## **I negate the resolution, the member nations of the World Trade Organization ought to reduce intellectual property protections for medicines.**

**To clarify,**

**WTO 21** *What is the WTO?* (2021). Wto.org. <https://www.wto.org/english/thewto_e/whatis_e/whatis_e.htm>

**WTO -- the only global international organization dealing with the rules of trade between nations**

**Intellectual property protections** -- **protection for inventions, literary and artistic works,symbols,**

**names, and images created by the mind**

<https://www.upcounsel.com/intellectual-property-protection>

**Reduce --** **to diminish in size, amount, extent, or number**  
<https://www.merriam-webster.com/dictionary/reduce>

**Medicine** -- **a substance or preparation used in treating disease**  
<https://www.merriam-webster.com/dictionary/medicine>

**I value Morality**

**The value criterion is Maximizing well being Prefer:**

#### The standard is maximizing expected well-being. Prefer:

#### 1] Only pleasure and pain are intrinsically valuable – all other frameworks collapse.

Moen 16 [Ole Martin Moen, Research Fellow in Philosophy at University of Oslo “An Argument for Hedonism” Journal of Value Inquiry (Springer), 50 (2) 2016: 267–281] TDI

Let us start by observing, empirically, that a **widely shared judgment about intrinsic value and disvalue is that pleasure is intrinsically valuable and pain is intrinsically disvaluable. On virtually any proposed list of intrinsic values and disvalues (we will look at some of them below), pleasure is included among the intrinsic values and pain among the intrinsic disvalues.** This inclusion makes intuitive sense, moreover, for **there is something undeniably good about the way pleasure feels and something undeniably bad about the way pain feels, and neither the goodness of pleasure nor the badness of pain seems to be exhausted by the further effects that these experiences might have.** “Pleasure” and “pain” are here understood inclusively, as encompassing anything hedonically positive and anything hedonically negative.2 **The special value statuses of pleasure and pain are manifested in how we treat these experiences in our everyday reasoning about values.** If you tell me that you are heading for the convenience store, **I might ask: “What for?” This is a reasonable question, for when you go to the convenience store you usually do so,** not merely for the sake of going to the convenience store, but for **the sake of achieving something further that you deem to be valuable.** You might answer, for example: “To buy soda.” This answer makes sense, for soda is a nice thing and you can get it at the convenience store. I might further inquire, however: “What is buying the soda good for?” This further question can also be a reasonable one, for it need not be obvious why you want the soda. You might answer: “Well, I want it for the pleasure of drinking it.” **If I then proceed by asking “But what is the pleasure of drinking the soda good for?” the discussion is likely to reach an awkward end. The reason is that the pleasure is not good for anything further; it is simply that for which going to the convenience store and buying the soda is good.**3 As Aristotle observes**: “We never ask [a man] what his end is in being pleased, because we assume that pleasure is choice worthy in itself**.”4 Presumably, a similar story can be told in the case of pains, for if someone says “This is painful!” we never respond by asking: “And why is that a problem?” We take for granted that if something is painful, we have a sufficient explanation of why it is bad. If we are onto something in our everyday reasoning about values, it seems that **pleasure and pain are both places where we reach the end of the line in matters of value.**

#### 2] If everyone has equal value, the rational solution is to maximize the lives and pleasure of as many as possible. We are all fundamentally equal, meaning some must give way for the sake of others.

#### 3] Actor specificity: A] Governments must aggregate since every policy benefit some and harms others, which also means side constraints freeze action. B] States lack wills or intentions since policies are collective actions. C] Actor-specificity comes first since different agents have different ethical standings.

**4] Uncertainty- if we’re unsure about which interpretation of the world is true, we should preserve the world to keep debating about it, extinction first.**

**5] Util is scientifically justified—brain studies show**

**Saalfield 12** Peter; Harvard Magazine; The Biology of Right and Wrong; <https://harvardmagazine.com/2012/01/the-biology-of-right-and-wrong;>

Unlike earlier philosophers, he can test his theories with neuroscientific instruments. His primary tool is functional magnetic resonance imaging (fMRI), which takes advantage of the fact that many mental functions are localized to specific areas of the brain. **Deliberative reasoning**, for instance, **is housed in the prefrontal cortex,** whereas the amygdala is considered the seat of the emotions. **By monitoring blood flow to these areas, fMRI allows Greene and his colleagues to observe exactly when someone is relying on “manual mode” or “automatic settings.”** For one experiment (published in Neuron in 2004), **Greene asked** his **subjects how they would respond to** a moral dilemma known as **“the trolley problem,”** which involves **pushing an innocent stranger** in front of a speeding trolley **in order to save five** other strangers from being killed. Despite the utilitarian value of killing a single stranger, most respondents said that doing so would be morally wrong: the thought of pushing an innocent person to his death was too much. Yet a handful of **subjects (who) said they would end the stranger’s life** in order to rescue the others, and Greene found that this group **exhibited increased activity in the dorsolateral prefrontal cortex,** a brain region he calls “the heart of manual i.e., rational mode.” More recently, though, Greene’s research has led to a slight alteration in his camera analogy. In a series of experiments published in Neuron in 2010, he used fMRI to further explore the interface between rationality and emotion. Again he scanned the brains of subjects responding to the trolley problem, but this time he repeatedly altered the number of lives at stake and the likelihood that the victims could be saved. **With 40 lives on the line and a 95 percent chance of their deaths without intervention,** for example, **nearly every test subject was willing to sacrifice one life to save the rest.** But with 15 people at risk and a 50-50 chance for their survival, Greene reports, “Respondents were split down the middle as to whether they would intervene.” As his subjects considered these variations, they all showed increased activity in brain areas that assign emotional value to items like food and money (the ventral striatum and the insula) and also in a region thought to integrate different approaches to decision-making (the ventromedial prefrontal cortex).

**This means that moral questions are physically answered by utilitarianism. Brain scans explain that before we can prioritize intents, we follow neurological patterns that indicate util is the only standard truly constitutive of humanity.**

## ****Contention 1: Reducing IP Protections on medicines kills innovation which is key to preventing bioterror and disease extinction****

#### The biopharmaceutical industry is uniquely reliant on IP protections – undermining them would kill innovation by making an already expensive process completely unfeasible.

Kristina M. Lybecker, PhD, 17 [PhD Economics, Associate Professor of Economics @ Colorado College], “Intellectual Property Rights Protection and the Biopharmaceutical Industry: How Canada Measures Up,” Fraser Institute, January 2017, <https://www.fraserinstitute.org/sites/default/files/intellectual-property-rights-protection-and-the%20biopharmaceutical-industry.pdf> C.VC

The unique structure of **the innovative biopharmaceutical industry necessitates** a variety of intellectual property protection mechanisms. In particular, the industry is characterized by a research and development (**R&D**) process that **is** lengthy, expensive, uncertain, and risky. According to DiMasi and colleagues, **the estimated cost of developing a new medicine is** US$2.6 billion (DiMasi, Grabowski, and Hansen, 2016).2 In addition**, the time** required to develop a new drug **is also significant, averaging 10 to 15 years** without any guarantee of success (PhRMA, n.d.). While these figures are highly controversial, biopharmaceutical innovation is unquestionably an expensive and lengthy undertaking.3 For the biopharmaceutical industry, innovation and its protection **are essential** and the source of both profits and growth. As such**, patent protection is** disproportionally more important for ensuring that the innovator appropriates the returns to R&D **for the** biopharmaceutical industry than virtually any other. Extending the findings of the 1987 “Yale Survey” (Levin, Klevorick, Nelson, and Winter, 1987), the “Carnegie Mellon Survey” established that while patents are again considered “unambiguously the least effective appropriability mechanisms,” the drug industry and other scholars regard them as strictly more effective than alternative mechanisms (Cohen, Nelson, and Walsh, 1996). The industry’s disproportionate reliance on patents and other forms of intellectual property protection is confirmed in numerous other studies.4

In essence, **IPR** protections **provide innovative biopharmaceutical firms with** an **assurance of some** return on their investment, thus **creating incentives for the** development of new technologies **that could otherwise be** easily replicated and sold by competitors. Due to the tremendous fixed costs required to develop new treatments and cures, a significant potential exists for **free riding** by follower firms, a market failure that **would** prevent investment in innovation were it not for the patents and other forms of intellectual property protections that provide a limited period of market exclusivity or other such incentives. Fundamentally, patents amount to an efficiency tradeoff. Society provides innovators with a limited period of market exclusivity to encourage innovation in exchange for public access to this knowledge. In exchange for the temporary static loss from market exclusivity, society gains complete knowledge of the innovation through disclosure, a permanent dynamic gain. Through this tradeoff, the existing patent system corrects the market failure that would stymie innovation. In its Apotex Inc. v. Wellcome Foundation Ltd. finding, Justice Binnie wrote for the Supreme Court of Canada, “A patent, as has been said many times, is not intended as an accolade or civic award for ingenuity. It is a method by which inventive solutions to practical problems are coaxed into the public domain by the promise of a limited monopoly for a limited time. Disclosure is the quid pro quo for valuable proprietary rights to exclusivity which are entirely the statutory creature of the Patent Act” (para. 37).

The biopharmaceutical industry is characterized by a number of legal and economic issues that distinguish it from other research-intensive industries. Danzon (1999) describes three features that are particularly noteworthy. First, given that the biopharmaceutical industry is characterized by an unusually high rate of R&D, intellectual property protection provides for the potential for significant market power and monopoly pricing that raises numerous public health policy questions surrounding prices and profits. Second, virtually **every aspect of the industry is** heavily regulated**, from safety and efficacy to** promotion and **advertising**, to pricing and reimbursement. Danzon describes **the impact of these regulations as “**profound and multidimensional **even within a single country, affecting consumption** patterns, productivity**, R&D and** hence **the supply of future technologies**” (Danzon, 1999: 1056). Lastly, while research and development costs are borne solely by the innovator, the resulting product is a global public good. “Each country faces an incentive to adopt the regulatory policies that best control its pharmaceutical budget in the short run, free-riding on others to pay for the joint costs of R&D and ignoring cross-national spillovers of national regulatory policies through parallel trade and international price comparisons” (Danzon, 1999: 1056). The combination of these characteristics defines a set of unique economic and legal challenges for the innovation of new drugs and the public health policies that surround their production, marketing, and distribution.

Innovative companies make far greater investments in time, resources, and financial support than do generic firms. Notably, **innovation-based companies spend** more than 200 times **that which generic companies spend** on the development of a particular drug (CIPC, 2011: 10). In addition, the investment of time, from laboratory to market, is also close to double for innovative companies relative to generic producers. Table 1 highlights the differences in the drug development processes of innovative and generic companies. For innovative biopharmaceutical companies, **the development process is expensive, risky, and time consuming, all of which points to the need for strong IP protection** to encourage investment and ensure companies are able to recover their investments.

The risk involved in biopharmaceutical development is starkly illustrated in a recent report by Biotechnology Innovation Organization (BIO), which reports that **less than one of every 10 drugs that enter clinical trials is ultimately approved** by the Food and Drug Administration in the United States. The report finds a success rate of merely 9.6%, a calculation that is significantly smaller than the widely-cited 11.8% figure from a 2014 study by the Tufts University’s Center for the Study of Drug Development.5 The International Federation of Pharmaceutical Manufacturers and Associations (2012) estimates that more than 3,200 compounds were at different stages of development globally in 2011, but only 35 new medicines were launched (Dawson, 2015).

Fundamentally, research-based biopharmaceutical companies incur greater expenses and risk in the development of their products than do generic manufactures. These investments of time and financial resources should be recognized and the effective patent life should be sufficient to recoup these investments. Continued investment and innovation are contingent upon strong, effective intellectual property protection and the ability of innovative firms to recoup their investments. Patents and other forms of intellectual property protection are disproportionally important to the research-based biopharmaceutical industry. Consequently, the legal architecture necessary to foster a robust innovation-based industry is multifaceted and is a powerful force shaping the biopharmaceutical industry, its profitability, productivity, and innovative future.

**Pharmaceutical innovation is key to protecting against future pandemics, bioterrorism, and antibiotic resistance.**

**Marjanovic and Fejiao ‘20** Marjanovic, Sonja, and Carolina Feijao. Sonja Marjanovic, Ph.D., Judge Business School, University of Cambridge. Carolina Feijao, Ph.D. in biochemistry, University of Cambridge; M.Sc. in quantitive biology, Imperial College London; B.Sc. in biology, University of Lisbon. "Pharmaceutical Innovation for Infectious Disease Management: From Troubleshooting to Sustainable Models of Engagement." (2020). [Quality Control]

As key actors in the healthcare innovation landscape, pharmaceutical and life sci-ences companies have been called on to develop medicines, vaccines and diagnostics for pressing public health challenges. The COVID-19 crisis is one such challenge, but there are many others. For example, MERS, SARS, Ebola, Zika and avian and swine flu are also infectious diseases that represent public health threats. Infectious agents such as anthrax, smallpox and tularemia could present threats in a **bioterrorism con-text**.1 The general threat to public health that is posed by **antimicrobial resistance** is also **well-recognised** as an area **in need of pharmaceutical innovation**. Innovating in response to these challenges does not always align well with pharmaceutical industry commercial models, shareholder expectations and compe-tition within the industry. However, the expertise, networks and infrastructure that industry has within its reach, as well as public expectations and the moral imperative, make pharmaceutical companies and the wider life sciences sector an **indispensable** partner in the search for solutions that save lives. This perspective argues for the need to establish more sustainable and scalable ways of incentivising pharmaceu-tical innovation in response to infectious disease threats to public health. It considers both past and current examples of efforts to mobilise pharmaceutical innovation in high commercial risk areas, including in the context of current efforts to respond to the COVID-19 pandemic. In global pandemic crises like COVID-19, the urgency and scale of the crisis – as well as the spotlight placed on pharmaceutical companies – mean that **contributing to the search for effective medicines**, vaccines or diagnostics is **essential** for socially responsible companies in the sec-tor.2 It is therefore unsurprising that we are seeing indus-try-wide efforts unfold at unprecedented scale and pace. Whereas there is always scope for more activity, industry is currently contributing in a variety of ways. Examples include pharmaceutical companies donating existing com-pounds to assess their utility in the fight against COVID-19; screening existing compound libraries in-house or with partners to see if they can be repurposed; accelerating tri-als for potentially effective medicine or vaccine candidates; and in some cases rapidly accelerating in-house research and development to discover new treatments or vaccine agents and develop diagnostics tests.3,4 Pharmaceutical companies are collaborating with each other in some of these efforts and participating in global R&D partnerships (such as the Innovative Medicines Initiative effort to accel-erate the development of potential therapies for COVID-19) and supporting national efforts to expand diagnosis and testing capacity and ensure affordable and ready access to potential solutions.3,5,6 **The** primary **purpose of such innovation is to benefit patients and** wider **population health**. Although there are also reputational benefits from involvement that can be realised across the industry, there are likely to be rela-tively few companies that are ‘commercial’ winners. Those who might gain substantial revenues will be under pres-sure not to be seen as profiting from the pandemic. In the United Kingdom for example, GSK has stated that it does not expect to profit from its COVID-19 related activities and that any gains will be invested in supporting research and long-term pandemic preparedness, as well as in developing products that would be affordable in the world’s poorest countries.7 Similarly, in the United States AbbVie has waived intellectual property rights for an existing com-bination product that is being tested for therapeutic poten-tial against COVID-19, which would support affordability and allow for a supply of generics.8,9 Johnson & Johnson has stated that its potential vaccine – which is expected to begin trials – will be available on a not-for-profit basis during the pandemic.10 Pharma is mobilising substantial efforts to rise to the COVID-19 challenge at hand. However, we need to consider how pharmaceutical innovation for responding to emerging infectious diseases can best be enabled beyond the current crisis. Many public health threats (including those associated with other **infectious diseases**, **bioterror-ism** agents **and antimicrobial resistance**) are **urgently in need of pharmaceutical innovation**, **even if their impacts are not as visible** to society **as COVID**-19 is in the imme-diate term. The pharmaceutical industry has responded to previous public health emergencies associated with infec-tious disease in recent times – for example those associated with Ebola and Zika outbreaks.11 However, it has done so to a lesser scale than for COVID-19 and with contribu-tions from fewer companies. Similarly, levels of **activity in response to** the threat of **antimicrobial resistance are** still **low**.12 There are important policy questions as to whether – and how – industry could engage with such public health threats to an even greater extent under improved innova-tion conditions.

## Contention Two:

## Alternative plan: Universal Healthcare CP

#### Counterplan-text: The members nations of the United Nations ought to implement a global Medicare for all or Universal healthcare program.

Pollitz et al. 18 Pollitz, Karen, et al. “Medicare-for-All and Public Plan Buy-In PROPOSALS:

Overview and Key Issues - ISSUE BRIEF.” *KFF*, 9 Oct. 2018, www.kff.org/report-section/medicare-for-all-and-public-plan-buy-in-proposals-overview-and-key-issues-issue-brief/. Executive Director, Program on Medicare Policy Senior Advisor to the President Washington, DC 202-347-5270 As senior vice president of the Henry J. Kaiser Family Foundation (KFF) and Executive Director of the KFF’s Program on Medicare Policy, Tricia Neuman oversees KFF’s policy analysis and research pertaining to Medicare, and health coverage and care for aging Americans and people with disabilities. A widely cited Medicare policy expert, Dr. Neuman focuses on topics such as the health and economic security of older adults, the role of Medicare Advantage plans, Medicare and out-of-pocket spending trends, prescription drug costs, payment and delivery system reforms, and policy options to strengthen Medicare for the future. Dr. Neuman received a Doctorate of Science degree in health policy and management and a Masters of Science degree in health finance and management from the Johns Hopkins School of Public Health.  She received her Bachelor’s degree from Wesleyan University. Karen Pollitzis a Senior Fellow at the Henry J. Kaiser Family Foundation (KFF).  She works on the Program for the Study of Health Reform and Private Insurance, tracking implementation of private market reforms with a focus on consumer protections.  Prior to joining KFF, she worked at the US Department of Health and Human Services on national health reform (2010-2011 and 1993-1997) and directed research on private health insurance at the Georgetown University Health Policy Institute. She has a Master’s Degree in Public Policy from the University of California, Berkeley, and a BA from Oberlin College. Jennifer Tolbert is Director of State Health Reform at the Henry J. Kaiser Family Foundation and an Associate Director for the Program on Medicaid and the Uninsured.  Ms. Tolbert leads an initiative to monitor state implementation of the Affordable Care Act with a particular focus on state efforts to establish health insurance marketplaces. She also directs research and policy analysis focusing on issues of affordability for low-income populations and areas of intersection between Medicaid and the health insurance marketplaces, such as eligibility and enrollment and consumer assistance.  In addition, Ms. Tolbert manages State Health Facts, a source for state-level data on over 800 key health topics. Prior to joining KFF, Ms. Tolbert served as the Assistant Vice President for Policy at the National Association of Public Hospitals and Health Systems and before that she worked in the Office of the Assistant Secretary for Planning and Evaluation at the Department of Health and Human Services.

Medicare-for-All, an approach championed most recently by Senator Sanders in the Senate and Representative Ellison in the House, represents the most sweeping proposed change to the U.S. health insurance system among these proposals. Once fully implemented, a single, federal, government-administered program would provide coverage to all U.S. residents**. Medicare-for-All would replace virtually all other sources of private health coverage** (employment-sponsored plans and insurance offered inside and outside ACA marketplaces) and most public programs, including Medicare, Medicaid and CHIP. Medicare-for-All would result in a major shift in the way in which health care is financed in the U.S. — away from households, employers and states to the federal government and taxpayers. The new Medicare-For-All program **would cover all medically necessary service**s, with defined categories of benefits to be covered, as well as dental and vision services — a broader definition of benefits than is currently covered by Medicare or by the ACA essential health benefits. Under the Ellison bill, the new public plan would also cover long-term services and supports (LTSS), whereas under the Sanders bill, Medicaid would continue to provide LTSS. The Sanders bill would have the public plan cover **all reproductive health services**, including abortion, and would repeal the Hyde Amendment. Under both bills, there would be no premium or cost-sharing requirements, other **than limited cost sharing (**up to $200 per year) **on prescription drugs** to encourage the use of generics under the Sanders bill. The Sanders bill would establish a beneficiary ombudsman program to help consumers with complaints, grievances, and requests for information, and to track and identify for the Secretary of Health and Human Services issues and problems in payment or coverage policies. Both **Medicare-for-All proposals would establish a global budget for health expenditures**. In addition, they would **create a national fee schedule to** make payments to hospitals and other facilities, doctors and other health professionals, and prohibit balance billing. The Sanders bill would establish a fee schedule consistent with Medicare payment rates, and a new process for updating such rates. The Ellison bill would take a somewhat different approach, establishing Medicare payment rates through negotiations between providers and State and regional directors, subject to the approval of the Medicare director. The Sanders bill would **leave an option for providers and patients to enter into private contacts** instead of using Medicare, while the Ellison bill has no similar provision. The Ellison bill would prohibit participation in Medicare by for-profit hospitals and facilities and by investor-owned provider practices. Both bills would require the Secretary to negotiate drug prices with manufacturers The on-budget **cost** of the new Medicare-for-All program would be **partially offset by** the elimination of current federal spending obligations for public programs (e.g., Medicare, Medicaid, CHIP), **tax expenditures for employer-sponsored coverage and subsidies for ACA marketplace coverage**. Both bills envision administrative savings associated with having one payer, and with having a single, Medicare-for-All fee schedule with lower rates than would otherwise be paid by employers and private insurers. The Ellison bill generally describes new revenue sources to cover additional costs; the Sanders bill, as drafted, does not specify further financing, although other financing options are described in a separate white paper. The Sanders bill **envisions a four-year phase-in period for implementation. During this time, a transitional public plan option**, similar to Medicare, would be **offered** through the marketplace with enhanced income-related subsidies available. Also during the phase-in period, the current Medicare program would be enhanced with a new out-of-pocket limit on annual cost sharing for Medicare-covered services, coverage of dental and vision benefits, and by expediting Medicare coverage for people with disabilities on SSDI by eliminating the 24-month waiting period. FEDERAL PUBLIC PLAN OPTION Three proposals would establish a federal public plan option to build upon, rather than replace, the current blend of private insurance and public coverage. In general, the bills aim to address some of the shortcomings in ACA marketplaces by giving individuals and employers a new option that may provide more affordable coverage. Two of these proposals invoke Medicare in naming the public plan (Medicare Part E and Medicare-X); the Schakowsky bill incorporates many of Medicare’s features in the public plan, without using its name. Under all three bills, the public plan option would be offered alongside private insurance through the ACA marketplace to individuals and small employers eligible to purchase coverage there. Two of the bills would also offer the public plan in the individual and small group markets outside of the marketplace. The Merkley bill would further extend eligibility to large employers who could obtain coverage under the public plan on behalf of their employees, while remaining in compliance with ACA requirements. The Merkley bill would allow large employers to buy fully insured large group policies from Medicare Part E, transferring risk to the public program. It would also allow self-insured group plans to retain risk and contract with Medicare Part E for third-party administrative services, such as paying claims and establishing a provider network and fee schedule. The Bennet bill would phase in the public program, beginning in areas with limited competition. All three bills would make **the public plan eligible for marketplace premium and cost-sharing subsidies for eligible individuals**. The Merkley bill would expand income eligibility for both premium and cost-sharing subsidies throughout the marketplace and enhance these subsidies for all participants by tying them to Gold-level plans. None of the bills would affect ACA subsidies for small employers. Under each of the three proposals, the new public plan would cover (at a minimum) all ACA essential health benefits. The Merkley Medicare Part E plan would also cover all Medicare benefits (Parts A, B, and D), all reproductive services, and abortion. The Schakowsky and Bennet bills would offer the public plan at all ACA metal levels and would apply the ACA annual out-of-pocket limit on cost sharing. Under the Merkley bill, the public plan would be offered at the Gold metal tier, and all marketplace subsidies would be tied to the Gold tier (vs. the Silver tier under current law), which would result in reduced cost sharing for most marketplace participants. The Merkley bill would also enhance financial protections under the current Medicare program by adding an out-of-pocket limit on cost sharing, which could affect program spending and premiums. All three bills would set the public plan premium to cover all costs for covered benefits and require the public plan to follow ACA rating rules. The Merkley bill would also extend ACA rating rules to the large group market, a departure from current law. Two of the proposals contain new consumer assistance provisions. The Schakowsky bill would establish an office of the ombudsman for the public plan to educate consumers about this coverage option and help them resolve complaints and grievances. The Merkley bill would authorize direct federal spending for marketplace navigator programs (vs current law funding by marketplaces) at funding levels needed to address capacity limitations. The Merkley bill also would require employers that do not offer health benefits to refer their employees to navigators. All three proposals **would require hospitals, physicians and other health care providers participating in Medicare to participate in the new public plan; this would result in a broad network of providers because the vast majority of all hospitals and physicians participate in the current Medicare program.** The Schakowsky and Bennet bills would also require Medicaid providers to participate in the public plan which would include pediatricians and others who may be less likely to treat the current Medicare population. Providers would have the ability to opt out of participating in the public plan without penalty under the Schakowsky bill. The three proposals would also require the Secretary to allow other providers to participate in the public plan – an important consideration in providing health coverage for children, and for meeting the needs of individuals with special needs. All three bills would extend Medicare payment rates, or some variation on those rates, to providers participating in the public plan to help lower the overall cost of the program, which in turn would reduce premiums and out-of-pocket cost sharing for patients. The Schakowsky proposal would have the Secretary negotiate rates with providers, using Medicare payment rates as a back-up, if negotiations are not successful. The Bennet proposals would use Medicare rates for the new Medicare-X plan, and authorize the Secretary to increase rates by up to 25% in rural areas. The Merkley proposal directs the Secretary to negotiate payment rates for Medicare Part E, between Medicare and private insurance plan rates. None of the public plan option bills specifically prohibits balance billing by physicians and other providers who treat patients enrolled in the public plan; however to the extent that they adopt Medicare payment rates and rules, these bills would appear to apply Medicare limits on balanced billing to the public plan. Under current rules, participating providers agree to accept assignment for all of their Medicare patients, and are prohibited from balance billing; non-participating providers do not agree to accept assignment for all patients or all services, and may choose to charge patients higher fees, up to a certain limit. All three bills acknowledge ongoing public concern about prescription drug costs by authorizing the Secretary to negotiate drug prices for the new public plan; two of the three proposals (Bennet and Merkley) would extend this policy to the current Medicare program. Under current law, the Secretary is prohibited from negotiating payments with drug manufacturers on behalf of Medicare Part D enrollees. The Merkley proposals is the only one of the three bills to include a failsafe to leverage lower drug prices under Medicare Part E and the current Medicare program. If negotiations are not successful in obtaining an appropriate price as determined by the Secretary, prices would be paid based on the lesser of those paid by the Veterans Administration or the federal supply schedule. In other respects, the three bills do not change the current Medicare program, other than the limit on out-of-pocket spending added to the current Medicare program under the Merkley proposal.

#### Medicare for all solves evergreening

**Narayanan 19** Narayanan, Srivats. “Medicare for All and Evergreening.” *Medium*,

Medium, 15 Aug. 2019, medium.com/@srivats.narayanan/medicare-for-all-and-evergreening-cb84c930e0ea. Srivats Narayanan is a Medical Student at the University of Missouri–Kansas City

Drug companies rake in massive profits. The pharmaceutical industry has some of the largest profit margins among American industries. Unfortunately, pharmaceutical giants don’t always have patients’ best interests in mind — they make a big portion of their money by exploiting the patent process instead of making breakthrough drugs that would meaningfully improve patients’ lives. Pharmaceutical corporations aren’t as innovative as one might expect. Although the Food and Drug Administration (FDA) has been consistently approving new (and expensive) drugs every year, most of these drugs aren’t impacting healthcare much. Many studies have revealed that a whopping 85–90% of new drugs since the mid-1990s “provide few or no clinical advantages.” This is because pharmaceutical firms are spending their time and money on a technique known as “evergreening.” Evergreening is when drug companies produce redundant drugs that are nothing but minor modifications of old drugs. By making slight alterations to their medicines, biotech companies continue to hold patents for drugs with minimal spending on research and development (R&D). Pharmaceutical companies then use those patents to prevent competitors from selling generic versions of their drugs. Without any competition, these corporations get away with ridiculously high drug pricing and can thus make big profits on their drugs. The companies simultaneously justify their absurd drug prices by pointing to the inflated R&D costs of producing new drugs. This excuse has been used time and again by the profit-hungry pharmaceutical industry, and it’s coming at the expense of patients who struggle to afford their medicines. A well-known example of evergreening pertains to the anticonvulsant medication gabapentin, which was first sold by Pfizer under the brand name Neurontin. When the drug became available as a generic medication over a decade ago, Pfizer created a very similar medicine, pregabalin (Lyrica), that didn’t have any significant benefits over the original drug. As a result, Pfizer has kept a control over the market for anticonvulsant drugs with negligible innovation. The drug industry’s reliance on evergreening is undoubtedly stifling innovation. This is where **Medicare for All**, which would impose the government as the only health insurer, **would be useful. In our current system, there are many insurers and they each have little market power** and consequently little negotiating power to reduce treatment prices. Since **the government would have consolidated control over healthcare financing under Medicare for All, its stronger bargaining power would force drug companies to charge lower prices for their products**. In addition, prescription drugs would be paid for by the government and not by patients under Medicare for All**. Medicare for All would prevent evergreening**. **National healthcare financing would align how much the government pays a drug company with how much patients benefit** from the company’s drugs. If a new drug had more clinical benefits than an older version, the government would pay more for it. If a new drug produced the same results as an older version, the government wouldn’t pay more for the new drug. So, **Medicare for All would encourage pharmaceutical companies to pursue truly innovative drugs because such drugs would be more profitable**. The policy would incentivize companies to invest in R&D for more useful drugs, instead of just producing redundant and expensive medications. A national healthcare plan would prioritize “patient and community needs” and match up pharmaceutical companies’ interests with actually improving public health. Evergreening has become the name of the game for the pharmaceutical industry. A major solution to the evergreening problem is Medicare for All. A single-payer system like **Medicare for All would sharply curtail evergreening**, since drug companies wouldn’t be able to profit from it. Medicare for All would **usher in a new era of medical innovation.**

#### 5 million die yearly from lack of quality healthcare and medicines, IPP reductions can’t solve

**Schreiber 18** Schreiber, Melody. “What Kills 5 Million People a YEAR? It's Not Just Disease.” *NPR*, NPR, 5 Sept. 2018,

https://www.npr.org/sections/goatsandsoda/2018/09/05/644928153/what-kills-5-million-people-a-year-its-not-just-disease. Melody is the D.C. correspondent for ArcticToday, where she covers climate change, geopolitics, gender and more in the circumpolar North. Her articles, essays and reviews have also been published by The Washington Post, The Guardian, The New Republic, New York, Wired, The Atlantic, Pacific Standard, Outside, NPR, STAT News, Vice, Insider, The Toast, Catapult, USA Today, Washingtonian, Delaware State News and elsewhere. Her fiction has been published by District Lines, Magical: An Anthology, and Abundant Grace. Melody’s newsletter, Not a Doctor, covers health, science, parenting and more from a personal lens. Right now, she has a strong focus on Covid-19. Melody reported on health and gender in Rwanda in 2019 on a reporting fellowship with the International Women’s Media Foundation (IWMF). Her story on malaria surveillance, for Undark Magazine, was selected as a Notable mention in Best American Science and Nature Writing 2021. As a journalism fellow with the GroundTruth Project in 2015-16, Melody reported first on the Paris climate agreement and then on the relationship between climate change and mental health in the Scandinavian and Canadian Arctic. Her story on mental health and climate change, with photographer Camilla Andersen for Pacific Standard, was selected as a Notable mention in Best American Science and Nature Writing 2019. She has spoken on CNN, C-SPAN Radio and Feature Story News, and Working Mother wrote about her email signature and efforts to balance working parenthood. Previously, Melody worked as a program manager and communications director at the International Reporting Project (IRP), and before that she was an assistant editor at the Woodrow Wilson International Center for Scholars. Before that, she worked at a tire shop, a telemarketing bank, a motorcycle shop, and food and retail businesses. (Mostly not at the same time.) Melody received her bachelor’s degree in English and linguistics from Georgetown University, and her master’s degree in writing from the Johns Hopkins University. As an alumna, she helped to teach science policy courses for Hopkins’ graduate science writing program in 2019 and 2020.

In the global health world, giving people access to health care — even if they're just basic services — has long been a top priority. But what if that approach is wrong? A new report published in The Lancet on Wednesday finds that when it comes to health, quality — not quantity — seems to be more important. The study estimates that **5 million people die every year because of poor-quality health care in low- and middle-income countries**. That's significantly more than the **3.6 million people in those countries** who **die from not having access to care**. It's also five times more than annual deaths from HIV/AIDS (1 million) and three times more than diabetes (1.4 million) in the same countries — although, of course, poor health care for these conditions can also be fatal. "For a very long time in global health, we have been really mandating and supporting and pushing access to care, without really thinking about what happens when people get to the clinic," says Dr. Margaret Kruk, the co-commissioner of this study and a professor at the Harvard T. H. Chan School of Public Health. These **findings come from** The Lancet Global Health Commission on High Quality Health Systems, **a two-year project** on measuring and improving the quality of health systems around the world. The commission is **made up of 30 experts** — academics, policymakers, health advocates — **in 18 countries**. **Their data comes from** a range of surveys, including household surveys in **47 countries**, a survey they conducted about quality of care and 81,000 assessments of care by researchers, funded by USAID, who observed health visits at clinics and hospitals in 18 countries. NPR spoke with Kruk about the study.This interview has been condensed and edited for clarity. What was perhaps the biggest finding of the report? There are **8.6 million deaths every year in low- and middle-income countries** — the majority of the world, 134 countries — that **could have been saved with good-quality health systems.** These were deaths from treatable conditions because people didn't get good care. Of that 8.6 million, we found that 5 million were people who got care but just got poor quality care. The remaining 3.6 million were because of a lack of access, which has been the traditional focus in global health. What are examples of poor health care? On average, in health care visits, we see providers typically follow fewer than half of the recommended clinical actions. For very sick children, an average length of visit might be 6, 7 or 8 minutes with a nurse. It's too little time to properly assess that child. In a five-country sample in sub-Saharan Africa, only 50 percent of providers can accurately diagnose pneumonia or diabetes — very common conditions. The system as a whole is failing people. There are huge delays. If someone comes forward with concerns of cancer in a low-income country, there can be months of delay between that visitation and actual diagnosis — never mind treatment. It's a crisis, particularly when governments all over the world are trying to expand health insurance. **If your insurance services won't save lives, what is the real value in expanding** insurance and universal health coverage? Can you talk about the background of this commission? Together with my co-chair, Muhammad Pate, who was the former Minister of State for Health in Nigeria, we assembled a group of people who are academics thinking about health systems and how they function, and another group of people who are on the ground, struggling to improve health systems in the field. The whole premise of the commission is to say: How are we doing on quality globally? We were concerned the focus on access has overshadowed our understanding of what actually happens in health systems. What is the message for health-care systems? If health systems are to improve health, they have to do two things. They have to promote utilization of essential services that save lives — malaria treatment, HIV treatment and so on. But they also have to deliver on good-quality treatment, good-quality care. As you mentioned, global health has long focused on providing access to care. Now, it seems the focus is shifting to equity, to equitable access — for instance, making sure women and children receive the same quality of care as men, or that poor people receive the same level of care as their richer neighbors. It's interesting that you use the word "equity." The other major focus [of the study was on] vulnerable groups. We looked at people who are poor, who are less educated, people who have stigmatized conditions, teenagers who are pregnant. And even in a setting of relatively poor overall care, they get worse care. Even just simple treatments. For example, younger teenagers are less likely to get iron [supplements] during a prenatal care visit. Equity is critical, but I would add the word "quality." It's about access to quality services. What does quality health care look like? For us, quality is about three things. One is effective care that can improve or maintain health. The second is about earning the trust of people. The third is that systems have to adapt and adjust. That means a quick adjustment when there's an outbreak but also the ability to change over time. Fundamentally, the big shift we propose is that systems should be for and about people. We should be judging them on what they do for people — not how many doctors they train. About 1 in 3 patients consistently has a poor experience of care. Disrespectful care, extremely short visits, poor communication, long wait times. Many parents — 40 to 50 percent — leave the clinic without knowing the child's diagnosis. Is it because the provider doesn't know or is it because the provider isn't communicating? That's hard to say in a survey. But the fact remains that the parent walks out not knowing what's going on. You've mentioned child health in particular. Did your research focus on that? If so, why? The reason I mentioned children is because the strongest data we have, and the most complete, are in those areas. The Millennium Development Goals have really been about children and women, in large part, and infectious diseases. So when you look at current measurement systems and surveys and research, they are quite focused on women, children, people with HIV and so on. We wanted to speak broadly about the range of health priorities in low-income countries — which includes noncommunicable diseases, cardiovascular disease, accidents and so on. Mental health is another huge area. But we found extremely limited data. We are calling these complete blind spots right now. You mentioned a previous focus, in global health, on infectious disease. According to this report, the total number of deaths from poor-quality health care is five times higher than HIV/AIDS. These numbers are really large. We identified about 5 million deaths due to poor quality among people already using the health system. When you look at global deaths from cardiovascular disease, it's about 2.5 million. Then there's about 900,000 tuberculosis deaths. It's an epidemic, really, of poor quality. Even though access to care is still incomplete — people with depression still can't get services, people with cancer often cannot get any care in low-income countries — even with that low level of access, quality is the bigger challenge. What are the potential solutions? Probably the biggest surprise for me is in this question of how we improve. That's because when we examine the evidence of very commonly used improvement strategies — checklists, refresher trainings, supervision — we were quite disappointed in the effectiveness of those strategies and the inability of these things to scale. Even if you have a result in one clinic, we have no samples where that's permeated the whole country. So we took a very different look at improvement. A lot of the improvement has been focused at the point of care — right at the moment where the provider meets the patient. But actually, given the scale of the problem, we need to move further back to a much more foundational strategy. We identified four universal actions. The first is establishing a system-wide focus on quality, because there's no accountability today. There's no system to sound an alarm, and there needs to be one. Second, **you've got to redesign health systems**. A lot of health systems today are organized to maximize access — a lot of small clinics spread out over a large territory. Just to give you an example, in the U.S., Australia, and other wealthy countries, very few women deliver in hospitals that don't offer C-sections — almost none. But in a five-country study we did in sub-Saharan Africa, we found that almost 1 in 3 babies born in health facilities are at very, very low-level [facilities] without C-sections, with minimally trained workers. This is an example where a service like delivery should be moved up to the hospital where surgery could be provided. Let's put that service in place and help women get to the hospital, rather than waiting for complications to develop in that remote clinic. Third, the health workforce education in many low- and middle-income countries is just really outdated. Clinicians come out very good at identifying pathologies on slides but have a harder time doing problem-solving and connecting with patients. And then the last area of improvement for us was public demand. In most service industries, it is the pressure of customers that often improves the product or service. Yet in health care, we ignore patients as consumers. Many people anticipate low quality and have low expectations. But people do want good care. So how do those people get better services? We really do need to gather together and think about what we can do to support low-income countries in the transformation we're calling for. One thing is **introducing new measures and new knowledge** that **will help one country learn from another**. We have to stop flooding the countries with quick fixes and shiny solutions. High-quality health systems are fundamentally a political issue. It's a critical moment for leaders to see what people are looking for from the health system.

#### Solvency Advocate: Global Universal Healthcare is possible and within reach. Countries have already begun discourse and declared intentions

**UN 19** *Achieving Universal Health Coverage by 2030 Hinges on “Bold National Leadership”,*

*Secretary-General Tells General Assembly, as World Leaders Commit to Declaration | Meetings Coverage and Press Releases*. (2019). Un.org. <https://www.un.org/press/en/2019/ga12181.doc.htm>

## World leaders gathering at the United Nations Headquarters today approved an action‑oriented political declaration on universal health coverage, committing themselves to achieving that objective by 2030. By the terms of the declaration, which was forwarded to the General Assembly for formal adoption at a later date, world leaders reaffirmed the right of every human being, without distinction of any kind, to the enjoyment of the highest attainable standard of physical and mental health, committing to accelerate efforts towards the achievement of universal health coverage. “Shockingly, half the world’s people are still waiting to exercise that right, with serious consequences for us all,” with some 100 million people worldwide impoverished by catastrophic health‑care expenses, said United Nations Secretary‑General António Guterres in his opening remarks to the high‑level meeting, held under the theme of “Universal health coverage: Moving together to build a healthier world”. The declaration approved today is the most comprehensive agreement ever reached on global health — a vision for universal health coverage by 2030, Mr. Guterres said, describing it as a “significant achievement” that will drive progress over the next decade on communicable diseases including HIV/AIDS, tuberculosis and malaria, while addressing non‑communicable disease and antimicrobial resistance through robust and resilient primary health‑care systems. The United Nations stands ready to assist Member States in these endeavours, but “making universal health coverage a reality by 2030 depends first and foremost on bold national leadership,” he stressed. Also addressing the opening segment of the meeting was Tijjani Muhammad-Bande, President of the seventy‑fourth session of the General Assembly, who said that genuine universal health care can only be realized through continued cooperation to improve infrastructure, especially for transport, allowing people to easily reach medical centres, and through seizing the opportunities created by technology advances and the information revolution. Indeed, he said, the old medical adage that prevention is better than cure holds true today and he called for continued investment in research to better equip countries in preventing disease. Tedros Adhanom Ghebreyesus, Director‑General of the World Health Organization, said that lack of access to affordable primary health care is a problem not only in low‑income countries, but also in high‑income ones, where cancer patients often choose death due to the financial disaster treatment would bring to their families. No one should have to make such a choice, he stressed, calling on countries to spend an additional 1 per cent of gross domestic product (GDP) on primary health care and make a crucial shift to people‑centred quality services. Investing an additional $200 billion a year on scaling up such services across low‑ and middle‑income countries would potentially save 60 million lives and increase average life expectancy by 3.7 years by 2030. “Ultimately, health is a political choice,” he emphasized, adding that the declaration approved today is a powerful statement. David R. Malpass, President of the World Bank Group, noted that the financing gap in the world’s 54 poorest countries — representing 1.5 billion people — is $176 billion annually. Closing it requires delivering good outcomes in four priority areas, including greater investments in affordable primary health care, engaging the private sector, supporting communities through education and job creation, and mobilization of domestic resources. If leaders commit to building smarter, data‑driven health systems, they can deliver quality health care and the World Bank will be a committed partner in those efforts, he added. Gro Brundtland, eminent high‑level champion of universal health coverage and member of The Elders, said that health cannot be left to the free market, as only the wealthy will access services, while the poor are plunged further into poverty. She said that universal health coverage can only be achieved through public financing, recalling that 30 years ago, development agencies and Western Governments pressured developing countries into cutting health budgets and pushing the burden onto households. “This was a huge mistake,” she said, warning that the situation persists today in countries dominated by out‑of‑pocket payment models and calling on all States to “ban this practice immediately”. In the ensuing panel discussion, titled “Universal Health Coverage as a Driver of Equity, Inclusive Development and Prosperity for All”, participants explored ways to operationalize the commitments made in the political declaration at the national level. In another panel discussion, titled “Accelerating multi‑sectoral and multi‑stakeholder action and investments for achieving universal health coverage”, participants tackled questions such as how to effectively and efficiently finance universal health coverage strategies through additional domestic revenue, budgetary reallocation, multisectoral policies and partnerships. In closing remarks, Mr. Ghebreyesus of the World Health Organization said history was made today, with Governments committing to a world in which no one misses out on quality health services simply because they lack access or cannot afford them. Noting that Japan began its journey to universal health coverage not when it was prosperous, but rather when it was weak after the Second World War, he said universal health coverage laid the foundation for it to become the economic powerhouse it is today. “No country can flourish if its people are trapped in cycles of diseases and poverty” he said. Japan Prime Minister Shinzo Abe expressed hope that every country attains universal coverage, as health is the cornerstone of human security, describing that national ownership and health financing for the vulnerable are key to achieving such services for all. Melinda Gates, Co-Chair and Trustee of the Bill and Melinda Gates Foundation, said that prioritizing primary health care requires hard trade-offs, urging Governments to regard primary health care as the most effective investment for their countries.