### Framework

#### The Standard is Maximizing Expected Wellbeing

#### [1] Extinction first –

#### a) Forecloses future improvement – we can never improve society because our impact is irreversible

#### b) Turns suffering – mass death causes suffering because people can’t get access to resources and basic necessities

#### c) Moral obligation – allowing people to die is unethical and should be prevented because it creates ethics towards other people

#### d) Objectivity – body count is the most objective way to calculate impacts because comparing suffering is unethical

#### [2] Util is a lexical pre-requisite to any other framework – Threats to bodily security preclude the ability for moral actors to act upon other theories since they are in a constant crisis that inhibits the moral conditions other theories presuppose.

#### [3] Pain provides an objective reason for why oppression is bad.

**Gray 09** [Gray, James W. "An Argument for Moral Realism." Ethical Realism. N.p., 07 Oct. 2009. Web. 04 Sept. 2015. <https://ethicalrealism.wordpress.com/2009/10/07/an-argument-for-moral-realism/>. MA in philosophy from San Jose State University (2008)]

#### If we have evidence that anything in particular has intrinsic value, then we also have evidence that moral realism is true. Our experiences of pleasure and pain are probably the most powerful evidence of intrinsic value because such experiences are tied to our belief that they have intrinsic value. My argument that pain has intrinsic disvalue is basically the following: We experience that pain is bad. We experience that pain is important. The disvalue of pain is irreducible. The disvalue of pain is real. If pain is bad in the sense of being important, irreducible, and real, then pain has intrinsic disvalue. Therefore, pain has intrinsic disvalue. I am not certain that the premises are true, but I currently find good reasons for accepting them. Therefore, we have reason for accepting the conclusion. The conclusion could be read saying, “We have reason to believe that pain has intrinsic disvalue.” If we accept that pain has intrinsic disvalue, then we will simultaneously accept moral realism.1 In order to examine the plausibility of my argument, I will examine each of the premises: We experience that pain is bad. We know pain is bad because of our experience of it. If someone described their pain as extremely wonderful, we would doubt they are feeling pain. Either the person is lying or doesn’t know what the word “pain” means. When a child decides not to touch fire because it causes pain, we understand the justification. It would be strange to ask the child, “So what? What’s wrong with pain?” We experience that pain is important. If pain is important in the relevant sense, then it can provide us reason to do something without merely helping us fulfill our desires. In other words, we must accept the following: The badness of pain isn’t just an instrumental value. The badness of pain is a final end. Pain’s badness isn’t an instrumental value – Pain’s disvalue is not an instrumental disvalue because pain can be quite useful to us. Pain can tell us when we are unhealthy or injured. We evolved pain because it’s essential to our survival. Pain’s bad for a different kind of reason. Pain’s disvalue is found in our negative experience, and this is why pain is a candidate for having an intrinsic disvalue. Whenever someone claims that something has intrinsic value, we need to make sure that it’s not just good because it’s instrumentally valuable. If it’s merely useful at bringing about something else, then it’s not good in and of itself (as intrinsic values are). Pain is perhaps the perfect example of something that is useful but bad. If usefulness was the only kind of value, then pain would actually be good because it helps us in many ways. Pain’s badness isn’t just our dislike of pain – We dislike pain because it feels bad.2 If pain didn’t feel bad, then we wouldn’t have such a strong desire to avoid intense pain. Pain means “feels bad” and it is manifested in various experiences, such as touching fire. We have to know the meaning of “bad” in order to understand pain at all. We attain an understanding of “bad” just by feeling pain. If pain was only bad because we dislike it, then we couldn’t say that “pain really matters.” Instead, the badness of pain would just be a matter of taste. However, we don’t just say pain is bad because we dislike it. We also say pain is bad because of how it feels. Avoiding pain is a final end – A final end is a goal people recognize as being worthy of being sought after for its own sake. Money is not a final end because it is only valuable when used to do something else. Pleasure and pain-avoidance are final ends because they are taken t be worthy of being avoided for their own sake. We know that avoiding pain makes sense even when it doesn’t lead to anything else of value, so avoiding pain is a final end.3 If I want to take an aspirin, someone could ask, “Why did you do that?” I could answer, “I have a headache.” This should be the end of the story. We understand that avoiding pain makes sense. It would be absurd for someone to continue to question me and say, “What difference does having a headache make? That’s not a good reason to take an aspirin!”4 Both realists and anti-realists can agree that pain is bad, and they can both agree that pain is a final end. Our desire to avoid pain is non-instrumental and such a desire is experienced as justified. (However, the ant-realist might argue that it is only taken to be justified because of human psychology.) If pain is a final end, then we understand (a) that pain is important and (b) it makes sense to say that we ought to avoid pain. Pain’s disvalue is irreducible. If the badness of pain was reducible to nonmoral properties, then we should be able to describe what “bad” means through a non-moral description. However, we currently have no way of understanding pain’s badness as being something else. We can’t describe pain’s badness in non-moral terms. If someone needs to know what ” bad” means, they need to experience something bad. To say that some moral states are irreducible is just like saying that some mental states are irreducible. Pain itself can’t be described through a non-mental description. If we told people the mental states involved with pain, they would still not know what pain is because they need to know what it feels like. Someone could argue that “bad” means the same thing as something like “pain,” and then we would find out that the badness of pain could be reduced to something else. However, pain and the badness of pain are conceptually separable. For example, I could find out that something else is bad other than pain. They could then reply that “bad” means the same thing as a disjunction of various other bad things, such as “pain or malicious intent.” But people who disagree about what constitutes what is “bad” aren’t just arguing about

the meaning of the word “bad.” They are arguing about what has the property “bad.”5 Additionally, the word “bad” would no longer have any importance. If “bad” just means “pain or malicious intent,” then why care about it? Why ought I refrain from causing pain or having a malicious intent? It could be that we can find out that “bad” and “pain” are identical, but then “bad” might not be entirely reducible to “pain” (or a disjunction of bad things). We might still think that there are two legitimate descriptions at work. The “pain” description and the “bad” description. (Some people think water is H2O through an identity relation similar to this.) This sort of irreducible identity relation require us to deny that pain is “important.” (If the identity theory did require us to deny that pain is “important,” then we would have a good reason to reject such an identity theory.) I have given reason to think the word “bad” is irreducible, but I haven’t proven it. If someone could prove that pain isn’t important, and we can reduce pain to something else, then I will be proven wrong. I just don’t see any reason to agree with that position at this time. I discuss the badness of pain as irreducible in more detail in my essays “Objection to Moral Realism Part 1: Is/Ought Gap” and “Objections to Moral Realism Part 3: Argument from Queerness.” The badness of pain is real. **If the badness of pain is real**, **then everyone’s pain is bad**. Pain isn’t bad just for me, but not for you. It states that **we don’t** all merely **share a subjective preference** in avoiding pain,

#### [4] Ground – Both debaters have ground to engage under util – Aff gets plans, while Neg gets DAs and counterplans. AND anything can function under util if it has an external benefit. Other fwrks deny 1 side engagement on link and impact level.  Hyper-specific theories mean people have little prep on the issue. TJFs OW because concerns fairness – OW all args concede valid of fairness.

#### The role of the ballot is to vote for the debater that produces the best material consequences based on the fiated implications of the plan –

#### [1] No performative or methodological offense – It’s extra-T which is a voter for limits, spiking out of af gfround making any discussion worse.

#### [2] Strat Skew – the resolution is the only stasis point and adding other factors to the round decks predictable limits which guts pre round prep.

#### [3] Inclusion – Novices and Lay debaters all use the material consequences in the plan – proven by every lay tournament outside the circuit – by increasing the burden to your model you exclude them from the space.

### Advantage

#### The advantage is drug prices.

#### Drug prices are high now, Rajkumar 20

[S. Vincent Rajkumar](https://www.nature.com/articles/s41408-020-0338-x#auth-S_-Vincent_Rajkumar), 6-23-2020, "The high cost of prescription drugs: causes and solutions," Blood Cancer Journal, <https://www.nature.com/articles/s41408-020-0338-x> //Lex AT

Global spending on prescription drugs in 2020 is expected to be ~$1.3 trillion; the United States alone will spend ~$350 billion[1](https://www.nature.com/articles/s41408-020-0338-x#ref-CR1). These high spending rates are expected to increase at a rate of 3–6% annually worldwide. The magnitude of increase is even more alarming for cancer treatments that account for a large proportion of prescription drug costs. In 2018, global spending on cancer treatments was approximately 150 billion, and has increased by >10% in each of the past 5 years[2](https://www.nature.com/articles/s41408-020-0338-x#ref-CR2). The high cost of prescription drugs threatens healthcare budgets, and limits funding available for other areas in which public investment is needed. In countries without universal healthcare, the high cost of prescription drugs poses an additional threat: unaffordable out-of-pocket costs for individual patients. Approximately 25% of Americans find it difficult to afford prescription drugs due to high out-of-pocket costs[3](https://www.nature.com/articles/s41408-020-0338-x#ref-CR3). Drug companies cite high drug prices as being important for sustaining innovation. But the ability to charge high prices for every new drug possibly slows the pace of innovation. It is less risky to develop drugs that represent minor modifications of existing drugs (“me-too” drugs) and show incremental improvement in efficacy or safety, rather than investing in truly innovative drugs where there is a greater chance of failure.

#### Trade secrets force high drug prices by hiding information from health plan companies and regulators, Feldman 1

Robin Feldman, 6 Oct 2020, "Naked Price and Pharmaceutical Trade Secret Overreach," No Publication, <https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3426225> //Lex AT

Other perverse incentives flow from the structure of industry, with its central players the Pharmacy Benefit Managers (PBMs). PBMs are middle players between drug companies and insurance plans— including both private insurers and Medicare. On behalf of insurance plans and patients, PBMs negotiate the prices of drugs with the companies. PBMs also help the plans set formularies, which determine whether patients will have access to a particular drug and the terms of that access. In an ideal world, this system would allow insurance plans and patients to pay the lowest cost possible for brand-name drugs. In reality, the deals between PBMs and brand companies frequently operate to channel patients into more expensive drugs, with resulting long-term and short-term effects on the system. Although a full discussion of the PBMs and the drug supply chain is beyond the scope of this Article, 29 certain aspects are important for understanding the role that assertions of trade secrecy are playing in this space. In simplified form, PBMs stand between their clients (the health plans) and drug companies. Although a health plan knows what it pays when a patient buys a particular drug at the pharmacy, the true price is hidden. Somewhere down the line, the health plan will receive a rebate check from the PBM that includes rebates for this, and many other, drug transactions. Along the way, PBMs pocket a large portion of the rebate dollars—as much as $166 billion each year30 by one estimate—although the health plans are not permitted to know the size of the rebates or the portions retained. In fact, the true net price, and the terms of the agreements between PBMs and drug companies are highly guarded secrets; even the health plan’s auditors are not given full access to the agreements.31 Moreover, given that PBMs help create their clients’ formularies, PBMs and drug companies can strike deals that may not be in the patient’s long-term interests. Recent case allegations and press reports have described patients who are forced to pay more for generics than for brand name drugs and patients completely blocked from access to generic versions of a drug. For example, a complaint filed in 2017 alleges that Allergan’s rebate scheme for its blockbuster dry-eye drug Restasis blocked access for competing generics. 32 One Medicare plan administrator quoted in the complaint explained that with the particular scheme, a new entrant could give its drug away for free and still would not be able to gain a foothold in the market.33 Similarly, a recent case alleges that Johnson and Johnson launched a rebate scheme for its rheumatoid arthritis drug Remicade that induced hospitals and health plans to essentially exclude the lower-priced biosimilar. 34 One physician called practices such as these “Alice-in-Wonderland” in the drug world.35 Moreover, these deals can maximize the payments that the PBMs are able to keep, while keeping patients away from cheaper generic drugs. In addition, although PBMs represent the health plan as its clients, the PBMs receive various large payments directly from the drug companies. As well as the rebate portions mentioned above, PBMs also receive various fees from drug companies, such as “data management fees” and “administrative fees.”36 With the formulary power of PBMs, these fees have the potential to encourage PBMs to drive patients toward the companies that are offering more attractive terms to them as a middle player, regardless of whether those terms benefit patients in either the short or long-term. Again, these fees are hidden from the health plan, from regulators, and from the public.37 One might think that the health plans and their patients, let alone government auditors, would have the right to know the net prices they are paying for each drug and to access the terms of agreements made on their behalf. So, just how is it that these terms are so deeply hidden? PBMs and drug companies claim that net price is a trade secret. It is under the cloak of trade secrecy that this system, and its impact on rising prices, remains sheltered from view.

#### Three impacts,

#### 1] High drug prices leads to use of substandard drugs which cause antimicrobial resistance, WBG 17

World Bank Group, March 2017, “DRUG-RESISTANT INFECTIONS A Threat to Our Economic Future”, <https://documents1.worldbank.org/curated/en/323311493396993758/pdf/final-report.pdf> //Lex AT

Even as there is overuse and misuse of antimicrobials, some poor populations still lack access to effective medicines. For example, one million children are estimated to die each year from untreated pneumonia and sepsis, which can be effectively managed with antibiotics (Laxminarayan et al. 2016). Weak health care systems, AMR, and the penetration of many countries’ antimicrobials markets by substandard and counterfeit drugs— these conditions all contribute to low access to effective antimicrobials. Relatively high prices of the more powerful, later-generation, antimicrobial drugs are also a factor. The development and marketing of these drugs occurred since the first-line, relatively inexpensive antimicrobials lost their effectiveness because of AMR. High drug prices then squeeze the finite health care budgets of governments, charities, and households, resulting in diminished access to treatment, especially for the poor and vulnerable. In addition to the effect on individual health outcomes, shrinking access to effective antimicrobials hinders progress toward universal health coverage (UHC), a pillar of the Sustainable Development Goals for 2030.4 We will discuss the potential development impacts of AMR extensively in Part II. In Part IV, we will show how country action to promote UHC can simultaneously enable more effective AMR control.

#### That kills Millions.

Greenberger 20 Phyllis E. Greenberger 12-3-2020 "Counterfeit Medicines Kill People" <https://www.healthywomen.org/health-care-policy/counterfeit-medicines-kill-people/who-suffers-because-of-counterfeit-drugs> (HealthWomen’s Senior Vice President of Science & Health Policy)//Elmer

**Over 1 million people die each year from fake drugs**. COVID-19 Have you ever had a hard time getting a prescription filled? Or maybe you've had to wrestle with your insurance provider to get them to pay for a medication vital for your health? Worse, maybe you're one of the 27.5 million uninsured Americans who find it difficult to get health care, let alone obtain the prescription drugs you may need. If you've had any of these experiences, then perhaps you've turned to the internet to buy medications that would require a prescription. While legal online pharmacies do exist, many online pharmacies are fraudulent, selling counterfeit medications, and millions of people have fallen victim to these scammers. Make no mistake: **Counterfeit medicine is not real**. The **active ingredients** that help you stay healthy may be **missing** **or diluted** to levels that are no longer potent. This **can be dangerous and even life-threatening**, as people rely on their medications to keep them well, and sometimes even alive. Many counterfeit medicines aren't even drugs at all, but rather **snake oil cures that make people sick** — they may even **contain** **dangerous ingredients such as heavy metals, highway paint or even rat poison.** The World Health Organization (WHO) estimates that over 1 million people die each year from these substandard drugs. It's estimated that more than 10% of all pharmaceuticals in the global supply chain are counterfeit in normal times, and during COVID-19, the increased use of telehealth and the appearance of fraudulent doctors has led to a surge in drug fraud. In October of this year, Peter Pitts, president of the Center for Medicine in the Public Interest, a nonpartisan research organization, said pharmaceutical fakery was a "spreading cancer." Counterfeiting is a major problem that requires the federal government to step up to slow — and eventually prevent — its spread. It's also vital that consumers know exactly what's at stake when taking these fake drugs. Who suffers because of counterfeit drugs? Expensive prescription medications and generic drugs in nearly every therapeutic class may be counterfeited. Out of $4.3 billion worth of counterfeit medications seized between 2014 and 2016, 35% were marked as antibiotics. Some of the other most common culprits in counterfeit medicine are used to "treat" HIV/AIDS, erectile dysfunction and weight loss. No matter what condition or disease the counterfeit medication is intending to treat, the outcome can be disastrous. **Counterfeit medications exacerbate other existing health crises**. The United States, for example, is in the midst of an opioid epidemic that is killing 130 people per day. As of 2018, counterfeit drugs containing illegally imported fentanyl (a powerful opioid) had contributed to this tragedy by causing deaths in 26 states. The U.S. Department of Justice found that, in at least one case, these counterfeit drugs had been sold through a fraudulent online pharmacy.

#### Generic competition arises as a patent expires – evergreening and stacked patents on delays it which drastically raises prices.

Christensen 20 [Connor Christensen, "The Evergreen Forests of Insulin Patents", Awakenwfu, The Creative Journal of Contemporary Bioethics, 9-14-2020, https://awakenwfu.com/2020/09/14/the-evergreen-forests-of-insulin-patents/, accessed: 9-7-2021.] //CHSTM and Lex VM

The prices of insulin have risen to unconscionable levels in just a little over two decades. What used to be a relatively minor expense for Americans with diabetes has, for some, become an insurmountable obstacle to living a normal life, or, in some cases living at all. The purpose of this brief commentary is to address just one of the many issues attributed to the stark increase in insulin prices: patent evergreening. People with Type I and Type II diabetes constantly depend on insulin injections to supplement their insufficient natural production of the blood-sugar regulating hormone in their pancreas.[1] Without this hormone, a diabetic person’s life expectancy is short and riddled with many serious health complications.[2] For many decades insulin was readily accessible and affordable for those who needed it. Recently, however, things have changed. In 1996, the list price of a single vial of insulin manufactured by Eli Lilly, a pharmaceutical firm, was only $25.[3] Since then, the formula for the same bottle of insulin hasn’t changed, but the list price has gone up to around $275 per vial.[4] This price increase alone is shocking, but it becomes even more unthinkable when you consider the fact that the average diabetic person uses between one and three vials per month.[5] Presently, a diabetic person without insurance requiring three vials per month could expect to pay at a minimum of $825 a month for just insulin alone.[6] Some people have even reported paying as much as $2880 for a month’s supply of insulin.[7] The exact reason for this stark increase in price is not uniformly agreed upon. Still, it’s speculated that it is a result of multiple “opaque” transactions among wholesalers, pharmacies, and manufacturers.[8] With figures this high, it is unsurprising that 27% of diabetics report that affording insulin has impacted their daily life.[9] The financially vulnerable are particularly put at risk by these exorbitant list prices. Being economically vulnerable and diabetic requires people to make sacrifices in other parts of their lives to keep affording insulin.[10] These sacrifices include staying at undesirable jobs, maintaining unhealthy relationships, foregoing higher education, selling valuables, and rationing food.[11] However, sometimes, even these sacrifices aren’t enough. In 2017, after aging out of his mother’s health insurance and despite making above minimum wage, Alec Smith, a 26-year-old diabetic man, died because he wasn’t able to afford enough insulin to live.[12] Tragic losses of life, like Alec’s, are entirely preventable, and there are a number of potential solutions that can fix or at least ameliorate the situation. Finding methods to prevent “patent evergreening ” is one of the possible solutions to the insulin crisis.[13] Evergreening occurs when brand-name companies patent “new inventions” that, in actuality, are simply old drugs with slight modifications.[14] Evergreening a patent can be done in various ways such as by “stacking patents,” (covering one drug with multiple patents) or by making small improvements to the drug and then pulling the old drug from the market.[15] Insulin, like many other drugs, has fallen prey to such evergreening.[16] Traditionally, patent monopolies on drugs eventually give way to generic competition after the patent expires. Upon expiration of the original patent other entities are allowed to produce the drug.[17] Evergreening, however, delays this process. The generic competition of once patented drugs is critical for consumers, consistently reducing the price of the drug by over 50%.[18] However, the unique development of insulin has allowed its formula and delivery to be continually improved upon since its discovery and first isolation.[19] Evergreening can essentially re-patent a drug, thus substantially extending the life of the monopoly granted to drug companies for their product.[20] As a consequence, by “evergreening” a patent, drug companies can effectively prevent biosimilar, or generic versions of that drug from being sold for far longer than the twenty years of a standard patent. Although there may be no protections remaining on the original formula, the “stacked” patents around that formula may cause it to be economically impossible to produce the original formula.[21] For example, Sanofi’s insulin, Lantus, has 74 patents associated with it, which will work together to protect it from generic competition for 37 years into the future.[22] Stacked patents not only discourage competition, but they also are incredibly effective at squashing potential patent infringers. Unsurprisingly, drug companies with multiple patents on their drugs are able to win 65% of the infringement cases against their drug.[23] Closing the loopholes that allow evergreening patents is a bipartisan issue. President Trump has even stated, “[o]ur patent system will reward innovation, but it will not be used as a shield to protect unfair monopolies.”[24] There is no question as to whether modern insulin is better than what we had in 1921; its formula, dosage, and administration improved beyond belief.[25] What used to be riddled with impurities is now a work-horse of a drug. However, it is highly questionable whether each small step in the lineage is deserving of patent protection.[26]

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

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

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

### Adv 2

#### The status quo ensures vaccine imperialism. Intellectual property law is the lynchpin of health inequality and has empirically resulted in disparate life outcomes.

Vanni 21 – Dr. Amaka Vanni is Lecturer in Law at the University of Leeds. ("On Intellectual Property Rights, Access to Medicines and Vaccine Imperialism," 3-23-2021, <https://twailr.com/on-intellectual-property-rights-access-to-medicines-and-vaccine-imperialism/>) julian

While the response to COVID-19 has shown what can be accomplished when the world works together, it has also underscored three interrelated points. First, the neoliberal framework – including the critical role intellectual property (IP) law plays in constituting this form of civilisation – is an unsuitable model for delivering the goods needed to respond to global health emergencies. The current economic/market system does not allow for equitable responses to infectious diseases, particularly access to sufficient medical and health resources. This inequity was obvious in the early days of the pandemic when test kits, PPEs, and ventilation machines were being distributed on the basis of who could pay the most rather than who needed them the most. Second, the beggar-thy-neighbor response currently adopted by developed countries hurts everyone because failing to stop the spread of the virus globally allows more mutations, which makes existing vaccines less effective. As COVID-19 has shown, no one is safe until everyone is safe. Yet, despite this warning, the hoarding of vaccines by developed countries continues unabated and speaks to the wider racist capitalist system we live in. If anything, this crude accumulation of vaccines reinforces North-South economic and political dominance and marks, as Onur Ince observes, the conceptual locus of political violence operative in the global genealogy of capitalism. Third, while COVID-19 may endanger us all, it is far more costly to some than others. Numerous reports have shown how black and brown people are most impacted by the pandemic. In the United States, for example, indigenous Americans have the highest COVID-19 mortality rates nationwide while African American communities have COVID-19 mortality that is 2.3 times higher than the rate for Asians and Latinxs, and 2.6 times higher than the rate for Whites. Similar data is also emerging in the UK where people from black and minority ethnic groups are at greater risk of dying from coronavirus. This means those groups suffer higher loss of life compared to other racial groups due to inequities in healthcare access as well as higher rate of pre-existing conditions. In other parts of the world, the most vulnerable and the economically marginalized such as those working in the informal sector and living in shanty towns are feeling the effects of the pandemic the most. In Latin America and the Caribbean, 70 per cent of domestic workers have been affected by the pandemic where most have stopped receiving income. In Ghana, residents of slums at Old Fadama – a suburb in Accra – were made homeless when the government demolished their homes. The ensuing homelessness means there is little to no space of observing social distancing rules, access to running water and access to other resources to practice basic hygiene. Meanwhile in India, the pandemic has unsurprisingly hit the country along caste lines where the Dalits are most impacted because many are poor and have limited access to healthcare. As Kimberlé Williams Crenshaw reminds us, the high number of minority deaths is not new. Rather, this crisis simply amplified racism and other forms of structural inequality as a pre-existing condition – an intersectional issue – where those disproportionately hurt are those who are already structurally marginalized. Thus, while recognising a broken global IP regime that triggered the scramble for vaccines, the racialized impact of the pandemic cannot be ignored, and it points to the entangled roots of race and capitalism. The rest of this analysis takes a close look at some of the legal, political and economic forces that have animated IP rights and access to COVID-19 vaccine. It will focus on how the entanglement of corporate capture of global IP regime, state complicity and vaccine imperialism have come together to shape public health responses to the pandemic. It underscores how the law, in this case international IP law, consistently shelters capital and operates as an expression to further corporate pharmaceutical interests. If there is a lesson to be gleaned from this pandemic, it is that intellectual property is not failing us but is functioning the way it is set up to do. As the history of IP globalization has shown, the World Trade Organization’s (WTO) Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS Agreement) is a transplant of the Euro-American model of property, driven by multinational corporations who used their respective national governments to underwrite and export their domestic IP claims. Therefore, it is unsurprising that this international legal regime employed to advance the interests of particular classes, nations and regions at the expense of others continues to reproduce extreme inequality with human costs.

#### This means COVID and future pandemics will reproduce untenable working conditions and racialized and classed life outcomes.

Sell 20 – Susan K. Sell is a Professor of Political Science and International Affairs at George Washington University. (“What COVID‑19 Reveals About Twenty‑First Century Capitalism: Adversity and Opportunity,” pg. 152-153) julian

The COVID-19 pandemic has revealed the lethal consequences of the sharp rise in economic inequality, the concentration of wealth in fewer and fewer hands and the increasing precarity of labour. For example, as COVID-19 slammed Manhattan, members of the top 1% flocked to their beach retreats in the Hamptons to ride out the contagion (Sellinger 2020). Meanwhile, ‘essential workers’ at the bottom of the contemporary economic hierarchy had no options but to continue to show up for work and face exposure to the deadly virus. First responders, bus drivers, nursing home workers, janitors, postal workers, grocery stockers, agricultural workers, Wal-Mart employees, Amazon warehouse workers, delivery drivers, and meat packers—many earning minimum wage and most without employer-subsidized health insurance or other benefits—had to keep working. As Bertha Bradley, a food service worker in North Carolina stated, ‘I don’t get health benefits, I don’t get sick time, I don’t get paid vacations, I don’t get a living wage’ (Jaffe and Chen 2020: 126). Katie Pine and Kate Henne refer to them as ‘new risk workers’, many of whom are given mandates for minimizing risk but few resources to implement them (Pine and Henne 2020). For example, in the John H. Stroger Hospital in Chicago, nurses were being told to reuse N95 masks, ‘sometimes up to forty-five days’ (Jaffe and Chen 2020: 138). By contrast, knowledge workers could work from the safety of their own homes and reduce their risks of becoming infected. COVID-19 has disproportionately attacked communities of colour, compounding economic inequality and systemic racism. It is clear that ‘race matters for the way that markets have been built historically and function today’ (McNamara and Newman 2020: 6). As Presidential candidate Joe Biden pointed out during the presidential debate in September 2020, 1 out of every one-thousand African Americans in the US has died from COVID-19. In Chicago about 70% of the COVID deaths were African Americans (Jaffe and Chen 2020: 140). The UN Secretary-General António Guterres pointed out that COVID-19 ‘is exposing fallacies and falsehoods everywhere … the delusion that we live in a post-racist world, the myth that we are all in the same boat’ (Guterres 2020). In September, Citigroup released a report that systemic racism, discrimination against African Americans, has cost the economy $16 trillion (Akala 2020). Many of the precariat are people of colour, recent immigrants and undocumented workers. By May 2020 slaughterhouses around the world became virus hot spots and exposed multiple layers of dysfunction. The meat processing industry is highly consolidated, dominated by global multinational corporations including Cargill, JBS, Smithfield and Tyson. Since the 1980s this industry has pursued the financialized model of consolidation and vertical integration, ‘aimed at increasing profits through efficiency and low wages’ (van der Zee et al. 2020). Many migrant workers in these plants live in communal housing; crowded working conditions, large plants and cramped housing, and lack of paid sick leave all exacerbate the spread of coronavirus in these environments. Indeed, Tyson was even offering workers $500 bonuses to keep working in the midst of plant outbreaks (van der Zee et al. 2020). Workers are shouldering all of the risk as slaughterhouse companies get the rewards. Structures of the global economy, including financialization and monopoly capitalism have amplified the dangers of the pandemic and pushed people further ‘into unequal groups that are not only divided by money but by matters of life and death’ (McNamara and Newman 2020: 11; Sell and Williams 2019).

#### The pandemic is raging through developing economies and inflicting loss on a horrific scale and prolongs economic hardships – timeframe is fast.

Lindsey 21. [(Brink Lindsey) “Why intellectual property and pandemics don’t mix,” Brookings Institution, June 3, 2021. <https://www.brookings.edu/blog/up-front/2021/06/03/why-intellectual-property-and-pandemics-dont-mix/>] TDI

\*\*cut part about economic hardships

Although focusing on these immediate constraints is vital, we cannot confine our attention to the short term. First of all, the **COVID-19 pandemic is far from over**. Although Americans can now see the light at the end of the tunnel thanks to the rapid rollout of vaccines, most of the world isn’t so lucky. The virus is **currently raging in India and throughout South America, overwhelming health care systems and inflicting suffering and loss on a horrific scale**. And consider the fact that Australia, which has been successful in suppressing the virus, recently announced it was sticking to plans to keep its borders closed until mid-2022. Criticisms of the TRIPS waiver that focus only on the next few months are **therefore short-sighted**: this pandemic could well **drag on long enough for elimination of patent restrictions to enable new vaccine producers to make a positive difference.**

#### The aff ensures the reduction of vaccine imperialism.

Vanni 21 – Dr. Amaka Vanni is Lecturer in Law at the University of Leeds. ("On Intellectual Property Rights, Access to Medicines and Vaccine Imperialism," 3-23-2021, <https://twailr.com/on-intellectual-property-rights-access-to-medicines-and-vaccine-imperialism/>) julian

Despite calls to make COVID-19 vaccines and related technologies a global public good, western pharmaceutical companies have declined to loosen or temporarily suspend IP protections and transfer technology to generic manufacturers. Such transfer would enable the scale-up of production and supply of lifesaving COVID-19 medical tools across the world. Furthermore, these countries are also blocking the TRIPS waiver proposal put forward by South Africa and India at the WTO despite being supported by 57 mostly developing countries. The waiver proposal seeks to temporarily postpone certain provisions of the TRIPS Agreement for treating, containing and preventing the coronavirus, but only until widespread vaccination and immunity are achieved. This means that countries will not be required to provide any form of IP protection on all COVID-19 related therapeutics, diagnostics and other technologies for the duration of the pandemic. It is important to reiterate the waiver proposal is time-limited and is different from TRIPS flexibilities, which are safeguards within the Agreement to mitigate the negative impact of patents such as high price of patented medicines. These safeguards include compulsory licenses and parallel importation. However, because of the onerous process of initiating these flexibilities as well as the threat of possible trade penalties by the US through the United States Trade Representative (USTR) “Special 301” Report targeting countries even in the absence of illegality, many developing countries are reluctant to invoke TRIPS flexibilities for public health purposes. For example, in the past, countries such as Colombia, India, Thailand and recently Malaysia have all featured in the Special 301 Report for using compulsory licenses to increase access to cancer medications. It is these challenges that the TRIPS waiver seeks to alleviate and, if approved, would also provide countries the space, without fear of retaliation from developed countries, to collaborate with competent developers in the R&D, manufacturing, scaling-up, and supply of COVID-19 tools. However, because this waiver is being opposed by a group of developed countries, we are grappling with the problem of artificially-created vaccine scarcity. The effect of this scarcity will further prolong and deepen the financial impact of this pandemic currently estimated to cost USD 9.2 trillion, half of which will be borne by advanced economies. Thus, in opposing the TRIPS waiver with the hopes of reaping huge financial rewards, developed countries are worsening pandemic woes in the long term. Another kind of scarcity caused by vaccine nationalism has also reduced equitable access. Vaccine nationalism is a phenomenon where rich countries buy up global supply of vaccines through advance purchase agreements (APA) with pharmaceutical companies for their own populations at the expense of other countries. But perhaps it is time to reorient our sight and call the ongoing practices of buying up global supply of vaccine what it truly is – vaccine imperialism. If we take seriously the argument put forward by Antony Anghie on the colonial origins of international law, particularly how these origins create a set of structures that continually repeat themselves at various stages, we will begin to see COVID-19 vaccine accumulation not only as political, but also as imperial continuities manifesting in the present. Take, for instance, the report released by the Duke Global Health Innovation Center that shows that high-income countries have already purchased nearly 3.8 billion COVID-19 vaccine doses. Specifically, the United States has secured 400 million doses of the Pfizer-BioNTech and Moderna vaccines, and has APAs for more than 1 billion doses from four other companies yet to secure US regulatory approval. The European Union has similarly negotiated nearly 2.3 billion doses under contract and is negotiating for about 300 million more. With these purchases, these countries will be able to vaccinate their populations twice over, while many developing states, especially in Africa, are left behind. In hoarding vaccines whilst protecting the IP interests of their pharmaceutical multinational corporations, the afterlife of imperialism is playing out in this pandemic. Moreover, these bilateral deals are hampering initiatives such as the COVID-19 Vaccine Global Access Facility (COVAX) – a pooled procurement mechanism for COVID-19 vaccine – aimed at equitable and science-led global vaccine distribution. By engaging in bilateral deals, wealthy countries impede the possibility of effective mass-inoculation campaigns. While the usefulness of the COVAX initiative cannot be denied, it is not enough. It will cover only the most vulnerable 20 per cent of a country’s population, it is severely underfunded and there are lingering questions regarding the contractual obligations of pharmaceutical companies involved in the initiative. For instance, it is not clear whether the COVAX contract includes IP-related clauses such as sharing of technological know-how. Still, even with all its faults, without a global ramping-up of production, distribution and vaccination campaigns via COVAX, the world will not be able to combat the COVID-19 pandemic and its growing variants. Health inequity and inequalities in vaccine access are not unfortunate outcomes of the global IP regime; they are part of its central architecture. The system is functioning exactly as it is set up to do. These events – the corporate capture of the global pharmaceutical IP regime, state complicity and vaccine imperialism – are not new. Recall Article 7 of TRIPS, which states that the objective of the Agreement is the ‘protection and enforcement of intellectual property rights [to] contribute to the promotion of technological innovation and to the transfer and dissemination of technology’. In similar vein, Article 66(2) of TRIPS further calls on developed countries to ‘provide incentives to enterprises and institutions within their territories to promote and encourage technology transfer to least-developed country’. While the language of ‘transfer of technology’ might seem beneficial or benign, in actuality it is not. As I discussed in my book, and as Carmen Gonzalez has also shown, when development objectives are incorporated into international legal instruments and institutions, they become embedded in structures that may constrain their transformative potential and reproduce North-South power imbalances. This is because these development objectives are circumscribed by capitalist imperialist structures, adapted to justify colonial practices and mobilized through racial differences. These structures are the essence of international law and its institutions even in the twenty-first century. They continue to animate broader socio-economic engagement with the global economy even in the present as well as in the legal and regulatory codes that support them. Thus, it is not surprising that even in current global health crisis, calls for this same transfer of technology in the form of a TRIPS waiver to scale up global vaccine production is being thwarted by the hegemony of developed states inevitably influenced by their respective pharmaceutical companies. The ‘emancipatory potential’ of TRIPS cannot be achieved if it was not created to be emancipatory in the first place. It also makes obvious the ways international IP law is not only unsuited to promote structural reform to enable the self-sufficiency and self-determination of the countries in the global south, but also produces asymmetries that perpetuate inequalities.

### Solvency

#### Plan – The member nations of the World Trade Organization ought to reduce intellectual property protections for medicines.

#### The plan solves price abuse, Feldman 2

Robin Feldman, 6 Oct 2020, "Naked Price and Pharmaceutical Trade Secret Overreach," No Publication, <https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3426225> //Lex AT

With trade secret becoming a weapon of choice in contemporary intellectual property litigation, there is a growing risk that it will be used in manners far beyond its animating logic of balancing interests between parties, generally those who were in privity with one another, regarding ordinary-course business information. Thus, courts should consider borrowing from copyright to develop its own version of thinness. 185 Thin trade secret would exist when the independent economic value or creation aspect of the secret is scant, such that the item of information qualifies for protection, but only just so.186 Unlike secret formula and manufacturing techniques, thin information would exist near the margins of trade secret protection. At this distance from the core conceptualization of what is protectable, they would rest on a lighter limb of the trade secret tree. In that case, the tug of a countervailing public policy interest would have particular force. One would not want defendants to simply claim any interest in the guise of public policy, however. Thus, thin copyright could be designed primarily for circumstances in which trade secret comes into conflict with other doctrinal areas embodying their own public policies. In those circumstances, the doctrine of thin trade secret creates space for navigating the boundaries. The doctrine of thin trade secret is distinct from the notion of confidential-but-not-secret information that a relational, nonproperty conception of trade secret law would entertain. Thin trade secret operates only when the information is within the bounds of statutory trade secret status, albeit at the edge of those bounds. In this manner, thin trade secret avoids the trap of creating a vague second tier of protectable information that falls outside the bounds of statutory trade secret protection, a development which would only incentivize the aggressive litigation of weak and nebulous claims, without the framework of rules and defenses the trade secret statutes provide to adjudicate and rebut such claims. There is a risk, of course, that with the existence of thin trade secret, judges could inadvertently sweep unwarranted information into the trade secret fold. Information might be easier to declare a trade secret, given the comfort of being able to deny protection in a particular case through the public interest. Without great care, such an approach could allow the boundaries of trade secret to creep ever wider across time. All jurisprudential arenas, however, face the temptation of rules of convenience, and the antidote is the same throughout. Regardless of the doctrinal area, courts and commentators must find analyses that can be applied with logical consistency across the regime, rather than resting on handy decisions in a particular case that create distinctions without a difference.187 The concept of thin trade secret has the potential to protect trade secret regime from a societal backlash as new claims stray into uncharted territory. Without such an outlet, courts, in frustration over expansive claiming, could be tempted to slash large and ambiguous swaths of territory, generating confusion in trade secret doctrine. By delineating an area of greater force for public policy, thin trade secret would cabin analysis into a common zone for discussion and thus lessen the chance of mayhem throughout the regime. To be sure, developing a theory of thin trade secret cannot be accomplished in one step. Practical questions, such as what justifications permit application of the concept and what degree of use or disclosure in particular concepts are weighed against protection, await future commentary. One could conceivably consider borrowing from copyright to develop a fair use trade secret defense. In that vein, courts could examine whether other policies might outweigh a finding that a party’s trade secret has been used. Thinness, however, has the advantage of signaling that the supposed trade secret just barely makes it over the line, a conclusion that seems particularly appropriate for these circumstances. Although intellectual property misuse may provide a useful pathway, we believe that more narrow and targeted rules will be important. In particular, at the dawn of doctrinal development, one would be welladvised to proceed with caution. Thus, the concept of thin trade secret provides a careful approach for recognition of expanding areas of innovation without trampling the public policies reflected in doctrinal areas with which trade secret must interact. Once again, the example of drug prices and regulatory disclosure is illustrative. As described above, naked price does not fall within the bounds of trade secrets. Even if a court were to find that bare negotiated price points between PBMs and pharmaceutical manufacturers fell within the bounds of trade secrets, those rights would be achingly close to the line. At most, if pricing information in the special context of PBM agreements were deemed to be a trade secret at all, it would be a thin and untraditional right, not core intellectual property. It should pale in comparison to thick IP rights such as manufacturing process details, formula details, and other scientific work products. A thin, barely-over-the-line trade secret hardly deserves the same deference in a regulatory disclosure context as the latter types of information.

#### The plan solves.

[Thomas **Hanna**, 9-21-20**20**, "Democratizing knowledge: Transforming intellectual property and research and development," Democracy Collaborative, [https://democracycollaborative.org/learn/publication/democratizing-knowledge-transforming-intellectual-property-and-research-and //](https://democracycollaborative.org/learn/publication/democratizing-knowledge-transforming-intellectual-property-and-research-and%20//) JB]

* Link turns cap Ks and setcol, read unhighlighted part
* R&D – research and development
* Specs patents

**As countries grapple with** the devastating **challenges of COVID-19** and **we**, hopefully, **move closer towards** the **development of a vaccine, the injustices and insufficiencies of the current approach to IP and R&D are becoming increasingly apparent. It is imperative that we quickly move away from the current system that prioritizes corporate profits sourced from monopoly rights to one that values and centers public health, social equality, and ecological sustainability**.

**The design**, implementation, and governance **of our IP and R&D systems are critically important**. However, the incredible rise of the intangible economy has dramatically altered these systems and our wider economic landscape. **Rather than stimulating and supporting the innovation needed to power the 21st-century digital economy**, the enclosure of **ownership of creations of the mind has been capitalized on to generate vast profits and considerably increase the power and control of a small group of large corporations and their owners. This** has **resulted in** a series of adverse **consequences, from** languishing **innovation to exacerbating racial, economic, gender, and geographic inequality**, to reducing competition, to abusive corporate practices related to workers’ rights, tax justice, and consumer protections. In sum, **it is becoming** increasingly **clear** to observers from **across the political spectrum that the current approach to IP and R&D is not fit for purpose.**

**Given** their inherently **political nature** and central role **in the economic system**, were **our IP and R&D systems to be transformed, they could be harnessed for the common good and to build an equitable, democratic, and environmentally sustainable future for all. Extending principles of democratic ownership is key to this transformation**. From the creation of a public knowledge commons, to substantially increasing public R&D funding, to embedding global solidarity and reparations, to challenging corporate power, to bolstering workers’

### Underview

#### 1] 1AR theory is legit – anything else means infinite abuse – drop the debater, round already skewed competing interp reasonability is arbitrary– 1AR is too short to make up for the time trade-off – no RVIs – 6 min 2NR means they can brute force me every time.

#### 3] Permissibility and presumption affirm.

**A] Freeze- otherwise we would not be able to justify morally neutral actions since there isn’t a prohibition and we would have to prove an obligation.**

B] Trivialism- statements are true until proven false, if I told you my name you’d believe me.

#### 2] Procedural fairness first a) probability – one round cant alter subjectivity, but it can rectify fairness skews, b) link turns their role of the ballot since it proves we couldn’t engage in it and it is exclusionary, c) answers are self-defeating since they presuppose the judge evals them fairly.

#### 3] Imagining extinction is good

Jessica Hurley 17, Assistant Professor in the Humanities at the University of Chicago, “Impossible Futures: Fictions of Risk in the Longue Durée”, Duke University Press, https://read.dukeupress.edu/american-literature/article/89/4/761/132823/Impossible-Futures-Fictions-of-Risk-in-the-Longue

If contemporary ecocriticism has a shared premise about environmental risk it is that genre is the key to both perceiving and, possibly, correcting ecological crisis. Frederick Buell’s 2003 From Apocalypse to Way of Life: Environmental Crisis in the American Century has established one of the most central oppositions of this paradigm. As his title suggests, Buell tells the story of a discourse that began in the apocalyptic mode in the 1960s and 70s, when discussions of “the immanent end of nature” most commonly took the form of “prophecy, revelation, climax, and extermination” before turning away from apocalypse when the prophesied ends failed to arrive (112, 78). Buell offers his suggestion for the appropriate literary mode for life lived within a crisis that is both unceasing and inescapable: new voices, “if wise enough….will abandon apocalypse for a sadder realism that looks closely at social and environmental changes in process and recognizes crisis as a place where people dwell” (202-3). In a world of threat, Buell demands a realism that might help us see risks more clearly and aid our survival.¶ Buell’s argument has become a broadly held view in contemporary risk theory and ecocriticism, overlapping fields in the social sciences and humanities that address the foundational question of second modernity: “how do you live when you are at such risk?” (Woodward 2009, 205).1 Such an assertion, however, assumes both that realism is a neutral descriptive practice and that apocalypse is not something that is happening now in places that we might not see, or cannot hear. This essay argues for the continuing importance of apocalyptic narrative forms in representations of environmental risk to disrupt conservative realisms that maintain the status quo

## 1AR

#### 1] Racial Capitalism thesis is incorrect – connection between Race and Cap is circumstantial not necessary

Walzer 20 Michael Walzer 7-29-2020 "A Note on Racial Capitalism" <https://www.dissentmagazine.org/online_articles/a-note-on-racial-capitalism> (a prominent American political theorist and public intellectual. A professor emeritus at the Institute for Advanced Study in Princeton, New Jersey)//Elmer

I have been puzzled for many months by the appearance of the phrase “racial capitalism” in the left press (see, for example, the article by K. Sabeel Rahman in the Summer 2020 issue of Dissent). What does it mean? Perhaps the adjective “racial” is simply an ordinary qualifying adjective. Racial capitalism is one kind of capitalism, and then there must be other kinds, requiring other adjectives. Here in the United States we have a kind of capitalism where the majority of exploited workers or a majority of the most exploited workers are people of color. The underclass and the reserve army are defined both racially and economically. Of course, no leftist writer would be indifferent to the exploitation of white workers, who might still make up the majority of the American workforce—and who are certainly the majority of exploited workers in Europe. The point of the adjective, then, is simply to focus our attention, for good reasons, on non-white workers. But is the exploitation of these workers a necessary feature of American capitalism? The phrase “racial capitalism” leaves us unclear about whether the hierarchical location of non-white workers is determined by race or by capitalism or by the two somehow working together. To begin to answer that question, we need to look at some examples of non-racial capitalism. The form of capitalism sponsored by the **Chinese communists** is obviously non-racial. Though the exploited workers are, in Western terminology, people of color, Western terminology is out of place here. If the Chinese imported white workers to take on the most menial jobs, that might make Chinese capitalism “racial,” **but no such importations have been reported**. The predatory version of capitalism that prevails in Putin’s Russia is also non-racial. It may be that Muslims are among the most exploited workers in Russia, but they are mostly Caucasian (some of them the original Caucasians), so we would have to talk about religious capitalism—where Orthodox Christians, not white people, are the privileged group. But no one is doing that. I have no statistics, but from what I read about China and Russia, I doubt that the rate of exploitation is higher in the United States, in racial capitalism, than it is in those two countries, **where capitalism is non-racial**. **Capitalism “works” with and without a racialized underclass** and reserve army. But is that right? The adjective “racial” sometimes makes a much stronger claim: it isn’t a qualifying but rather a definitional adjective. Capitalism is necessarily, inherently, racist. Forget about China and Russia, which are capitalist latecomers. Western capitalism is the prototypical version, and it has been racist from day one (if we can agree on day one)—always and forever racist. Does this mean that Manchester in 1844, as Engels described it, where all the exploited workers were white, wasn’t capitalist? No, for those workers were producing fabrics from cotton raised and harvested by Black slaves in the American South. That’s true enough, but I am not sure it is sufficient for an argument about necessity. Consider a counterfactual possibility: had no Black slaves been available, the recruitment of Irish workers would have started much earlier than it did. The rise of capitalism would not have been halted had the slave trade never begun. But the Manchester/Southern plantation example suggests what we all now know: capitalism is a global economic system, and it depends on the exploitation of people of color around the world. Here, however, it seems clear that the key **issue is exploitation, not racism**.

Given global demography, the majority of workers in any global economy will be people of color. Even in a democratically or social democratically regulated global system, the majority of workers and the majority of managers—the underclass and the overclass—will be non-white. Indeed, it would be the refusal of any transnational corporation to hire people of color that would rightly be called racist. (In the Pennsylvania town where I grew up, the local steel company did not hire, and therefore did not exploit, Jews or Black people. I suppose that this is also an example of racial capitalism.) All this suggests that capitalism and racism **have to be analyzed separately**. They overlap sometimes, as they do today in the United States. But the overlap is **circumstantial, not necessary**. **The two phenomena are distinct. They don’t rise and fall together. Each one, for different reasons, requires severe criticism and sustained opposition.** Many years ago, socialist writers argued that the triumph of the working class would liberate women, Jews, Black people, and everyone else. Separate political struggles against sexism, anti-Semitism, or racism were unnecessary—indeed they were a distraction from the all-important class war. Today some people on the left seem to believe that the end of racism will bring with it the downfall of capitalism. Both these theories are wrong. Overthrowing racism will still leave us with capitalism; overthrowing capitalism will still leave us with racism. Putting the adjective and noun together gives us a false sense of the **relationship** between the two phenomena. It might make sense, then, to ban the phrase from the pages of left newspapers and magazines. But since I am opposed to bans of that sort, I would only suggest that the phrase should always be queried by the editors. Do the writers who use it have some idea about what it means? Or are they just against racial capitalism, whatever it means?

#### 2] The alt fails – class focus results in a colorblind approach will either reproduce violence or drive the proletariat away.

**Belkhir 1** <Jean Ait. “Marxism Without Apologies: Integrating Race, Gender, Class; A Working Class Approach” Race, Gender & Class8.2 (Apr 30, 2001): 142.>

More than ever there is a need for the continued struggle against historical social inequalities based on race, class and gender. We need to integrate racism, sexism and classism into the Marxist analysis of capitalism in which race or gender or class serves as a point of entry through which the varied forms of social inequality can and must be understood. Thus, in recognizing the centrality of race, gender and class issues in the struggle against economic inequality and exploitation and cultural subordination and domination, we will be able to avoid the dramatic mistakes of the past that considered racism, sexism and classism as divisive issues.¶ Marxism and the "Woman Question"¶ In their article Marxist Theory and the Oppression of Women, Morrissey & Stoecker (1994) argue "those who follow Marx and Engels are left with a Marxist theory that is ambiguous on whether the source of women's oppression might be independent of the source of capitalism and whether this oppression could be ended by ending capitalism alone." Feminism often suggests that Marxism produced virtually nothing of real usefulness about gender inequality and the liberation of women. For Vogel (1983): "Marx and his collaborator Engels had little to say about the emancipation of women.... For them it was a marginal problem." As a result, the sexist bias in Marxism contributed to the growth of distortions in their analysis of capitalism. In her famous article entitled: The Unhappy Marriage of Marxism and Feminism: Towards a More Progressive Union, Hartman (1981) argued that: "The marriage of Marxism and feminism has been like the marriage of husband and wife depicted in English common law: Marxism and feminism are one, and that one is Marxism." As such feminists argued (e.g., Hartman, 1981), since capital and private property do not cause the inequality of women, their abolition alone will not result in the end of gender inequality. Only specifically feminist analysis revealed the systemic character of the patriarchal relations between men and women necessary to understand gender inequality.¶ Most women writing on feminism began with the central notion that there was a distinction between sex and gender and argued that "women" were not born, but made: the problem was culture, not nature that were at the center of women's so-called inferiority. Other feminist writers also argued that the end of capitalism or patriarchy would not necessarily end the objectification and "subordination" of women because the control was within culture and the unconscious. Some feminist theorists believe that the gender hierarchical system is more deeply embedded in the male ego and thus, the various changes in the social order have remained male dominated, whether capitalist, socialist, fascist, communist, authoritarian, or liberal. Central to the reproduction of the "inferiorisation of women" is the socialization process of children outside and inside the home where "the patriarchal ideology, that men are superior to women," are taught and, where the inferior position of women is reinforced by the churches, unions, armies, factories, offices, media, publicity, schools, etc. The extensive list of practices, such as clitoridectomy, infibulation, prostitution, pornography, rape, foot-banding, body-veiling, involuntary sterilization, and sex-object advertising, illustrate the unequal power relationship of women to men, and finally, modern Asia's anomaly; the girls who do not get born.¶ MARXISM AND THE "RACE PROBLEM."¶ Although much contemporary sociological writing concerns itself with analyses of race, theories of racial ethnic inequality have never been a priority in Marxist social science. As Geschwender & Levine (1994) reminds us: "Classical social theorists, such as Marx, Durkheim, and Weber, were not concerned with the race problem...The authors conclude their reviews of Classical and Recent Theoretical Developments in the Marxist Analysis of Race and Ethnicity in regretting that certain Marxist theorists make the error of denying the race problem in the U.S. For instance, Bonacich (1980) reduced racism to an ideological adjunct to class exploitation. Wallerstein (1972) came very close to eliminating the concept together by stripping it of any meaning independent of the exploitation process.¶ As consequence, Manning Marable (1996) argues that racism has blunted the critical faculties of white progressives from the colonial period to the present Blacks have seen an endless series of prominent white liberal and progressive allies betray their trust and embrace the politics of white supremacy. Marxists have always insisted that the flow of social history is determined by the relationship between subjective and objective factors -- the superstructure or ideological, cultural, and political apparatuses and the base, or forces of production. But what most American progressives and Marxists adhered to was a philosophy not of Marxism -- which also suggests that the relations between superstructure and base are reciprocal, each affecting the other -- but of economic determinism. Racism was, therefore, only part of the larger class question. Small wonder, then, that until today, no progressive or Marxist white organizations, Old Left or New, had won over any significant number of black and people of color activists, intellectuals, or workers.