## 1:

#### Interpretation: The Aff must defend a reduction on all medicines, not on a specific type.

#### Violation: They defend covid vaccine, don’t let them fool u by their plan text saying Covid Vacc and then “medicines,” because their entire aff is literally just on covid vaccines. Seriously command F the aff.

#### We’ll insert this chart of medicines, and these are only the ones from Aa – Ac (go to the link if you want to see more)

<https://www.medicinenet.com/medications/alpha_a.htm>

Application

Description automatically generated with medium confidence

Graphical user interface, application

Description automatically generated

Graphical user interface, text

Description automatically generated

#### Standards:

#### 1] Limits/Ground – you can specify any subset of medicines with tens of thousands to choose from, meaning there are millions of combinations you can make and there’s no universal arg that applies to all of those you spec. Generics don’t solve since you will always be ahead of me on those since you have infinite prep time. This explodes neg prep because I must prep infinite arguments which makes cutting prep impossible. Limits key to fairness because they create a case list for neg prep without which I can’t engage in the round.

#### CX doesn’t check since u commited the violation while reading the aff.

#### Voters:

#### 1] Fairness is a voter because debate is a competitive activity

#### 2] Education is a voter because it’s the reason schools fund debate, we wouldn’t have debate without it

#### Competing interps

#### 1] Reasonability is arbitrary and invites judge intervention

#### No aff RVIs on T –Two.

#### 1 – No abuse from reading T – we aren’t making up arbitrary rules for debate like “spikes on top”, we’re presenting a well-grounded vision of the topic. Topicality debates require a substantial investment from both sides in terms of both prep and speech.

#### 2 –Time skew – aff gets infinite prep time, and policy kids give five-minute 1ARs on T after a thirteen-minute neg block without RVIs – if you allocate your time properly on the T debate instead of trying to go for RVIs you’ll be fine.

## 2:

#### Covid-19 vaccines are safe and effective right now.

Moline ‘21

(Heidi L. Moline, MD; Michael Whitaker, MPH; Li Deng, PhD; Julia C. Rhodes, PhD; Jennifer Milucky, MSPH; Huong Pham, MPH; Kadam Patel, MPH; Onika Anglin, MPH; Arthur Reingold, MD Shua J. Chai, MD; Nisha B. Alden, MPH; Breanna Kawasaki, “Effectiveness of COVID-19 Vaccines in Preventing Hospitalization Among Adults Aged ≥65 Years” <https://www.cdc.gov/mmwr/volumes/70/wr/mm7032e3.htm> , August 13)

Clinical trials of COVID-19 vaccines currently authorized for emergency use in the United States (Pfizer-BioNTech, Moderna, and Janssen [Johnson & Johnson]) indicate that these vaccines have high efficacy against symptomatic disease, including moderate to severe illness (1–3). In addition to clinical trials, real-world assessments of COVID-19 vaccine effectiveness are critical in guiding vaccine policy and building vaccine confidence, particularly among populations at higher risk for more severe illness from COVID-19, including older adults. To determine the real-world effectiveness of the three currently authorized COVID-19 vaccines among persons aged ≥65 years during February 1–April 30, 2021, data on 7,280 patients from the COVID-19–Associated Hospitalization Surveillance Network (COVID-NET) were analyzed with vaccination coverage data from state immunization information systems (IISs) for the COVID-NET catchment area (approximately 4.8 million persons). Among adults aged 65–74 years, effectiveness of full vaccination in preventing COVID-19–associated hospitalization was 96% (95% confidence interval [CI] = 94%–98%) for Pfizer-BioNTech, 96% (95% CI = 95%–98%) for Moderna, and 84% (95% CI = 64%–93%) for Janssen vaccine products. Effectiveness of full vaccination in preventing COVID-19–associated hospitalization among adults aged ≥75 years was 91% (95% CI = 87%–94%) for Pfizer-BioNTech, 96% (95% CI = 93%–98%) for Moderna, and 85% (95% CI = 72%–92%) for Janssen vaccine products. COVID-19 vaccines currently authorized in the United States are highly effective in preventing COVID-19–associated hospitalizations in older adults. In light of real-world data demonstrating high effectiveness of COVID-19 vaccines among older adults, efforts to increase vaccination coverage in this age group are critical to reducing the risk for COVID-19–related hospitalization. COVID-NET includes data on laboratory-confirmed COVID-19–associated hospitalizations in 99 U.S. counties in 14 states, representing approximately 10% of the U.S. population.† COVID-NET cases were hospitalizations that occurred in residents of a designated COVID-NET catchment area who were admitted within 14 days of a positive SARS-CoV-2 test result. COVID-NET program personnel collected information on COVID-19 vaccination status (vaccine product received, number of doses, and administration dates) from state IISs for all sampled COVID-NET cases.§ Some sites expanded collection of information on vaccination status to all reported COVID-NET cases, not only sampled cases, which were included for analysis if all cases in a single month had vaccination status available. Data from 13 sites were included for analysis; one site (Iowa) does not have access to the state IIS and cannot collect vaccination data.¶ Population-level vaccination coverage was determined using deidentified person-level COVID-19 vaccination data reported to CDC by jurisdictions, pharmacies, and federal entities through the IISs,\*\* Vaccine Administration Management System,†† or direct data submission.§§ The study was restricted to adults aged ≥65 years and included the period February 1–April 30, 2021. The Janssen vaccine was authorized for use during the study period beginning March 15, 2021.¶¶ Patients were classified as 1) unvaccinated (no IIS record of vaccination), 2) partially vaccinated (1 dose of Moderna or Pfizer-BioNTech received ≥14 days before hospitalization or 2 doses, with the second dose received <14 days before hospitalization), or 3) fully vaccinated (receipt of both doses of Moderna or Pfizer-BioNTech with second dose received ≥14 days before hospitalization or receipt of a single dose of Janssen ≥14 days before hospitalization). Patients with only 1 dose of any COVID-19 vaccine received <14 days before hospitalization were excluded. Daily county-level coverage data for adults aged 65–74 and ≥75 years in the COVID-NET catchment area were estimated using population denominators from the U.S. Census Bureau; vaccination status was classified as described for hospitalized cases.\*\*\* For vaccine records missing county of residence, county of vaccine administration was used. To estimate vaccine effectiveness and corresponding 95% CIs, methods were adapted based on previously published literature (4). Poisson regression was used to compare case counts by vaccination status (outcome) and the proportion of the population vaccinated and unvaccinated (offset).††† Data were stratified by age group because of the potential for confounding by age, and adjusted for COVID-NET site, time (number of weeks since the start of the study period as a categorical covariate), and monthly site-specific sampling frequency.§§§ Vaccine effectiveness was calculated as one minus the exponent of the estimated coefficient of the exposure (vaccination status) variable. For estimating effectiveness of full vaccination, partially vaccinated persons were excluded; for estimating effectiveness of partial vaccination, fully vaccinated persons were excluded. Vaccine product–specific estimates excluded persons who had received other COVID-19 vaccines. To account for the interval between infection and hospitalization, sensitivity analyses were conducted using a reference date 1 week and 2 weeks before admission, rather than admission date, for classification of vaccination status for cases (i.e., adding 7 and 14 days, respectively between last vaccine dose and hospital admission date); the same adjustment was included for population vaccination coverage. Statistical analyses were conducted using SAS software (version 9.4; SAS Institute). This activity was reviewed by CDC and was conducted consistent with applicable federal law and CDC policy.¶¶¶ During February 1–April 30, 2021, among 7,280 eligible COVID-NET patients, 5,451 (75%) were unvaccinated, 867 (12%) were partially vaccinated, and 394 (5%) were fully vaccinated; 568 (8%) who received a single vaccine dose <14 days before hospitalization were excluded from the analysis (Table). Vaccination coverage in the population increased rapidly during this period among persons aged ≥65 years and varied by age and vaccine product (Figure 1). Among adults aged ≥65 years in the COVID-NET catchment area, full vaccination coverage from any of the three authorized vaccines ranged from 0.7% on February 1, 2021, to 72% on April 30, 2021. Effectiveness of full vaccination in preventing hospitalization among adults aged 65–74 years was estimated at 96% (95% CI = 94%–98%) for Pfizer-BioNTech, 96% (95% CI = 95%–98%) for Moderna, and 84% (95% CI = 64%–93%) for Janssen vaccine products. Among adults aged ≥75 years, effectiveness of full vaccination was 91% (95% CI = 87%–94%) for Pfizer-BioNTech, 96% (95% CI = 93%–98%) for Moderna, and 85% (95% CI = 72%–92%) for Janssen vaccine products (Figure 2). Effectiveness of partial vaccination among adults aged 65–74 years was 84% (95% CI = 76%–89%) for Pfizer-BioNTech and 91% (95% CI = 87%–93%) for Moderna vaccine products. Among those aged ≥75 years, effectiveness of partial vaccination was 66% (95% CI = 48%–77%) for Pfizer-BioNTech and 82% (95% CI = 76%–86%) for Moderna vaccine products. Sensitivity analyses accounting for interval between infection and hospitalization did not yield notably different vaccine effectiveness estimates, with point estimates varying by <1% for Pfizer-BioNTech and Moderna vaccine models. Point estimates for Janssen COVID-19 vaccine models varied by <10%, with few cases eligible for inclusion and wide CIs.

#### But, waiving patent rights does not guarantee vaccine safety

Smith Spark ‘21

(Laura,- Former Senior Broadcast Journalist for the BBC, and Newsweek editor of CNN,,“Right Countries Urged to Share Vaccine Knowledge as WTO Debates Waving Patents” <https://www.cnn.com/2021/05/05/world/covid-19-vaccine-patents-wto-intl/index.html>, May 05)

If the proposed waiver were to be approved, then **technological know-how** must be transferred to new production sites as well as the intellectual property rights, Rockwell said. Countries must also ensure that they have a strict but transparent regulatory infrastructure in place, he added. The proposed waiver has previously been obstructed by a ["small number" of wealthier nations](https://www.msf.org/countries-obstructing-covid-19-patent-waiver-must-allow-negotiations), according to Doctors Without Borders. When it was blocked at the WTO in March, aid organization [Oxfam](https://reliefweb.int/report/world/oxfam-response-wto-trips-waiver-covid-19-vaccines-being-blocked-again-rich-countries) slammed the decision as a "massive missed opportunity" to speed up worldwide vaccine production, and accused rich countries of "siding with a handful of pharmaceutical corporations in protecting their monopolies against the needs of the majority of developing countries who are struggling to administer a single dose."**Gross Failure of Leadership** Rights group Amnesty International and the People's Vaccine Alliance urged G7 leaders Wednesday to listen to their people and ensure vaccine knowledge is shared. "G7 governments have clear human rights obligations to put the lives of millions of people across the world ahead of the interests of the pharmaceutical companies that they have funded," said Steve Cockburn, head of economic and social justice at Amnesty International, [in a news release](https://www.amnesty.org/en/latest/news/2021/05/an-average-of-7-in-10-across-g7-countries-think-their-governments-should-force-big-pharma-to-share-vaccine-know-how/). "It would be a gross failure of leadership to continue blocking the sharing of life-saving technologies, and would only serve to prolong the immense pain and suffering caused by this pandemic." Wednesday's WTO meeting comes a day after the chief of Pfizer said the company was expecting approximately $26 billion in revenue from its Covid-19 vaccine in 2021.More than 300 public health experts [signed a letter](https://www.publichealth.columbia.edu/sites/default/files/trips_sign_on_letter_4-30-21.pdf) Friday arguing that the United States should join an effort to force vaccine makers to waive intellectual property rights to coronavirus vaccines and treatments so more countries can start making them. The group, led by Columbia University professors Terry McGovern and Chelsea Clinton, said the so-called TRIPS waiver would allow local manufacture of vaccines, treatments and diagnostics. "Allowing countries to manufacture locally will speed access to vaccines and treatment, prevent unnecessary deaths, and facilitate a stronger, faster economic recovery," they wrote. "Until vaccines, testing, and treatments are accessible to everyone everywhere we risk recurring new variants, drug resistance, and greater loss of life and suffering at home and globally." That appeal came a fortnight after more than 170 former world leaders and Nobel laureates, including former UK Prime Minister Gordon Brown, former President of Liberia Ellen Johnson Sirleaf and former French President François Hollande sent an [open letter to the White House](https://peoplesvaccinealliance.medium.com/open-letter-former-heads-of-state-and-nobel-laureates-call-on-president-biden-to-waive-e0589edd5704) urging President Joe Biden to support the temporary waiver on IP rights for Covid-19 vaccines at the WTO. **Legal Battles** But even as public pressure grows, some experts argue that handing over the IP rights for Covid-19 vaccines won't necessarily mean that more can be rapidly produced worldwide at large scale. US infectious diseases chief Anthony Fauci [told the UK's Financial Times](https://www.ft.com/content/2f41b122-5738-4707-a822-0d79276710c5) on Monday that he was not convinced that forcing companies to share their intellectual property was the most effective approach, warning that legal battles could slow the process."Going back and forth, consuming time and lawyers in a legal argument about waivers -- that is not the endgame. People are dying around the world and we have to get vaccines into their arms in the fastest and most efficient way possible," he said. Thomas Bollyky, director of the Global Health Program at the Council on Foreign Relations, told CNN on Friday that what's really needed to scale up global manufacturing of vaccines is technology transfer. "It's not just a matter of intellectual property. It's also the **transfer of know-how,**" he said. "I **don't think there's clear evidence** that a waiver of an intellectual property is going to be the best way for that technology transfer to occur."Waiving patents will not work in the same way for vaccines as it has for drugs, Bollyky said. For HIV drugs, for example, manufacturers were more or less able to reverse engineer them without much help from the original developer. It's **very different for vaccines**, where it's really a **biological process** as much as a product. It's hard to scale up manufacturing in this process for the original company, let alone another manufacturer trying to figure this out without assistance," he said. "**It requires a lot of knowledge that's not part of the IP."** The deal between AstraZeneca and the Serum Institute of India is a successful example of such technology transfer, Bollyky said, where the licensing of IP happened voluntarily. "The question is what can we do to facilitate more deals like the one between AstraZeneca and the Serum Institute of India to have this transfer," he said.

#### The plan leads to uncontrolled use of patented technologies, which turns vaccine access, and causes dangerous health consequences.

Crosby and Diamond ‘21

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Waiver risks uncontrolled use of patented technologies, without improving vaccine access.Pharmaceutical companies can provide, and have provided, licenses to distribute or scale-up production of COVID-19 vaccines and therapies at reduced cost. Such license agreements allow for expanded access in low- and middle-income countries, while also setting reasonable parameters

so that patents and other IP rights are used to address the specific medical needs of the COVID-19 pandemic at hand, and not for other purposes. License agreements also allow for orderly technology transfer, including of unpatented “trade secret” information and other critical “know-how,” that may be essential to efficiently producing and scaling-up safe and effective versions of technologically complex vaccines and biologic drug products. Under the present TRIPS waiver proposal, however, member countries could try to exploit an extraordinarily broad scope of IP and copy patented technologies so long as they are “in relation to prevention, containment or treatment of COVID-19.” For example, under an expansive reading of the proposed waiver language, a member country could try to produce patented pharmaceutical compounds that have other indicated uses predating COVID-19, if such compounds had later been studied or experimentally used for potential symptomatic relief or antiviral activity in COVID-19 patients. The same risks may be faced by manufacturers of patented materials or devices that have multiple uses predating COVID-19, but also may be used as “personal protective equipment” or components thereof, or in other measures arguably relating to COVID-19 “prevention” or “containment.”At the same time, it is unclear how the proposed TRIPS waiver could provide the technology transfer and know-how critical for making the complex molecules and formulations constituting the various COVID-19 vaccines. Vaccine manufacture undertaken by an unauthorized party without the proper processes and controls could result in a different product that is potentially ineffective or results in unwanted health consequences. And even if an unauthorized manufacturer could overcome those substantial hurdles to reverse-engineer and scale up a safe and effective vaccine copy, it would likely take substantial time and a series of failures to do so. Notably, several of the original COVID-19 vaccine developers have recently faced low product yield and other manufacturing challenges during pre-commercial scale-up efforts and the initial months of commercial production.