## Disclosure

#### A] Interpretation: Debaters must, on the page with their name and the school they attend, disclose all taglines, full citations, and the first and last three words of the pieces of evidence read in their cases on the NDCA wiki at least one hour before the round

#### B] Violation: My opponent hasn’t posted cites: I can provide screen shots if necessary.

#### C] Net Benefits:

**1] Research** – disclosure increases research and gets rid of anti-educational arguments because debaters are forced to prepare cases knowing that people will have answers AND people get the opportunity to research answers to disclosed cases.

**Nails 13** - (Jacob [I am a policy debater at Georgia State University. I debated LD for 4 years for Starr's Mill High School (GA) and graduated in 2012.] "A Defense of Disclosure (Including Third-Party Disclosure)" http://nsdupdate.com/2013/a-defense-of-disclosure-including-third-party-disclosure-by-jacob-nails/)

I fall squarely on the side of disclosure. I find that **the largest advantage of widespread disclosure is the educational value it provides.** First, **disclosure streamlines research. Rather than every team and every lone wolf researching completely in the dark, the wiki provides a public body of knowledge that everyone can contribute to and build off of.** Students can look through the different studies on the topic and choose the best ones on an informed basis without the prohibitively large burden of personally surveying all of the literature. **The best arguments are identified and replicated, which is a natural result of an open marketplace of ideas. Quality of evidence increases across the board. In theory,** the increased quality of information **[this] could trade off with quantity**. If debaters could just look to the wiki for evidence, it might remove the competitive incentive to do one’s own research. **Empirically**, however**, the opposite has been true.** In fact, a second advantage of **disclosure is that it motivates research. Debaters cannot expect to make it a whole topic with the same stock AC – that is, unless they are continually updating and frontlining it.** Likewise, **debaters with access to their opponents’ cases can do more targeted and specific research. Students can go to a new level of depth, researching not just the pros and cons of the topic but the specific authors, arguments, and adovcacies employed by other debaters.** The incentive to cut author-specific indicts is low if there’s little guarantee that the author will ever be cited in a round but high if one knows that specific schools are using that author in rounds. In this way, disclosure increases incentive to research by altering a student’s cost-benefit analysis so that the time spent researching is more valuable, i.e. more likely to produce useful evidence because it is more directed. In any case, if publicly accessible evidence jeopardized research, backfiles and briefs would have done LD in a long time ago. Lastly, and to my mind most significantly, **disclosure weeds out anti-educational arguments. I have in mind the sort of theory spikes and underdeveloped analytics whose strategic value comes only from the fact that the time to think of and enunciate responses to them takes longer than the time spent making the arguments themselves. If [theory spikes] these arguments were made on a level playing field where each side had equal time to craft answers, they would seldom win rounds, which is a testimony to the real world applicability (or lack thereof) of such strategies.** A model in which arguments have to withstand close scrutiny to win rounds creates incentive to find the best arguments on the topic rather than the shadiest. Having transitioned from LD to policy where disclosure is more universal, I can say that **debates are more substantive, developed, and responsive when both sides know what they’re getting into prior to the round**. The educational benefits of disclosure alone aren’t likely to convince the fairness-outweighs-education crowd, but I’ve learned over the course of many theory debates that most of that crowd has a very warped and confusing conception of fairness. **Debaters who produce better research are more deserving of a win. Debaters who can make smart arguments and defend them from criticism should win out over debaters who hide behind obfuscation.** That so many rounds these days are resolved on frivolous theory and dropped, single-sentence blips suggests that wins are not going to the “better debaters” in any meaningful sense of the term. The structure of LD in the status quo doesn’t incentivize better debating.

**2] Clash** – Disclosure is the best method for increasing clash in debates because it allows debaters to substantively engage positions rather than relying on sketchy tricks to avoid the discussion. It also allows for more specific clash because debaters can see specific arguments disclosed instead of trying to link generic arguments in. Key to education because without clashing ideas there is no in-round eductaion

#### 3] Evidence ethics

Let’s be realistic: disclosure is the only way to prevent evidence distortion before it occurs. Without transparency and publicity, competitors have no way to check their opponents' evidence until after the debate, after the wrong has occurred, and decisions disclosed. At a fast-paced national tournament, the window of opportunity to redress such wrongs is slim to none. This is key to fairness because debates with evidence ethics violations are inherentky unfair.

#### D] Voters:

Drop the debater to set a norm – if they lose they’ll disclose in the future

The voters are fairness and education. Fairness is constitutive of competition because we assume that the judge makes their decision after listening to both sides equally and coming to a just conclusion. Education is the only long-term impact of the round and skills we learn in debate are portable. The reason that we are in this round debating in the first place is because our schools fund debate and they do that because of the educational value.

No RVIs: They force the round to be decided on theory—the round ends once the judge determines who wins theory. That kills all substantive engagement because there’s no topical debate.

Prefer competing interps over reasonability as it is more productive and generates more clash which is more productive for the debate. Argumentation of how to better the debate space is infinitely more productive than justifying a subjective measure of “reasonable” amounts of abuse.

Theory comes first: fairness and education are prereqs to substantive debate

Graphical user interface, application

Description automatically generated with medium confidence(JPG OR John Paul The Great Academy not on wiki)

## Framing

#### I value morality as implied by the word ought in the resolution with a criterion of preventing structural violence.

#### Structural Violence is

Farmer, Connors & Simmons, 1996, “Women, Poverty, and AIDS: Sex, Drugs, and Structural Violence” Monroe, Maine: Common Courage Press./ Livingston RB

large scale forces ranging from gender inequality and racism to poverty which structure unequal access to goods and services

#### You should privilege everyday violence for two reasons- A) social bias underrepresents its effects B) its effects are exponential, not linear which means even if it only causes a small amount of structural violence, its terminal impacts are huge

**Nixon ’11** (Rob, Rachel Carson Professor of English, University of Wisconsin-Madison, Slow Violence and the Environmentalism of the Poor, pgs. 2-3)

Three primary concerns animate this book, chief among them my conviction that we urgently need to rethink-politically, imaginatively, and theoretically-what I call "slow violence." By slow violence I mean a violence that occurs gradually and out of sight, a violence of delayed destruction that is dispersed across time and space, an attritional violence that is typically not viewed as violence at all. Violence is customarily conceived as an event or action that is immediate in time, explosive and spectacular in space, and as erupting into instant sensational visibility. We need, I believe, to engage a different kind of violence, a violence that is neither spectacular nor instantaneous, but rather incremental and accretive, its calamitous repercussions playing out across a range of temporal scales. In so doing, we also need to engage the representational, narrative, and strategic challenges posed by the relative invisibility of slow violence. Climate change, the thawing cryosphere, toxic drift, biomagnification, deforestation, the radioactive aftermaths of wars, acidifying oceans, and a host of other slowly unfolding environmental catastrophes present formidable representational obstacles that can hinder our efforts to mobilize and act decisively. The long dyings-the staggered and staggeringly discounted casualties, both human and ecological that result from war's toxic aftermaths or climate change-are underrepresented in strategic planning as well as in human memory. Had Summers advocated invading Africa with weapons of mass destruction, his proposal would have fallen under conventional definitions of violence and been perceived as a military or even an imperial invasion. Advocating invading countries with mass forms of slow-motion toxicity, however, requires rethinking our accepted assumptions of violence to include slow violence. Such a rethinking requires that we complicate conventional assumptions about violence as a highly visible act that is newsworthy because it is event focused, time bound, and body bound. We need to account for how the temporal dispersion of slow violence affects the way we perceive and respond to a variety of social afflictions-from domestic abuse to posttraumatic stress and, in particular, environmental calamities. A major challenge is representational: how to devise arresting stories, images, and symbols adequate to the pervasive but elusive violence of delayed effects. Crucially, slow violence is often not just attritional but also exponential, operating as a major threat multiplier; it can fuel long-term, proliferating conflicts in situations where the conditions for sustaining life become increasingly but gradually degraded.

#### it’s a prerequisite. Morality must be applied equally to everyone, or else it wouldn’t be moral. Oppression excludes minorities from moral consideration.

#### Winter and Leighton explain:

Deborah DuNann Winter and Dana C. Leighton. Winter "Peace, conflict, and violence: Peace psychology in the 21st century." 1999

Finally, to recognize the operation of structural violence forces us to ask questions about how and why we tolerate it, questions which often have painful answers for the privileged elite who unconsciously support it. A final question of this section is how and why we allow ourselves to be so oblivious to structural violence. Susan Opotow offers an intriguing set of answers, in her article Social Injustice. She argues that our normal perceptual/cognitive processes divide people into in-groups and out-groups. Those outside our group lie outside our scope of justice. Injustice that would be instantaneously confronted if it occurred to someone we love or know is barely noticed if it occurs to strangers or those who are invisible or irrelevant. We do not seem to be able to open our minds and our hearts to everyone, so we draw conceptual lines between those who are in and out of our moral circle. Those who fall outside are morally excluded, and become either invisible, or demeaned in some way so that we do not have to acknowledge the injustice they suffer. Moral exclusion is a human failing, but Opotow argues convincingly that it is an outcome of everyday social cognition. To reduce its nefarious effects, we must be vigilant in noticing and listening to oppressed, invisible, outsiders. Inclusionary thinking can be fostered by relationships, communication, and appreciation of diversity. Like Opotow, all the authors in this section point out that structural violence is not inevitable if we become aware of its operation, and build systematic ways to mitigate its effects. Learning about structural violence may be discouraging, overwhelming, or maddening, but these papers encourage us to step beyond guilt and anger, and begin to think about how to reduce structural violence. All the authors in this section note that the same structures (such as global communication and normal social cognition) which feed structural violence, can also be used to empower citizens to reduce it. In the long run, reducing structural violence by reclaiming neighborhoods, demanding social justice and living wages, providing prenatal care, alleviating sexism, and celebrating local cultures, will be our most surefooted path to building lasting peace.

#### Ethical theories must directly address structural violence first, otherwise they cannot be considered moral

## Contention 1: Access

#### IP drives up the costs of life saving medication

**Jung and Kwon 15** [Jung, Youn, Institute of Health and Environment, Seoul National University, Seoul, Republic of Korea and Soonman Kwon, School of Public Health, Seoul National University, Seoul, Republic of Korea, July 2015, “The Effects of Intellectual Property Rights on Access to Medicines and Catastrophic Expenditure,” *International Journal of Health Services, vol. 45*, no. 3, pp. 507–29. DOI.org (Crossref), doi:10.1177/0020731415584560]/ Triumph Debate

However, under the Agreement on Trade-Related Intellectual Property Rights (TRIPS) in 1995, all nations as a condition of membership in the WTO had to recognize and enforce product patents in all fields of technology, including pharmaceuticals (compliance was postponed until 2005 for developing countries and 2016 for least-developed countries). In addition to the multilateral pressures derived from membership in the World Trade Organization, developing countries also face bilateral pressures from the United States to impose even higher levels of intellectual property protection (TRIPS-Plus), even though TRIPS provides a relatively high level of protection to IPR. These include data exclusivity, banning of parallel importing, linkage of marketing approval process and the patent status of a drug, increase in the scope for patentability, and extension of the patent protection period.3 The main problem caused by this monopoly on the pharmaceutical market, including patent protection for pharmaceuticals in many poor countries, is that the production and import of cheaper generic medicines would be delayed. As a result, average medicine prices will increase and people in low-income countries will suffer from a deficiency of pharmaceutical supply and limited access to medicines, considering that they lack capacity to develop and produce medicines by themselves. There is growing evidence that stronger protection of IPR for pharmaceuticals may adversely impact medicine prices. Duggan and Goyal4 found a significant increase in the market share of patented drugs and an increase in average prices after the introduction of stronger product patents by exploring the effects of introducing product patents for central nervous system drugs. Borrell5 also found that patents shifted drug prices up, through his analysis of sales data on human immunodeficiency virus (HIV) and acquired immune deficiency syndrome (AIDS) drugs in 34 developing countries between 1995 and mid-2000. Watal6 simulated the maximum likely increase in pharmaceutical prices in India when product patents are introduced in the existing 22 patentable pharmaceutical markets after TRIPS agreement (Patentable pharmaceuticals are defined throughout this article as pharmaceuticals that are on product patents elsewhere where such patents are allowed. Following is the list of 22 patentable pharmaceuticals: Cefuroxime sodium, Cefaclor, Netilmicin, Albendazole, Fluoxetine, Aciclovir, Domperidone, Ranitidine, Cefotaxime Sodium, Ketorolac, Norfloxacin, Pefloxacin, Ketoconozole, Famotidine, Enalapril Maleate, Omeprazole, Astemizole, Ceftazidime, Ciprofloxacin, Ofloxacin, and Roxithromycin). This price rise was estimated from 26% up to 242%, depending on demand function. Maskus and Konan7 and Subramanian8 estimated maximum price increases up to 67% as a result of the introduction of pharmaceutical product patent rights.

#### High costs because of patents uniquely harm minority communities

**ACRE 20** [Action Center on Race and the Economy, August 2020, “Poi$on: How Big Pharma’s Racist Price Gouging Kills Black and Brown Folks,” Action Center on Race and the Economy, [https://acrecampaigns.org/wp-content/uploads/2020/08/new-poison-final.pdf]/](https://acrecampaigns.org/wp-content/uploads/2020/08/new-poison-final.pdf%5d/) Triumph Debate

As this report goes to press, Gilead’s decision to charge over $3,000 for remdesivir, a COVID-19 drug that was jointly developed by Gilead and federal research agencies, is reigniting debate about drug pricing in the United States.ii At the same time, COVID-19 itself has brought structural racism in the U.S. health care system to the foreground as Black and Brown communities bear vastly disproportionate levels of COVID-19 infections and death. Systemic race-based exclusion, discrimination, and violence in employment, housing, policing, and health care have created greater risk for COVID-19 exposure, infection, complications, and death in Black and Brown communities.iii Under the U.S. model of monopoly drug patents, Black and Brown people have also been exposed to more concentrated risk of price gouging by pharmaceutical companies. This report confronts the complicity of price gouging by pharmaceutical companies in racial and ethnic health inequities by bringing together two sets of research: data analysis showing that Black and Latinx patients are forced to ration medications at higher rates than white patients and historical analysis of the monopoly patent model, which gives private, for-profit pharmaceutical companies power over drug pricing. Price gouging excludes Black and Brown communities from access to medications for the chronic diseases that put patients at higher risk of death from COVID-19. Drug-pricing debates often focus on what prices pharmaceutical companies should charge rather than whether pharmaceutical companies should have the power to set prices for medicine. The public interest in government-regulated pharmaceutical pricing is undeniable: $33 billion in government-funded drug research makes most new drug discoveries possible; price gouging adds significant costs to public programs, like Medicare and Medicaid; and medication rationing due to high cost leads to avoidable complications and premature death, defeating the fundamental public health goals of prevention and health equity. The decision to rely on a monopoly patent model that cedes pricing power completely to pharmaceutical companies has always been motivated by neoliberal ideology. Medical innovation, the stated rationale for monopoly patents and inflated prices, is stymied by the maze of intellectual property protections that protect private pricing power. The profits that ostensibly incentivize research and development for breakthrough medicines actually flow directly to Wall Street in the form of stock buybacks and dividend payments. A steady stream of political contributions and payments to researchers and medical providers props up the narrative of private profits as “the price of progress.” This rationale dismisses the damage, disproportionately afflicting Black and Brown communities, that results from price gouging essential medications. Our Preexisting Condition: Race COVID-19 has shined a light on long-standing health inequities that harm Black and Latinx communities. The higher prevalence and mortality rates of Black and Latinx COVID-19 patients mirror the heightened incidence of diabetes, hypertension, heart disease, and other illnesses that put Black and Brown people at greater risk for COVID-19 complications and death. At the root of the United States’ social and economic system is the plunder of wealth and health from Black and Indigenous people and other people of color to enrich wealthy white individuals and institutions. The much-discussed economic and health disparities experienced by these communities are the result of this targeted racial discrimination. Yet the disproportionate effect of prescription drug price gouging on Black and Latinx communities is rarely mentioned, even as the competition for COVID-19 vaccines and cures puts pharmaceutical companies at the center of attention. Across insurance status, age, and disease type, Black and Latinx patients report higher rates of medication rationing—forgoing or delaying filling a prescription, skipping doses, and reducing doses below the prescribed amount due to cost.iv Even before the current pandemic, medication rationing due to inflated prices was contributing to unconscionable levels of preventable disease and death in Black and Latinx communities. This should be a forewarning of the likely barriers to access to COVID-19 vaccines and medicine and of the empty promises of pharmaceutical companies to mitigate the harm of their own practices. Consider diabetes and hypertension, two conditions that appear to be strongly associated with COVID-19 mortality and that disproportionately afflict Black and Latinx people. Black people are twice as likely as whites to have hypertension, are more likely to experience the onset of hypertension at younger ages,v and are more likely to experience severe complicationsvi Latinx hypertension patients are less likely than white people to have their blood pressure controlled, and Mexican Americans are more likely to die from hypertensionvii Black and Latinx people are both more likely than whites to have diabetes and more likely to die from diabetes Latinx patients have higher rates of diabetes-related kidney failure and vision lossviii Black people with diabetes have higher rates of kidney failure and amputationsix A strong body of evidence shows that high levels of stress due to racial and ethnic discrimination, including that involving police encounters, are associated with elevated blood pressure and high levels of inflammation (which is a characteristic of diabetes, hypertension, and COVID-19) in Black and Latinx people. The heightened vigilance and 8 anticipatory stress that characterize Black and Latinx people’s attempts to cope with persistent but unpredictable threats of racism in their daily lives trigger stress responses that over time can cause or worsen cardiovascular and cardiometabolic disease.x Racism contributes to the development of hypertension and diabetes, and price gouging blocks Black and Latinx patients from accessing treatment. Diabetes and hypertension are manageable chronic diseases for which the standard of care includes prescription medications to control symptoms and avoid complications. In surveys of medication use, Black hypertension patients report more medication rationing due to cost than do white patients.xi Analysis of pharmacy claims and patient registry data confirms that Black and Latinx patients experience more barriers to either filling or routinely refilling prescriptions for diabetes and hypertension medications.xii Price gouging that restricts access to medications literally costs Black and Brown people their lives and limbs. Whereas taking the proper doses of anti-hypertensive medications has been shown to reduce cardiovascular mortality,xiii medication rationing is “a leading cause of inadequate hypertension management leading to cardiovascular disease, stroke, and chronic kidney disease.”xiv Restricted access to affordable hypertension medication is one reason that overall decreases in cardiovascular disease mortality in the U.S. have not been equally seen by Black, Latinx, and white people.xv Diabetes medications are among the most expensive among all chronic disease medications, and insulin users in particular are most likely to report medication rationing.xvi Black and Latinx diabetics are more likely than whites to use insulinxvii and more likely to report that they skip or reduce doses of diabetic medications due to cost.xviii Underusing necessary diabetes medications is a major cause of poor glycemic control, which is, in turn, a cause of vascular disease that can (though, with proper and timely treatment, usually should not) lead to amputations, kidney failure, and blindness.xix A ProPublica investigative report on racism in U.S. diabetes care documents a systemwide disinvestment in diabetes-related vascular disease prevention that drives the “epidemic of amputations” in Black communities. The same racist policies and practices also increase the risks of other diabetes-related vascular complications, such as kidney disease, retinopathy, and blindness, all of which disproportionately afflict Black and Latinx patients.xx This pattern of treatment amounts to systemic neglect of and inhumanity for the health of these patients. 9 But the academic literature on racial disparities generally discusses “race” rather than racism and avoids the topic of price gouging by pharmaceutical companies altogether. Too often, researchers shift responsibility for medication access onto Black and Latinx patients.xxi The language of medication “nonadherence” and “underuse” conveys this assumption of individual failings and echoes the Trump administration’s victim blaming that attributes susceptibility to COVID-19 to the unhealthy “culture” of immigrant Latinx meat plant workers and the individual behavior of Black people.xxii Yet, mainstream research does recognize the high stakes of medication rationing. One study acknowledged that racial inequities in health outcomes are due at least in part to “persistent problems in getting necessary medications that eventually lead to the most debilitating effects of unmanaged chronic illness.”xxiii Researchers tend to identify at the root of these persistent problems some version of the “financial wherewithal to pay for prescription medications.”xxiv This explanation obscures the fundamental factor of wealth extraction from Black and Brown communities. Most notably, the history of residential segregation and racial and ethnic discrimination in employment, wages, and access to basic goods and services in the U.S. drives a racial wealth gap that gives white households greater “financial wherewithal.”xxv Structural barriers to Black and Brown wealth attainment and intergenerational progress expose Black and Brown households to greater economic insecurity, which makes them more vulnerable to the price-gouging tactics of pharmaceutical companies.xxvi As a mechanism to maximize profit and enrich pharmaceutical company investors at the expense of Black and Brown health and wealth, drug price gouging is itself another instance of the same process of wealth extraction. The profits accumulated from price gouging further enrich wealthy investors, feeding the cycle of wealth extraction and exploitation. The History and Politics of the Pharmaceutical Patent Monopoly Model Along with attention to racial and ethnic health inequities, the COVID-19 pandemic has directed public awareness to the complexity of the health care supply chain. The complexity of the pharmaceutical industry, from research and manufacturing to regulatory approval and insurance negotiations, has been used to muddy the waters of debate over medication access for decades. What appears plainly as price gouging— triple-digit-percentage increases in lifesaving drugs that have existed for years or astronomical markups from the cost of drug production—are explained away as one piece of a complex process that leads to innovative medicine that would otherwise be undiscovered and unavailable to treat sick people around the globe. The unstated assumption behind the “myth of the price of progress”xxvii is that the current pharmaceutical pricing regime arose naturally, as the best possible solution to produce 10 the best possible medicines to meet the most pressing health care needs. Demands for changes to the status quo to make drugs affordable are greeted with patronizing explanations of how such well-meaning policies would inevitably result in the opposite: higher prices for more people and fewer medical breakthroughs for everyone. Such demands “represent an easy but wrongheaded way to avoid the messy work of constructing a system to incentivize medical breakthroughs and make them widely available in the context of 21st century economic realities,” according to one such admonishment.xxviii The actual political history of the U.S. pharmaceutical industry and its complicity in racial health inequities is obscured in the heroic tales of market-driven discovery and in the scolding dished out to its critics. So, too, is the racism embedded in “21st century economic realities” hidden in plain sight. The pricing power of private pharmaceutical companies was deliberately created by free-market ideologues, not to incentivize medical breakthroughs but to empower private corporations as a counterforce to public-sector regulations and consumer protections.xxix Apologists for unchecked corporate power repeat the myth of the price of progress more loudly as the evidence accumulates that the “innovation” that high drug prices are purportedly paying for amounts mostly to stock buybacks, executive compensation, and a flood of expensive new drugs with no demonstrated efficacy over established standards of care.xxx The Origins of Patent Monopolies in the Pharmaceutical Industry The history of patent monopolies in the pharmaceutical industry is a history of the gradual ceding of public control of public goods—drugs developed by government-funded research—to private companies. Drug patents granted to private entities were rare before 1968, when the Institutional Patent Agreement gave universities the right to own patents on federally funded drug discoveries.xxxi Those universities were then free to sell the licenses to manufacture new drugs to the highest bidder.xxxii The New Deal agencies that originally boosted U.S. medical research and vaccine development had required private contractors to assign intellectual property rights from publicly funded research back to the government.xxxiii Since 1968, freemarket ideologues have cast aside New Deal–era concerns about the corruption of medical research by “undue concentration of economic power in the hands of few large corporations”xxxiv and doubled down on the maximization of private profit from public research by 11 Expanding private patent rights for drugs developed with federal funds to all private contractors in the Bayh-Dole Act of 1980;xxxv Extending licenses and granting tax breaks for “rare diseases” in the 1983 Orphan Drug Act, under which remdesivir, Gilead’s treatment candidate for COVID-19 (perhaps the least rare disease ever), briefly qualified for seven-year market exclusivity and federal grants and tax credits to reimburse clinical testing costs;xxxvi Extending drug patents from 17 to 20 years in the 1995 Uruguay Round Agreements Act;xxxvii Prohibiting Medicare from negotiating lower drug prices in the Medicare Modernization Act of 2003;xxxviii and Facilitating direct-to-consumer drug marketing in the Food and Drug Administration (FDA) Modernization Act of 1997.xxxix This is not a history of abandoning a just system for an unjust one, however. There is no golden age of truly equitable U.S. drug policy, and the development of pharmaceutical drugs is marked by racist and gendered exploitation. In the 1940s and ’50s, when U.S. government officials were strongly insisting on “public control over patents”xl on vaccines and other medicines, Black and Brown people were excluded from “the public” by laws restricting every aspect of their lives and by the racial violence that enforced segregation and exclusion. The government’s commitment to publicly funded and controlled medical research included medical experiments on Black and Brown bodies, like the deliberate withholding of medication in the U.S. Public Health Service–funded Tuskegee syphilis experiments on Black men from 1932 to 1972 and the deliberate, sometimes fatal, infection of healthy Guatemalan men, women, and children in experiments from 1946 to 1953.xli While some in the federal government fretted over the misuse of patented medical breakthroughs, a private surgeon was surreptitiously removing cancer cells from the body of Henrietta Lacks, without informing Lacks or her family.xlii The cells have been used for decades thereafter to develop profit-making drugs to treat cancer and other diseases.xliii This history must be the interpretive lens for understanding victimblaming statements attributing medication rationing and poor health in Black and Brown communities to “noncompliance” with medical experts and mistrust of medical authority. It must also guide a forwardthinking, explicitly antiracist solution to pharmaceutical price gouging that recognizes the racism in the New Deal–era public drug development system. 12 Maximizing Profit Extraction: Abuses of the Patent System Economic historian Edward Nik-Khah sums up the ideological roots of the monopoly patent model by noting, “Pharma was the perfect test case for a neoliberal project that celebrates markets, but is fine with large concentrations of power and monopoly.”xliv Patents grant a temporary monopoly, but corporate power, once concentrated, rarely accepts such limits. The decision to transfer public knowledge to private profit-making corporations also transferred power. Pharmaceutical companies have used that power to extend patent monopolies far beyond the 20 years originally granted, all while maintaining the $33 billion in annual governmentfunded drug research that makes new discoveries possible.xlv Every drug approved in the U.S. between 2010 and 2016 was based on National Institutes of Health– funded research.xlvi The patent system privatizes the return from this public investment, and pharmaceutical companies further abuse patent law to perpetuate their monopoly power and continue profit-maximizing price gouging. The Initiative for Medicines, Access, and Knowledge (I-MAK) submitted public comments to the Federal Trade Commission in 2018 warning that “people worldwide—including in the United States—are not receiving the lifesaving treatment they need due to skyrocketing prices based on the abuse of the patent system.”xlvii I-MAK outlines the abusive practices that the pharmaceutical industry uses to “secure the market on entire diseases and artificially inflate the price of treatment.”xlviii By obtaining multiple patents, pharmaceutical companies delay or block generic competition for decades, keeping cheaper medications off the market without improving treatment in any way. I-MAK found that the 12 best-selling drugs in the U.S. have an average of 135 patent applications and 71 approved patents per drug. A member of I-MAK, Tahir Amin, pointed out that the decline of pharmaceutical industry investment in new antibiotics to treat drug-resistant infections, an urgent global health crisis, coincides with pharmaceutical companies’ strategic decision to “spend more time finding ways to keep existing drug franchises profitable.”xlix We could say the same about the indifference to preventing diabetesrelated amputations and avoidable deaths from chronic disease in Black and Brown communities in the United States. In a familiar trend, the financialized pharmaceutical sector directs more of its profits toward enriching shareholders and building “a tangle of IP protections”l to block access to the discoveries it already owns than to productive uses, like research and development, or reducing the inflated prices that put lifesaving medication out of reach of Black and Brown patients. 13

#### This is a form of structural violence

**Reeves et al 13**, [Janet Page-Reeves](https://www.ncbi.nlm.nih.gov/pubmed/?term=Page-Reeves%20J%5BAuthor%5D&cauthor=true&cauthor_uid=24052924), [Joshua Niforatos](https://www.ncbi.nlm.nih.gov/pubmed/?term=Niforatos%20J%5BAuthor%5D&cauthor=true&cauthor_uid=24052924), [Shiraz Mishra](https://www.ncbi.nlm.nih.gov/pubmed/?term=Mishra%20S%5BAuthor%5D&cauthor=true&cauthor_uid=24052924), [Lidia Regino](https://www.ncbi.nlm.nih.gov/pubmed/?term=Regino%20L%5BAuthor%5D&cauthor=true&cauthor_uid=24052924), [Andrew Gingrich](https://www.ncbi.nlm.nih.gov/pubmed/?term=Gingrich%20A%5BAuthor%5D&cauthor=true&cauthor_uid=24052924), and [Robert Bulten](https://www.ncbi.nlm.nih.gov/pubmed/?term=Bulten%20R%5BAuthor%5D&cauthor=true&cauthor_uid=24052924), 2013 Sep 17, “Health Disparity and Structural Violence: How Fear Undermines Health Among Immigrants at Risk for Diabetes” <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3775498/#R70> Livingston RB

When using a structural violence framework to consider public health contexts, biology and the environment are not treated as independent variables ([Singer 2001](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3775498/#R70)). From this perspective, we can understand that individual health behavior is circumscribed by structured and institutionalized inequality that limits the ability of individuals to make choices. Limited options then directly affect health outcomes. Individual agency is limited by and contained within the options that are realistically available. In many cases, health-promoting choices are not an option, or they may not represent the most valuable strategy for an individual in the context of other limiting factors—regardless of whether other options are healthy or not. [Maar, et al. (2011)](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3775498/#R52) used a structural violence approach focusing on the circumstances in which Aboriginal people live to understand barriers to diabetes maintenance and treatment. They suggest that “it is important to look beyond the surface and identify the root causes of non-adherence, to prevent the unjustifiable blaming of socio-politically disadvantaged and vulnerable patients for deteriorating their health” (p. 13). Their findings are “compelling” (p. 13). They show that barriers created by social and political marginalization. Our study corroborates what [Singer (2001)](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3775498/#R70) observed of social inequalities and health, namely, that structural forces create the social, emotional, and physical conditions that invite and sustain disease. Among Hispanic immigrants in the ID, fear is one of these conditions. Using a structural violence framework to conceptualize the multidimensionality of this fear, we can see how structural violence operates to further limit the personal agency of individuals already significantly constrained by structural inequality. Physician-anthropologist Arthur Kleinman (2006a) observes that a limit in personal agency causes an “enervating anxiety...[an] existential fear that wakes us at 3 a.m. with night sweats and a dreaded inner voice, that has us gnawing our lip, because of the threats to what matters most to us.” This type of existential fear is palpable in the ID, dramatically undermining the opportunity for immigrants at risk for diabetes to be healthy. Given the consequences of diabetes, the result is ultimately a matter of life and death.

#### Removing Patents allows for access in minority communities, reducing structural violence

**Benavidez and Frankt 18** [Gilbert Benavidez is a policy analyst for the Partnered Evidence-based Policy Resource Center (PEPReC), Austin Frakt, PhD, is a health economist and director of the Partnered Evidence-based Policy Resource Center at the Boston, August 21 2018, “Racial Disparities, Prescription Medications, and Promoting Equity,”Public Health Post, [https://www.publichealthpost.org/viewpoints/racial-disparities-prescription-medications-equity/]/](https://www.publichealthpost.org/viewpoints/racial-disparities-prescription-medications-equity/%5d/) Triumph Debate

The United States has the highest drug prices in the world and it’s not even close. For millions in the country, the cost of prescription drugs is an ever-growing barrier to proper disease treatment. This is most often the case for minority groups, who have long experienced disproportionally adverse health access and outcomes. But high drug prices alone do not explain the inequity we see. Though cost is a major factor, Colon, et al. found that disparities are not simply a function of socioeconomic status—the story is more complicated. Minorities Face Many Barriers to Prescription Medicines Costs White Americans are, on average, much wealthier than Black and Hispanic Americans. The median net worth of White households in 2016 was 9.7 times higher than African-American households and 8.3 times higher than Hispanic households. Wealth disparities result in negative health consequences. Among insured adults with diabetes, Tseng, et al, found race and ethnicity to be a significant predictor of medication underuse—patients underusing their medication in order to prolong supply—due to cost. (Medication underuse is a somewhat common cost saving strategy, per the CDC.) The authors attribute this to lower incomes and higher out-of-pocket drug costs. Although study participants all had health insurance, disparities persisted. Lack of Insurance Affording medications is even harder for those without coverage. Though the Affordable Care Act (ACA) reduced the number of uninsured Americans, over 28 million remain without insurance. More than half (55%) of uninsured Americans under the age of 65 are people of color. For those with no insurance, paying retail prices for medications is often financially impossible. Implicit Racial Bias in Prescribing Practice Race can have an implicit effect on the prescribing practices of providers. For example, one study showed that White children treated at pediatric emergency departments inappropriately received antibiotics for respiratory infections more often than Black or Hispanic children, indicating that prescribing patterns can vary depending on the race of the patient. Terrell, et al., found that in their sample, ethnic and racial minorities were prescribed analgesics at a lower rate compared to White patients when discharged from the emergency department. Practical Policy Pursuits Here are four policy options for addressing racial disparities in access to prescription medication: Continue to Expand Medicaid One in five people of color have access to prescription drugs through Medicaid. Virginia recently expanded Medicaid (becoming the thirty-third state to do so). Medicaid expansion is on the November 2018 ballot in Utah and Idaho (Atkeson and Jones write more about the Idaho intiative here) while supporters in Nebraska are collecting signatures to get it on the ballot. A Maine state court has ruled that Governor LePage must submit the paperwork to expand. Promote the ACA and an Essential Benefits Package The ACA has played a key role in increasing health insurance among low-income people of color. Prescription drugs are one of ten essential health benefits the ACA requires insurers to cover. Interventions to increase coverage are needed, particularly in regard to medications. Research shows that promoting coverage gains through increased advertising is effective. Reduce Implicit Bias in Prescribing Parity in prescribing practices is possible. New research shows that reducing stigmatizing language in electronic health records can reduce implicit bias in physicians-in-training, influencing their attitudes about both patients and prescribing behavior.

## Contention 2: Wealth Concentration

#### Patents are concentrated in more developed countries

**Dutta et al 19** [Soumitra Dutta, Professor of Management and the former founding Dean of the Cornell SC Johnson College of Business at Cornell University, Bruno Lanvin, Executive Director for Global Indices at INSEAD, and Sacha Wunsch-Vincent, Head of Section, Economics and Statistics Division, and co-editor of The Global Innovation Index (GII), 2019, “GLOBAL INNOVATION INDEX 2019 Creating Healthy Lives—The Future of Medical Innovation 12th Edition,” Cornell SC Johnson School of Business, [https://www.wipo.int/edocs/pubdocs/en/wipo\_pub\_gii\_2019.pdf]/](https://www.wipo.int/edocs/pubdocs/en/wipo_pub_gii_2019.pdf%5d/) Triumph Debate

\*More Developed Countries = MDC’s

Regarding the quality of publications, rankings are rather stable with the U.S., the U.K., and Germany leading the GII rankings. Among middle-income economies, China takes the top position, followed by India. Regarding international patents, European countries take seven of the top 10 positions—with the three remaining spots going to Israel, Japan, and the Republic of Korea. Among the middle-income economies, China and South Africa take the top two positions, with India and Turkey registering improvements in this indicator. As in the previous two years, the GII 2019 includes a Special Section, which presents the latest ranking of the world’s largest science and technology (S&T) clusters. The top 10 clusters are the same as last year (Table C). Tokyo– Yokohama tops this ranking, followed by Shenzhen–Hong Kong. Figure H shows the concentration of top science and technology clusters worldwide. The U.S. continues to host the largest number of clusters (26), followed by China (18, two more than in 2018), Germany (10), France (5), the U.K. (4), and Canada (4). Australia, India, Japan, the Republic of Korea, and Switzerland all hosted three clusters each. In addition, there are clusters from five middle-income economies in the top 100—Brazil, India, the Islamic Republic of Iran, the Russian Federation, and Turkey. Compared to last year, almost all Chinese clusters moved up the ranks. Also, compared to last year, there is a notable shift in the distribution of top patenting fields. Coinciding with this year’s GII theme, medical technology is now the most frequent patenting field—present in 19 clusters. Pharmaceuticals dropped to second place. Beijing is the top collaborating cluster for scientific co-authorships, followed by Washington, DC–Baltimore, MD; New York City, NY; Boston–Cambridge, MA; and Cologne, Germany. San Jose– San Francisco, CA is the most frequent top co-inventing cluster, followed by Beijing; Shenzhen–Hong Kong; and New York City, NY. The Chinese Academy of Sciences was the top academic entity for all of Beijing's collaborations. Entities that also drove their clusters’ collaborations were Johns Hopkins University (8, Washington, DC–Baltimore, MD), Columbia University (7, New York City, NY), and Harvard University (6, Boston–Cambridge, MA).

#### The wealth concentration created by IP aids white communities, creating income inequality

**Bultman 20**, Matthew Bultman, July 14, 2020, 6:01 AM, “For Black Inventors, Road to Owning Patents Paved With Barriers” <https://news.bloomberglaw.com/ip-law/for-black-inventors-road-to-owning-patents-paved-with-barriers> Livingston RB

A U.S. Patent and Trademark Office council will begin tackling a huge challenge this year: boosting the percentage of patent owners who are Black—a figure that hovers in the single digits by some estimates. The U.S. patent system, long regarded as among the world’s best, has also been stubbornly difficult for Black inventors to access. Researchers say the underrepresentation means the U.S. is missing out on significant inventions, with fewer perspectives and ideas in the pipeline. Black people and other minority inventors have been left behind for many reasons, including too few resources, a lack of access to capital, and a low level of awareness of the patenting system in general, according to consultant Janeya Griffin. “They don’t necessarily know about it,” said Griffin, who runs a consulting firm, The Commercializer LLC, that works with entrepreneurs and startups to monetize their technologies. “They’ve never really seen it, it’s not something they’re aware of.” There have been periods of history where the patent system wasn’t even available to large swaths of the Black population, stymieing their participation. Some of those effects still linger, according to those who have studied the issue. Researchers point to the Supreme Court’s infamous 1857 Dred Scott ruling that Americans of African descent, whether free or enslaved, were not U.S. citizens. The decision essentially precluded Black people from patenting their inventions. “That practice, in and of itself, said this process is not for you,” said Shontavia Johnson, an attorney and entrepreneur who also serves as associate vice president for entrepreneurship and innovation at Clemson University. Johnson highlights another contributing factor: low numbers of Black intellectual property attorneys. Fewer than 2% of IP lawyers are Black, according to 2017 data from the American Intellectual Property Law Association. That may have a dampening effect on Black people seeking intellectual property rights. “If you are a person of color, particularly a Black person, and you want to find a lawyer who is not going to think of you as intellectually inferior, who is not going to have some of those barriers and those implicit biases that may exist, it’s hard,” Johnson said. The ramifications go beyond individual inventors. Owning patents, and other intellectual property, can help people earn money from their inventions. It can also help businesses attract investment and create jobs, “raising the bar” for entire communities, said Griffin. “There’s a direct correlation between the racial wealth gap and IP ownership,” said Nina Archie, diversity and tech policy adviser at The Commercializer. ‘Deep Historical Roots’ Whites are over three times more likely to become inventors as Blacks, Harvard University researchers found in 2018. The Information Technology and Innovation Foundation found African Americans, while making up 13% of the U.S.’s native-born population, comprised less than 1% of the U.S.-born innovators it surveyed. Another study, from Michigan State University researchers, found that from 1976 to 2008, African American inventors were awarded six patents per 1 million people, compared to 235 patents per 1 million for all U.S. inventors. The diversity gap in the patent system has “deep historical roots,” Northeastern University law professor Kara Swanson said. Over 160 years ago, in 1857, the U.S. commissioner of patents said a slave’s invention couldn’t be patented. At the time, applicants were required to take an oath of citizenship—the same year the high court ruled out citizenship for Blacks in Dred Scott v. Sanford. The Confederate states allowed slave owners to patent the inventions of their slaves. Their president, Jefferson Davis, had unsuccessfully tried before to get a U.S. patent on a propeller invented by a man, Benjamin Montgomery, enslaved by his brother, according to research from University of Kentucky law professor Brian Frye. Although formal barriers to the patent system were removed with the abolition of slavery and the passage of the 14th Amendment—which guarantees citizenship to anyone born in the U.S.—studies show Black inventors continued to face legal and societal obstacles. Lisa Cook, an economics professor at Michigan State, linked declines in African American patenting to race riots and acts of violence, including the decimation of a once-thriving Black business community in Tulsa, Okla., in 1921 when a white racist mob killed hundreds of Black residents. Segregation laws also made it harder for Blacks to patent their inventions. “The offices of patent attorneys (all white at the time) were in ‘white-only’ commercial districts, hindering African American inventors from applying for patents,” Cook wrote in an often-cited 2013 study that examined patent activity from 1870 to 1940. “With little recourse to the courts, African Americans would have found it nearly impossible to fight patent infringement, even if they had been represented by white attorneys,” Cook wrote. Racial Gap Sustained The racial divide persists for many reasons that don’t lend themselves to simple fixes. The cost of getting a patent, which can run into the thousands of dollars, and a lack of early exposure to the patent system present barriers to already marginalized communities. Another problem is a gap in those who leave college with degrees in patent-intensive fields like science, technology, engineering, and math, experts say. Black STEM students are more likely to switch majors or leave college than Whites, researchers from the University of Texas and Florida International University found recently. When Griffin polled colleagues and clients, who ranged from small business owners to NASA engineers, on when they learned about patents, and that they had value, most said either in graduate school or after starting their careers. And while Thomas Edison and Alexander Graham Bell are household names, inventors like Percy Julian and Granville Woods haven’t been as celebrated. Woods developed the railroad telegraph; Julian figured out how to synthesize different hormones, including cortisone. Sarah E. Goode is thought to be one of the first Black women to receive a patent, in 1885, for inventing a folding bed that could be made into a desk when not in use. “These are not the inventors that we’re growing up learning about,” said Griffin, who testified to Congress about patent diversity this year. “I think that also plays a role because we don’t see ourselves being owners of intellectual property.” Reaching Women and Children The underrepresentation of Black inventors, and documented disparities in numbers of women and Hispanic inventors, was acknowledged in a patent office [report](https://aboutblaw.com/RXe) to Congress last fall. Government has tried to take some steps, but progress has been slow. House and Senate lawmakers in 2019 introduced the [IDEA Act](https://www.congress.gov/116/bills/s2281/BILLS-116s2281is.pdf) (H.R. 4075, S. 2281), which would require the patent office to collect demographic information, including gender and race, from patent applicants on a voluntary basis. The agency would also be required to make the data public. The bills were referred to their respective committees but have seen no further action. The PTO created a council, which will meet for the first time this year, to develop a plan to promote the participation of underrepresented groups in the patent system. Other PTO efforts to close the gap for women and minorities include launching the Expanding Innovation Hub, with resources for inventors, and programs like Camp Invention, a STEM program for elementary-aged students. “If the data is going to change it will take intentional efforts to reach women and children at a young age,” Bismarck Myrick, director of the Office of Equal Employment Opportunity and Diversity at the PTO, said in an interview. That’s the goal of the NextGen IP Foundation, a new program that helps grade-school students apply for patents. NextGen IP’s founder, Flo Donovan, said the “only way to ensure in my life-time that minority inventors are included in the patent process was to create a foundation for this purpose.” There are also organizations like the New Voices Foundation, which helps women of color who are entrepreneurs, and the Chicago Inventors Organization, which has worked with a number of Black inventors.

#### This drives structural violence

“Structural violence occurs whenever people are disadvantaged by political, legal, economic or cultural traditions. Because they are longstanding, structural inequities usually seem ordinary, the way things are and always have been,” according to [D.D. Winter and D.C. Leighton](http://sites.saumag.edu/danaleighton/wp-content/uploads/sites/11/2015/09/SVintro-2.pdf). Rather than being focused on direct, brutal acts, structural violence is the result of societal systems, such as [social stratification](https://online.campbellsville.edu/criminal-justice/social-stratification-inequality-and-the-u-s-criminal-justice-system/), that have been in place for years — systems that create situations where people don’t have access to the things required to fulfill their basic human needs. “Structural violence is problematic in and of itself,” continue Winter and Leighton, “but it is also dangerous because it frequently leads to direct violence. Those who are chronically oppressed are often, for logical reasons, those who resort to direct violence.” This, in turn, usually leads to direct violence from law enforcement and the military that is directed at the oppressed community to re-exert the dominance of the status quo. Perhaps the most challenging aspect of addressing structural violence is how difficult it can be to bring attention to it. “When social inequities are noticed, attempts are made to rationalize and understand them,” Winter and Leighton say. “Unfortunately, one outcome of this process is to assume that victims must in some way deserve their plight.” Because the constant presence of structural violence is desensitizing, the structures that maintain the violence become normalized and seen as “the way things are.” Because of this, it can be difficult to convince those with the ability to create change that there is a problem or that it can be addressed. In 2015, 13.5 percent of the U.S. population — around 43 million people — fell below the federal poverty line of $24,250 for a family of four. When broken down into specific populations, it becomes easy to see that [some populations have higher poverty rates](https://talkpoverty.org/basics/). Poverty among whites was 9.1 percent during that time, compared to 24.1 percent among African-Americans; African-Americans have a [long history](http://www.latimes.com/opinion/topoftheticket/la-na-tt-history-hinders-black-americans-20140908-story.html) of being the victims of structural violence in America. Structural violence usually has, at its root, some political or economic structure that disenfranchises a group of people. For example, children in inner cities typically lack access to adequate schools, which limits their access to jobs with good salaries when they get older. This, in turn, limits their access to healthcare, legal protections, political power, safe housing and other important resources. This cycle of poverty perpetuates itself, creating entire communities subject to regular structural violence. Access to resources like education, healthcare and purchasing power are all vital to breaking the [cycle of poverty](https://borgenproject.org/cycle-poverty/). Individuals without adequate access to healthcare are not only more likely to have shorter life spans, but also to spend a significant portion of their income treating illnesses and other health issues, or simply enduring them and reducing their ability to work and earn money. Without adequate education, access to good jobs and influence within society is limited. An inability to buy necessities like food and shelter leads to worse healthcare outcomes, less money spent on educating the next generation and so forth.

#### Plan: The Member Nations of the WTO ought to eliminate patent protections.

Topical: 1- patent protections are just one type of intellectual property- this constitutes a reduction 2- any reduction is topical