### 1

#### The standard is consistency with utilitarianism

#### 1] Preventing extinction is the most ethical outcome

Bostrom 13 (Nick, Professor at Oxford University, Faculty of Philosophy & Oxford Martin School, Director, Future of Humanity Institute, Director, Oxford Martin Programme on the Impacts of Future Technology University of Oxford, “Existential Risk Prevention as Global Priority”, Global Policy Volume 4, Issue 1, February 2013 // AKONG)

Some other ethical perspectives We have thus far considered existential risk from the perspective of utilitarianism (combined with several simplify- ing assumptions). We may briefly consider how the issue might appear when viewed through the lenses of some other ethical outlooks. For example, the philosopher Robert Adams outlines a different view on these matters: I believe a better basis for ethical theory in this area can be found in quite a different direction—in a commitment to the future of human- ity as a vast project, or network of overlapping projects, that is generally shared by the human race. The aspiration for a better society—more just, more rewarding, and more peaceful—is a part of this project. So are the potentially end- less quests for scientific knowledge and philo- sophical understanding, and the development of artistic and other cultural traditions. This includes the particular cultural traditions to which we belong, in all their accidental historic and ethnic diversity. It also includes our interest in the lives of our children and grandchildren, and the hope that they will be able, in turn, to have the lives of their children and grandchil- dren as projects. To the extent that a policy or practice seems likely to be favorable or unfavor- able to the carrying out of this complex of pro- jects in the nearer or further future, we have reason to pursue or avoid it. ... Continuity is as important to our commitment to the project of the future of humanity as it is to our commit- ment to the projects of our own personal futures. Just as the shape of my whole life, and its connection with my present and past, have an interest that goes beyond that of any iso- lated experience, so too the shape of human history over an extended period of the future, and its connection with the human present and past, have an interest that goes beyond that of the (total or average) quality of life of a popula- tion-at-a-time, considered in isolation from how it got that way. We owe, I think, some loyalty to this project of the human future. We also owe it a respect that we would owe it even if we were not of the human race ourselves, but beings from another planet who had some understanding of it (Adams, 1989, pp. 472–473). Since an existential catastrophe would either put an end to the project of the future of humanity or drasti- cally curtail its scope for development, we would seem to have a strong prima facie reason to avoid it, in Adams’ view. We also note that an existential catastrophe would entail the frustration of many strong preferences, sug- gesting that from a preference-satisfactionist perspective it would be a bad thing. In a similar vein, an ethical view emphasising that public policy should be determined through informed democratic deliberation by all stake- holders would favour existential-risk mitigation if we suppose, as is plausible, that a majority of the world’s population would come to favour such policies upon reasonable deliberation (even if hypothetical future peo- ple are not included as stakeholders). We might also have custodial duties to preserve the inheritance of humanity passed on to us by our ancestors and convey it safely to our descendants.23 We do not want to be the failing link in the chain of generations, and we ought not to delete or abandon the great epic of human civili- sation that humankind has been working on for thou- sands of years, when it is clear that the narrative is far from having reached a natural terminus. Further, many theological perspectives deplore naturalistic existential catastrophes, especially ones induced by human activi- ties: If God created the world and the human species, one would imagine that He might be displeased if we took it upon ourselves to smash His masterpiece (or if, through our negligence or hubris, we allowed it to come to irreparable harm).24 We might also consider the issue from a less theoreti- cal standpoint and try to form an evaluation instead by considering analogous cases about which we have defi- nite moral intuitions. Thus, for example, if we feel confident that committing a small genocide is wrong, and that committing a large genocide is no less wrong, we might conjecture that committing omnicide is also wrong.25 And if we believe we have some moral reason to prevent natural catastrophes that would kill a small number of people, and a stronger moral reason to pre- vent natural catastrophes that would kill a larger number of people, we might conjecture that we have an even stronger moral reason to prevent catastrophes that would kill the entire human population.

#### 2] Actor specificity – Util is the only moral system available to policymakers. Goodin 95

Robert E. Goodin 95 [professor of government at the University of Essex, and professor of philosophy and social and political theory at Australian National University], “Utilitarianism as a Public Philosophy”, Cambridge Studies in Philosophy and Public Policy, May 1995, BE

Consider, first, the argument from necessity. Public officials are obliged to make their choices under uncertainty, and uncertainty of a very special sort at that. All choices - public and private alike - are made under some degree of uncertainty, of course. But in the nature of things, private individuals will usually have more complete information on the peculiarities of their own circumstances and on the ramifications that alternative possible choices might have for them. Public officials, in contrast, are relatively poorly informed as to the effects that their choices will have on individuals, one by one. What they typically do know are generalities: averages and aggregates. They know what will happen most often to most people as a result of their various possible choices. But that is all. That is enough to allow public policy-makers to use the utilitarian calculus - if they want to use it at all - to choose general rules of conduct. Knowing aggregates and averages, they can proceed to calculate the utility payoffs from adopting each alternative possible general rule. But they cannot be sure what the payoff will be to any given individual or on any particular occasion. Their knowledge of gener- alities, aggregates and averages is just not sufficiently fine-grained for that.

#### A] No intent-foresight distinction – If we foresee a consequence, then it becomes part of our deliberation which makes it intrinsic to our action since we intend it to happen.

#### 3] Pleasure and pain are intrinsically valuable.

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] SJDI, brackets in original

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.**

#### 4] No act-omission distinction –

#### A] Psychology – choosing to omit is an act itself – governments decide not to act which means being presented with the aff creates a choice between two actions, neither of which is an omission.

#### B] Actor specificity – governments are culpable for omissions because their purpose is to protect the constituency – otherwise they would have no obligation to make murder illegal. Only util can escape culpability in the instance of tradeoffs – i.e. it resolves the trolley problem because a deontological theory would hold you responsible for killing regardless. Actor spec o/w – different agents have different ethical standings that affect their obligations and considerations.

### 2

#### The pharma industry is strong now but patents are key for continued economic growth. Batell and PhRMA 14:

Batell and PhRMA {Battelle is the world’s largest nonprofit independent research and development organization, providing innovative solutions to the world’s most pressing needs through its four global businesses: Laboratory Management, National Security, Energy, Environment and Material Sciences, and Health and Life Sciences. The Pharmaceutical Research and Manufacturers of America (PhRMA) represents the country’s leading pharmaceutical research and biotechnology companies, which are devoted to inventing medicines that allow patients to live longer, healthier, and more productive lives.}, 14 – “The U.S. Biopharmaceutical Industry: Perspectives on Future Growth and The Factors That Will Drive It,” http://phrma-docs.phrma.org/sites/default/files/pdf/2014-economic-futures-report.pdf//marlborough-wr//

Compared to other capital-intensive, advanced manufacturing industries in the U.S., the biopharmaceutical industry is a leader in R&D investment, IP generation, venture capital investment, and R&D employment. Policies and infrastructure that helped foster these innovative activities have allowed the U.S. to seize global leadership in biopharmaceutical R&D over the past 30 years. However, as this report details, other countries are seeking to compete with the U.S. by borrowing and building upon some of these pro-innovation policies to improve their own operating environment and become more favorable to biopharmaceutical companies making decisions about where to locate their R&D and manufacturing activities. A unique contribution of this report was the inclusion of the perspective of senior-level strategic planning executives of biopharmaceutical companies regarding what policy areas they see as most likely to impact the favorability of the U.S. business operating environment. The executives cited the following factors as having the most impact on the favorability of the operating environment and hence, potential growth of the innovative biopharmaceutical industry in the U.S.: • Coverage and payment policies that support and encourage medical innovation • A well-functioning, science-based regulatory system • Strong IP protection and enforcement in the U.S. and abroad The top sub-attribute identified as driving future biopharmaceutical industry growth in the U.S. cited by executives was a domestic IP system that provides adequate patent rights and data protection. Collectively, these factors underscore the need to reduce uncertainties and ensure adequate incentives for the lengthy, costly, and risky R&D investments necessary to develop new treatments needed by patients and society to address our most costly and challenging diseases. With more than 300,000 jobs at stake between the two scenarios, the continued growth and leadership of the U.S. innovative biopharmaceutical industry cannot be taken for granted. Continued innovation is fundamental to U.S. economic well-being and the nation’s ability to compete effectively in a globalized economy and to take advantage of the expected growth in demand for new medicines around the world. Just as other countries have drawn lessons from the growth of the U.S. biopharmaceutical sector, the U.S. needs to assess how it can improve the environment for innovation and continue to boost job creation by increasing R&D investment, fostering a robust talent pool, enhancing economic growth and sustainability, and continuing to bring new medicines to patients.

#### COVID has kept patents and innovation strong, but continued protection is key to innovation by incentivizing biomedical research – it’s also crucial to preventing counterfeit medicines, economic collapse, and fatal diseases, which independently turns case. Macdole and Ezell 4-29:

Jaci Mcdole and Stephen Ezell {Jaci McDole is a senior policy analyst covering intellectual property (IP) and innovation policy at the Information Technology and Innovation Foundation (ITIF). She focuses on IP and its correlations to global innovation and trade. McDole holds a double BA in Music Business and Radio-Television with a minor in Marketing, an MS in Education, and a JD with a specialization in intellectual property (Southern Illinois University Carbondale). McDole comes to ITIF from the Institute for Intellectual Property Research, an organization she co-founded to study and further robust global IP policies. Stephen Ezell is vice president, global innovation policy, at the Information Technology and Innovation Foundation (ITIF). He comes to ITIF from Peer Insight, an innovation research and consulting firm he cofounded in 2003 to study the practice of innovation in service industries. At Peer Insight, Ezell led the Global Service Innovation Consortium, published multiple research papers on service innovation, and researched national service innovation policies being implemented by governments worldwide. Prior to forming Peer Insight, Ezell worked in the New Service Development group at the NASDAQ Stock Market, where he spearheaded the creation of the NASDAQ Market Intelligence Desk and the NASDAQ Corporate Services Network, services for NASDAQ-listed corporations. Previously, Ezell cofounded two successful innovation ventures, the high-tech services firm Brivo Systems and Lynx Capital, a boutique investment bank. Ezell holds a B.S. from the School of Foreign Service at Georgetown University, with an honors certificate from Georgetown’s Landegger International Business Diplomacy program.}, 21 - ("Ten Ways Ip Has Enabled Innovations That Have Helped Sustain The World Through The Pandemic," Information Technology & Innovation Foundation, 4-29-2021, https://itif.org/publications/2021/04/29/ten-ways-ip-has-enabled-innovations-have-helped-sustain-world-through)//marlborough-wr/

To better understand the role of IP in enabling solutions related to COVID-19 challenges, this report relies on 10 case studies drawn from a variety of nations, technical fields, and firm sizes. This is but a handful of the thousands of IP-enabled innovations that have sprung forth over the past year in an effort to meet the tremendous challenges brought on by COVID-19 globally. From a paramedic in Mexico to a veteran vaccine manufacturing company in India and a tech start-up in Estonia to a U.S.-based company offering workplace Internet of Things (IoT) services, small and large organizations alike are working to combat the pandemic. Some have adapted existing innovations, while others have developed novel solutions. All are working to take the world out of the pandemic and into the future. The case studies are: Bharat Biotech: Covaxin Gilead: Remdesivir LumiraDX: SARS-COV-2 Antigen POC Test Teal Bio: Teal Bio Respirator XE Ingeniería Médica: CápsulaXE Surgical Theater: Precision VR Tombot: Jennie Starship Technologies: Autonomous Delivery Robots Triax Technologies: Proximity Trace Zoom: Video Conferencing As the case studies show, IP is critical to enabling innovation. Policymakers around the world need to ensure robust IP protections are—and remain—in place if they wish their citizens to have safe and innovative solutions to health care, workplace, and societal challenges in the future. THE ROLE OF INTELLECTUAL PROPERTY IN R&D-INTENSIVE INDUSTRIES Intangible assets, such as IP rights, comprised approximately 84 percent of the corporate value of S&P 500 companies in 2018.4 For start-ups, this means much of the capital needed to operate is directly related to IP (see Teal Bio case study for more on this). IP also plays an especially important role for R&D-intensive industries.5 To take the example of the biopharmaceutical industry, it is characterized by high-risk, time-consuming, and expensive processes including basic research, drug discovery, pre-clinical trials, three stages of human clinical trials, regulatory review, and post-approval research and safety monitoring. The drug development process spans an average of 11.5 to 15 years.6 For every 5,000 to 10,000 compounds screened on average during the basic research and drug discovery phases, approximately 250 molecular compounds, or 2.5 to 5 percent, make it to preclinical testing. Out of those 250 molecular compounds, approximately 5 make it to clinical testing. That is, 0.05 to 0.1 percent of drugs make it from basic research into clinical trials. Of those rare few which make it to clinical testing, less than 12 percent are ultimately approved for use by the U.S. Food and Drug Administration (FDA).7 In addition to high risks, drug development is costly, and the expenses associated with it are increasing. A 2019 report by the Deloitte Center for Health Solutions concluded that since 2010 the average cost of bringing a new drug to market increased by 67 percent.8 Numerous studies have examined the substantial cost of biopharmaceutical R&D, and most confirm investing in new drug development requires $1.7 billion to $3.2 billion up front on average.9 A 2018 study by the Coalition for Epidemic Preparedness found similar risks and figures for vaccines, stating, “In general, vaccine development from discovery to licensure can cost billions of dollars, can take over 10 years to complete, and has an average 94 percent chance of failure.”10 Yet, a 2010 study found that 80 percent of new drugs—that is, the less than 12 percent ultimately approved by the FDA—made less than their capitalized R&D costs.11 Another study found that only 1 percent (maybe three new drugs each year) of the most successful 10 percent of FDA approved drugs generate half of the profits of the entire drug industry.12 To say the least, biopharmaceutical R&D represents a high-stakes, long-term endeavor with precarious returns. Without IP protection, biopharmaceutical manufacturers have little incentive to take the risks necessary to engage in the R&D process because they would be unable to recoup even a fraction of the costs incurred. Diminished revenues also result in reduced investments in R&D which means less research into cancer drugs, Alzheimer cures, vaccines, and more. IP rights give life-sciences enterprises the confidence needed to undertake the difficult, risky, and expensive process of life-sciences innovation secure in the knowledge they can capture a share of the gains from their innovations, which is indispensable not only to recouping the up-front R&D costs of a given drug, but which can generate sufficient profits to enable investment in future generations of biomedical innovation and thus perpetuate the enterprises into the future.13 THE IMPORTANCE OF INTELLECTUAL PROPERTY TO INNOVATION Although anti-IP proponents have attacked biopharmaceutical manufacturers particularly hard, the reality is all IP-protected innovations are at risk if these rights are ignored, or vitiated. Certain arguments have shown a desire for the term “COVID-19 innovations” to include everything from vaccines, therapeutics, diagnostics, and PPE to biotechnology, AI-related data, and educational materials.14 This could potentially open the floodgates to invalidate IP protection on many of the innovations highlighted in this report. However, much of the current discussion concerning IP focuses almost entirely on litigation fears or R&D incentives. Although R&D is an important aspect of IP, as previously mentioned, these discussions ignore the fact that IP protection can be—and often is—used for other purposes, including generating initial capital to create a company and begin manufacturing and, more importantly, using licensing agreements and IP to track the supply chain and ensure quality control of products. This report highlights but a handful of the thousands of IP-enabled innovations that have sprung forth over the past year in an effort to meet the tremendous challenges brought on by COVID-19 globally. In 2018, Forbes identified counterfeiting as the largest criminal enterprise in the world.15 The global struggle against counterfeit and non-regulated products, which has hit Latin America particularly hard during the pandemic, proves the need for safety and quality assurance in supply chains.16 Some communities already ravaged by COVID-19 are seeing higher mortality rates related to counterfeit vaccines, therapeutics, PPE, and cleaning and sanitizing products.17 Polish authorities discovered vials of antiwrinkle treatment labeled as COVID-19 vaccines. 18 In Mexico, fake vaccines sold for approximately $1,000 per dose.19 Chinese and South African police seized thousands of counterfeit vaccine doses from warehouses and manufacturing plants.20 Meanwhile, dozens of websites worldwide claiming to sell vaccines or be affiliated with vaccine manufacturers have been taken down.21 But the problem is not limited to biopharmaceuticals. The National Intellectual Property Rights Coordination Center has recovered $48 million worth of counterfeit PPE and other products.22 Collaborative efforts between law enforcement and manufacturers have kept numerous counterfeits from reaching the population. In countries with strong IP protection, the chances of counterfeit products reaching the market are significantly lower. This is largely because counterfeiting tends to be an IP-related issue, and these countries generally provide superior means of tracking the supply chain through trademarks, trade secrets, and licensing agreements. This enables greater quality control and helps manufacturers maintain a level of public confidence in their products. By controlling the flow of knowledge associated with IP, voluntary licensing agreements provide innovators with opportunities to collaborate, while ensuring their partners are properly equipped and capable of producing quality products. Throughout this difficult time, the world has seen unexpected collaborations, especially between biopharmaceutical companies worldwide such as Gilead and Eva Pharma or Bharat Biotech and Ocugen, Inc. Throughout history, and most significantly in the nineteenth century through the widespread development of patent systems and the ensuing Industrial Revolution, IP has contributed toward greater economic growth.23 This is promising news as the world struggles for economic recovery. A 2021 joint study by the EU Intellectual Property Office (EUIPO) and European Patent Office (EPO) shows a strong, positive correlation between IP rights and economic performance.24 It states that “IP-owning firms represent a significantly larger proportion of economic activity and employment across Europe,” with IP-intensive industries contributing to 45 percent of gross domestic product (GDP) (€6.6 trillion; US$7.9 trillion).25 The study also shows 38.9 percent of employment is directly or indirectly attributed to IP-intensive industries, and IP generates higher wages and greater revenue per employee, especially for small-to-medium-sized enterprises.26 That concords with the United States, where the Department of Commerce estimated that IP-intensive industries support at least 45 million jobs and contribute more than $6 trillion dollars to, or 38.2 percent of, GDP.27 In 2020, global patent filings through the World Intellectual Property Organization’s (WIPO) Patent Cooperation Treaty (PCT) system reached a record 275,900 filings amidst the pandemic, growing 4 percent from 2019.28 The top-four nations, which accounted for 180,530 of the patent applications, were China, the United States, Japan, and Korea, respectively.29 While several countries saw an increase in patent filings, Saudi Arabia and Malaysia both saw significant increases in the number of annual applications, with the top two filing growths of 73 percent and 26 percent, respectively.30 The COVID-19 pandemic slowed a lot of things, but it certainly couldn’t stop innovation. There are at least five principal benefits strong IP rights can generate, for both developing and developed countries alike.31 First, stronger IP protection spurs the virtuous cycle of innovation by increasing the appropriability of returns, enabling economic gain and catalyzing economic growth. Second, through patents—which require innovators to disclose certain knowledge as a condition of protection—knowledge spillovers build a platform of knowledge that enables other innovators. For instance, studies have found that the rate of return to society from corporate R&D and innovation activities is at least twice the estimated returns that each company itself receives.32 Third, countries with robust IP can operate more efficiently and productively by using IP to determine product quality and reduce transaction costs. Fourth, trade and foreign direct investment enabled and encouraged by strong IP protection offered to enterprises from foreign countries facilitates an accumulation of knowledge capital within the destination economy. That matters when foreign sources of technology account for over 90 percent of productivity growth in most countries.33 There’s also evidence suggesting that developing nations with stronger IP protections enjoy the earlier introduction of innovative new medicines.34 And fifth, strong IP boosts exports, including in developing countries.35 Research shows a positive correlation between stronger IP protection and exports from developing countries as well as faster growth rates of certain industries.36 The following case studies illustrate these benefits of IP and how they’ve enabled innovative solutions to help global society navigate the COVID-19 pandemic.

#### This sets a precedent that spills over to all future diseases – Hopkins 21:

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The Biden administration’s unexpected support for [temporarily waiving Covid-19 vaccine patents](https://www.wsj.com/articles/u-s-backs-waiver-of-intellectual-property-protection-for-covid-19-vaccines-11620243518?mod=article_inline) won’t have an immediate financial impact on the companies making the shots, industry officials and analysts said. Yet the decision could mark a shift in Washington’s longstanding support of the industry’s valuable intellectual property, patent-law experts said. A waiver, if it does go into effect, may pose long-term risks to the vaccine makers, analysts said. [Moderna](https://www.wsj.com/market-data/quotes/MRNA) Inc., [MRNA -4.12%](https://www.wsj.com/market-data/quotes/MRNA?mod=chiclets) [Pfizer](https://www.wsj.com/market-data/quotes/PFE) Inc. [PFE -3.10%](https://www.wsj.com/market-data/quotes/PFE?mod=chiclets) and other vaccine makers weren’t counting on sales from the developing countries that would gain access to the vaccine technology, analysts said. If patents and other crucial product information behind the technology is made available, it would take at least several months before shots were produced, industry officials said. Yet long-term Covid-19 sales could take a hit if other companies and countries gained access to the technologies and figured out how to use it. Western drugmakers could also confront competition sooner for other medicines they are hoping to make using the technologies. A World Trade Organization waiver could also set a precedent for waiving patents for other medicines, a long-sought goal of some developing countries, patient groups and others to try to reduce the costs of prescription drugs. “It sets a tremendous precedent of waiving IP rights that’s likely going to come up in future pandemics or in other serious diseases,” said David Silverstein, a patent lawyer at Axinn, Veltrop & Harkrider LLP who advises drugmakers. “Other than that, this is largely symbolic.”

#### 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.

### 3

#### **CP Text: The member nations of the World Trade Organization should establish a global system that provides universal healthcare to all of those nations’ citizens. This system should centrally purchase medicines in accordance with all IP rights and laws and should then universally distribute that medicine, with funds from the richest and healthiest going to subsidize the care of the poorest and sickest as per recommendations made by the CP evidence.**

2) In order for universal healthcare to be achieved for all citizens, the system has to be global so that inequity between countries (not just within countries) may be resolved.

Faulkner, 19 - ("Global Universal Healthcare: Is It Within Reach?," Middletown Media, 5-4-2019, https://muncievoice.com/22657/global-universal-healthcare-is-it-within-reach/)//va

One of the biggest questions about global healthcare is how the costs will be distributed. In developed countries, raising taxes is a valid answer, but in some poorer nations, there is little room for tax reform on an already underprivileged population. So what can be done about it? ¶ For global universal healthcare to work, costs must be shared globally. This may mean [charity in third-world nations](https://borgenproject.org/fighting-poverty-developing-countries/), and more public and private partnerships in those areas. In other cases, global organizations can be formed, and surrounding nations that are more prosperous will need to help share the burden of costs with their neighbors. ¶ The biggest key with global universal healthcare is a shift in mentality from [selfishness and nationalism](https://www.muncievoice.com/11582/gop-just-trying-derail-affordable-health-care/) to a worldwide perspective on healthcare and the welfare of world citizens. No one entity can do it alone. ¶ Is [global universal healthcare within reach](https://www.economist.com/leaders/2018/04/26/universal-health-care-worldwide-is-within-reach)? With modern technology and communication and the innovations we have seen in healthcare, the answer is yes. The question then becomes: “Will we reach for it together?” ¶

3) Most people lack access to quality basic healthcare even though they spend shocking amounts of money trying to get it – a global universal healthcare system would pool resources to ensure everyone’s access at a much more efficient price and would solve better than the money currently spent on aid because it would establish infrastructure and employ rural community health workers

Guardian, 18 - ("Universal health care, worldwide, is within reach," Economist, 4-26-2018, https://www.economist.com/leaders/2018/04/26/universal-health-care-worldwide-is-within-reach)//va

BY MANY measures the world has never been in better health. Since 2000 the number of children who die before they are five has fallen by almost half, to 5.6m. Life expectancy has reached 71, a gain of five years. More children than ever are vaccinated. Malaria, TB and HIV/AIDS are in retreat. ¶ Yet the gap between this progress and the still greater potential that medicine offers has perhaps never been wider. At least half the world is without access to what the World Health Organisation deems essential, including antenatal care, insecticide-treated bednets, screening for cervical cancer and vaccinations against diphtheria, tetanus and whooping cough. Safe, basic surgery is out of reach for 5bn people. ¶ Those who can get to see a doctor often pay a crippling price. More than 800m people spend over 10% of their annual household income on medical expenses; nearly 180m spend over 25%. The quality of what they get in return is often woeful. In studies of consultations in rural Indian and Chinese clinics, just 12-26% of patients received a correct diagnosis. ¶ That is a terrible waste. As this week’s special report shows, the goal of universal basic health care is sensible, affordable and practical, even in poor countries. Without it, the potential of modern medicine will be squandered. ¶ How the other half dies Universal basic health care is sensible in the way that, say, universal basic education is sensible—because it yields benefits to society as well as to individuals. In some quarters the very idea leads to a dangerous elevation of the blood pressure, because it suggests paternalism, coercion or worse. There is no hiding that public health-insurance schemes require the rich to subsidise the poor, the young to subsidise the old and the healthy to underwrite the sick. And universal schemes must have a way of forcing people to pay, through taxes, say, or by mandating that they buy insurance. ¶ But there is a principled, liberal case for universal health care. Good health is something everyone can reasonably be assumed to want in order to realise their full individual potential. Universal care is a way of providing it that is pro-growth. The costs of inaccessible, expensive and abject treatment are enormous. The sick struggle to get an education or to be productive at work. Land cannot be developed if it is full of disease-carrying parasites. According to several studies, confidence about health makes people more likely to set up their own businesses. ¶ Universal basic health care is also affordable. A country need not wait to be rich before it can have comprehensive, if rudimentary, treatment. Health care is a labour-intensive industry, and community health workers, paid relatively little compared with doctors and nurses, can make a big difference in poor countries. There is also already a lot of spending on health in poor countries, but it is often inefficient. In India and Nigeria, for example, more than 60% of health spending is through out-of-pocket payments. More services could be provided if that money—and the risk of falling ill—were pooled. ¶ The evidence for the feasibility of universal health care goes beyond theories jotted on the back of prescription pads. It is supported by several pioneering examples. Chile and Costa Rica spend about an eighth of what America does per person on health and have similar life expectancies. Thailand spends $220 per person a year on health, and yet has outcomes nearly as good as in the OECD. Its rate of deaths related to pregnancy, for example, is just over half that of African-American mothers. Rwanda has introduced ultrabasic health insurance for more than 90% of its people; infant mortality has fallen from 120 per 1,000 live births in 2000 to under 30 last year. ¶ And universal health care is practical. It is a way to prevent free-riders from passing on the costs of not being covered to others, for example by clogging up emergency rooms or by spreading contagious diseases. It does not have to mean big government. Private insurers and providers can still play an important role. ¶ Indeed such a practical approach is just what the low-cost revolution needs. Take, for instance, the design of health-insurance schemes. Many countries start by making a small group of people eligible for a large number of benefits, in the expectation that other groups will be added later. (Civil servants are, mysteriously, common beneficiaries.) This is not only unfair and inefficient, but also risks creating a constituency opposed to extending insurance to others. The better option is to cover as many people as possible, even if the services available are sparse, as under Mexico’s Seguro Popular scheme. ¶ Small amounts of spending can go a long way. Research led by Dean Jamison, a health economist, has identified over 200 effective interventions, including immunisations and neglected procedures such as basic surgery. In total, these would cost poor countries about an extra $1 per week per person and cut the number of premature deaths there by more than a quarter. Around half that funding would go to primary health centres, not city hospitals, which today receive more than their fair share of the money. ¶ The health of nations Consider, too, the $37bn spent each year on health aid. Since 2000, this has helped save millions from infectious diseases. But international health organisations can distort domestic institutions, for example by setting up parallel programmes or by diverting health workers into pet projects. A better approach, seen in Rwanda, is when programmes targeting a particular disease bring broader benefits. One example is the way that the Global Fund to Fight AIDS, Tuberculosis and Malaria finances community health workers who treat patients with HIV but also those with other diseases. ¶ Europeans have long wondered why the United States shuns the efficiencies and health gains from universal care, but its potential in developing countries is less understood. So long as half the world goes without essential treatment, the fruits of centuries of medical science will be wasted. Universal basic health care can help realise its promise. ¶

4**)** The body responsible for medicine acquisition would be able to negotiate lower prices from pharma firms without violating IPR – having seven billion customers at a lower price is better than the status quo, so innovation ramps UP because there’s a guaranteed market. This is especially true for diseases that still haven’t been cured because it’s not profitable – the system is prepared to buy those medicines on a massive scale.

5) Public-private partnerships are key to universal health care systems & have been successful in the real world. The CP spills over to investment in education, sanitation, housing, and other public goods because countries have an incentive to pay less for emergency health care.

Guardian, 17 - ("How to make global universal healthcare a reality," 7-7-2017, <https://www.theguardian.com/global-development-professionals-network/2017/jul/07/how-to-make-global-universal-healthcare-a-reality)//va>

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1 | Accept there’s no such thing as a ‘perfect healthcare model’ All healthcare models have their challenges in terms of systems capacity, fiscal space and good governance. I think the progress of countries like Thailand and Sri Lanka towards universal health is certainly laudable, but they each have different approaches to getting there. Thailand’s journey began incrementally and over the years through consistent investment in Primary Health Care (PHC). Meanwhile, India is more focused on achieving Universal Health Care (UHC) through mixed health markets featuring both public and private sector players. Priya Balasubramaniam, senior public health scientist and director, PHFI-RNE Universal Health Initiative,[Public Health Foundation of India](http://www.phfi.org/), New Delhi, India ¶ 2 | Have the same healthcare provider for the rich and the poor If we have dual systems with the “national service” caring for the poor and the private sector caring for the rich, quality will be an afterthought. We need the rich and poor to be cared for by the same provider – this ensures that high quality will be a political priority as those with voting influence are directly affected by the quality of services provided. Jolene Skordis, director,[UCL Centre for Global Health Economics](http://www.ighe.org/), London, UK[@JSkordis](https://twitter.com/JSkordis) ¶3 | Give public-private partnerships serious consideration The PPP model needs to be taken to scale in PHC in order to achieve UHC in a planned time frame. I have worked in many parts of the developing world and in general governments have not been able to step up. Now is the time to test new models as the old system is not working. We need a blended service delivery mechanism. We have to open up the insurance space and governments must push for universal insurance cover for all citizens. This is what we’re trying to do in [Kenya](http://www.huffingtonpost.com/siddharth-chatterjee/kenyas-health-sector-chal_b_11503202.html?ncid=engmodushpmg00000004). Siddharth Chatterjee, resident coordinator to Kenya, United Nations, Nairobi, Kenya[@sidchat1](https://twitter.com/sidchat1)[@UNDPKenya](https://twitter.com/UNDPKenya) ¶4 | Learn from the places getting it right Ghana’s health system isn’t the best I’ve seen but they’ve got some very fundamental things right and have been continually improving over many years. Some of the fundamentals are a commitment to all Ghanaians getting quality, affordable healthcare, and trying to create a national-level risk pool – so the healthier and wealthier subsidise the sicker and poorer. From small-scale experimentation with community-based health insurance, they scaled up to national health insurance, and are now working through the tough challenges of purchasing health services more strategically and sustainably for everyone. The private sector plays a significant role in Ghana’s healthcare provision – a recent World Bank study of Ghana’s private sector noted that Ghanaians access care from private sources more than half of the time. Cicely Thomas, senior programme officer,[Results for Development](http://www.r4d.org/), Washington DC, US [@results4dev](https://twitter.com/results4dev)[@cicelysimone](https://twitter.com/cicelysimone) ¶5 | Raise taxes to reach the poorestIn the majority of developed countries, health services are mostly private. But they are publicly regulated and financed. What we have learned over time is that an equitable system always relies on cross-subsidy, from rich to poor and from healthy to sick. Progressive taxation and public subsidy to ensure access to services is the essence if we want to reach universality of access to health services. Agnes Soucat, director, health financing and governance,[World Health Organisation](http://www.who.int/en/), Geneva, Switzerland[@asoucat](https://twitter.com/asoucat)[@WHO](https://twitter.com/WHO) ¶6 | Don’t focus on arbitrary targets for health spending The Abuja declaration expects African governments to spend 15% of GDP on healthcare. That’s not easy to do – and is not essential. Singapore spends about 5% of GDP on healthcare and has done a fantastic job in ensuring every citizen has access to a good quality service. Sri Lanka spends between 3%–5% and India is pushing for 2.5%. But the question should be about what can you do best with what you can afford to spend. There is no magic GDP number that will deliver UHC since every country has varied resources. Ultimately it is not only about more money, but also how you end up spending your existing health budget that matters. Resources are often misspent in the health sector with an inordinate focus towards hospital care. Siddharth Chatterjee and Priya Balasubramaniam ¶7 | Invest more in preventing people getting sick Health is not just the remit of health ministries – sanitation, housing, welfare and education are just a few of the bedrocks of improving population health. We shouldn’t think of healthcare as a pill or a hospital or programme to treat a single disease. Healthcare is clean water and a diet that does not place you at risk of diabetes or stunting. Healthcare is the education you need to find work and pay for a safe and warm home for your family. Healthcare is delaying early marriage and early pregnancy for vulnerable girls. Prevention has been relatively neglected in our policy priorities. Perhaps because prevention activities can seldom be charged for and people are not yet sick so it can be hard to convince both the public and policymakers of the benefits of preventative measures, even though prevention is usually the most cost-effective way to address disease. Jolene Skordis ¶8 | Make tackling individual diseases have a wider impact In resource-limited settings, what health initiatives can catalyse overall healthcare systems strengthening? Vertical initiatives anchored to one disease, such as the focus on HIV through PEPFAR and Global Fund, have led to broader health-system strengthening by alleviating the HIV burden as well as increasing outcomes in mother-to-child transmission. Anand Reddi, corporate and medical affairs, Gilead Sciences Inc, San Francisco, US[@ReddiAnand](https://twitter.com/ReddiAnand)[@GileadSciences](https://twitter.com/GileadSciences) ¶9 | Focus on equity, not just the number of people reached If we look back at the millennium development goals it is clear that the focus on reaching big numbers has had a detrimental effect on equity. Too often, national policies do not specifically address how marginalised groups will be reached by development programmes in order to benefit from the new facilities and services provided. This problem is often made worse in low-income areas where the services are offered on a cost recovery basis. Helen Hamilton, policy adviser for health,[Sightsavers](http://www.sightsavers.org/), Haywards Heath, UK[@HelenCHamilton](https://twitter.com/HelenCHamilton)[@Sightsavers\_Pol](https://twitter.com/Sightsavers_Pol) ¶10 | Be honest about how money shapes healthcare decisions India’s case (and that of South Africa, Brazil and the US) proves how users of a health services are often not the best judge of health services. We rely on doctors to tell us what care we need. If doctors can profit from giving us incorrect advice, they may well do so – particularly if there is little harm likely to be done (eg sending paying patients for extra, unneeded tests or procedures). This results in the cost of care increasing rapidly in the private sector, to the point where even the middle classes can’t afford health insurance in South Africa and the US. We need to remove the profit motive from healthcare if we want efficiency and effectiveness. Jolene Skordis ¶

#### 5) The CP is the only true adherence to the categorical imperative – we preserve individuals’ rights to their inventions but also universalize health

## Case

### Framing

#### They don’t say what the Categorical Imperative is or why consequentialism isn’t consistent with it

#### “Ought” means “should” – it’s not a moral obligation

Merriam-Webster, 19 – (“Ought," http://www.learnersdictionary.com/definition/ought)

Ought is almost always followed by to and the infinitive form of a verb. The phrase ought to has the same meaning as should and is used in the same ways, but it is less common and somewhat more formal. The negative forms ought not and oughtn't are often used without a following to.

#### Kantian theory collapses into consequentialism -- the only reason a maxim would be bad to universalize is that it produces bad consequences.

#### And hold the Aff to a high burden of proof to exclude Neg impacts.

#### And even if you don’t buy any of this, *we still win under Kantianism*

#### Free-riding - People should have a right to property and their ideas; anything else violates the categorical imperative because they don’t get to enjoy the fruits of their labor

#### Extinction first –

#### The aff takes too long for COVID---only vaccine donations solve. Fabricius 6/25

Peter Fabricius [institute for security services consultant], 6/20 - ("South Africa: Is Ramaphosa Tripping Over a TRIPS Waiver?," allAfrica, 6/25/2021, accessed 6-30-2021, https://allafrica.com/stories/202106260001.html)//ML

His fervour is prompting some suspicion that the waiver campaign is an ideological issue for South Africa and others on the left - who have always been suspicious of big pharma - rather than an objective solution to a crisis. That's because a TRIPS waiver cannot possibly rescue Africa from the immediate grips of the pandemic.¶ Even the mRNA project in South Africa would take at least around 12 months before manufacture can begin, WHO Chief Scientist Soumya Swaminathan said. And this would be with voluntary licensing and full technological cooperation and training from the patents' owners. Manufacturing vaccines from scratch and without that cooperation through a TRIPS waiver would take much longer.¶ The only immediate remedy is a vigorous campaign to pressure rich countries to donate vaccines¶ Yogesh Pai, Assistant Professor at the National Law University in Delhi, said the TRIPS waiver proposal was 'simplistic' in assuming that allowing the formulae of companies making vaccines to be copied would automatically enable other manufacturers to produce COVID-19 vaccines quickly.¶ Pai said most complex technologies, such as vaccines, comprised not only the knowledge, which is patented to prevent copying. It also involved undisclosed information and know-how about quality control measures for production and clinical data required for regulatory clearances.¶ An intellectual property waiver wouldn't give another company access to this deeper level of know-how. Only a cooperative agreement in which the technology owner helped the new manufacturer produce the vaccines could do this, Pai suggested.¶ Prashant Yadav, an expert on medical supply chains at Harvard Medical School, told ISS Today that it would probably take two to three years to produce a vaccine via a TRIPS waiver. First, the waiver would need to be secured, and then the necessary processes worked out without the help of the original developer.¶ Can Africa wait that long? At the launch of the mRNA project this week, Michael Ryan, Head of the WHO's Health Emergencies Programme, stressed that manufacturing COVID-19 vaccines in Africa, while commendable, wouldn't address the immediate crisis. The only solution was for rich countries to stop hoarding vaccines immediately. 'It will be a catastrophic moral failure at global level if we do not do that,' Ryan warned.¶ Yadav says the urgent strategy should be reallocating doses purchased by countries that don't need them and expanding vaccine production through voluntary licensing and tech transfer from the originator companies.¶ Of course, Ramaphosa could be right in suspecting that rich countries aren't altruistic enough to donate their 'surplus' vaccines, and so Africa and the rest of the global south must become more self-reliant.