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# **IMPACT: HIV is not solved yet. ARV access is key to solve the issue**

**HIV.gov** 20**21**. [Governmental agency] “Global HIV/AIDS Overview” https://www.hiv.gov/federal-response/pepfar-global-aids/global-hiv-aids-overview

**Despite advances in** our scientific understanding of **HIV** and its **prevention and treatment as well as** years of **significant effort by the global health community** and leading government and civil society organizations, **too many people with HIV** or at risk for HIV still **do not have access to prevention, care, and treatment,** and there is still no cure. Further, the HIV epidemic not only affects the health of individuals, it also impacts households, communities, and the development and economic growth of nations. Many of the countries hardest hit by HIV also suffer from other infectious diseases, food insecurity, and other serious problems

## 9.8 million people aren’t accessing treatment -UNAIDS ‘21

UNAIDS. *2018 GLOBAL HIV STATISTICS*. , 2020.

**37.7 million** [30.2 million–45.1 million] **people globally were living with HIV in 2020.** 1.5 million [1.0 million–2.0 million] people became newly infected with HIV in 2020. **680 000** [480 000–1.0 million] **people died from AIDS-related illnesses** in 2020. **27.5 million** [26.5 million–27.7 million] **people were accessing antiretroviral therapy** in 2020. 79.3 million [55.9 million–110 million] people have become infected with HIV since the start of the epidemic. 36.3 million [27.2 million–47.8 million] people have

**I affirm. I offer the following plan text: the member nations of the WTO ought to remove patent protections on HIV/AIDS related treatments.**

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# **Framework**

#### **I value consequentialism**

#### **Moral rights and wrongs are based on consequences – proves Consequentialism comes first. Johnson ‘85**

Johnson, 85(Conrad D. Johnson, 'The Authority of the Moral Agent', Journal of Philosophy 82, No 8 (August 1985), pp. 391)

If we follow the usual deontological conception, there are also well-known difficulties. If it is simply wrong to kill the innocent, th**e wrongness must** in some way **be connected to** the **consequences**. That an innocent person is killed must be a consequence that has some important bearing on the wrongness of the action; else why be so concerned about the killing of an innocent? Furth**er, if it is wrong in certain cases for the agent to weigh the consequences in deciding whether to kill** or to break a promise, **it is hard to deny that this has some connection to the consequences.** Following one line of thought, it is consequentialist considerations of mistrust that stand behind such restrictions on what the agent may take into account.3 But then again it is hard to deal with that rare case in which the agent can truly claim that his judgement about the consequences is accurate, or, in that

**Thus, my value criterion is minimizing pain and maximizing pleasure Whomever best upholds this should win the debate.**

# **Prefer**

## 1. Actor specificity:

## a. No act-omission distinction—governments are responsible for everything in the public sphere so inaction is implicit authorization of action: they have to say yes/no to bills, which means everything collapses to aggregation.

## b. No intent-foresight distinction – the actions we take are inevitably informed by

## predictions from certain mental states, meaning consequences are a collective part of

## the will.

## c. Actor-specificity comes first since different agents have different ethical standings.

## Takes out util calc indicts since they’re empirically denied and link turns them because

## the alt would be no action.

# **C1: IP Limits Accessibility, leading to new disease variants**

**The TRIPS agreement blocks access to HIV/AID treatments especially for developing countries in global south Agniam ‘11**

Dr. Obijiofor Aginam is a Black academic and advocate, a Senior Research Fellow and Head of Governance for Global Health at the UNU International Institute for Global Health in Kuala Lumpur, and an Adjunct Research Professor of Law at Carleton University (Ottawa, Ontario, Canada). “South-South Cooperation: Intellectual Property and AIDS Medicines - United Nations University.” *Unu.edu*, 2011, unu.edu/publications/articles/south-south-cooperation-intellectual-property-and-aids-medicines.html#info. Accessed 29 Aug. 2021.

**‌**Despite the tremendous increase in access to ARVs, the still-glaringly disproportionate distribution of the mortality and morbidity burdens of AIDS between the poorer and industrialized regions of the world reinforces the “Life versus Profit” debate. **This discourse is important because it pitches profit by pharmaceutical corporations against access to essential medicines by vulnerable populations in developing and least developed countries.** Since AIDS is an incurable-but-treatable disease, the impediments to accessing ARVs by people living with HIV in poor countries are compelling factors that demand a re-assessment of the policy framework for emergent South-South cooperation.This framework would inevitably engage with and confront the normative architecture of global IP regimes, especially the TRIPS Agreement. **Although TRIPS-codified flexibilities have been pursued by a few developing countries, these measures, in the face of the high prevalence of HIV/AIDS among their populations, were either blocked or legally challenged by** some industrialized Member States of **the WTO**. It is not surprising, therefore, that within the first decade of the life of the TRIPS Agreement (1995-2005), initiatives such as the WTO Doha Ministerial Declaration on the TRIPS Agreement and Public Health and the WTO General Council Decision in 2003 emerged — all aimed at balancing the imperatives of intellectual property “rights” and access to life-saving pharmaceutical drugs. In the context of the Doha Declaration and the 2003 Decision, most scholars and commentators have rightly observed that difficult questions still linger on how and when to use TRIPS flexibilities on access to drugs and how to reconcile “conflicting” provisions of intellectual property and human rights treaties. In recent years, the “intellectual property versus access” debate seems to have shifted towards “innovation-plus-access”. This more holistic framework, championed and advocated by civil society and developing countries, is aimed at generating health-driven research and development that would strike a balance between promoting and protecting the right to access medicines, and the inventor’s “right” to profit. This shift, which is captured in the Global Strategy and Plan of Action on Public Health, Innovation and Intellectual Property (GSPoA), adopted at the 2008 World Health Assembly, is being led by health authorities under the auspices of the World Health Organization (WHO). The success and sustainability of this framework, as observed by Ellen ‘t Hoen, will “depend on WHO’s forcefulness and resolve”. Given the history of WHO, which often favors non-binding (soft-law) governance instruments as opposed to legally-binding norms, it is open to debate whether WHO could be resolute enough to push the GSPoA framework to confront the normative architecture of the WTO in a way that satisfies public health and trade-economic-IP interests in a win-win scenario.

**Cost of ARV’s is the barrier to controlling/stopping HIV. Prices for medicines would drop if we reduced IPP**

Fernando **Pascual 2014** [Consultant on HIV Health Policy, Barcelona, Spain]

https://www.intmedpress.com/journals/avt/article.cfm?id=2901&pid=88&sType=AVT

**The cost of** antiretroviral therapy (ART) – mostly determined by the price of **antiretroviral** (ARV) **medicines** and diagnostics, and the cost of service delivery and programme management – **is still an important barrier to successfully controlling** the **HIV** pandemic [**1**,**2**]. Over the past years, efforts to provide access to HIV care at national and international levels have permitted almost 10 million people living with HIV (PLHIV) to start ART, but there are still an estimated 16 million PLHIV eligible according to the 2013 WHO guidelines. More than three-quarters of PLHIV live in low- and middle-income countries [**3**]. International funds so far have been key in enabling this expansion; in 2012 donor money accounted for almost 50% of the resources available for HIV responses in low- and middle-income countries [**4**]. However, despite the international aid and the reduction of drug prices, ARVs account for at least 35% of the total annual treatment cost per patient [**5**]. Achieving the 2011

HIV/AIDS High Level Meeting [**6**] target of 15 million PLHIV on ART by 2015 will require an estimated total cost of at least 6.7 billion USD [**1**].

The increased number of patients requiring ART represents a challenge to many countries as this increasing number of patients will need to be on ART for longer as life expectancy of PLHIV on ART is increasing. Retention in care of patients who initiate therapy will require the use of effective drugs that are better-tolerated and with fewer side effects. This will include developing and using **new ARV drugs** and classes [**3**]. These newer drugs and ARV classes may be more affordable but **are** also **subject to intellectual property (IP) rights.**

In this context, a good understanding of the IP landscape, defined as an overview of patent issues affecting ARVs and other drugs, is key. The objective of this paper is to analyse how patents on ARVs may affect market competition and, in turn, access to ARVs for PLHIV in low- and middle-income countries. It will also look at which mechanisms have been used in the interests of public health and could continue to play important roles in the future.

IP rights are exclusive rights granted to the owner of a variety of ‘creations of the mind’. One particular type of these rights are patents, which are exclusive rights given by law to inventors to make use of, and exploit, their inventions for a limited period of time. Generally speaking, a patent provides the patent owner with the right to decide how – or whether – the inventions can be used by others. The inventor is granted this temporary monopoly in exchange for a full description of how to perform the invention publicly available in the published patent document. Patents are granted by national authorities, mostly patent offices. In some cases, patents are granted by a regional organization. Patents on pharmaceuticals may be applied to active pharmaceutical ingredients (APIs) and, in some cases, their pharmaceutical compositions, or the processes for their manufacture [**7**].

The contemporary rationale behind the patent system is to provide incentives to develop new products and processes through the possibility of getting a high return on research and development (R&D) investment. Innovation in the field of HIV is particularly important, as the virus can develop resistance to existing ARVs over time, thus requiring switch to more effective drugs. In addition, ARVs have become an important part of biomedical prevention strategies, including preexposure prophylaxis and treatment as prevention. Requirements to ensure the availability of ARVs for these multiple purposes depend on the existence of various contextual factors including a solid industrial R&D base, availability of risk capital and profitable commercial opportunities, conditions that are often lacking in many developing countries. In addition to the political environment coupled with the perception that the HIV pandemic was a global threat, market incentives also seem to have worked for the development of new ARVs, with 28 ARVs currently having received regulatory approval by the US Food and Drug administration (US FDA) since 1995. However, patents fall short of stimulating innovation for products needed in developing country markets because the market cannot ensure return on R&D investment [**8**]. A clear example is paediatric HIV, for which there is a very limited market in high-income countries and as a result there is a more limited incentive for private R&D investment in developing paediatric ARVs. A similar case may apply to the development of medicines required for treatment of certain coinfections, which are highly prevalent in resource-limited settings.

Patents are granted and recognized by national or regional patent offices, and they protect an invention in a country or region on the basis of certain criteria: the invention has to be novel, involve an inventive step – or be ‘non-obvious’, as this criterion is known in certain countries – and be industrially applicable or useful [**9**]. National laws govern the enforcement and granting of patents and it is in principle up to the patent offices to decide on the way in which the patentability criteria are applied. However, country members of the World Trade Organization (WTO) have the obligation to comply with international treaties regarding patents, in particular, the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) that set minimum standards on IP rights protection [ **10**].

A patent gives the rights holder, such as a pharmaceutical company, the exclusive right to make, use, sell, export and import, with some limitations, the patented invention. This exclusivity is usually valid for 20 years counted from the date of filing the patent application. This means that, during this period, if a patent is granted, the patent owner has a monopoly over the patented product. They can prevent production and sale from generic producers and delay market competition until patent expiry. They can also choose to enable generic manufacturers to enter the market, for example by issuing voluntary licences to one or more manufacturers.

Medicines were not widely patented in the developing world before the TRIPS Agreement entered into force in 1995 [**10**,**11**]. This agreement established obligations regarding the protection of IP rights, including the obligation on all WTO member countries to accept and enforce, after the end of various transitional periods, patents on industrial goods, including medicines, in accordance with some minimum standards. Currently, only the transitional period for Least Developed Countries (LDCs) is still in force. Importantly, a WTO member that deviates from such standards may be subject, after dispute settlement procedures conducted under WTO rules, to trade retaliations imposed by other WTO members.

As noted, during the lifetime of a patent, **the** **patent holder can limit** market **competition and charge higher prices than those** that would exist **in a competitive environment.** After patent expiry, prices generally drop dramatically as competitors enter the market. **Lower prices** are **essential to make treatment accessible to patients,** particularly **in the developing world**, as illustrated by the progress made in HIV treatment [**10**].

Broad availability of generic drugs, especially in the form of fixed-dose combinations, was key in allowing the rapid increase in the number of PLHIV receiving ART during the past few years. From 2003 to 2008 there was a fourfold increase in the number of Indian generic drugs on the market that represented 80% of the global ARV market [**12**]. Generic competition facilitated a drop in prices of drugs to levels that allowed national HIV programmes to include significantly more PLHIV on ART without an unsustainable increase in health budgets. In addition, the availability of funding from the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) and other bilateral donors, like the US President’s Emergency Plan for AIDS Relief (PEPFAR) helped these countries scale-up the provision of ART. The international community has established as a target to have 15 million people on treatment by 2015 [**6**]. The number of ART-eligible PLHIV will increase to 26 million with the implementation of the new threshold to start ART at a CD4+ T-cell count <500 cells/mm3 as recommended by the 2013 World Health Organization (WHO) consolidated guidelines [**13**]. The WHO seems to be progressively moving towards a ‘test and treat’ strategy that will imply treating all patients regardless of CD4+ T-cell count. A number of studies have suggested the mid- to long-term cost-effectiveness of this strategy [**14**], but once implemented in countries it could have a short-term effect of increasing drug budgets, unless more affordable and optimized drug regimens are widely available.

## IP protections also prevent development of generic drugs that can save the lives of the poor – the status quo secures the interests of multinationals.

**Shah 10** (Anup: editor, health writer; "Pharmaceutical Corporations and Medical Research — Global Issues"; 10-2-2010; Global Issues; http://www.globalissues.org/article/52/pharmaceutical-corporations-and-medical-research; DT)

Ideologically, many **drug companies support the position of less government involvement, yet in the developing world in particular, diseases and illnesses affect the poorest the most who cannot afford expensive** (or even sometimes cheap) **treatments**. In the past decade or so, pharmaceutical companies have therefore also been criticized for ignoring this “market” because they can’t pay. [M]any people, most of them in tropical countries of the Third World, die of preventable, curable diseases.… Malaria, tuberculosis, acute lower-respiratory infections—in 1998, these claimed 6.1 million lives. People died because the drugs to treat those illnesses are nonexistent or are no longer effective. **They died because it doesn’t pay to keep them alive**. — Ken Silverstein, Millions for Viagra, Pennies for Diseases of the Poor, The Nation, July 19, 1999 Public announcements of drug donations to poor countries are often welcome, but sometimes the details reveal murkier intentions; some of the drugs are close to, or even past, their expiry date (and are expensive to dispose, adding more costs to recipient countries) for example. **Poorer countries encourage their drug companies to make cheaper generic alternatives to expensive branded ones or use other tools available at their disposal to help bring the price of medicines down to more affordable levels**. But **they face immense pressure from international institutions and multinational pharmaceutical corporations, even when generics and other options pursued are legitimate under international rules**. For these **multinationals**, **they’ve poured billions into some of these drugs and therefore want a patent system that will protect their investments for as long as possible. For the developing and poorer countries, as remote as these issues may seem, patents and intellectual property rights issues can mean life or death**. (For example, **at the end of the 1990s, the pharmaceutical industry lobbied the US government to threaten sanctions on South Africa for trying to produce generic drugs to fight** its growing **AIDS** problem. It took huge public outcry to get the case dropped some 2 years later.) The establishment of the World Trade Organization … imposed US style intellectual property rights around the world. These rights were intended to reduce access to generic medicines and they succeeded. Developing countries paid a high price for this agreement. But what have they received in return? **Drug companies spend more on advertising and marketing than on research, more on research on lifestyle drugs than on life saving drugs, and almost nothing on diseases that affect developing countries only. This is not surprising. Poor people cannot afford drugs, and drug companies make investments that yield the highest returns.** The chief executive of Novartis, a drug company with a history of social responsibility, said “We have no model which would [meet] the need for new drugs in a sustainable way … You can’t expect for profit organizations to do this on a large scale.” — Joseph Stiglitz (former World Bank Chief Economist and Nobel Prize winner for economics), Scrooge and intellectual property rights, British Medical Journal, December 23, 2006, Volume 333, pp. 1279-1280 These and many other issues are discussed further below.

**Pharma companies don’t direct enough money into R&D as they still haven't found a cure but don’t care enough about HIV/AIDS.**

**EZEKIEL J. EMANUEL, MARCH 23, 2019, The Atlantic, “Big Pharma’s Go-To Defense of Soaring Drug Prices Doesn’t Add Up”**

[**https://www.theatlantic.com/health/archive/2019/03/drug-prices-high-cost-research-and-development/585253/f**](https://www.theatlantic.com/health/archive/2019/03/drug-prices-high-cost-research-and-development/585253/f)**unding goes towards profits.**

**The most telling data on a disconnect between drug prices and research costs has received almost no public attention. Peter Bach, a researcher at Memorial Sloan Kettering, and his colleagues compared prices of the top 20 best-selling drugs in the United States to the prices in Europe and Canada. They found that the cumulative revenue from the price difference on just these 20 drugs more than covers all the drug research and development costs conducted by the 15 drug companies that make those drugs—and then some. To be more precise, after accounting for the costs of all research—about $80 billion a year—drug companies had $40 billion more from the top 20 drugs alone, all of which went straight to profits, not research. More excess profit comes from the next 100 or 200 brand-name drugs.**

**HIV has the highest mutation rate of all biological entities**

**Cuevas. (2015)** “High Mutation Rates of HIV-1 in the Human Body | Immunopaedia.” *Immunopaedia.org*, 2015, www.immunopaedia.org.za/breaking-news/2016-articles/what-causes-the-high-mutation-rates-of-hiv-1-in-the-human-body/#:~:text=In%20the%20most%20recent%20PloS.

**In the most recent PloS Biology, Cuevas and colleagues quantify the HIV-1 genome-wide rate of spontaneous mutation in DNA sequences from peripheral blood mononuclear cells. They reveal a mutation rate 4 × 10−3 per base per cell, which is the highest reported mutation rate for any biological entity. When they sequenced plasma-derived HIV-1, they found the mutation rate was 44 times lower: “indicating that a large fraction of viral genomes are lethally mutated and fail to reach plasma.”**

**The longer we wait to stop HIV, the more likely it is that HIV will mutate and develop drug resistance, because retroviruses have high mutation rates. These mutations lead to superbug creation. We need to stop HIV now to prevent.**

Kayla M. **Peck 18** [Division of Infectious Diseases, Department of Internal Medicine, University of Michigan] “Complexities of Viral Mutation Rates” 2018

https://journals.asm.org/doi/10.1128/JVI.01031-17

The higher per-site mutation rates of RNA viruses can be explained in part by the RNA-dependent RNA polymerases (RdRp) that replicate their genomes. Unlike many DNA polymerases, RdRp do not have proofreading activity and are thus unable to correct mistakes during replication. Notable exceptions are members of the *Nidovirales*family, including coronaviruses, toroviruses, and roniviruses, which have an RdRp-independent proofreading activity and thus lower mutation rates. This proofreading is thought to be a key factor in explaining how these viruses have much larger genomes (>26 kb) compared to other RNA viruses (7). **Retroviruses also have high mutation rates, because reverse transcriptase**, like most RdRp, **lacks proofreading activity**. Finally, for unclear reasons, single-stranded viruses tend to mutate more rapidly than double-stranded viruses, causing some single-stranded DNA (ssDNA) viruses to have rates comparable to those of double-stranded RNA (dsRNA) viruses (Fig. 1A) (5).

Mutation rates determine the amount of genetic variation generated in a population, which is the material upon which natural selection can act. For this reason, a **higher mutation rate correlates with a higher evolutionary rate**, but only to a point (Fig. 1Aand B). While the high mutation rates of retroviruses and RNA viruses may explain their higher evolutionary rates relative to those of DNA viruses, several DNA viruses exhibit evolutionary rates comparable to those of RNA viruses (3, 5). This highlights the importance of additional factors in determining the evolutionary rate, such as within-host dynamics (4) or cell tropism (8). Overall, **mutation rates are important, because they determine the probability that a mutation conferring drug resistance,** antibody escape, or expanded host range **will arise**. Additionally, mutation rates can determine whether a virus population will be susceptible to drug-induced lethal mutagenesis (9).

https://amr-review.org/sites/default/files/160525\_Final%20paper\_with%20cover.pdf JIM **O’NEILL 16** “Tackling Drug-Resistant Infections Globally: Final Report and Recommendations” May 2016

**Our ability to cure infections** that were once considered benign **is already damaged**. For instance, the r**apid development of drug-resistant strains** of gonorrhoea combined with the fact that we do not have a rapid diagnostic test to guide doctors’ choice of prescription, means we are down to using our ‘last line’ antibiotic to treat gonorrhoea**4**. After this antibiotic fails, there are no more treatment options on the shelf. For other infections, **doctors running out of better options** are **using antibiotics** that were once **avoided due to their bad side effects**. This is the case with colistin, for example, which can cause kidney failure and so was never given to patients for many years. Over the past decade however, it has re-entered use as a last resort treatment for patients with particularly hard-to-treat Gram-negative bacterial infections**5**, and already colistin resistance is emerging. The economic impact is also already material. In the US alone, more than two million infections a year are caused by bacteria that are resistant to at least first-line antibiotic treatments**6**, costing the US health system 20 billion USD in excess costs each year**7**. This challenge **will only get worse in the future if we do not act now**. Based on scenarios of rising drug resistance for six pathogens to 2050, we estimated that **unless action is taken,** the burden of **deaths from AMR** could **balloon to 10 million lives each year by 2050**, at a cumulative **cost to global economic output of 100 trillion USD**. On this basis, by 2050, the **death toll** could be a **staggering one person every three seconds** and each person in the world today will be more than 10,000 USD worse off**8**. It is impossible to predict the path of emerging drug resistance, but it is a trend that has largely run only in one direction so far. What we can be certain of is that, in the absence of interventions to slow the emergence of resistance, and increase the supply of new antibiotics, **the impacts** will be **felt** not just in isolated areas but at a far more fundamental level, **across our societies and healthcare systems.**

**As** the **antibiotics** available to us **become less effective**, so the **risks of many treatments** which rely upon antibiotics **becomes higher**. This will progressively undermine the viability of interventions that many may not directly associate with antibiotics. Cancer **chemotherapy** or **organ transplantation** are just two examples of medical treatments that leave the patient highly vulnerable to bacterial infections. Most **invasive surgery** (particularly ‘dirty’ procedures, such as those involving the gut) is today routinely and dependably ‘de-risked’ by effective antibiotic prophylaxis and by the availability of reliable therapy for infections that do occur despite best practices. Intubated **patients in intensive care facilities** already experience very high rates of infection, including drug-resistant ones, as a result of the ventilation that they receive – and **the mortality risk associated** with this **will rise further if treatment options for such**

**infections deplete**. These **secondary impacts** are difficult to quantify but they **threaten to dramatically change healthcare as we know it today.**

**Cutler**, David M., and Lawrence H. Summers. “The COVID-19 Pandemic and the $16 Trillion Virus.” *JAMA*, vol. 324, no. 15, 12 Oct. 20**20**, 10.1001/jama.2020.19759.

The estimated cumulative financial costs of the COVID-19 pandemic related to the lost output and health reduction are shown in the [Table](https://jamanetwork.com/journals/jama/fullarticle/2771764#jvp200215t1). The total cost is estimated at more than $16 trillion, or approximately 90% of the annual gross domestic product of the US. For a family of 4, the estimated loss would be nearly $200 000. Approximately half of this amount is the lost income from the COVID-19–induced recession; the remainder is the economic effects of shorter and less healthy life.

Output losses of this magnitude are immense. The **lost output in the Great Recession was** only **one-quarter** as large. The e**conomic loss is more than twice** the total monetary outlay for **all the wars the US has fought since September 11, 2001**, including those in Afghanistan, Iraq, and Syria. By another metric, this cost is approximately the estimate of damages (such as from decreased agricultural productivity and more frequent severe weather events) from 50 years of climate change.

**Look to this pandemic as an example for what will happen in the next thirty years if research and development does not improve and cure HIV/AIDS mutations. The damage to the economy will cause WW3**

Qian **Liu 18**. China-based economist. “From economic crisis to World War III.” Project Syndicate. 11/8/2018.

https://www.project-syndicate.org/commentary/economic-crisis-military-conflict-or-structural-reform-by-qian-liu-2018-11

The next economic crisis is closer than you think. But what you should really worry about is what comes after: in the **current social, political, and technological landscape**, a **prolonged economic crisis**, combined with rising income inequality, could well escalate into a **major global military conflict**. The 2008-09 global financial crisis almost bankrupted governments and caused systemic collapse. Policymakers managed to pull the global economy back from the brink, using massive monetary stimulus, including **q**uantitative **e**asing and near-zero (or even negative) interest rates. But monetary stimulus is like an adrenaline shot to jump-start an arrested heart; it can revive the patient, but it does nothing to cure the disease. Treating a sick economy requires structural reforms, which can cover everything from financial and labour markets to tax systems, fertility patterns, and education policies. Policymakers have utterly failed to pursue such reforms, despite promising to do so. Instead, they have remained preoccupied with politics. From Italy to Germany, forming and sustaining governments now seems to take more time than actual governing. Greece, for example, has relied on money from international creditors to keep its head (barely) above water, rather than genuinely reforming its pension system or improving its business environment. The lack of structural reform has meant that the unprecedented excess liquidity that central banks injected into their economies was not allocated to its most efficient uses. Instead, it raised global asset prices to levels even higher than those prevailing before 2008. In the United States, housing prices are now 8% higher than they were at the peak of the property bubble in 2006, according to the property website Zillow. The price-to-earnings (CAPE) ratio, which measures whether stock-market prices are within a reasonable range, is now higher than it was both in 2008 and at the start of the Great Depression in 1929. As monetary tightening reveals the vulnerabilities in the real economy, the collapse of asset-price bubbles will trigger another economic crisis – one that could be even more severe than the last, because we have built up a tolerance to our strongest macroeconomic medications. A decade of regular adrenaline shots, in the form of ultra-low interest rates and unconventional monetary policies, has severely depleted their power to stabilise and stimulate the economy. If history is any guide, the consequences of this mistake could extend far beyond the economy. According to Harvard’s Benjamin Friedman, **prolonged periods of economic distress** have been characterised also by public antipathy toward minority groups or foreign countries – attitudes that can help to **fuel unrest**, **terrorism**, or even **war**. For example, during the Great Depression, US President Herbert Hoover signed the 1930 **Smoot-Hawley** Tariff Act, intended to protect American workers and farmers from foreign competition. In the subsequent five years, global trade shrank by two-thirds. Within a decade, **World War II** had begun. To be sure, WWII, like World War I, was caused by a multitude of factors; there is no standard path to war. But there is reason to believe that high levels of inequality can play a significant role in stoking conflict. According to research by the economist Thomas **Piketty**, a spike in income inequality is often followed by a great crisis. Income inequality then declines for a while, before rising again, until a new peak – and a new disaster. Though causality has yet to be proven, given the limited number of data points, this correlation should not be taken lightly, especially with wealth and income inequality at historically high levels. This is all the more worrying in view of the numerous other factors stoking social unrest and diplomatic tension, including technological disruption, a record-breaking migration crisis, anxiety over globalisation, political polarisation, and rising nationalism. All are symptoms of failed policies that could turn out to be trigger points for a future crisis. Voters have good reason to be frustrated, but the emotionally appealing **populists** to whom they are increasingly giving their support are offering ill-advised solutions that will **only make matters worse**. For example, despite the world’s unprecedented interconnectedness, **multilateralism is increasingly being eschewed**, as countries – most notably, Donald J. Trump’s US – pursue unilateral, isolationist policies. Meanwhile, **proxy wars** are **raging in Syria and Yemen**. Against this background, we must take seriously the possibility that the **next economic crisis could lead to a large-scale military confrontation**. By the logic of the political scientist Samuel Huntington, considering such a scenario could help us avoid it because it would force us to take action. In this case, the key will be for policymakers to pursue the structural reforms that they have long promised while replacing finger-pointing and antagonism with a sensible and respectful global dialogue. The alternative may well be global conflagration.

**Conventional war means extinction, even without nukes.**

**Dvorsky 12** George Dvorsky, 12-12-2012, "9 Ways Humanity Could Bring About Its Own Destruction," [Dvorsky is a Canadian bioethicist, transhumanist and futurist. He is a contributing editor at io9[1] and producer of the Sentient Developments blog and podcast. He was Chair of the Board for the Institute for Ethics and Emerging Technologies (IEET)[2][3] and is the founder and chair of the IEET's Rights of Non-Human Persons Program,[4] a group that is working to secure human-equivalent rights and protections for highly sapient animals. He also serves on the Advisory Council of METI (Messaging Extraterrestrial Intelligence). Bio from https://en.wikipedia.org/wiki/George\_Dvorsky]

https://io9.gizmodo.com/9-ways-humanity-could-bring-about-its-own-destruction-5967660, SJBE

**World War III At the close of the Second World War, nearly 2.5% of the human population had perished**. Of the 70 million people who were killed, about 20 million died from starvation. And disturbingly, civilians accounted for nearly 50 percent of all deaths — a stark indication that war isn't just for soldiers any more. **Given the incredible degree to which technology has advanced in the nearly seven decades since this war, it's reasonable to assume that the next global ‘conventional war' — i.e. one fought without nuclear weapons — would be near apocalyptic in scope. The degree of human suffering that could be unleashed would easily surpass anything that came before it, with combatants using many of the technologies already described in this list, including autonomous killing machines and weaponized nanotechnology. And in various acts of desperation (or sheer malevolence), some belligerent nations could choose to unleash chemical and biological agents that would result in countless deaths. And like WWII, food could be used as a weapon; agricultural yields could be brought to a grinding halt.** Thankfully, we're a far ways off from this possibly. **Though not guaranteed, the global conflicts of the 20th century may have been an historical anomaly — one now greatly mitigated by the presence of nuclear arms.**

# C2: fixes relations, also decreasing likelihood of war

**Walt ‘20**, Walt, Stephen M. “Why Is the United States so Bad at Foreign Policy?”

*Foreign Policy*, 13 Jan. 2020,https://foreignpolicy.com/2020/01/13/trump-iran-china-why-united-states-so-bad-foreign-policy/

**Trump abandoned the Trans-Pacific Partnership, a slap in the face to the 11 Asia-Pacific countries that had worked hard to reach an agreement that would have provided some modest economic benefits and kept them more closely linked to the U.S. economy. Then Trump launched his own trade war with China. But instead of lining up other key economic powers, he threatened or waged trade wars with most of them, too. Instead of presenting China with a united front, the United States has been facing China more or less alone, with substantially reduced leverage. The predictable result: a face-saving trade compromise that rolls back the clock and no progress on the real bones of contention with Beijing.**

**A reduction in IPP for ARV’s comes across as US health aid, which develops strong relations with developing countries.**

Eran **Bendavid 19** [*communications manager for the Center for Health Policy/Center for Primary Care and Outcomes Research.*] “Foreign aid for public health bolsters America’s ‘soft power’” 2019 https://med.stanford.edu/news/all-news/2019/05/foreign-aid-for-public-health-bolsters-americas soft-power.html

**U.S.** government **aid** for treating children and adults with HIV and malaria in developing countries has done more than expand access to lifesaving interventions: It **has changed how people around the world view the United States**, according to a new study by researchers at the Stanford University School of Medicine.

Compared with other types of foreign aid, **investing in health is uniquely associated with a better opinion of the U**nited **S**tates, **improving** its “**soft power” and standing in the world**, the study said.

**Favorability ratings of** the **U**nited **S**tates **increased in proportion to health aid** from 2002 to 2016 and rose sharply after the implementation of the President’s Emergency Plan for AIDS Relief in 2003 and the launch of the President’s Malaria Initiative in 2005, the researchers reported.

Their findings were published online May 16 in the *American Journal of Public Health*. The lead author is postdoctoral scholar Aleksandra Jakubowski, PhD, MPH. The senior author is Eran Bendavid, professor of medicine.

“Using data on aid and opinions of the United States, we found that **investments in health** offer a unique opportunity to **promote the perceptions of the U**nited **S**tates **abroad**, in addition to disease burden relief,” the authors wrote. “Our study provides new evidence to support the notion that **health diplomacy** is a **net win** for the United States and recipient countries alike.”

The Trump administration, however, has proposed a 23% cut in foreign aid in its 2020 budget, including large reductions to programs that fight AIDS and malaria overseas.

The Stanford researchers believe their study is the first to add heft to the argument that U.S. health aid boosts the “soft power” that wins the hearts and minds of foreign friends and foes.

“Our study shows that **investing in health aid** improves our nation’s standing abroad, which could **have important downstream diplomatic benefits** to the United States,” Jakubowski said. “Investments in health aid help the United States **accumulate soft power.** Allowing the U.S. reputation to falter would be contrary to our own interests.”

**Health diplomacy’s key to global cooperation that solves multiple existential threats**

**James 17**, Wilmot James, Honorary Professor in the Division of Human Genetics at the University of Cape Town's Medical School and Non-residential Senior Fellow at Bard College’s Hannah Arendt Centre, Ph.D. from University of Wisconsin at Madison, “In an Age of Zika and a Threat of Biochemical Terror, Health Security Must Be Everybody’s Concern”, Daily Maverick, 4-2, [https://www.dailymaverick.co.za/article/2017-04-02-op-ed-in-an-age-of-zika-and-a-threat-of-biochemica l-terror-health-security-must-be-everybodys-concern/#.WOY8xTvDHHw](https://www.dailymaverick.co.za/article/2017-04-02-op-ed-in-an-age-of-zika-and-a-threat-of-biochemical-terror-health-security-must-be-everybodys-concern/#.WOY8xTvDHHw) [language modified]

With Zika there too was political failure to act quickly, give honest advice and confront the abortion conundrum head-on, the result being that 3,000 and likely more children with microcephaly will test the emotional resilience and financial resources of their families to breaking point.We should never cease to invest in the public health and medical science of disease, but it seems to me that our fundamental problem is not the quality of the health sciences but the grim mediocrity of our politics. Party-political bickering for short-term gain paralyses and drains the national effort in South Africa as much as it does in the United States, undermining our ability to see with compelling clarity the solutions the issues of the day deserve.Health security is humanity’s shared concern. Promoting health and preventing death define us at our most altruistic and advanced. The Hippocratic Ideal, the concept of the physician as the guardian of human health, encapsulates a fundamental human quality common to all the world’s great religions. Medicine is one of the earliest and greatest human achievements because it is a co-operative enterprise involving highly skilled individuals; and it is **as a result of cooperation** – and our unusual ability for complex language – that cumulative **civilisation is possible**. In the age of globalisation, it is health security, a recent Lancet editorial stated, that “is **now the most important foreign policy issue of our time**”. The rapid emergence and re-emergence of **pathogenic infectious disease**, of which Zika is the most recent, the slow but steady cumulative acts of nature associated with **climate change**, **high-risk forced migration** caused by desperation and war, the creeping reality of **biochemical [use]** ~~terror~~ and the threat of **nuclear war**, propel **human survival** and well-being to the frontline of what today must be everybody’s concern. The field of **health diplomacy** provides an **unprecedented opportunity** to build human solidarity. It is an area of human endeavour that **cuts through inherited antagonisms**. Governments that offer health improvements as part of aid to nations with whom they wish to **develop stronger diplomatic links** succeed in cultivating deeper cultural relationships precisely because of their direct benefit to citizens. To advance health diplomacy requires health leaders with an inclusive global vision...

**The aff has five different impacts: 1st. We solve HIV/AIDS pandemic occurring in status quo, 2nd stop creation of superbugs that will lead to extinction, 3rd stop collapse of healthcare system, 4th stop war through helping keep the economy stable, and 5th stop war through increased diplomatic relations.**

**Underview**

**1AR Theory – a] the aff gets it because otherwise the 1NC could engage in unchecked, infinite abuse which outweighs anything else,**

**b] it’s drop the debater because the 2AR is too short to win a shell AND substance so theory can only check abuse for the aff if it’s a win condition,**

**c] no neg RVI because otherwise they could dump in the 2nr for 6 minutes and get away with anything by sheer brute force,**

**d) competing interps because you have 6 minutes to respond to my 1ar arguments so you should have to prove a better model**

**e) Aff theory first – it’s a much larger strategic loss because 1min is ¼ of the 1AR vs 1/7 of the 1NC which means there’s more abuse if I’m devoting a larger fraction of time.**

**For these reasons, I strongly urge a vote for the affirmation**

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# **Definitions**

**Ought: a moral obligation or duty,** (according to Cambridge Dictionary)

#### **A patent,**( according to the WIPO)**, is**

(https://www.wipo.int/patents/en/faq\_patents.html)

A patent is an exclusive right granted for an invention. In other words, a patent is **an exclusive right to a product or a process** that generally provides a new way of doing something, or offers a new technical solution to a problem. To get a patent, technical information about the invention must be disclosed to the public in a patent application.

Merriam Webster defines “Antiretroviral” as- acting, used, or effective against

Retroviruses

**HIV/AIDS related treatments include: Antiretroviral therapies, pre exposure prophylaxis, liposomal amphotericin , and combination medicines according to the CDC**

#### **For clarification: IP stands for intellectual property and ARV stands for antiretrovirals**

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# Takeaways:

1. Life-saving medicines for the HIV/AIDS epidemic are not accessible to the global south
2. Decreasing IP protections decreases cost, which increases accessibility to global south
3. We need to solve now, to prevent new variants of HIV/AIDS that will increase rate of death exponentially
4. It is important to cultivate global cooperation in order to solve.

#### d we take instead? How do we incentivize drug makers to undertake the hefty R&D costs to develop new vaccines without giving them exclusive rights over their production and sale? The most effective approach during a public health crisis is direct government support: public funding of R&D, advance purchase commitments by the government to buy large numbers of doses at set prices, and other, related payouts. And when we pay drug makers, we should not hesitate to pay generously, even extravagantly: we want to offer drug companies big profits so that they prioritize this work above everything else, and so that they are ready and eager to come to the rescue again the next time there’s a crisis.

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#### **On innovation turn, econ recovery and more are swamping invest now**

#### **Langley 4/21 [(Kare, reporter for The Wall Street Journal in New York, where she primarily covers the U.S. stock market), “Biotech Stocks Fall Out of Favor After Disappointing Trial Results, Big Rally “, WSJ, 4/21/2021,** [**https://www.wsj.com/amp/articles/biotech-stocks-fall-out-of-favor-after-disappointing-trial-results-big-rally-11619016330**](https://www.wsj.com/amp/articles/biotech-stocks-fall-out-of-favor-after-disappointing-trial-results-big-rally-11619016330)**] ¶**

#### **Shares of Sarepta Therapeutics Inc., Amicus Therapeutics Inc. and Frequency Therapeutics Inc. are among the recent losers for biotech investors, having lost more than half their value so far this year. “It’s felt like a kitchen sink in terms of the number of factors weighing on biotech sentiment in the near term,” said Andy Acker, who manages the Janus Henderson Global Life Sciences Fund. Among those are disappointing clinical trials, concern about the possibility of renewed focus on drug prices in Washington and the recent rotation into economically sensitive stocks. Biotech shares enjoyed a powerful rally last year. The Nasdaq biotech gauge soared 26% in 2020 on excitement about the potential for Covid-19 treatments and vaccines as well as a broader rally in shares of companies that can perform when the economy is struggling. The S&P 500, meanwhile, gained 16% last year, and the Nasdaq Composite surged 44%. Rapid gains or losses in share prices following clinical-trial results or regulatory decisions are a feature of biotech investing, but a smattering of negative news has damped enthusiasm in recent months. Shares of Sarepta Therapeutics plunged 51% on Jan. 8 after mixed results from a study of a drug targeting a form of muscular dystrophy. The shares are now down 58% for the year. Amicus Therapeutics shares dropped 33% on Feb. 12 after trial results for its treatment of a rare disorder called Pompe disease disappointed investors. And shares of Frequency Therapeutics plunged 78% on March 23 after the company found its lead drug aimed at treating sensorineural hearing loss didn’t lead to any hearing benefit when given in a four-dose schedule. Those stocks are down 57% and 72%, respectively, this year. Also weighing on sentiment: The Federal Trade Commission has indicated it is preparing to take a harder line on drug-company mergers, which are a source of potential value for investors in small biotech shops. The commission in March said it would reconsider its approach to scrutinizing deals that could harm competition. “Biotech can be driven by mergers,’ said Jeremie Capron, director of research at ROBO Global, a research and investment-advisory firm. “A change at the FTC, it reduces the probability of a favorable outcome in terms of an acquisition.” Analysts will also be keeping an eye on any efforts in Washington to reduce drug prices. Some investors are betting against companies in the industry. Biotech stocks accounted for five of the 10 most-shorted stocks on U.S. exchanges at the end of March, according to S&P Global Market Intelligence. Short interest in Esperion Therapeutics Inc.stood at 34% of shares outstanding as of March 31, followed by Clovis Oncology Inc. at 31% and Inovio Pharmaceuticals Inc. at 26%, an S&P analysis showed. As Covid-19 vaccines reach more people and the economy picks up, investors have favored shares of banks, energy producers and other companies that tend to do well in a strong economy. They have been less interested in stocks that hold out the prospect of innovation-driven growth in fields like technology and biotech. Expectations of a strong recovery have also been seen in the bond market, where falling prices lifted the yield on the benchmark 10-year U.S. Treasury note to 1.566% on Wednesday from 0.913% at the end of last year. As yields climb, borrowing costs for businesses also rise. That often lands hard on biotech companies, where hefty bills for research and development can arrive long before revenue.**

#### **TURN US Government Produced COVID-19 Vaccine Success frank,dach and lurie ‘21 (government funds)**

**The success of the US COVID-19 vaccine effort didn’t happen on its own; it was enabled by decades of long-term investments by the federal government, followed by additional federal investment in the development of the COVID-19 vaccines themselves. The government invested extensively in every aspect of the basic science, preclinical development, and clinical trials for the vaccines; it executed procurement contracts that were critical to creating successful vaccines and ensuring they were available to the US public. In the case of vaccines in general, the government often plays an outsized role, but in the era of COVID-19 the government’s role was even more central than usual. The government essentially removed the bulk of traditional industry risks related to vaccine development: a) scientific failures, b) failures to demonstrate safety and efficacy, c) manufacturing risks; and d) market risks related to low demand. Since 2000, taxpayer dollars have financed the development of various vaccine platforms for HIV, pandemic flu, and other threats to public health. In response to the COVID-19 pandemic, the government leveraged investments in those platforms in three ways. First, it supported additional preclinical studies. Second, it absorbed the bulk of human testing costs and risk through a set of contracts that paid for the various phases of vaccine development and manufacturing. And third, it reduced manufacturing risk by underwriting capacity investments.**

#### **A2 COVID solved**

**Innovation has only increased and spread to western countries. The pandemic has done nothing for developing countries.**

***Berger, Miriam. “Global Vaccine Inequality Runs Deep. Some Countries Say Intellectual Property Rights Are Part of the Problem.” The Washington Post, WP Company, 23 Feb. 2021, www.washingtonpost.com/world/2021/02/20/poor-countries-arent-getting-vaccines-waiving-intellectual-property-rights-could-help/.***

**Berger ‘21**

**On the other side are** [**South Africa and India**](https://www.doctorswithoutborders.org/what-we-do/news-stories/news/india-and-south-africa-propose-no-patents-covid-19-medicines-and-tools)**, leading the charge on behalf of the vast number of countries without any — or a limited supply of — vaccine doses and other equipment for fighting the virus.** They argue that **the rest of the world cannot keep waiting for the lifesaving shots, which Western countries have monopolized by buying up existing supplies and pre-purchasing future rounds.**

Fidler, however, disagreed that intellectual property rights represent an immediate impediment to vaccine access. In the short term, he said, the issue is not simply that production is constrained because only certain companies, and under certain restrictions, can make vaccines. Rather, it’s that **Western countries have monopolized current and future supplies by buying up and pre-purchasing doses at rates other countries cannot afford.**