## 1AC

### Top Level

#### Dr. Benjamin Mitra-Khan , a world renowned economist at the Australian patent office stated – “When it comes to intellectual property rights, not everything that glitters is gold.”

#### Thus I affirm the resolution Resolved – Member nations of the world trade organization ought to reduce intellectual property protections for medicines.

### Fwrk

#### My value is morality as per the word ought in the resolution

#### My value criterion is maximizing expected wellbeing

#### Prefer for actor specificity – governments must aggregate averages between populations to conduct accurate policy

#### Observation – the affirmative’s obligation is to prove that as a whole, intellectual property protections for medicines are immoral. Even if there’s one intellectual property that is good, so long as the affirmative proves that in general, IP are bad, that is sufficient to affirm. For example, if I say the statement that dogs make good pets indicating a dog that is bad pet doesn’t disprove the more holistic statement that dogs make good pets.

### Contention 1 – Vaccine Inequality

#### The status quo ensures vaccine imperialism. Intellectual property law is the lynchpin 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.

### Contention 2 – Innovation

#### 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.

#### US insulin prices are skyrocketing – lifesaving drugs for patients with diabetes are becoming more unaffordable.

Rajkumar 20 [S. Vincent Rajkumar, “The High Cost of Insulin in the United States: An Urgent Call to Action,” Mayo Clinic Proceedings, vol. 95, no. 1, Jan. 2020, pp. 22-28. Rajkumar, MD, is Consultant at the Division of Hematology, Department of Internal Medicine at the Mayo Clinic.] [CHSTM](file://CHSTM) recut //Lex VM

The most commonly used forms of analog insulin cost 10 times more in the United States than in any other developed country.3 There have been many other recent reports of deaths in patients with type 1 diabetes because of lack of affordable insulin.4,5 The high prevalence of diabetes, the chronic lifelong nature of the disease, and the fact that patients with type 1 diabetes will die without access to insulin make this an urgent problem that must be solved expeditiously. The price of insulin is also a stark and troubling example of the rising cost of prescription drugs in the United States and highlights a systemic problem with how drugs are priced compared with every other commodity.6,7 This commentary will address the reasons for the high cost of insulin and examine possible solutions. By understanding and solving this problem, we can create a roadmap that brings much needed reform and fairness to the existing system and helps make all prescription drugs more affordable.

The 3 main reasons cited by pharmaceutical companies for the high cost of new prescription drugs do not apply to insulin. First, the “high cost of development” is not relevant for a drug that is more than 100 years old; even the latest and most commonly used analog insulin products are all over 20 years old.8 Second, the pricing is not the product of a free market economy. Free market forces are clearly not operational; there is limited competition on price, the person who needs the product is not in a position to negotiate the price, and there is no relationship of price increases over time compared with overall market inflation. The price of insulin has risen inexplicably over the past 20 years at a rate far higher than the rate of inflation.9 One vial of Humalog (insulin lispro), which used to cost $21 in 1999, costs $332 in 2019, reflecting a price increase of more than 1000%.10-12 In contrast, insulin prices in other developed countries, including neighboring Canada, have stayed the same. Insulin pricing in the United States is the consequence of the exact opposite of a free market: extended monopoly on a lifesaving product in which prices can be increased at will, taking advantage of regulatory and legal restrictions on market entry and importation. Third, the arguments that high costs are needed for continued innovation and that attempts to lower or regulate the prices will hamper innovation are not a valid excuse.13 There is limited innovation when it comes to insulin; the more pressing need is affordability.

#### 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.

#### 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]

## Solvency

#### Thus, the advocacy – Resolved: The member nations of the World Trade Organization ought to reduce intellectual property protections for medicines.

#### 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’

#### The plan allows for direct state funding which is the only thing that can solve their future impacts

Lindsey 21 Brink Lindsey is Vice President and Director of the Open Society Project at the Niskanen Center. Previously he was the Cato Institute's vice president for research [Brink Lindsey, 6-3-2021, "Why intellectual property and pandemics don’t mix," Brookings, <https://www.brookings.edu/blog/up-front/2021/06/03/why-intellectual-property-and-pandemics-dont-mix/>] //Lex AKo

THE NATURE OF THE PATENT BARGAIN When we take the longer view, we can see a fundamental mismatch between the policy design of intellectual property protection and the policy requirements of effective pandemic response. Although **patent law**, properly restrained, **constitutes one important element of a well-designed national innovation system**, the way it goes about encouraging technological progress **is singularly ill-suited to the emergency conditions** of a pandemic or other public health crisis. Securing a TRIPS waiver for COVID-19 vaccines and treatments would thus establish a salutary precedent that, in emergencies of this kind, **governments should employ other, more direct means to incentivize the development of new drugs.** Here is the basic bargain offered by patent law: encourage the creation of useful new ideas for the long run by slowing the diffusion of useful new ideas in the short run. The second half of the bargain, the half that imposes costs on society, comes from the temporary exclusive rights, or monopoly privileges, that a patent holder enjoys. Under U.S. patent law, for a period of 20 years nobody else can manufacture or sell the patented product without the permission of the patent holder. This allows the **patent holder to block competitors from the market**, or extract licensing fees before allowing them to enter, and consequently charge above-market prices to its customers. Patent rights thus slow the diffusion of a new invention by restricting output and raising prices. The imposition of these short-run costs, however, can bring net long-term benefits by sharpening the incentives to invent new products. In the absence of patent protection, the prospect of easy imitation by later market entrants can deter would-be innovators from incurring the up-front fixed costs of research and development. But with a guaranteed period of market exclusivity, inventors can proceed with greater confidence that they will be able to recoup their investment. For the tradeoff between costs and benefits to come out positive on net, patent law must strike the right balance. **Exclusive rights should be valuable enough to encourage greater innovation, but not so easily granted or extensive in scope or term that this encouragement is outweighed by output restrictions** on the patented product and discouragement of downstream innovations dependent on access to the patented technology. Unfortunately, the U.S. patent system at present is out of balance. Over the past few decades, the expansion of patentability to include software and business methods as well as a general relaxation of patenting requirements have led to wildly excessive growth in these temporary monopolies: the number of patents granted annually has skyrocketed roughly fivefold since the early 1980s. One unfortunate result has been the rise of “non-practicing entities,” better known as patent trolls: firms that make nothing themselves but buy up patent portfolios and monetize them through aggressive litigation. As a result, a law that is supposed to encourage innovation has turned into a legal minefield for many would-be innovators. In the pharmaceutical industry, firms have abused the law by piling up patents for trivial, therapeutically irrelevant “innovations” that allow them to extend their monopolies and keep raising prices long beyond the statutorily contemplated 20 years. Patent law is creating these unintended consequences because policymakers have been caught in an ideological fog that conflates “intellectual property” with actual property rights over physical objects. Enveloped in that fog, they regard any attempts to put limits on patent monopolies as attacks on private property and view ongoing expansions of patent privileges as necessary to keep innovation from grinding to a halt. In fact, patent law is a tool of regulatory policy with the usual tradeoffs between costs and benefits; like all tools, it can be misused, and as with all tools there are some jobs for which other tools are better suited. A well-designed patent system, in which benefits are maximized and costs kept to a minimum, is just one of various policy options that governments can employ to stimulate technological advance—including tax credits for R&D, prizes for targeted inventions, and direct government support. PUBLIC HEALTH EMERGENCIES AND DIRECT GOVERNMENT SUPPORT For pandemics and other public health emergencies, patents’ mix of costs and benefits is misaligned with what is needed for an effective policy response. The basic patent bargain, even when well struck, is to pay for more innovation down the road with slower diffusion of innovation today. In the context of a pandemic, that bargain is a bad one and should be rejected entirely. Here the imperative is to accelerate the diffusion of vaccines and other treatments, not slow it down. Giving drug companies the power to hold things up by blocking competitors and raising prices pushes in the completely wrong direction. What approach to encouraging innovation should we take instead? How do we incentivize drug makers to undertake the hefty R&D costs to develop new vaccines without giving them exclusive rights over their production and sale? **The most effective approach** during a public health crisis **is direct government support: public funding of R&D, advance purchase commitments by the government to buy large numbers of doses at set prices, and other, related payouts**. And when we pay drug makers, we should not hesitate to pay generously, even extravagantly: **we want to offer drug companies big profits so that they prioritize this work** above everything else, and so that they are ready and eager to come to the rescue again the next time there’s a crisis.