# NC

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

## 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 innovation

#### Patents are the prerequisite to medical innovation

Roin 9 [Benjamin Roin, Assistant Professor of Technological Innovation at MIT, 02-2009, “Unpatentable Drugs and the Standards of Patentability,” Texas Law Review, https://www-proquest-com.ezproxy.library.unlv.edu/docview/203704797?pq-origsite=primo]/Kankee

II. Background: Patents and Pharmaceutical Innovation **Pharmaceutical innovation is** often seen as **the** golden child **of the patent system,** with patents taking credit for the discovery and development of valuable new drugs that provide tremendous health benefits to the public.4 The purpose of the patent system is to encourage socially valuable investments in R&D that firms would not otherwise make due to the profit-eroding effects of competition. In the pharmaceutical industry, **firms must invest hundreds of millions** of dollars **in clinical trials** on their drugs before they can be sold to the public, **while their generic rivals are exempted** from those requirements and can enter the market at low cost. Without some way to delay generic competition, therefore, pharmaceutical companies would usually find it impossible to recoup their R&D investments and would likely invest their money elsewhere. With strong patent protection, however, firms can expect to enjoy a lengthy monopoly over their drugs, providing them an opportunity to profit from their investment in R&D. Although the public suffers from high prices for drugs while they are covered by a patent, most of those drugs probably would not have been developed without that protection. As a result, it is widely thought that the benefits of drug patents far outweigh their costs. The economic function of the patent system is to promote the creation, development, and commercialization of inventions.5 Successful innovation can be of great value to society, but it often requires significant investments in R&D.6 The public relies on private industry to provide most of that investment,7 and unless firms expect to profit from their R&D efforts, they are likely to spend their money on something else. Appropriating the returns from an R&D investment can be difficult in a competitive market since other firms may be able to imitate successful inventions without incurring the same costs and risks.8 The resulting price competition can undermine the original inventors' profits as competitors free ride off of their efforts. The patent system is an attempt to preserve the incentive to invest in R&D that would otherwise be vulnerable to free riding by awarding inventors temporary exclusive rights to make, use, and sell their inventions, thereby protecting them from the profit-eroding effects of competition.9 Although patent-law scholars typically focus on the role of patents in promoting inventive activity,10 patents can be equally important in encourag- ing investment in the subsequent development and commercialization of inventions." The idea for an invention is usually of little value to the public until it has been turned into a marketable product,12 and the process of doing so can be both risky and expensive. Indeed, the cost and risk of bringing an invention to market is often much greater than that faced during the initial research that gave rise to the invention.13 If competitors can produce and sell copies of the invention while avoiding its development and commercializa- tion costs, then there may be little or no incentive for firms to ever bring that invention to market. Under these circumstances, a patent can be essential for the investment that enables the practical use of an invention - a fact known to economists for at least 100 years.14 Even when patents are unnecessary for motivating the creation of an invention, therefore, they can still be critical for encouraging the subsequent investment in its development. Of course, not all inventions need a patent to incent their development and commercialization.15 In many cases the costs and risks of getting an invention to market are relatively small, and the inherent lead-time advantage that the inventors will enjoy over competitors is sufficient for them to recoup their R&D investments.16 In other cases patents are unnecessary for motivating post-invention spending because those investments are not vulnerable to free riding. For example, a firm might be willing to build an expensive new manufacturing plant to produce an unpatented invention because competitors would have to make the same investment in building their own plant before they could launch an imitation product.17 Additionally, on some occasions the underlying invention does not need a patent because the efforts to develop and commercialize it give rise to their own patentable invention,18 which can make it difficult for competitors to capitalize on the innovative firm's post-invention expenses.19 In any of these situations, the absence of patent protection for an invention may not deter its development. For some inventions, however, patents do play an essential role in promoting development and commercialization, and drugs are a clear example.20 **Pharmaceutical companies** on average **spend** upwards of $**800 million on R&D** for each new drug that reaches the market.21 Roughly half of that money is spent satisfying the FDA's clinical-trial requirements to establish the safety and efficacy of new drugs,22 producing data that cannot be protected with patents.23 Meanwhile, generics are exempted from the FDA's clinical-trial requirements and enter the market based on the clinicaltrial data submitted by the original pharmaceutical company.24 As a result, **generic-drug manufacturers spend** on average **only about $2 million** on the approval process.25 Once they are on the market, **those drugs** dramatically reduce **the sales of (and profits from) the brand-name drugs** **they imitate**.26 Pharmaceutical companies therefore rely on a lengthy period of market exclusivity to recoup their investments in developing new drugs. With strong patent protection, they are usually able to keep generics off the market for somewhere between ten and fourteen years27 and will invest hundreds of million of dollars in R&D in anticipation of this reward.28 For this reason, scholars often view drug development as "the paradigm of patents spurring innovation."29 Relying on the patent system to promote pharmaceutical innovation admittedly has its costs, since patents allow manufacturers to charge premium prices for their products.30 Although pharmaceutical companies sink vast sums of money into R&D of new drugs, the actual costs of manufacturing those drugs is usually quite low.31 Generic drugs are sold at prices that reflect these lower production costs, whereas patented drugs are priced much higher.32 When a drug is patented, therefore, some consumers who would be willing to buy it at the generic price are forced out of the market, and they must wait until the patent on the drug expires before benefiting from its use. Economists refer to this harm as deadweight loss, and it is a problem inherent in the patent system.33 With pharmaceuticals, the deadweight loss caused by patent protection is especially troubling because some people must forgo the use of drugs that would improve their health and sometimes even save their lives.34 Although the temporary high prices that result from patent protection are a significant problem, the benefits of the patent system can sometimes outweigh these costs. The public may suffer for a time from the higher prices charged for a patented invention, but that harm is necessarily smaller than the injury that would result if no one ever created or developed the invention in the first place, or if it had taken much longer for the invention to reach the public. As a rule of thumb, therefore, patents are socially desirable when, in their absence, the public would not otherwise benefit from the invention or there would be a substantial delay in the public's receipt of that benefit.35 The pharmaceutical industry is probably the best example of where patents are socially desirable under this rule of thumb because patents appear to be a prerequisite for the vast majority of pharmaceutical innovation.36 **Given** their **high R&D costs** compared to those of their generic rivals, **pharmaceutical companies** rely on **lengthy periods of market exclusivity**normally ten or more years for the drugs currently developed- **to support their investments** in bringing drugs to market.37 Not surprisingly, firms in the industry consistently report that patent protection is essential to their efforts to discover and develop new drugs.38 Moreover, it is well known that **pharmaceutical companies generally** refuse **to develop new drugs unless they have strong patent protection** over them.39 Indeed, drug researchers who work in government and academia report that when they are looking for partners in private industry to fund the development of the drugs they discover, it is almost impossible to attract interest unless the drugs are patented.40 Some scholars even worry that the patent system may be too effective at promoting pharmaceutical innovation,41 although the available evidence indicates that society's investment in pharmaceutical R&D continues to generate substantial positive returns. In theory, the patent system could be harming the public by causing wasteful and duplicative R&D in "patent races."42 In the case of pharmaceuticals, however, numerous economic studies have found that the social benefits produced by new medical technologies signifi- cantly outweigh the costs of society's investment in medical R&D.43 According to one estimate, the average new drug launch in the United States increases average life expectancy among the U.S. population by about one week, leading to a cost-effectiveness ratio for pharmaceutical R&D spending of $6,750 for each additional year of life saved.44 Since most studies put the value of a year of life at $75,000 to $150,000,45 the social return on pharma- ceutical R&D investments appears to be extraordinarily high.46 This is not to say that all investments in pharmaceutical R&D are beneficial, because some of that spending goes toward drugs that fail to complete the FDA's clinical- trial requirements,47 drugs that offer little or no therapeutic advantage over existing drugs,48 and sometimes even drugs that do more harm than good,49 such as the now-infamous pain reliever Vioxx®.50 On the whole, however, society's investments in discovering and developing new drugs seem to yield substantial net benefits. The discussion above demonstrates why the case for the patent system is at its strongest in the pharmaceutical industry: innovation in the field is incredibly valuable to society and most of it would not occur without the patent system.51 Indeed, it is considered well established that the availability of patent protection for drugs improves social welfare.52 This is not to say that the patent system is perfect; no one questions that the public suffers greatly from high drug prices. At the moment, however, the public depends on the patent system to promote pharmaceutical innovation, and the public usually benefits when the system is successful in that task. III. The Patentability Standards for Pharmaceuticals: Rewarding the Invention of Drugs but Not Their Development

**There are 2 Huge Impacts to why innovation incentives are important**

#### First. Without innovation incentives, Diseases continue to get ignored in developing countries

Soyeju and Wabwire 18 [Olufemi Soyeju, Lecturer at Lagos State University, and Joshua Wabwire, educator at the Catholic University of Eastern Africa, 01-2018, “The WTO-TRIPS Flexibilities on Public Health: A Critical Appraisal of the East African Community Regional Framework,” World Trade Review; Cambridge <https://www-proquest-com.ezproxy.library.unlv.edu/docview/1994279823?accountid=3611&pq-origsite=primo>]/Kankee

Conclusions The problem that this research has highlighted is the already too familiar tension between patent protection and access to medicines. The legal framework for patents and access to medicines in the EAC region consists of the Policy and the accompanying Protocol. What has emerged from the analysis is that the policy tools are aimed at enhancing access to medicines mainly through price reduction. This is done at the direct expense of promoting research and development of medicines, which, in line with the utilitarian justification, is achievable through patent protection. This policy position that weakens patent protection is not appropriate for developing African countries. This is because **African countries are faced with peculiar,** region-specific **diseases.** Currently, **these diseases are largely** neglected **by the profit-driven pharmaceutical companies, which do not have economic incentives to invest in developing medicines for populations that cannot afford** to pay for **them**. Most of these pharmaceutical companies are foreign, largely based in the Global North. Since these companies do not have economic incentives to invest in the research and development of medicines for developing countries' diseases, even patent protection has not necessarily been an attractive incentive.194The focus of these companies is now on developed countries' diseases. In these circumstances, **the** only standing **incentive**, especially **for spurring** domestic innovation **from within developing countries, is patent protection**. Consequently, **any strategy that eliminates this** last straw **will only** worsen **the** already **bad situation**. The situation described above underscores the urgent need to develop **local pharmaceutical industries** and to create alternative **incentives for investment in research and development of medicines for neglected diseases,** for example through Public-Private Partnerships (PPPs). Both of these **can be attained through** an appropriate **patent protection** regime that does not weaken patent protection. Such a regime must, for instance, be omniscient of domestic innovators' limited capacity and, consequently, avoid strict patentability criteria, which cannot be met by the small-scale, underfunded domestic innovators. Strict patentability criteria may also discourage disclosure of certain important discoveries, for fear of not attaining the criteria and losing out by disclosure. In developing local pharmaceutical industries, it is also necessary to find ways of affording patent protection to indigenous medicines and practices, which, for centuries, have been as useful to the populations as western medicine now is. It is the failure to protect these medicines and practices in the first place that has resulted in foreign pharmaceuticals appropriating the knowledge and patenting it, only to return with expensive medicines.195 It is the argument here that a patent protection policy would only achieve the greatest good for the greatest number of people, in line with utilitarianism, if it balances the goal of price reduction with the need to encourage further research and development of medicines by ensuring that inventors are able to recoup their investments in research and development. It is only through research and development that the medicines will be made available.

#### Secondly **Reducing patents would prevent future innovations in Covid-19 and other pandemics due to risks without a patent**

Cueni, 20 [Thomas Cueni, director-general of International Federation of Pharmaceutical Manufacturers and Associations, May 17th, 2020, “Intellectual property is not a hindrance but a help to end Covid-19”, Financial Times, <https://www.ft.com/content/e82dd07c-95c5-11ea-899a-f62a20d54625> ] /TriumphDebate

While we have good reason to hope science will prevail, there is understandable concern about how the fruits of innovation will be shared equitably and whether the pharmaceuticals industry can be trusted to put public health ahead of private profits. Some point to previous pandemics and warn that, unless deliberate steps are taken, the most vulnerable people will be left out. Academics including Mariana Mazzucato at University College London and Ellen ‘t Hoen at Groningen university are bringing to the fore a longstanding argument about intellectual property and innovative pharmaceutical products. The contention is that if the inventor’s IP rights were waived in a public health emergency, this would increase access to medicines and vaccines. The pharmaceutical industry holds the contrary view that IP is not a hindrance but a help to contain and end Covid-19. Last month, Francis Gurry, director-general of the World Intellectual Property Organisation, a UN body, said that “there does not appear to be any evidence that IP is a barrier to access to vital medical preventive measures, such as vaccines, or to treatments or cures”. For the past three months, both public and private scientists, and pharma businesses have pulled out all the stops, pushing the boundaries of science, developing workable solutions and ensuring there is capacity to scale up eventual treatments or vaccines, while ensuring continuity of global supply of the critical medicines and vaccines already on offer. Now, of all times, is not the moment to undermine IP. It would create uncertainty and send the wrong message to pharma companies that have taken risks on huge investments to repurpose medicines for Covid-19 treatment and scale up manufacturing. Patents, and IP more generally, are the main reason that there is such a strong innovation base to work from to find solutions. Today there are more than 1,000 clinical trials ongoing, over 150 treatments being tested, and more than 120 vaccine projects. There is no guarantee of success as few treatments and even fewer vaccines may prove to be safe and effective. This level of risk-taking would be impossible without a flourishing innovation ecosystem built on strong IP incentives. There will be much talk of creating an IP-free space to respond to Covid-19 around the World Health Assembly in Geneva on May 18-19. But such ideas miss the more important challenge, which is that demand for treatments could outstrip supply should the results of clinical trials prove positive. This is why companies are already exploring collaborations and voluntary licences to ramp up capacity. The creation of yet another “patent pool” would be a waste of time and resources. Such an initiative already exists in the form of the Medicines Patent Pool along with bilateral licensing agreements. The pharmaceutical industry draws a line at an open-access platform to enforce worldwide open-licence agreements for Covid-19 vaccines and treatments. This could significantly undermine trust in a predictable IP framework just when the industry is doing all it can, spending billions upfront with no guarantee of success. It has signed up to the World Health Organization’s Access to Covid-19 Tools Accelerator, committing to accelerate development, production and equitable global access to safe, effective and affordable therapeutics and vaccines with the belief that it is the right thing to do.

## C2 Single Payer ALT

#### Single Payer aids innovation and Incentives due to easy access to medicine for consumers

Lemley et al. 20 [MARK A. LEMLEY, William H. Neukom Professor of Law, Stanford Law School, LISA LARRIMORE OUELLETTE, Associate Professor of Law and Justin M. Roach, Jr. Faculty Scholar, Stanford Law School, and RACHEL E. SACHS, Associate Professor of Law, Washington University, 04-2020, “THE MEDICARE INNOVATION SUBSIDY,” NYU Law Review, https://www.nyulawreview.org/wp-content/uploads/2020/04/NYULAWREVIEW-95-1-LemleyOuelletteSachs.pdf]/Kankee

II PHARMACEUTICAL SUBSIDIES AS INNOVATION INCENTIVES Governments have created the complex array of prescription drug allocation mechanisms described in Part I because those drugs are costly and public payers face tradeoffs about how to allocate scarce resources. As noted above, the ability of drug manufacturers to set prices well above the cost of production stems from the IP used to protect R&D investments.168 This ex post, market-set incentive is provided not only through patent law, but also through other forms of IP, including trade secrets, trademarks, and regulatory exclusivity.169 It is hard to disentangle the effects of these different forms of IP, but companies generally report that the pharmaceutical industry is the sector in which patents are most effective,170 and scholars often agree.171 But patents and other forms of IP come with significant drawbacks. They raise prices, impose administrative costs, and can discourage follow-on innovation. As discussed below, market-based IP rewards are misaligned from social value for a variety of biomedical innovations, including for goods that generate positive externalities or for which the social value exceeds consumers’ ability to pay. Governments can offset these IP-related biases with other innovation policies, including R&D tax incentives, direct funding through grants and research at national labs, and prizes.172 Here, we focus on one such policy tool—one that policymakers have rarely seemed to think of as implementing innovation policy at all: government subsidies for particular drugs through health insurance programs like Medicare and Medicaid. From an incentive perspective, reimbursement programs can function as market-based prizes, in which the reward incorporates both a government assessment of social value and market information based on consumer choices.173 For example, suppose policymakers decide that the expected IP-based market reward is insufficient for incentivizing a vaccine for a particular disease.174 The government could offer an additional fixed prize—say, $1 billion for the first firm to develop a cure. But to encourage distribution of the vaccine and to tie the reward to some measure of patient preference, policymakers could also offer a market-based prize—say, $100 per patient vaccinated. Particularly for interventions with positive externalities or high disparities between patients’ ability and willingness to pay, administering this kind of additional incentive through government health insurance programs improves the alignment between the returns to innovation and social value. The incentive effect of demand-side healthcare subsidies depends critically on details of institutional design. Section II.A shows how **Medicare-like programs can provide a** significant subsidy **to drug manufacturers** beyond expected profits in an unsubsidized market. Section II.B discusses the effect of this kind of subsidy on overall pharmaceutical innovation. Finally, Section II.C examines how subsidies from government insurance can bias innovation incentives in favor of particular biomedical technologies. But those details should not obscure the larger point, to which we turn in Part III: **Healthcare reimbursements are** innovation incentives. Indeed, they may be among **the** largest innovation incentives **in the pharmaceutical sector**. A. The Medicare Innovation Subsidy To illustrate how pharmaceutical profits under Medicare reflect more than the “market value” of a drug, we begin with an ordinary, unsubsidized market in which a seller has monopoly power, as illustrated in Figure 1. The demand curve (D) represents how much quantity of the drug (Q) consumers will purchase at a given price (P); an ordinary market has a downward-sloping demand curve because more consumers are typically able to purchase a good at lower prices.175 The supply curve (S) represents the quantity of drug that will be sold at a given price. Monopoly pricing involves reducing sales in order to increase the price. Why do monopolists reduce output while increasing prices? The key to this “normal” monopoly is the absence of price discrimination. The patentee would like to sell to everyone who is willing and able to pay more than it costs to sell them a drug: that is, everyone for whom the demand curve is higher than the supply curve. But if they lower the price to reach those who can afford to pay less, they also lower the price for all the other buyers, too, reducing the marginal revenue from adding a new sale. Monopolists, then, price not where the supply curve meets the demand curve (the competitive market price),176 but instead where the supply curve meets the marginal revenue curve (MR), resulting in a higher price (Pmonop) and lower quantity (Qmonop) than in a competitive market. If they cut the price any further, the money they would lose from existing customers would counteract the additional sales, making the additional sale unprofitable. If this monopoly price is used to allocate access to the drug, consumers who value the drug above the cost of production but below the monopoly price are unable to access the drug. The social loss due to these lost transactions is known as deadweight loss (DWL), represented by the striped triangle in Figure 1. In the context of essential medicines, this represents patients who will be unable to access the treatments they need. IP policy tolerates this allocative inefficiency on the theory that it will be exceeded by gains in dynamic efficiency: The prospect of monopoly profits will incentivize a producer to create this drug in the first place. In other words, the development of the drug is necessary to provide any access at all. IP policy is thus typically described as representing a tradeoff between short-term access and longer-term innovation.177 The full interaction between IP and pharmaceutical access is more complicated than this simple model suggests. One of us has recently questioned the conventional view that the fundamental tradeoff in IP is between dynamic and allocative efficiency: IPfacilitated market power does create incentives to restrict quantity and thus decrease consumption, but it also has consumptionexpanding effects.178 But for our purposes, the standard monopolypricing model suffices to illustrate the basic effect of insurance and demand-side subsidies. In Figure 2 we add the effect of coinsurance, in which an insurer covers a fixed percentage of medical costs. Compared to a market without insurance, a coinsurance system expands demand, moving the demand curve to the right. The curve pivots rather than simply shifting because coinsurance pays a percentage of the total cost, so it magnifies the effect of a consumer’s existing willingness and ability to pay. If insurance pays 80% of the cost, a consumer who can pay $100 out of pocket can buy a $500 drug. But a consumer who can pay $1000 ($900 more than her neighbor) can buy a $5000 drug.179 The effect of adding insurance is to expand the patent owner’s profits beyond the monopoly profit without insurance. **Because consumers effectively can pay more (with the help of their insurers), a monopolist can** charge each consumer more and can also **sell to more consumers.** Note that as patients’ share of costs decreases, the demand curve pivots further to the right, and more consumers gain access to the drug. This effect is generally framed in the health economics literature in terms of the resulting moral hazard problem in which patients may choose treatments that are more expensive than the value they actually receive.180 But there has been less attention to the way insurance greatly increases prices and profits for a seller with market power. If patients’ share of costs declines to zero (such as through insurance that requires only a flat copayment), then there would be no upper bound on price. That’s why, as a practical matter, public or private insurance systems providing free or low-cost care must have some other mechanism to contain costs. For example, as described in Part I, Medicaid links prices to private markets, the VA and UK systems can exclude drugs from coverage, and the German system will only reimburse up to a reference price. Coinsurance systems in which insurers cover a large percentage of costs typically also have some cost-control mechanism, including copayments, deductibles, and formulary management tools. But even if there is some mechanism for limiting price, the patentee may still receive additional profits in a market in which all patients have coinsurance as compared with the “normal” monopoly market, as we illustrate in Figure 3.181 A mechanism for limiting prices is particularly necessary if the model moves from one in which all consumers have coinsurance (requiring them to pay some percentage of the price) to one in which all consumers have generous access to drugs with no cost-sharing, as suggested by some Medicare for All proposals.182 As we illustrate in Figure 4, even if prices are limited to the original monopoly price, providing **coverage for all patients** with no cost-sharing **leads to a** substantial additional profit **for the patentee.**183 Real-world pharmaceutical markets are substantially more complex than any of the simplified models shown in Figures 1–4. The important conceptual point, however, is that when insurance-related policies effectively shift demand upward or to the right, the seller of a drug with market power can receive higher profits for that drug. These added profits grow as patients’ share of pharmaceutical costs shrinks, particularly in the absence of robust cost-containment mechanisms. To some degree, this is what Medicare’s prescription drug benefits do. Medicare beneficiaries generally are responsible for only twenty to twenty-five percent of brand-name drug costs under Parts B and D,184 and millions of patients receive government subsidies lowering these amounts.185 Many of these are people who didn’t have private insurance or who had insurance that was less generous,186 who can now effectively pay much more for drugs than they used to. Medicare also increases overall demand for drugs by causing beneficiaries to live longer.187 These factors tend to push the demand curve upward to the right, artificially adding to the number of people who can pay the monopoly price. And unlike private insurers, who have greater legal authority to negotiate prices freely and to refuse to cover drugs that cost too much, Medicare Parts B and D often impose coverage requirements with little ability for the government to negotiate prices beyond the price set in the private market, giving drug manufacturers significant leverage in setting prices.188 Expanding the demand curve in this way increases the patentee’s profits even further beyond what they would make without government insurance. The patentee no longer has to worry about cutting prices to match demand for customers who can pay less; some combination of the government and supplemental private insurance will pay the monopoly price for almost everyone. Medicare does expand access to consumers who value the drug more than its cost of production but less than the unsubsidized monopoly price (the striped DWL triangle in Figure 1). But it also transfers a great deal of additional profit to the patent owner. The scope and duration of the patent hasn’t changed, but it is generating a lot more profit for the simple reason that, thanks to the government subsidy, there are many more customers who can pay and they all pay the monopoly price or close to it, even if they value the drug at less than that price. We call this added profit the Medicare innovation subsidy. The real world has more complications than this stylized model, of course. Here are four important ones: First, not all pharmaceutical patents confer market power, though they are more likely to than patents in other fields.189 Even where drugs face quite a lot of competition, as with antidepressants, patentees may not face effective price competition if doctors don’t view the drugs as substitutes for any given patient or if Medicare must cover all FDA-approved drugs for certain illnesses.190 Second, Medicare plans and the PBMs that negotiate on their behalf do have some bargaining leverage, including threatening to cover only certain drugs for non-protected classes, using prior authorization or step therapy, and threatening to move drugs to less desirable formulary tiers.191 This leverage has allowed them to lower prices for drugs with competition in a particular therapeutic class, although their bargaining power is limited by the government’s inability to directly negotiate and by the plans’ inability to walk away from the table in most cases.192 As Figure 3 illustrates, however, patentees still receive substantial additional profits even with tools for limiting price. Third, Medicare Part D covers primarily Americans aged over sixty-five. For drugs that affect only the elderly, the model just described is accurate. But it doesn’t apply to drugs for diseases that only affect children, and it applies only partially to drugs taken by patients of all ages. We discuss the biases this may cause in more detail in Section II.C. Finally, the above graphs assume that Part D was created against a baseline in which seniors did not have prescription drug insurance. This was true for twenty-seven percent of seniors,193 creating a demand expansion effect among this population. Before Part D implementation, sixty-six percent of Medicare-eligible seniors already had some prescription drug insurance plan.194 However, at least some of those patients also increased pharmaceutical returns when substituting into Medicare—nine million patients moved from lowerreimbursement Medicaid coverage to higher-reimbursement Part D coverage.195 Effects may be more variable for the beneficiaries substituting from private insurance into Medicare. Despite these complications, the Medicare innovation subsidy is real. It has significantly increased the returns to pharmaceutical patent owners. Medicare now accounts for thirty percent of U.S. retail prescription drug spending,196 even though it applies primarily to people over sixty-five, who make up just thirteen percent of the population,197 and not all of whom even opt-in to Medicare. Medicare, then, is a big source of additional money for drug companies, both because it increases the number of people who can afford drugs and because it may increase the price companies can charge for those drugs. B. Effect on Innovation Above-baseline-monopoly profits aren’t necessarily bad. Few dispute that higher profits for certain innovations increase incentives to produce those knowledge goods,198 and a number of empirical studies have found increases in private-sector R&D investment following legal changes that increased market size in the contexts of vaccines and orphan drugs.199 Based on analysis of time-series data of drugs entering clinical development, Margaret Blume-Kohout and Neeraj Sood conclude that “passage and implementation of Medicare Part D is associated with significant increases in pharmaceutical R&D for therapeutic classes with higher Medicare market share.”200 They found that this was largely new investment, not substitution away from other drugs, and that the effect was smaller for drugs that had been previously covered under Part B and larger for drugs in protected Part D classes.201 (In contrast, the original introduction of Medicare in 1965—without the prescription drug benefit—didn’t increase drug use among the elderly or induce significant pharmaceutical innovation,202 though it did increase medical-equipment patenting.)203 True, increases in R&D alone do not necessarily enhance patient welfare. Subsequent work focused on biologics found a similar incentive effect from Part D implementation, but also concluded that “most of this effect is concentrated among products aimed at diseases that already have multiple existing treatments,”204 and the net welfare impact of such drugs is ambiguous. Even though the size of the Medicare subsidy is large, its net innovation benefit might be relatively modest. The United States offers a huge array of innovation incentives in the pharmaceutical industry already, including not just patents but also direct research funding through grants and national laboratories, prizes, tax incentives, regulatory exclusivities, data exclusivities, and special incentives for orphan drugs and pediatric research.205 Pharmaceutical “lifecycle management” through secondary patents and regulatory gaming mean that companies keep market power for years and even decades after initial patent expiration.206 For at least some drugs, patent-owner returns for pharmaceuticals seem to far exceed the risk-adjusted R&D costs.207 Greatly increasing this innovation subsidy through expansion of government insurance may thus lead to limited innovation gains— although, as discussed in the following Section, existing incentives appear to be insufficient for at least some kinds of socially valuable innovation. Even so, perhaps we should celebrate the expansion of patent owner profits above the baseline monopoly level, since it seems to spur at least some additional R&D investment. If **Medicare** Part D is justified solely for the access benefits it provides for the elderly, the fact that there **is** also **an innovation subsidy that leads to** the production of even some **new drugs** is an extra benefit for the world. It is found money. And more drugs to treat diseases for no extra cost seems like an unambiguously good thing.

#### Single payer is extremely affordable

Galvani et al. 20 [Alison P Galvani, PhD, Alyssa S Parpia, MPH, Eric M Foster, Burton H Singer, PhD, and Meagan C Fitzpatrick, PhD, 02-15-2020, “Improving the prognosis of health care in the USA,” Lancet, https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(19)33019-3/fulltext#%20]/Kankee

The bottom line of Medicare for All Through the mechanisms detailed previously, we predict that a **single-payer** health-care system **would require $3·034 trillion annually** (figure 3; appendix p 5), $458 billion less **than national** health-care **expenditure in 2017**.40 Even after accounting for the increased costs of coverage expansion, our data-driven base case includes $59 billion savings on hospital care, $23 billion on physician and clinical services, $217 billion on overheads, and $177 billion on prescription drugs (figure 3; appendix p 11). Consequently, annual expenditure per capita would decrease from $10 7396 to $9330, equivalent to a 13·1% reduction. The expectation of savings is robust and remains following variation in the input parameters. For example, if overhead costs only dropped to 6% of total health expenditure—rather than Medicare’s current 2·2%—the **Medicare for All Act would** still **reduce costs by 10·3%.** Conversely, **savings would increase** beyond our base case **if our model overestimates the unfulfilled demand in people who do not have insurance** or are underinsured. Given that $2261 billion is already allocated to health care by existing governmental and philanthropic sources (appendix p 5), a further $773 billion must be collected by the government to fully fund the Medicare for All Act. Restructuring health-care expenditure by employers, individuals, and as a country