’s the result of pharmaceutical companies having total control over their pricing. Of course, in the capitalist hellscape we live in, they always choose to put profits over people without oversight from our government. “Poi$on” also finds that there are some clearly identifiable bad actors here. Eli Lilly hiked the price of its insulin, Humalog, 30 times in just 20 years, including a 585 percent increase between 2001 and 2005. After buying the patent rights to two blood pressure drugs, Nitropress and Isuprel, Valeant Pharmaceutical immediately raised their prices by 212 percent and 525 percent, respectively. A Valeant spokesperson referred to its duty to “maximize the value” for shareholders as justification for this egregious and arbitrary leap in price. If it seems bananas that they’re able to do this, it is. The reason why? These pharmaceutical corporations have the authority to monopolize patents, and then do everything they can to abuse them. With no oversight on drug pricing, greedy pharma executives can gouge prices on a whim, willfully killing countless Black and Brown people in the name of profit. On top of abusing an already corrupt patent system, pharmaceutical companies assemble tangled webs of intellectual property protection that stifle truly innovative medical research, while keeping already hyper-inflated drug prices high. It hasn’t always been this way. Patent monopolies giving pharmaceutical companies control over pricing weren’t introduced until the 1960s, when right-wingers worked to empower corporations and wealthy investors by weakening public-sector regulations and consumer protections. These days, the excuse for the high prices of drugs is attributed to innovation or keeping the market competitive. But the truth is that government-funded research has always been the backbone of medical breakthroughs—pharmaceutical companies profit by buying the patents and monopolizing public knowledge. Luckily, there are some clear solutions. First, and most urgently, our elected officials must ensure medications and vaccines for COVID-19 are offered free of charge. Second, the Department of Health and Human Services must designate systemic racism as a public health emergency, and issue reparations for past harms from the pharmaceutical industry. Third, the federal government must impose compulsory licensing to prevent further abuse of patents by big pharmaceutical companies that lead to monopoly and price gouging. And finally, we must push for measurable steps toward strengthening the public’s ownership of medicine. While everyone deserves access to free, comprehensive healthcare, including medication, the reality is that Black and Latinx communities are being torn apart by the pharmaceutical industry’s insistence on the greedy exploitation of our communities. Congress must step in with bold action plans. Our lives, quite literally, depend on it.

#### Diabetes provides the best example: Amputations’ increase among vulnerable populations showing a lack of affordability of insulin mirrors existing inequalities

**Mizelle 21**, Richard M. "Diabetes, Race, And Amputations". The Lancet, vol 397, no. 10281, 2021, pp. 1256-1257. Elsevier BV, doi:10.1016/s0140-6736(21)00724-8. Accessed 19 Sept 2021.

Diabetes is a window into the nation’s health. Amputations in the USA have been increasing since the economic recession of 2007 and highlight the ways in which broader socioeconomic and racial inequalities can lead to disability and death. These issues have been underlined in the COVID-19 pandemic. COVID-19 and its social and economic impacts have taken a harsh toll on people with diabetes in the USA; the loss of wages, food insecurity, fear of exercising in public, stress, unaffordability of insulin, and less frequent access to diabetes and related specialists point to some of the reasons people with diabetes have not fared well. Much of this was anticipated by diabetes scholars and activists. In the COVID-19 response, numerous countries temporarily disrupted services for patients with diabetes and other non-communicable diseases in ways that would cause long-term harm. Among the many impacts are amputations. Worldwide the rates of amputations have increased as a result of COVID-19 as foot care is delayed, wound care centres and clinics closed, and available beds for non-COVID-19-related illness reduced. In some parts of the USA, the rates of major amputations during the pandemic have tripled. Since amputations will lead to death for some people, I would suggest these deaths are a direct result of the disruptions caused by the pandemic and scenarios in which many people became unnecessarily vulnerable. The bodies of Black people in the USA have been devalued for centuries: mutilated, tortured, set afire, cut, dismembered, and murdered. Racism and antiBlackness inform the historical subjugation and violence Black people in the USA have faced in social, political, and economic life. The delivery of health care is no exception. From medical experimentation on enslaved populations in the Antebellum period to racist notions of Black immunity to pain, Black bodies have long been rendered expendable and inconsequential in the domain of medicine. The epidemic of amputations among Black communities across the USA is a brutal reminder of the enduring complications of this chronic disease among underserved populations and the ways in which harsh environments, structural racism, and systematic medical neglect inform this moment of disability, lost limbs, and lives cut painfully short. There is, in my view, a wilful ignorance when it comes to amputations in people with diabetes and the many inadequacies of our health system. Addressing these challenges will require broad reform in society and the delivery of health care, including making sure people who live with diabetes are insured and can readily access specialists, insulin, and live in healthy environments. Until addressed, we will continue to see a metaphorical mountain of legs, toes, and feet piling up; the lives of American citizens amputated out of the body politic piece by piece.

#### Patents on newer insulin are renewed by Big Pharma for profit; Cheaper off-patent insulin has no place in the market.

**Kaplan 17** Kaplan, W.A., Beall, R.F. The global intellectual property ecosystem for insulin and its public health implications: an observational study. J of Pharm Policy and Pract 10, 3 (2017). https://doi.org/10.1186/s40545-016-0072-8

The statement that insulin IP is not a barrier to market entry is accurate only for the presently marketed insulins not linked to devices (Fig. 1: black symbols), and the main insulin producers are continually filing for patents on analog insulins in their R&D pipelines so their market exclusivity (assuming that these patent applications mature into issued patents) are likely to continue for years to come (Fig. 1: red symbols). In short, analysis of publicly-available data on global insulin patents and manufacturers indicates that the vast majority of world’s insulin markets are dominated by brand-name manufacturers long after the original product and process patents have expired. The North American insulin market is dominated by the small number of companies who are the sole suppliers of one or more of six insulin analogs, which are available exclusively as brand name products. There is no US or Canadian human, non-analog insulin. Although third parties are likely free to exploit technology claimed by expiring OB/HC patents, it is possible that existing (i.e., non-expired) IP portfolios of Lilly, Novo, Sanofi and Pfizer in the U.S. and Canada (Fig. 1: red symbols) would prevent or hinder such exploitation. Given that the IP for recombinant human insulin, including DNA sequences and vectors is long off-patent, the existing insulin portfolios are unlikely to be sufficient to block production of human, recombinant insulin. Patent barriers are not the main reason for a lack of a generic version of recombinant human insulin in the U.S. marketplace or indeed, anywhere else in the world. Moreover, insulin markets have evolved towards containing the newest, most expensive analog products not only in the US and Europe but in every measured insulin market in the world. These shifts greatly complicate access to medicines for the 2.8 billion people living on less than $2 a day, and for many living on higher incomes as well.

#### Black and brown bodies show the highest rate of cost-related insulin underuse

**Tseng et. Al 8** Chien-Wen Tseng, Edward F. Tierney, Robert B. Gerzoff, R. Adams Dudley, Beth Waitzfelder, Ronald T. Ackermann, Andrew J. Karter, John Piette, Jesse C. Crosson, Quyen Ngo-Metzger, Richard Chung, Carol M. Mangione. Diabetes Care Feb 2008, 31 (2) 261-266; DOI: 10.2337/dc07-1341

In this large, insured, racially diverse population of adults with diabetes, one in seven respondents reported cost-related medication underuse. Given the high rates of cost related medication underuse, even among an insured population, efforts to decrease financial barriers to medications for individuals with diabetes are clearly still needed. Since one-fourth of our participants had medical coverage but not drug benefits, one consideration would be to tie drug benefits closer to medical coverage by not offering them separately but only as a combined benefit for those with chronic diseases such as diabetes. To our knowledge, ours is the first study to report cost-related medication underuse for three primary racial/ethnic minorities (Latinos, African Americans, and Asian/Pacific Islanders). In unadjusted rates, cost-related medication underuse was much higher among Latinos (23%) and African Americans (17%) compared with whites (13%). Thus, cost related medication nonadherence could be an important contributor to racial/ ethnic disparities in diabetes in the sense that general medication nonadherence is associated with greater diabetes-related morbidity (9,15,16–18) and mortality (15). In our study, these racial/ethnic differences in rates of cost-related medication nonadherence were minimal after adjusting for economic, health, and other demographic variables. Latinos remained the only group to be significantly different from whites, and this difference in adjusted rates of cost-related medication underuse (4%) was less than those observed across categories of income (10%), out of-pocket drug costs (17%), and age (17%). Additionally, the two-way interaction terms of “race/ethnicity by income” and “race/ethnicity by out-of-pocket drug costs” were not found to be significant predictors of cost-related underuse. These results indicate that a potential reason why we found higher rates of cost related medication underuse among certain racial/ethnic minorities may be more due to the lower income levels and higher out-of-pocket drug costs faced by these racial/ethnic minorities and less due to racial/ethnic differences in responding to cost pressures when it comes to medication nonadherence. Therefore, interventions to decrease racial/ethnic disparities in cost-related medication underuse should focus on decreasing financial barriers to medications. As an example, Latinos and African Americans were also the least likely to have drug coverage in our study, and this was a strong predictor of cost-related nonadherence. Since all our participants had health insurance, an important policy question would be to examine whether certain minorities are less likely to have access to drug benefits or are more likely to choose health coverage without drug benefits. Our finding that race/ethnicity is a significant but weak independent predictor of cost-related underuse would explain why the general literature on cost related medication underuse (not necessarily in individuals with diabetes) has been split on race/ethnicity as a significant, independent predictor (24). We examined designs of previous studies, looking for commonalities in studies that did or did not find an association between race/ethnicity and cost-related medication underuse, and found no patterns in whether studies controlled for economic variables (which nearly all have), reported on only white versus nonwhite groups (11,19,20,27), and/or included African Americans (14,19,21), Latinos (14,23,27) or Asian/Pacific Islanders separately. We know of only two earlier studies (11,14) of cost-related medication underuse that included large numbers of patients with diabetes and reported on race/ethnicity. Piette et al. (11) studied only white versus nonwhite and Mojtabai et al. (14) studied African Americans and Latinos, but not Asian/Pacific Islanders, as a separate group. Neither study found race/ethnicity to be a significant predictor after adjusting for economic variables (e.g., income). Again, this supports targeting financial barriers to medications to improve medication adherence and targeting specific racial/ethnic groups if these financial barriers are more likely to exist within them.

#### Black and brown bodies are subject to amputations, heart disease, and death.

**Mizelle 21**, Richard M. "Diabetes, Race, And Amputations". The Lancet, vol 397, no. 10281, 2021, pp. 1256-1257. Elsevier BV, doi:10.1016/s0140-6736(21)00724-8. Accessed 19 Sept 2021.

2021 marks the centenary of the insulin revolution that changed the lives of millions of people with diabetes and transformed diabetes from a deadly disease into a chronic illness. Insulin was one of the world’s first so-called wonder drugs and although affording the opportunity of a longer life, chronic complications now define the disease. About 8·3 million people with type 1 and type 2 diabetes in the USA need insulin to live. Globally, the number of people with this disease who require insulin is estimated at 30–40 million. In the USA, structural racism, underinvestment and medical neglect in hospitals and clinics, and living in disadvantaged environments with infrequent access to diabetes specialists make painfully clear the vulnerability of African Americans and other minority groups to diabetic complications. Kidney failure, heart disease, amputations, retinopathy, and physical disability in these populations tell us much about the long and tortured history of diabetic complications which are often exacerbated by overlapping social inequalities. Amputations and peripheral arterial disease (PAD) provide a window into the stark realities of diabetes, race, and exclusion in the USA. The word amputation brings debilitating fear. Uncontrolled diabetes can lead to gangrene, infections, foot ulcers, and PAD. Close to 140000 diabetes-related amputations occur every year in the USA and structural inequality leads to Black people being four times more likely to have an amputation than white people. Low rates of angiogram screening for nerve damage and PAD result in many unnecessary amputations. Zip codes tell the story as residents in low-income and neglected neighbourhoods suffer amputations at rates double that of people in higherincome communities. People with diabetes who live in poor and segregated US neighbourhoods experience a constellation of social factors that lead to amputations, including not having health insurance, high insulin costs, and lack of, or inadequate access to, revascularisation surgeons and large research hospitals with cutting-edge technology. Regular access to foot care specialists, nutritionists, ophthalmologists, and other diabetes specialists reduces the risk of amputations and other complications. Regional hospitals and clinics that serve low-income and Black communities may be more likely to perform amputations and less likely to undertake screening procedures that could save limbs. Insufficient resources and bias among some health professionals toward amputation among poor Black patients without exhausting other options, have laid the groundwork for the convergence of race and amputation. Living in a food desert makes controlling diabetes with healthy foods difficult and travel to healthy food markets burdensome. Neglected neighbourhoods still suffer from few usable green spaces and parks for exercise, and after an amputation, exercise can become even more difficult. Immobility after an amputation is exacerbated by the physical and social pain of limited employment opportunities, loss of self-sufficiency, stigma related to debility, and fear of losing additional limbs. Amputations are also costly. Prosthetic limbs are expensive, require replacement every 3–5 years to account for changes in the body, and demand months of physical therapy that can be economically prohibitive. Medicare and many Medicaid plans cover prosthetics; however, the bureaucratic enrolment and state eligibility requirements for the latter can make access difficult. The mortality rate among people who have had diabetes related amputations is an important issue that needs to be addressed through medical intervention, awareness, and legislation. The average life span after a full leg is amputated is roughly 5 years. And there are other social and cultural contexts that shape the lives of Black people with diabetes who have had amputations. Amputations are made visible through the lens of disability, race, and the built environment. House ramps and wheelchairs dot landscapes and neighbourhoods with high amputation rates and are regarded by some as symbols of Black irresponsibility and neglect of their own health. Such views do not recognise the systematic discrimination in society, medicine, and public health that impacts Black people’s experiences. Amputations also give rise to questions about which forms of disability warrant sympathy and which ones do not. A common narrative suggests that Black people with diabetes suffer amputations because of The art of medicine Diabetes, race, and amputations Vitapix/Getty images Perspectives www.thelancet.com Vol 397 April 3, 2021 1257 personal failings; artificial limbs may be racially stigmatised and individuals may be blamed for their own pain and suffering, while their presence in public spaces can be met with disdain and contempt. Politicians, diabetes organisations, and public health officials in the USA are finally starting to take note of the diabetes amputation crisis among Black communities. The Amputation Reduction and Compassion Act (ARC) of 2020 seeks to make PAD screening a requirement before an amputation can occur, prevent physician reimbursement without proper screening, include a public education initiative, and expand both Medicare and Medicaid coverage to include PAD screening at no cost to patients. The Social Security Amendments of 1972 made access to dialysis under Medicare a reality for millions of people with diabetes-related kidney failure and end-stage renal disease. We should similarly extend the public charge of Medicare and Medicaid for PAD screening to help reverse the high diabetes burden in minoritised communities. Diabetes organisations and patient groups can also lobby for treatment changes. Amputation should be a last resort, after all treatment and therapeutic options have been exhausted. Screening for PAD and surgery must be an option before the life-changing decision to amputate a person’s limb. Physicians should be incentivised to provide non-amputation-related treatment. In the US political climate, legislation to provide more access to resources and ensure equitable health care remains difficult. Patient groups and the public should voice support for the ARC and seek additional policy solutions at the local and national levels. Clinics that screen for PAD should be opened in rural and underserved communities. The dangers of poor glucose management and amputations must be made visible in public health campaigns. Another focus should be advocating for globally affordable insulin. It is deplorable that insulin remains far out of reach for millions of people worldwide due to high costs. The global advocacy for generic and affordable insulin production should continue and would help to curtail diabetes and its complications, including amputations. The American Diabetes Association, patient advocacy groups, amputation-prevention groups, civil society, and social uplift groups need to make insulin access a key platform. Insulin is not a cure, but regular access helps to prevent many of the disabling complications of diabetes that disproportionately impact African Americans and minorities in the USA, and the socioeconomically poor worldwide.

### Protectionism

#### IP protections have been used to protect US pharma to exploit vulnerable states

**Sell 95** Sell, Susan K. “Intellectual Property Protection and Antitrust in the Developing World: Crisis, Coercion, and Choice.” International Organization, vol. 49, no. 2, [MIT Press, University of Wisconsin Press, Cambridge University Press, International Organization Foundation], 1995, pp. 315–49, http://www.jstor.org/stable/2706974.

American policymakers learned through systematic bilateral consultations that a coercive strategy was more promising. The United States tightened this linkage between trade and intellectual property through its amendments to the Trade and Tariff Act in 1984 and again in 1988. It now can swiftly retaliate with trade sanctions in the event that targeted countries fail adequately to protect its intellectual property. The link between U.S. power and the move toward the market by developing countries is the U.S. ability to exploit the vulnerability of targeted states. The United States possesses considerable market power, and access to the U.S. market is critical for many developing countries. In response to the economic crisis of the early 1980s, developing countries increasingly have tipped the balance away from import-substituting industrialization toward export-led strategies. The debt crisis, the perceived exhaustion of models of import-substituting industrialization, and the success of the East Asian countries all have contributed to this export-led shift. Therefore, access to northern markets has become more important. Tables 1-4 illustrate the extent of targeted developing countries' vulnerability to U.S. trade threats. Table 1 shows the value of selected developing countries' exports as a percentage of their gross domestic product (GDP) between 1982 and 1992. Table 2 shows the dollar value of these countries' exports to the United States. Table 3 indicates the percentage of selected developing countries' trade conducted with the United States. With the lone exception of China, the United States is the largest importer for each of these countries' goods. By contrast, as illustrated in Table 4, only two of the targeted states, Mexico and South Korea, rank in the top ten trading partners for the United States (ranked third and sixth, respectively). Therefore, these countries are far more dependent on trade with the United States than the United States is on them. By the mid-1980s, the U.S. market absorbed more than half of Latin American exports and one-third of exports from East Asia. Thus, the United States has significant potential leverage over these countries. As Alan Sykes points out, "If access to the U.S. market is restricted, the target nation cannot readily make up the losses by redirecting its exports."9 The United States has wielded its market power through Section 301 of the Trade Act, which allows it to threaten trade retaliation for inadequate intellectual property protection to induce policy changes in targeted states. Section 301 of the Trade Act of 1974 gives the President power to enforce U.S. rights under trade agreements or to eliminate policies and practices that discriminate or impose unjustifiable burdens on U.S. commerce. The act also permits industries, trade associations, and individual companies to petition the United States Trade Representative (USTR) to investigate actions of foreign governments. If the USTR decides to investigate, the first step is consultation with the foreign government to try to resolve the problem. If these efforts fail, within a year (in all but subsidies cases, for which a shorter time period is mandated) the USTR recommends appropriate action to the President. This appropriate action often consists of the threat of retaliation via trade sanctions. After pressure from the private sector, the United States also linked generalized system of preferences (GSP) benefits, which grant preferential market access for developing countries, to the effective protection of intellectual property.

#### Failure to comply to the US’s IP regime causes retaliation. Violators are coerced into increasing IP protections. Brazil and Mexico prove:

**Sell 03** Sell, Susan K. Private Power, Public Law: The Globalization of Intellectual Property Rights. Cambridge University Press, 2003.

In 1987 the PMA initiated a case against Brazil for its lack of patent protection for pharmaceutical products. This was the first case that resulted in trade retaliation by the United States under the 301 provisions. After Brazil refused to alter its policy the United States placed a $39 million tariff on imports of Brazilian pharmaceuticals. Brazil filed a GATT complaint over US trade retaliation, but it “withdrew its complaint when the sanctions were dropped [in summer 1990] in exchange for Brazil’s patent commitments” (Mossinghoff, 1991: 77). The United States first invoked the GSP provisions of the 1984 Trade and Tariff Act in a case against Mexico in 1987 and denied Mexico GSP 90 A trade-based approach to IP benefits for Mexico’s failure to offer protection to pharmaceutical products. The Mexican government had long held that the availability of affordable pharmaceuticals was a matter of the public interest. Therefore, it persisted in its refusal to enact pharmaceutical product patent protection, and lost $500 million in GSP benefits (Mossinghoff, 1991: 76).

#### Medical apartheid is the new normal — black people are used as guinea pig test subjects to serve whites in the “innovation” medical community

**Washington**, Harriet A. Medical apartheid : the dark history of medical experimentation on Black Americans from colonial times to the present / Harriet A. Washington Doubleday New York 2006 <http://www.loc.gov/catdir/enhancements/fy0704/2005051873-s.html>

The terrorists’ felling of the World Trade Center towers and concomitant attack upon the Pentagon were followed a month later by anthrax attacks in which five people died and thirteen were sickened.26 When anthrax was found in mail addressed to several congresspersons and contamination was suspected, Congress was immediately shut down and lawmakers fled the buildings, which were immediately closed and sealed, then decontaminated. But at the Brentwood Mail Processing and Distribution Center facility in Washington, D.C., where 92 percent of the 2,646 workers were black, letters contaminated with Bacillus anthracis spores were processed by both machines and human handlers. 27 Four U.S. Postal Service workers at Brentwood fell ill with what was tardily diagnosed as inhalational anthrax; two died. Many African Americans perceived a clear racial disparity in how the black and white victims of the anthrax attacks were treated. Thousands of D.C.-area postal workers may have been exposed to anthrax spores from contaminated letters such as those mailed to Senators Thomas A. Daschle and Patrick Leahy. Although inhaled anthrax is 89 percent fatal, a three-day delay intervened before these workers were treated with a sixty-day course of antibiotics. 28 Afterward, postal workers were offered the same experimental anthrax vaccine that was being tested on U.S. soldiers without their consent, which is discussed in the Epilogue. But instead of a clear recommendation from government physicians, postal workers were told that making the complex decision to risk the experimental vaccine and its possible side effects was their own responsibility. Prominent epidemiologists gave conflicting advice. Some cited the dangers of side effects and other experts stressed the need for additional protection, such as adjunct vaccine to discourage the development of anthrax in the exposed, because the antibiotics offered protection only up to sixty days. But no one had warned the workers that the sixty-day course of antibiotics they accepted would not be sufficient to protect them, and when workers were belatedly told of this and offered the experimental vaccine to supplement the antibiotics, this fed, rather than damped, their suspicions. This offer of a vaccine also seemed to contradict government assurances that the facilities were perfectly safe. When HHS Secretary Tommy Thompson finally officially recommended the vaccine, suspicion reigned among the black staffers that experimentation, not treatment, was the real goal of vaccine administration. The situation was not improved when Washington, D.C., health director Ivan C. A. Walks and Mayor Anthony Williams advised workers to shun the vaccine because of its side effects and unproven efficacy. “There was a public perception that people on Capitol Hill got treated quickly and effectively and lost no one, while the perception at Brentwood was that people were ignored and lost two co-workers,” said Walks. The coverage by Black Enterprise, a highly respected financial magazine, was entitled “Cures for the Privileged?” 29 Nor did the Washington Post shrink from reporting the racial nature of the distrust: Using words like “guinea pigs” and references to the Tuskegee experiments, postal workers, many of whom are African American, said that two times now the Bush administration has relegated them to second-class status. “These are the same guys that told us when the Daschle letter went through that it was perfectly okay to go into Brentwood,” said Azeezaly Jaffer, the Postal Service’s vice president for communications. 30 Meanwhile, four machines at New York City’s Morgan Station Center tested positive for anthrax, prompting the union to demand its closure and decontamination before workers returned. They, too, cited the alacrity with which congressional representatives had been evacuated and Congress was adjourned to nullify the risk of contamination. But the USPS responded with a ten-day supply of Cipro, latex gloves, paper masks, and a refusal to test the employees or to close the facility. “It’s absurd. It’s criminal. There are live spores in these machines,” protested one union representative who refused to return to work. By November, 30 percent of the facility’s employees had joined him in boycotting the postal facilities. In the end, only the machines, not the building, were decontaminated. The New York Area Metro Postal Union’s president, Willie Smith, an astute and plainspoken everyman, laid the case of resentful postal workers, many of them black. “We’re simply asking the post office to close the building and make sure it’s safe,” Smith told the New York Times. “I realize that Morgan employees are not Supreme Court justices or senators or congressmen, but they are God’s children…. They have the same right to life as the aristocrats. No one piece of mail is worth a human life.” It remains to be seen how much of the Defense Department’s Domestic Preparedness Program’s forty-million-dollar allocation for 120 U.S. cities will be used to protect the largely African American postal workers who believe themselves on the front line of domestic bioterrorism threats. 31

### Framing

#### I affirm the resolution, resolved: The member nations of the World Trade Organization ought to reduce intellectual property protections for medicines.

#### ROB: To vote for the debater who best disrupts institutions that bolster and protect anti-blackness

**Breaking down racial scripts is uniquely key. Racial scripts are written not only into the discursive formation of political life, but also rooted in intellectual property.**

Vats 20 Vats, A., 2020. The Color of Creatorship: Intellectual Property, Race, and the Making of Americans. Stanford, CA: Stanford University Press.

Tracing “racial scripts” is a tangible method for understanding America’s racial episteme and how it informs citizenship and creatorship/infringement as discursive formations. Racial scripts are historically grounded and flexible racist logics about racial groups that can be accessed at any time to exclude the original or other people of color.5 They operate as shorthand mechanisms for calling upon dominant American ideals of national identity, patriotism, political economy, and personhood without necessarily explicitly invoking racial categories or colonial logics. In this way, racial scripts can be baked into the seemingly colorblind ideals of American citizenship that, in turn, inform intellectual property law. Examining how intellectual property law operates as a space of racial formation in which the meaning of racial categories evolves over time is a prerequisite to undoing entrenched white privilege and democratizing knowledge production and ownership

**Prefer our model of education. Racial justice comes prior to other questions in debate. Racial justice and intellectual property justice are intricately intertwined. The aff is a necessary step toward attending to the contours of structural inequality.**

Vats 20 Vats, A., 2020. The Color of Creatorship: Intellectual Property, Race, and the Making of Americans. Stanford, CA: Stanford University Press.

Accordingly, addressing intellectual property law’s structural inequalities requires thinking about how these racial evolutions persist in a nation that claims to value all people equally. When marginalized groups are considered to be “aberrations from the ethnoclass of Man”10 contra a white ideal, as Alexander Weheliye writes, they cannot fully occupy the space of creatorship or (intellectual) property ownership until the nation attends to the contours of inequality and exclusion. While Weheliye is commenting on anti-Blackness, his statement is true for all those people of color who are considered outside of the ethnoclass of Man. In the so-called information economy, intellectual property justice is racial justice.

#### IP protection historically hinge on the exclusion and exploitation of black and brown bodies.

**Harris 93** Harris, Cheryl I. “Whiteness as Property.” Harvard Law Review, vol. 106, no. 8, The Harvard Law Review Association, 1993, pp. 1707–91, https://doi.org/10.2307/1341787.

The origins of property rights in the United States are rooted in racial domination. 17 Even in the early years of the country, it was not the concept of race alone that operated to oppress Blacks and Indians; rather, it was the interaction between conceptions of race and property that played a critical role in establishing and maintaining racial and economic subordination. The hyper-exploitation of Black labor was accomplished by treating Black people themselves as objects of property. Race and property were thus conflated by establishing a form of property contingent on race - only Blacks were subjugated as slaves and treated as property. Similarly, the conquest, removal, and extermination of Native American life and culture were ratified by conferring and acknowledging the property rights of whites in Native American land. Only white possession and occupation of land was validated and therefore privileged as a basis for property rights. These distinct forms of exploitation each contributed in varying ways to the construction of whiteness as property.

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