# Generic AC

**I Affirm the resolution Resolved: The member nations of the World Trade Organization ought to reduce intellectual property protections for medicines.**

**One obv before going on to FW**

**since the resolution uses the word reduce instead of eliminate all negative arguments that are in the context of the aff removing all IP protections are not topical to the round since that is not what the affirmative is advocating for**

## FW

#### Value- Justice defined as giving each their due

**prefer justice because**

**Justice is a prior question to all values because we need to know what is due to us as individuals before we can prescribe what the state should value**

#### Thus, the Criteria is Utilitarianism defined as doing what is best for the most amount of people

**Prefer Util because**

#### It is the best way for states to create policies.

Goodin 90, Robert Goodin, fellow in philosophy, Australian National Defense University, THE UTILITARIAN RESPONSE, 1990, p. 141-2

My larger argument turns on the proposition that there is something special about **the situation of public officials** that **makes utilitarianism more probable** for them than private individuals. Before proceeding with the large argument, I must therefore say what it is that makes it so special about public officials and their situations that make it both more necessary and more desirable for them to adopt a more credible form of utilitarianism. Consider, first, the argument from necessity. **Public officials are obliged to make their choices under uncertainty**, and uncertainty of a very special sort at that. All choices – public and private alike – are made under some degree of uncertainty, of course. But in the nature of things, private individuals will usually have more complete information on the peculiarities of their own circumstances and on the ramifications that alternative possible choices might have for them. **Public officials**, in contrast, are relatively poorly informed as to the effects that their choices will have on individuals, one by one. What they typically do **know** are generalities: **averages and aggregates. They know what will happen most often to most people as a result of their** various **possible choices, but that is all. That is enough to allow public policy-makers to use** the **utilitarian calculus** – assuming they want to use it at all – to chose general rules or conduct.

## C1 Generic Drugs

#### **Patents are given to Big Pharma to keep generic drugs off the market for a limited time**

O’Connor 18 (Kevin O’Connor) **How patents play a role in drug pricing Kevin O’Connor is a partner at Neal, Gerber & Eisenberg in the Intellectual Property practice. He has a PhD in neuroscience from the University of Colorado.** [**https://www.thepharmaletter.com/author/kevin-o-connor 8/12/21**](https://www.thepharmaletter.com/author/kevin-o-connor%208/12/21) **TR**

The cost of prescription drugs is at the forefront of discussions among patients, advocacy groups, prescribers, payers, pharmaceutical companies, and policy makers. One factor – though not the only factor – in driving the cost of prescription drugs is the availability of competing products. Certain **competing products, such as generic or biosimilar versions of approved drugs, are not immediately available as a result of the market exclusivities granted to the innovator company by the federal government in the form of** exclusive marketing rights and/or **patent rights.** The rationale for granting such market exclusivities is to incentivize innovation and development of new, better, and/or safer prescription drugs. The single largest cost to a pharmaceutical company in developing a new drug is securing regulatory approval, which entails conducting several clinical studies to demonstrate that the drug is safe and effective. Even conservative estimates of the cost to develop a new prescription drug are in the range of $500 million to $1 billion. See, eg, Prasad & Mailankody, JAMA Intern Med. 2017;177(11):1569-1575. The Tufts Center for the Study of Drug Development estimated that the average pre-tax industry cost per new prescription drug approval at $2.6 billion. Though the various estimates differ in methodology (eg, whether opportunity costs or the cost of failed candidates are factors or not), it is undeniable that the quest to bring a new drug to market is a costly undertaking. **Both the regulatory and patent exclusivities are limited in time in order to further promote progress and foster competition upon their expiration.** Exclusive marketing rights granted by Food and Drug Administration are set by statute: 5 years for a new small molecule and 12 years for a new biologic product. These time periods were attempts by Congress to balance the incentive for the innovator company to develop and seek approval of new drugs with the desire to facilitate generic or biosimilar competition following the period of exclusivity. Similarly, the foundation of the patent system is a balance of interests between the public and the patentee. **The patentee, in exchange for public disclosure of the invention, receives the right of exclusivity for a limited time – 20 years from the date on which the application for the patent was filed.** The term of certain patents may be extended for up to five years to, in part, make up for the reduction of the effective patent life caused by the regulatory approval process. Nevertheless, by the time most new drugs are approved, the patents covering the drug molecule often have less than 12 years left on their term due to the years required for development, clinical studies, and regulatory review.

#### **However even after the 20 year mark Big Pharma continues to extend their patents by using loopholes in the patent system**

Glasgow 02 (Lara J. Glasgow) **STRETCHING THE LIMITS OF INTELLECTUAL PROPERTY RIGHTS: HAS THE PHARMACEUTICAL INDUSTRY GONE TOO FAR?** No BIO cited [https://ipmall.law.unh.edu/sites/default/files/hosted\_resources/IDEA/2.Glasgow01.pdf 8/8/21](https://ipmall.law.unh.edu/sites/default/files/hosted_resources/IDEA/2.Glasgow01.pdf%208/8/21) TR

**An**other **effective** and relatively unscrutinized **strategy employed** by brand name drug companies **is the layering of patents and combining of drugs leading to the grant of new patents.** **By securing patents on different aspects of the same drug,** the **manufacturers can ensure that the drug will not go “off-patent**” for purposes of the Hatch-Waxman Act.126 Brand name pharmaceutical companies now patent the process of manufacturing the raw material, the medical indications to which the drug can be applied, the formulation of the medicine, and the metabolites resulting from the enzymatic degradation of the parent drug by the body.127 **These patents are applied for over a staggered period of time so that there is a new patent being issued as an old one nears expiration, a practice known as “layering.”**128 This sets the original drug manufacturer in a position to initiate patent litigation should a generic drug manufacturer attempt to apply for marketing approval from the FDA.129 **Drug companies can additionally use the grant of new patents on what are essentially old drugs as a marketing tool to disguise the** likely **motivation behind the new patent.** Consider the example of Prozac, the "medication whose name has become almost shorthand for antidepressant."130 The FDA recently approved a new once-a-week version of the drug after Eli Lilly & Company, the drug's manufacturer, submitted data from clinical trials indicating that the new version demonstrated comparable efficacy for people who had been taking the old version of the drug, in addition to similar side effect profiles.131 While it is true that the new version of Prozac has some beneficial qualities over the old version, namely convenience for the consumer, some experts have voiced their opinion concerning Eli Lilly's true motivation

#### **Having high levels of patent protection creates medicine shortages that can only be resolved by generic drugs which patents block**

Oxfam NO DATE (Oxfam) **Intellectual property and access to medicine** **Oxfam is a confederation of 20 independent charitable organizations focusing on the alleviation of global poverty, founded in 1942 and led by Oxfam International. It is a major nonprofit group with an extensive collection of operations.** [**https://www.oxfamamerica.org/explore/issues/economic-well-being/intellectual-property-and-access-to-medicine/**](https://www.oxfamamerica.org/explore/issues/economic-well-being/intellectual-property-and-access-to-medicine/) **8/8/21 TR**

intellectual property (IP) has different forms; **in the case of access to medicines**, we are talking about patents. Patents are a public policy instrument aimed at stimulating innovation. By providing a monopoly through a patent—which gives inventors an economic advantage—governments seek to provide an incentive for R&D. At the same time, the public benefits from technological advancement. This trade-off underpins patent systems everywhere. Governments need to maintain an appropriate balance between incentivizing innovation, on the one hand, and, on the other, ensuring that new products are widely available. **High levels of IP protection in developing countries exacerbate**, rather than help solve**, the problem of access to affordable medicines.** **Extensive patent protection for new medicines delays the onset of generic competition.** **And** because **generic competition is the only proven method of reducing medicine prices in a sustainable way**, such high levels of IP protection are extremely damaging to public health outcomes. A word on background: The 1994 TRIPS Agreement represented the single greatest expansion of IP protection in history, but it also includes a range of public health safeguards and flexibilities, which were reinforced by the 2001 Doha Declaration on the TRIPS Agreement and Public Health. Yet US trade agreements over the past decade have sought to redefine and even undermine the Doha Declaration, as FTAs have included provisions that curb governments’ ability to use the health safeguards in TRIPS and have mandated higher levels of IP protection. These provisions block or delay the onset of generic competition, keeping medicine prices high. Higher treatment costs are devastating to poor people, and they undermine the sustainability of public health programs—particularly in low- and middle-income countries, where public finance for health care is limited and most patients pay for medicines out of pocket. **A 2010 study by a Peruvian government entity** (the Director General of Medicines, Supply and Drugs, or DIGEMID) **revealed** this stark reality: **the monthly cost of** one key **patented medicine needed to treat head and neck cancer is equivalent to 880 times the daily minimum wage in Peru**, **an amount that would take a worker more than two years to earn**, without a single day off. **The** TPP **[Protected Propterty] would** not only **undermine the efforts of other countries to protect public health,** but would also undermine US efforts to improve access to health care around the world. **Thanks to the cost savings from use of generics, PEPFAR** **(the President’s Emergency Plan for AIDS Relief)** has **successfully initiated treatment for more than three million people worldwide, and saved $380 million in 2010 alone.**

#### **Without Generic drugs Medicine shortages Spark Clinical consequences**

Phuong et al 19 (Jonathan Phuong) “**The impacts of medication shortages on patient outcomes: A scoping review” Jonathan Phuong: Sydney Pharmacy School, Faculty of Medicine and Health, University of Sydney, Sydney, Australia** [**https://pubmed.ncbi.nlm.nih.gov/31050671/**](https://pubmed.ncbi.nlm.nih.gov/31050671/) **8/25/21 TR**

The **results of this review demonstrate that medication shortages are a complex, global phenomenon, which affects patients' economic, clinical, and humanistic outcomes.** While drug shortages have been reported to be a global issue which are reported by 99% of pharmacists each year [[19](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6499468/#pone.0215837.ref019)], there were only 40 studies gained from our comprehensive search strategy which reported patient outcomes that met inclusion criteria for review. The reasons for such underreporting may be due to the problem being so ubiquitous that no one has ever really questioned it, or that drug shortages are a new phenomenon which has not yet been fully explored, or that clinician time is spent dealing with workarounds, and time for research, audits, documentation and follow-up is not available. Even though research evidence of patient consequence may be an underreported phenomenon, this review highlighted that regardless of the medicine that was in short supply, the majority of patient outcomes resulting from the shortage were disadvantageous to patients’ clinical, economic and humanistic outcomes. **With respect to economic outcomes,** these were only reported in five studies. This could be attributed to lack of economic data generated as the majority of studies focused on clinical outcomes and used retrospective chart analysis for information. **Economically, drug shortages in all reported instances increased** OOP **costs for patients. These increased costs were attributed to factors such as switching brand of the same medicine, switching to an alternative medicine, and expenses such as fuel for travelling further distances to acquire medicines.** Patient OOP expenses were the only economic outcome reported, perhaps this may be due to health research being biased towards clinical outcomes or that it is difficult to capture the actual economic cost of drug shortages. No studies reported other economic outcomes such as productivity costs (e.g. time off work) or cost-utility, demonstrating that there may be a lack of sophistication in analysing the actual economic impact that shortages have on patients [[53](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6499468/#pone.0215837.ref053)]. It should be noted that **other economic considerations were reported in some studies such as institutional costs. One institution reported having to pay 300–500% more for shortage medicines** [[46](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6499468/#pone.0215837.ref046)], another reported having to pay up to 1704% more for an alternative agent [[40](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6499468/#pone.0215837.ref040)]. Furthermore, studies reported having to have dedicated staff to manage shortages [[30](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6499468/#pone.0215837.ref030)]. As many of these studies were from the USA, it is unknown if or how these costs would be passed onto the patients directly or their insurance companies and affect premiums and as these other economic considerations were not reported to affect patients directly, we can only theorise their impacts. Furthermore, different countries have different healthcare systems, where the costs of access to medicines during times of shortage may vary. **Clinical outcomes were reported in the majority of studies**. However, these were generally retrospective reviews of data from patient records. Data gathered via this medium included specific patient outcomes related to the treatment, such as rates of infection or seizures. Other outcomes such as adverse drug reactions and drug errors were also often gathered via this retrospective audit of notes. Utilising this modality may have its limitations, as clinical documentation may not always be complete [[54](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6499468/#pone.0215837.ref054)]. For example, studies which reported only on adverse events did not give a full depiction as to whether the alternative treatments were beneficial in treating the primary condition [[38](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6499468/#pone.0215837.ref038), [39](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6499468/#pone.0215837.ref039)]. The other method utilised to report the clinical outcomes of drug shortages were self-report mainly from clinicians via survey or semi-structured interviews. These data collection methods may also lead to a problematic interpretation of the actual impact of the medication shortages on patient outcomes, as they may generate recall bias, particularly if participants were surveyed some-time after the shortage. Furthermore, survey questions may be leading, inflating the perceived outcomes of the shortage, also, these methods are only reporting perceptions of the impact of the shortage on the patient from the lens of the health professional and not from the patients themselves. Rates of adverse events were reported in 20 studies. **The majority of reports indicated an increase in adverse events such as increased toxicity of the alternative treatment.** Interestingly, two studies reporting on the impact of piperacillin-tazobactam shortages on secondary *Clostridium difficile* infection and had conflicting results. One study reported an increased rate of *Clostridium difficile* infection [[38](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6499468/#pone.0215837.ref038)], whereas the other, a decrease [[39](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6499468/#pone.0215837.ref039)]. The changes in infection rate and adverse events may be attributed to the alternative therapy used, rather than the shortage itself. Thus, in order to use data from shortages, comprehensive clinical documentation is needed to guide future research and treatment protocols, particularly if improved responses to alternative treatments are reported. Interestingly, many of the studies reviewed were regarding drug shortages of antimicrobials or oncology medicines. These shortages may be more likely to be studied, due to the perceived importance placed on these medicines. However due to the heterogenous reporting of patient outcomes across studies, few comparisons of results can be compared. Drug shortages were also associated with increased medication errors. This was attributed to factors such as unfamiliarity with alternative agents. **Pharmacy staff noted in a 2003 study reporting on 109 shortages at one institute that in 54% of shortages clinicians may be unfamiliar with the alternative product regarding its mechanism of action, adverse effects, or interactions** [[55](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6499468/#pone.0215837.ref055)]. **Lack of medication availability causing death is the most severe consequence of drug shortages and mortality was reported in 18 studies. Some of these studies reported few deaths, whereas others could attribute hundreds.** In a 5-year retrospective cohort study of 27,835 patients with septic shock during a norepinephrine shortage, alternative vasopressor use resulted in an increased mortality of 3.7% (p = 0.3) [[30](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6499468/#pone.0215837.ref030)]. In contrast to this long-term comparative study, others directly gathered physician perspectives on the relationships between drug shortages and mortality. This was the case in the study by Abdelrahman et al. where approximately 1/3 of physicians stated that shortages caused death, 1/3 said they did not, and 1/3 responded neutrally on the survey tool [[36](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6499468/#pone.0215837.ref036)]. These heterogeneous methods used to report the impact of shortages, again making it difficult to draw firm conclusions on true impacts, and more comprehensive studies comparing those receiving no drug, or alternative treatment are required to highlight the full clinical consequence of shortages. In addition to clinical and economic outcomes, it has been stated that health care is more than just treating a condition, and humanistic outcomes such as quality of life is also an important measure of successful health care [[56](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6499468/#pone.0215837.ref056)]. However, in our review, we found only ten studies which reported humanistic outcomes. These studies reported patients having difficulty accessing their medications, patients complaining to health professionals about drug shortages, patients having to be transferred to other facilities to find suitable health care, and patients being anxious and distressed**.** One study used a quantitative tool to measure QOL during a clobazam shortage and reported no significant difference [[22](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6499468/#pone.0215837.ref022)]. However, within the same study, there were extracts from patient interviews which suggest otherwise. Previous literature has also reported that often QOL tools may not be sensitive enough to capture the true impact of an intervention on the patient and that other tools measuring humanistic outcomes may need to be developed [[56](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6499468/#pone.0215837.ref056)]. It is doubtful that this review captured the entire range of humanistic impacts of drug shortages, however, those reported predominantly seem to be negatively affecting the patient. Further research investigating humanistic outcomes and the patients’ perspective of how drug shortages affect them is warranted in order to create holistic solutions to the shortage problem.

#### To avoid future medicine shortages the WTO should have a one and done approach to patents

Feldman 19 (Robin Feldmen) **‘One-and-done’ for new drugs could cut patent thickets and boost generic competition Robin Feldman is a law professor, researcher, and author best known for her contributions to intellectual property and health care law.** [**https://www.statnews.com/2019/02/11/drug-patent-protection-one-done/**](https://www.statnews.com/2019/02/11/drug-patent-protection-one-done/) **TR 8/10/21**

**I believe that one period of protection should be enough.** **We should make the** legal **changes necessary to prevent companies from building patent walls and piling up mountains of rights. This could be accomplished by a “one-and-done” approach for patent protection.** Under it, **a drug would receive just one period of exclusivity, and no more.** The choice of which “one” could be left entirely in the hands of the pharmaceutical company, with the election made when the FDA approves the drug. Perhaps development of the drug went swiftly and smoothly, so the remaining life of one of the drug’s patents is of greatest value. Perhaps development languished, so designation as an orphan drug or some other benefit would bring greater reward. The choice would be up to the company itself, based on its own calculation of the maximum benefit. The result, however, is that a pharmaceutical company chooses whether its period of exclusivity would be a patent, an orphan drug designation, a period of data exclusivity (in which no generic is allowed to use the original drug’s safety and effectiveness data), or something else — but not all of the above and more..

## C2 Covid

#### **In the status quo developing countries don’t have access to vaccines because of IP protections**

Dyer 20 (Owen Dyer) “**Covid-19: Many poor countries will see almost no vaccine next year, aid groups warn” Owen Dyer is a freelance journalist who has written news and features for newspapers and for medical journals including the BMJ and Canadian Medical Association Journal. He has no health-related investments, grants, or other competing interests.** [**https://www.bmj.com/content/371/bmj.m4809**](https://www.bmj.com/content/371/bmj.m4809) **TR 8/26/21**

**At least 90% of people in 67 low income countries stand little chance of getting vaccinated** against covid-19 **in 2021** **because wealthy nations have reserved more than they need and developers will not share their intellectual property**, says the People’s Vaccine Alliance, which includes Amnesty International, Frontline AIDS, Global Justice Now, and Oxfam.[**1**](https://www.bmj.com/content/371/bmj.m4809#ref-1) “**Unless something changes dramatically, billions of people around the world will not receive a safe and effective vaccine for covid-19 for years** to come,” said Anna Marriott, Oxfam’s health policy manager**. Rich countries with only 14% of the world’s population have bought up 53% of the eight most promising vaccines**, the alliance said, including all of the Moderna vaccine doses expected to be produced over the next year and 96% of the Pfizer-BioNTech vaccine doses. Oxford University and AstraZeneca have pledged to distribute 64% of their vaccine in developing nations, but at best this will reach only 18% of the world’s population next year, the alliance said. Mohga Kamal Yanni, a physician speaking for the People’s Vaccine Alliance, said, “**Rich countries have enough doses to vaccinate everyone nearly three times over, whilst poor countries don’t even have enough to reach health workers and people at risk.**

#### **The WTO Continues to block a push to waive patent right on covid-19**

Blenkinsop 21 (Phillip Blekinsop) “**Rich, developing nations wrangle over COVID vaccine patents” Phillip Blenkinsop is a writer for Reuters** [**https://www.reuters.com/article/us-health-coronavirus-wto/rich-developing-nations-wrangle-over-covid-vaccine-patents-idUSKBN2B21V9**](https://www.reuters.com/article/us-health-coronavirus-wto/rich-developing-nations-wrangle-over-covid-vaccine-patents-idUSKBN2B21V9) **TR 8/26/21**

**Rich**er **members of the** World Trade Organization **(WTO)** **blocked a push by over 80 developing countries** on Wednesday **to waive patent rights in an effort to boost production of COVID-19 vaccines for poor nations.** South Africa and India renewed their bid to waive rules of the WTO’s Trade-Related Aspects of Intellectual Property (TRIPS) agreement, a move that could allow generic or other manufacturers to make more vaccines. **South Africa argued the current TRIPS system does not work, pointing to the failure to secure life-saving medicines during the HIV/AIDS pandemic that had cost at least 11 million African lives.** Medecins Sans Frontieres in October put together a letter signed by over 375 civil society organisations supporting the waiver. **The South Africa and India proposal was backed by dozens of** largely **developing countries** at the WTO, **but opposed by Western countries,** including Britain, Switzerland, EU nations and the United States, **which have large domestic pharmaceutical industries.** India is a major manufacturer of generics, although **many of the largest generic companies are based in Western and developed countries,** including Viatris, Sandoz and Teva.

#### **The WTO should waive their patients on covid-19 vaccines because it would increase the number of people vaccinated and re-open economies**

Bhalla 21 (Nita Bhalla) **Africans slam rich nations for blocking access to generic COVID vaccines Nita Bhalla covers disasters and conflicts, development, womens rights, climate change and governance.** [**https://www.reuters.com/article/us-health-coronavirus-africa-vaccines/africans-slam-rich-nations-for-blocking-access-to-generic-covid-vaccines-idUSKBN2B32P9 8/11/21**](https://www.reuters.com/article/us-health-coronavirus-africa-vaccines/africans-slam-rich-nations-for-blocking-access-to-generic-covid-vaccines-idUSKBN2B32P9%208/11/21) **TR**

**Charities in Africa slammed rich nations** on Thursday **for blocking efforts to waive patents for COVID-19 vaccines, saying this would prolong the pandemic for years in poorer nations** and push millions across the continent deeper into poverty. More than 40 charities**,** including Amnesty International and Christian Aid,saidWednesday’s [the] move by Western nations to prevent generic or other manufacturers making more vaccines in poorer nations was “an affront on people’s right to healthcare.” **Peter Kamalingin, Oxfam** International’s **Africa director, said sub-Saharan Africa - 14% of the global population - had received only 0.2% of 300 million vaccine doses administered worldwide.** “**Ensuring every African can get a safe and effective COVID-19 vaccine ... is the most effective way to save lives and livelihoods, keep our children in school, reduce unemployment rates and re-open our economies,”** he told a news conference. “Without it, gains made by African countries on issues of food security, democratic governance, gender justice and women’s rights will be reversed completely.” Richer members of the World Trade Organization (WTO) blocked a push by some 80 developing countries - led by India and South Africa - to waive its Trade-Related Aspects of Intellectual Property (TRIPS)agreement rules on patents. **The move sent a message that African lives were less important than those of people in rich nations,** Kamalingin said.

**There are 2 major Impacts**

#### **First Access to vaccines reduces cases and deaths the U.S proves**

Johnson and Stobbe 21 (Carla Johnson and Mike Stobbe) “**Nearly all COVID deaths in US are now among unvaccinated” Carla K. Johnson (@CarlaKJohnson) is a medical writer at The Associated Press and has covered health and medicine since 2001. A former member of AHCJ's board of directors, she leads the Chicago AHCJ chapter. Mike Stobbe is a national medical correspondent for The Associated Press and is based in New York City. He covers the CDC and writes on a range of health and medical topics. He has a doctorate in public health policy and administration from the University of North Carolina.** [**https://apnews.com/article/coronavirus-pandemic-health-941fcf43d9731c76c16e7354f5d5e187**](https://apnews.com/article/coronavirus-pandemic-health-941fcf43d9731c76c16e7354f5d5e187) **TR 8/26/21**

**Nearly all COVID-19 deaths in the U.S. now are** in **people who weren’t vaccinated**, a staggering demonstration of how effective the shots have been and an indication that **deaths per day — now down to under 300 — could be practically zero if everyone eligible got the vaccine.** An **Associated Press analysis** of available government data from May **shows that “breakthrough” infections in fully vaccinated people accounted for fewer than 1,200 of more than 107,000 COVID-19 hospitalizations. That’s about 1.1%. And only about 150 of the more than 18,000 COVID-19 deaths in May were in fully vaccinated people.** That translates to about 0.8%, or five deaths per day on average. The AP analyzed figures provided by the Centers for Disease Control and Prevention. The CDC itself has not estimated what percentage of hospitalizations and deaths are in fully vaccinated people, citing limitations in the data. Among them: Only about 45 states report breakthrough infections, and some are more aggressive than others in looking for such cases. So the data probably understates such infections, CDC officials said. Still, the overall trend that emerges from the data echoes what many health care authorities are seeing around the country and what top experts are saying. Earlier this month, Andy Slavitt, a former adviser to the Biden administration on COVID-19, suggested that 98% to 99% of the Americans dying of the coronavirus are unvaccinated. And CDC Director Dr. Rochelle Walensky said on Tuesday that the vaccine is so effective that “nearly every death, especially among adults, due to COVID-19, is, at this point, entirely preventable.” She called such deaths “particularly tragic.” **Deaths in the U.S. have plummeted from a peak of more than 3,400 day on average in mid-January, one month into the vaccination drive.**

#### Secondly Re-opening economies is the up most importance to avoid further medical based deaths. Long term Economic recession causes thousands of deaths due to poor health systems Brazil proves

Hone et al 19 (Thomas Hone) “Effect of economic recession and impact of health and social protection expenditures on adult mortality: a longitudinal analysis of 5565 Brazilian municipalities” Correspondence to: Dr Thomas Hone, Public Health Policy Evaluation Unit, School of Public Health, Imperial College London, London W6 8RP, UK <https://www.thelancet.com/journals/langlo/article/PIIS2214-109X(19)30409-7/fulltext> TR 8/26/21

**This study finds that the 2012–16 economic recession in Brazil was countercyclically associated with adult mortality. Increases in unemployment between 2012 and 2017 were associated with more than 30 000 additional deaths,** mainly from cancer and cardiovascular disease. **The largest increases in mortality were observed in black and mixed race populations,** men, and individuals aged 30–59 years. Considering that these populations generally have poorer health than women and white Brazilians**, it is likely the economic recession increased existing health inequalities.** Municipalities with higher expenditures on health and social protection programmes had lower or no unemployment-associated increases in mortality. The countercyclical association identified between recession and mortality contradicts the associations identified in many studies done in high-income countries; however, other Latin American studies have shown increases in overall mortality during recession, especially in the poorest areas. This difference could result from multiple factors. Similar to many other Latin American and middle-income countries, sizeable health and socioeconomic inequalities exist in Brazil, which has weaker health-care and social protection systems and more precarious job markets than high-income countries. Thus, the level of exposure to the negative effects of recession and unemployment might be higher in Brazilian populations than individuals in high-income countries. In 2017, 37·3 million Brazilians (40·8% of the labour force) were employed in informal jobs, earning on average 48·5% of the income of individuals employed in formal jobs. Lower income, greater risk of poverty-related poor health, and increased psychosocial stress could have contributed to increases in mortality during recession. Unemployment has known negative health effects. The finding that mortality increased to a greater extent among black and mixed race Brazilians than white Brazilians during the 2014–16 recession is concordant with previous evidence that black and mixed race Brazilians are more likely to be in informal employment than white Brazilians (46·9% vs 33·7% ), have lower incomes than white Brazilians employed in the same role, are at higher risk of falling into poverty, and have a greater need for investment in health and social protection programmes. In the USA, evidence also shows the health of men, black individuals, and Hispanic individuals, and individuals with lower education is most affected by economic recession. **The 2014–16 economic crisis in Brazil has had a negative effect on health-care access, which** might partly **explain our findings. During the recession, delays in paying medical staff, medicine shortages, and clinic closures were widely reported.** Assessment of the long-term trends in health-care funding and changes in health service availability following the recession will be an important area for future research when data become available. Notably, increases in unemployment were not associated with increases in mortality in municipalities with higher health-care and social protection spending, which is consistent with research from North America and Europe. Evidence from the 2008 recession across European countries has highlighted the importance of social protection expenditure in negating recession-related mortality. **Evidence also suggests that universal health coverage and social protection expenditures are important for reducing the harmful effects of unemployment on mortality** The association between increased mortality from neoplasms and unemployment might be surprising, but is concordant with global studies, which argue that declining income and socioeconomic status increase barriers to accessing care. However, increases in cardiovascular diseases mortality contrasts with the findings of studies from high-income countries. The mechanisms that contribute to decreases in cardiovascular diseases mortality during recession in high-income countries are unclear, but are possibly due to declining working hours, increased time spent on healthy activities, and less participation in unhealthy behaviours (ie, drinking, smoking, and unhealthy diets). In Brazil, similar to other middle-income countries, these pathways might be less important since **precarious employment can reduce an individual's ability to purchase medicines, unemployment might result in the loss of private insurance, healthy and unhealthy behaviours might be less linked to the economic cycle than in high-income countries, and health service inadequacies** (eg, delays in providing medicines ) **are likely to also be greater.** The decreases in unintentional injury mortality (majority road traffic injuries) associated with higher unemployment in black and mixed race individuals, men, and individuals of working age is consistent with studies from Europe, and generally explained by reduced car use during recession.

**In Conclusion without available medicines to all those that are living in functioning societies the world will continue to trap itself in global health crises which is a violation of Justice and of what people are due by their governments under the utilitarian calculus, thus I must affirm**

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