#### The standard is maximizing expected well being

#### Pleasure and pain inherently good and bad. For instance when we touch a stove it hurts, and we do not want to do it again, but when we eat good food, we want to repeat the pleasurable experience. This means we need to maximize expected wellbeing so that we do not hurt people.

#### 1] Death is bad and outweighs – a) people can’t act if they fear for their bodily security which comes first b) it destroys the subject itself – kills any ability to achieve value in ethics since life is a prerequisite

#### 2] Actor spec—governments must use util because they don’t have intentions and are constantly dealing with tradeoffs—outweighs since different agents have different obligations

#### Extinction first –

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

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

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

#### 4 – Moral uncertainty – if we’re unsure about which interpretation of the world is true – we ought to preserve the world to keep debating about it

#### Use epistemic modesty for comparing impacts: that means take the probability of the impact and multiply it by how bad it is.

### Contention

#### 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 allow middle players to reap profits 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.

#### 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

#### 2] PBMs bar access to cancer drugs, Siddiquia 12

Mustaqeem Siddiquia, Oct 2012, "The High Cost of Cancer Drugs and What We Can Do About It," PubMed Central (PMC), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3538397/> //Lex AT

Current legislation also contributes to the high cost of drugs in the United States. As written into the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Medicare is prohibited from directly negotiating with manufacturers. Negotiation, instead, is done through local contractors. In addition, an array of legislation prevents Medicare from categorizing cancer drugs with related chemical structures and indications from being considered interchangeable, thereby eliminating competition in the market for an indication. Therefore, every drug has its own payment rate and unique billing code. This prevents Medicare from using strategies such as blended reimbursement and least costly alternative, which it uses for noncancer drugs to decrease or control prices. [20](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3538397/#bib20) This cedes pricing power to manufacturers, thus making Medicare a price taker.

#### Contagious Cancer is a major and legitimate threat AND causes extinction.

Johnson 16 George Johnson 2-23-2016 “Scientists Ponder the Prospect of Contagious Cancer” <https://www.nytimes.com/2016/02/23/science/scientists-ponder-the-prospect-of-contagious-cancer.html?mcubz=0> (columnist and science journalist for the New York Times, M.A. in Journalism and Public Affairs, American University)//Elmer

For all its peculiar horror, cancer comes with a saving grace. If nothing else can stop a tumor’s mad evolution, the cancer ultimately dies with its host. Everything the malignant cells have learned about outwitting the patient’s defenses — and those of the oncologists — is erased. The next case of cancer, in another victim, must start anew. Imagine if instead, cancer cells had the ability to press on to another body. A cancer like that would have the power to metastasize not just from organ to organ, but from person to person, evolving deadly new skills along the way. While there is no sign of an imminent threat, several recent papers suggest that the eventual emergence of a contagious human cancer is in the realm of medical possibility. This would not be a disease, like cervical cancer, that is set off by the spread of viruses, but rather one in which cancer cells actually travel from one person to another and thrive in their new location. So far this is known to have happened only under the most unusual circumstances. A 19-year-old laboratory worker who pricked herself with a syringe of colon cancer cells developed a tumor in her hand. A surgeon acquired a cancer from his patient after accidentally cutting himself during an operation. There are also cases of malignant cells being transferred from one person to another through an organ transplant or from a woman to her fetus. On each of these occasions, the malignancy went no further. The only known cancers that continue to move from body to body, evading the immune system, have been found in other animals. In laboratory experiments, for instance, cancer cells have been transferred by mosquitoes from one hamster to another. And so far, three kinds of contagious cancers have been discovered in the wild — in dogs, Tasmanian devils and, most recently, in soft shell clams. The oldest known example is a cancer that spreads between dogs during sexual intercourse — not as a side effect of a viral or bacterial infection, but rather through direct conveyance of cancer cells. The state of the research is described in a review, “The Cancer Which Survived,” published last year by Andrea Strakova and Elizabeth P. Murchison of the University of Cambridge. The condition, canine transmissible venereal tumor disease, is believed to have sprung into existence 11,000 years ago — as a single cell in a single dog — and has been circulating ever since. (Why did this happen in dogs and not, say, cats? Perhaps because of what the authors demurely call the dogs’ “long-lasting coital tie” — the half an hour or so that a male and female are locked in intercourse, tearing genital tissues and providing the cancer cells with a leisurely crossing.) Normally a cancer evolves in a single body over the course of years or decades, accumulating the mutations that drive it to power. But to have survived for millenniums, researchers have proposed, canine cancer cells may have developed mechanisms — like those in healthy cells — to repair and stabilize their own malignant genomes. Early on, cancer cells typically flourish by disabling DNA repair and ramping up the mutational frenzy. Somewhere along the way, the age-old canine cells may have reinvented the device to extend their own longevity. There is also speculation that this cancer may have learned to somehow modify canine sexual behavior in ways that promote the disease’s spread and survival. The second kind of contagious cancer was discovered in the mid-1990s in Tasmanian devils, which spread malignant cells as they try to tear off one another’s faces. Though it may be hard to sympathize, devil facial tumor disease threatens the creatures with extinction. With so few examples, transmissible cancer has been easy to dismiss as an aberration. But in December, scientists at the Universities of Tasmania and Cambridge reported in Proceedings of the National Academy of Sciences that Tasmanian devils are passing around another kind of cancer — genetically distinct from the first. It’s weird enough that one such cancer would arise in the species. What are the chances that there would be two? One theory is that the animals are unusually vulnerable. Driven so close to extinction — by climate change, perhaps, or human predators — the species is lacking in genetic diversity. The cells of another devil injected through a vicious wound may seem so familiar that they are ignored by the recipient’s immune system. If some of the cells carry the mutations for the facial cancer, they might be free to flourish and develop into a new tumor. But the scientists also proposed a more disturbing explanation: that the emergence of contagious cancer may not be so rare after all. “The possibility,” they wrote, “warrants further investigation of the risk that such diseases could arise in humans.” Cancer has probably existed ever since our first multicellular ancestors appeared on Earth hundreds of millions of years ago. The life spans of even the longest-lived animals may be just too brief for cancers to easily evolve the ability to leap to another body. Otherwise, contagious cancer would be everywhere.

#### The plan allows the USFG to fight for price reform, Pierson 8-12

Brendan Pierson, 8-12-2021, "PBMs sue U.S. to keep prescription drug prices hidden from public," Reuters, <https://www.reuters.com/legal/litigation/pbms-sue-us-keep-prescription-drug-prices-hidden-public-2021-08-12/> //Lex AT

(Reuters) - The Pharmaceutical Care Management Association, an organization representing pharmacy benefit managers, has sued the federal government in an effort to block a rule requiring them to disclose the net prices they negotiate with drug companies. In a [complaint](https://www.pcmanet.org/wp-content/uploads/2021/08/2021-08-12-1-PCMA-v.-HHS-Complaint.pdf) filed Thursday in Washington, D.C., federal court, the PCMA said the November 2020 rule would drive up prescription drug prices. The lawsuit targets the Department of Health and Human Services, Internal Revenue Service and Department of Labor, all of which were involved in the rule. The agencies did not immediately respond to requests for comment. Pharmacy benefit managers (PBMs) serve as intermediaries between drug manufacturers, health insurance plans and pharmacies to negotiate prescription drug prices. PBMs typically negotiate concessions below the nominal list prices of prescription drugs. The PCMA is challenging a provision of the rule set to take effect in January that would require them to disclose the historical net prices (list price minus a rebate) they negotiate with manufacturers. The information would have to be available to the public in a so-called machine-readable file, which can be processed by a computer. The rule, the organization said, threatens to "drive up the total drug price ultimately borne by health plans, taxpayers and consumers by advantaging drug manufacturers in negotiations over price concessions." Armed with information about prices negotiated between manufacturers and PBMs, the group said, manufacturers will be able to "tacitly collude with each other to increase drug prices." The group also said that the rule "offers consumers no actionable information because net prescription drug prices are not charged to consumers and never appear on a bill," and "will likely only confuse them." Furthermore, it said, ordinary consumers will not be able to interpret a machine-readable file. The PCMA alleges that the Affordable Care Act does not give the government the authority to require PBMs to disclose proprietary information. It also alleges that the requirement that the information be in a machine-readable file, which received negative comments during the notice and comment rulemaking period, is arbitrary and capricious under the Administrative Procedure Act. The lawsuit is the latest in a string of healthcare industry challenges to rules passed late in former President Donald Trump's administration aiming to curb prescription drug prices. While it is not yet clear whether President Joe Biden will seek to defend those specific rules, he has also pledged to lower drug prices. The Biden administration in February agreed to postpone a last-minute Trump administration rule aimed at lowering drug prices by restricting rebates from drug companies to PBMs, which had sued to block the rule. PhRMA, the nation's largest drug manufacturer group, also won a notable victory last December when a federal judge blocked a rule that would have tied Medicare reimbursement for some drugs to prices paid by other countries.

### We Solve

#### Plan – The member nations of the World Trade Organization ought to reduce intellectual property protections for medicines by increasing the bar for trade secrets in the TRIPS agreement.

#### 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.

#### Regulations exist in the status quo—BUT lack of transparency is the only barrier, Feldman 3

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

Public outcry over rising prices in the United States, particularly in contrast to comparable countries across the globe, has prompted numerous legislative and regulatory attempts to reform the system. More than 40 states have introduced legislation to address rising pharmaceutical pricing, with many of those bills directed at transparency in drug pricing. Transparency has been an issue for Congress and federal regulators as well, with the introduction of transparency bills and regulations.45 As state actors have sought to regulate or even investigate pharmaceutical pricing and practices, they have run into claims of trade secrecy. For example, Caremark is one of three major Pharmacy Benefit Managers that control 85% of the market. When the State of Ohio investigated in 2018 how PBMs spent state and federal funds, a third party prepared a report for the state which included details of such spending. Caremark then objected to publication of the report, filed a lawsuit seeking to suppress the report. In shrill language, the Pharmacy Benefit Manager argued that pricing information regarding prescription drugs in its contracts with entities that manage Medicaid for patients constituted “proprietary” “trade secrets,” such that publication would be “devastating,” with “severe financial harm” to its business.46 Trying to have it both ways, Caremark represented that the report it did not want the public to read found that “allegations against Caremark were not true” with respect to “preferential pricing.”47 Along the same lines, a California court enjoined the state from publishing information about a pharmaceutical company’s planned drug price increases before those prices would go into effect on the ground that for purposes of the order, the information constituted trade secrets.48