#### Plan text: The member nations of the World Trade Organization ought to reduce intellectual property protections for medicines, this is best exemplified with Covid Vaccines

## I. Vaccine Apartheid

#### A TRIPS waiver for covid vaccines will not pass in the squo. Baschuk 7/26

Bryce Baschuk [Reporter, Bloomberg Economics], 21 - ("WTO Holiday From Vaccine Equity Talks Draws Calls for Action," Bloomberg, 7-26-2021, accessed 8-18-2021, https://www.bloomberg.com/news/articles/2021-07-26/wto-s-holiday-from-vaccine-equity-talks-draws-calls-for-action)//ML

An urgent global effort to rebalance the inequity between rich, vaccinated nations and poor nations sliding further into pandemic misery is colliding with an immovable calendar conflict: the European summer holiday. Next week World Trade Organization delegates are planning to depart Geneva for their August break and, in doing so, pause their fractious debate over a proposal to waive intellectual-property protections for Covid-19 shots until the second week of September.¶ Before they leave, members will adopt a report that acknowledges they’ve made scant headway on the proposal aimed at making doses more widely available, which the world’s top health expert says is critical to ending a “moral failure.”¶ “With so many lives on the line, profits and patents must come second,” World Health Organization Director-General Tedros Adhanom Ghebreyesus [said](https://www.who.int/director-general/speeches/detail/who-director-general-s-opening-remarks-at-the-wto---who-high-level-dialogue-expanding-covid-19-vaccine-manufacture-to-promote-equitable-access) during a virtual summit last week.¶ WTO Director-General Ngozi Okonjo-Iweala previously urged ambassadors to shorten their usual six-week summer holiday to focus on pressing issues like the waiver. Nevertheless, members aren’t planning to reconsider the matter until the week of Sept. 6, according to officials familiar with the planning.¶ “August doesn’t matter in Geneva; it doesn’t matter if people are dying around the world,” said Shailly Gupta, a spokesperson at Médecins Sans Frontières. “We hope members will move at a faster pace.”¶ Disagreement persists on the fundamental question of whether a waiver is the “appropriate and most effective way” to address the shortage of vaccines, according to a draft status report produced by Dagfinn Sørli, the chairman of WTO council on Trade-Related Aspects of Intellectual Property Rights, or TRIPS.¶ That split could sink prospects for an ambitious vaccine waiver because WTO decisions must be taken on the basis of consensus -- which means any of the 164 members can veto a final agreement for any reason.¶ ”The WTO’s response to Covid is the most critical issue before our organization right now,” WTO spokesman Keith Rockwell said a phone interview. “Millions have died and lives are at stake. Finding a pragmatic outcome by December is essential.”¶ Proponents of the waiver had hoped to conclude their negotiations by the [end of July](https://pmindiaun.gov.in/public_files/assets/pdf/Statement_as_delivered_on_Waiver_Proposal.pdf) and are now criticizing the European Union and other developed nations for sandbagging the talks.¶ EU ‘Not Interested’¶ The European Commission, which [opposes a WTO TRIPS waiver](https://ec.europa.eu/commission/presscorner/detail/en/STATEMENT_21_2361), has proposed a [series of measures](https://www.bloomberg.com/news/articles/2021-06-03/eu-s-trade-response-to-pandemic-stops-short-of-vaccine-ip-waiver) that it argues will create greater legal certainty for nations to leverage existing trade tools in order to expand their production capacities.¶ “The EU is not interested,” Gupta said. “Switzerland, Norway and the United Kingdom are not engaging. They’re saying: ‘This or that won’t work; the waiver won’t work.’ There is no intention of engaging.”¶ A spokesman for the EU mission in Geneva declined to comment.§ Critics counter that the proposal from Brussels is a distraction to redirect focus from India and South Africa’s earlier waiver proposal and to prevent members from engaging in more detailed negotiations.¶ “The EU’s actions are incredibly cynical and dangerous,” said Lori Wallach, the founder of Public Citizen’s Global Trade Watch. “They have submitted a paper that basically conflicts with the text-based negotiations by saying ‘We don’t want a waiver.’”¶ The U.S., meanwhile, has taken a back seat in the process and enthusiasm about Washington’s engagement on the issue has begun to wane in the three months since Trade Representative Katherine Tai announced American [support for a waiver](https://twitter.com/AmbassadorTai/status/1390021205974003720?s=20).¶ Though Tai’s surprise announcement briefly knocked shares of [Moderna Inc.](https://www.bloomberg.com/quote/MRNA:US), [Pfizer Inc.](https://www.bloomberg.com/quote/PFE:US), and [BioNTech SE](https://www.bloomberg.com/quote/BNTX:US), the stocks quickly rebounded and all are now trading at or near their highest levels of the year.¶ “People feel that message from Ambassador Tai is not playing out on the ground or being implemented in a meaningful way,” said Thiru Balasubramaniam a managing director at [Knowledge Ecology International](https://www.bloomberg.com/quote/0746610D:US) in Europe.

#### The only way to solve the pandemic is global vaccination, but current production is woefully short.

Public Citizen 3/29 - Public Citizen [“Public Citizen is a nonprofit consumer advocacy organization that champions the public interest in the halls of power. We defend democracy, resist corporate power and work to ensure that government works for the people – not for big corporations. Founded in 1971, we now have 500,000 members and supporters throughout the country. We don’t participate in partisan political activities or endorse any candidates for elected office. We take no government or corporate money, which enables us to remain fiercely independent and call out bad actors – no matter who they are or how much power and money they have.”], “Waiver of the WTO’s Intellectual Property Rules: Facts vs. Common Myths,” *Public Citizen Global Trade Watch Series*. March 29, 2021. Accessed Aug. 10, 2021. <https://www.citizen.org/article/waiver-of-the-wtos-intellectual-property-rules-myths-vs-facts/> AT

The COVID-19 public health disaster and resulting economic crises won’t end anywhere unless people everywhere are vaccinated. Despite this obvious truth, rich countries with only 14% of the global population have secured preferential access to over 50% of projected global vaccine supplies. Ongoing outbreaks anywhere allow the virus to mutate, threatening the whole world with vaccine-resistant variants or more deadly or easily spread variants. Governments invested billions to create the vaccines. But, there is a dire shortage, with no end in sight. As we enter the second quarter, about one billion doses have been produced in 2021. We need 10 to 12 billion to reach global herd immunity. And we will need far more if, like flu vaccines, they must be repeated or require booster shots. In every region, there are existing firms that could gear up production and governments willing to invest in expanding supply. But WTO rules require countries to guarantee pharmaceutical corporations monopoly control. More than 100 countries support a temporary, emergency suspension of these WTO rules, so more vaccines, treatments and diagnostic tests can be manufactured in as many places as possible. The United States and a handful of other WTO members are blocking the waiver: They won’t even agree to negotiate about waiver language to address whatever concerns that they may have with the current text. Donald Trump started this self-defeating blockade. President Joe Biden must reverse it to speed the end of the COVID-19 pandemic.

**Changing IP laws is key to combatting global health inequality and vaccine apartheid. Rich countries hoard vaccine supply, which means donor models never solve and reinforce colonialism. Harman et al 6/21**

Sophie Harman [professor of Politics and International Relations, Queen Mary University of London], Parsa Erfani [Fogarty Global Health Fellow at the University of Global Health Equity and a medical student at Harvard Medical School], Tinashe Goronga [Community Organiser Equal Health Global Campaign Against Racism at EqualHealth], Jason Hickel, Michelle Morse, Eugene T Richardson 6/21 - ("Global vaccine equity demands reparative justice — not charity," BMJ Global Health, 6/21/2021, <https://gh.bmj.com/content/6/6/e006504)//ML>

By late April, more than 80% of the world’s COVID-19 vaccines had gone to people in wealthy countries, with just 0.3% to people in low-income countries.[1](https://gh.bmj.com/content/6/6/e006504#ref-1) This reprehensible imbalance is no accident. High-income countries have used neocolonial negotiating power, global policy leverage and capital to procure enough doses to cover 245% of their citizens while leaving few doses for poorer countries.[2](https://gh.bmj.com/content/6/6/e006504#ref-2) As a result, lower-income countries may not be able to vaccinate their populations until 2023.[3](https://gh.bmj.com/content/6/6/e006504#ref-3)¶ Such inequity is yet another example of how the interests of racial capitalism run roughshod over the golden rule of global solidarity—attend to the highest risk first.[4](https://gh.bmj.com/content/6/6/e006504#ref-4) Currently, older and medically vulnerable individuals are dying from COVID-19 disproportionately in poor countries, while young, healthy individuals are getting vaccinated in wealthy ones.[5](https://gh.bmj.com/content/6/6/e006504#ref-5) Vaccine apartheid is a not novel phenomenon. The notion that only certain corners of the world get to benefit from life-saving treatments is an everyday reality of a global health system driven by a capitalist, philanthropic model.[6 7](https://gh.bmj.com/content/6/6/e006504#ref-6) But in times of crises—and as new variants threaten the vaccination plans of wealthy countries—these inequities and their solutions come to the forefront of global debate.[8](https://gh.bmj.com/content/6/6/e006504#ref-8)¶ Policy-makers in rich nations are aware of these issues. But the solutions they have proposed so far do nothing to address the underlying structural problems. They offer charitable donations and partial, temporary fixes that are designed to deflect the substantive demands for reform that global South countries are fighting for, including challenges to unethical intellectual property (IP) regimes.[9](https://gh.bmj.com/content/6/6/e006504#ref-9) This approach will not work, because it is not designed to ‘work.’ If we want to end vaccine apartheid, we need to target the root causes of global health inequities. We need reparative justice.¶ Three limited ‘solutions’ to vaccine inequity¶ There are currently three approaches to reduce inequity in COVID-19 vaccine distribution: bilateral charity, multilateral charity and temporary waivers or suspensions of IP.¶ The first is the most straightforward. States that stockpile COVID-19 vaccines have committed to sharing their leftovers with low-income and middle-income countries. Norway was one of the first nations to accede to donating doses to poorer countries in parallel with its vaccine programme.[10](https://gh.bmj.com/content/6/6/e006504#ref-10) This is the weakest form of equity as it is unclear if this will be done for free, at a lower cost, tied to diplomacy or conditionality, or crucially, when these vaccines will be made available, where they will go, or how many will be delivered. The bilateral charity approach has little to do with equity and more to do with geopolitics, wealth and aid dependency.[11 12](https://gh.bmj.com/content/6/6/e006504#ref-11)¶ The second is multilateral charity, best exemplified by COVAX. In 2020, COVAX emerged as an international collaboration by the World Health Organisation (WHO), United Nations Children’s Fund, Gavi and the Coalition for Epidemic Preparedness Innovations to ensure equitable global access to COVID-19 vaccines.[13](https://gh.bmj.com/content/6/6/e006504#ref-13) Rich countries can access doses for 10%–50% of their populations, depending on how much they have paid in, and poor countries can access doses for 20% through the scheme. It is the 20% for poor countries that has come to be COVAX’s unique selling point: here is a mechanism that ensures every country in the world can get the vaccine regardless of ability to pay. This is the first time such an initiative has been trialled.¶ The shortcomings of COVAX are numerous. If vaccines are delivered as planned, COVAX may reach 27% of the population in lower-income countries by the end of 2021—a depressing goal compared with the estimated 70% coverage needed for herd immunity and the open vaccine access currently granted to Americans.[14 15](https://gh.bmj.com/content/6/6/e006504#ref-14) Furthermore, COVAX is still significantly underfunded and there are concerns regarding supply chains. While capital and resource transfer from wealthy countries to poorer ones is surely needed in the current pandemic response, any system that solely relies on aid will ultimately fail to achieve equity. In the setting of vaccine scarcity, in which suppliers are unable to deliver doses as scheduled and countries are banning exports to keep vaccines at home, there is a risk that COVAX aid-recipient states will fall further down the priority list, awaiting the leftover vaccines from the rich country stockpiles.[16–18](https://gh.bmj.com/content/6/6/e006504#ref-16)¶ What may be most pernicious about the COVAX scheme, however, is that rich countries and their pharmaceutical companies have repeatedly used it as a shield to deflect demands for IP waivers. This is an enduring problem with aid: it papers over and distracts our attention away from the underlying structural violence. And in so doing, it maintains and perpetuates inequalities. Over 50 years ago, Kwame Nkrumah observed how aid is a ‘revolving credit’ which returns to countries of the global North in the form of increased profits.[19](https://gh.bmj.com/content/6/6/e006504#ref-19) To the extent that COVAX is being leveraged to protect corporate patents and profits, Nkrumah’s words continue to be germane¶. The third approach is focused on pooling, temporary waivers, or suspension of IP. In May 2020, the WHO created the COVID-19 Technology Access Pool for companies to share IP and transfer technologies in a coordinated manner. But to date, not a single company has utilised the transfer process—likely because such forms of global IP sharing would quell profits, even if royalties are included.[20](https://gh.bmj.com/content/6/6/e006504#ref-20) Pharmaceutical companies and universities prefer one-off transfer deals because it enables them to set their own terms with non-disclosure agreements. Given that they are accountable to shareholders and boards—not patients—financial incentives will drive transfer decisions, not public health demand.¶ Following the blockages at the WHO around IP, attention shifted towards the World Trade Organisation (WTO). In October 2020, India and South Africa proposed a temporary waiver of IP rights to COVID-19 technologies for the duration of the pandemic, so that all manufacturers with sufficient capacity and shared know-how could start production.[21](https://gh.bmj.com/content/6/6/e006504#ref-21) Although backed by over 100 countries within the WTO and a global campaign for the ‘People’s Vaccine,’ the proposal has been repeatedly blocked at every committee meeting since then by select wealthy countries with large pharmaceutical industries, including the UK, Japan and EU states.[22 23](https://gh.bmj.com/content/6/6/e006504#ref-22)¶ Those who oppose the IP waiver argue that it will not do anything to solve the problem: even if you were to liberate the recipe for the vaccines, low-income and middle-income countries do not have the capacity to produce it.[24](https://gh.bmj.com/content/6/6/e006504#ref-24) But this argument is specious. For one, several middle-income countries—including India, Brazil, Senegal and South Africa—do have the ability to ramp up production by repurposing existing manufacturing capacity.[25](https://gh.bmj.com/content/6/6/e006504#ref-25) In addition, an IP waiver can and should be supplemented with technology transfers, logistical support and financial investment to facilitate this repurposing process. And the most important point is that such a waiver could drastically reduce costs across the board, making vaccine imports more affordable for poor countries.¶ Opponents of the waiver also claim that IP-related obstacles can be addressed through existing arrangements for ‘compulsory licensing’ under the WTO’s Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS).[26](https://gh.bmj.com/content/6/6/e006504#ref-26) But the past evidence suggests that this process is slow, cumbersome and subject to various shaming practices by the international community.[27 28](https://gh.bmj.com/content/6/6/e006504#ref-27) Some point instead to the possibility of voluntary licensing. But voluntary licenses are often executed secretly and are limited to companies or governments that can afford them. The University of Pennsylvania, which owns IP rights relating to the mRNA vaccines, is helping Chulalongkorn University in Bangkok develop a vaccine production facility. This partnership was possible because Thailand—unlike other middle-income countries—was able to put up the money.[29](https://gh.bmj.com/content/6/6/e006504#ref-29) Poorer countries are left out. Sharing of IP and technology transfers can and will accelerate global vaccine production. The question is on whose terms. Organisations such as the WHO and African Union are currently mobilising support and resources to accelerate production in low-income and middle-income countries.[30 31](https://gh.bmj.com/content/6/6/e006504#ref-30) But these efforts will be to waste unless IP for COVID-19 technologies is shared broadly and quickly.¶ Vaccine coloniality¶ Donor-based approaches to vaccine equity are grounded in old, even colonial ideas of aid and dependency, which have failed to serve the health needs of the Majority World or deliver on health equity. This failed model has not promoted health equity in the past and is clearly inadequate in the present, on account of dependency on donor whims (the bilateral ‘leftovers’ approach), persistent funding gaps and shortfalls (COVAX), and time-consuming diplomacy and filibustering over what is or is it not within current trade rules (WTO).¶ Once again in the political economy of global health, the charitable model of COVAX becomes the smokescreen for inequitable systems. When states are asked about their stockpiling, they point to COVAX. When pharmaceutical companies are asked about IP, they point to COVAX or their low-cost commitment. The focus on a donor-based model of aid in achieving vaccine equity has distracted leaders from the ideologies, economic systems and trade regulations that leave access to medicine to the forces of the marketplace rather than global health priorities.[32](https://gh.bmj.com/content/6/6/e006504#ref-32) Achieving global vaccine justice requires a rapid shift in trade regulations and contract transparency that streamlines IP sharing and technology transfers. The resultant collaborations across economies will not only accelerate vaccine production but will also increase competition and push vaccine prices down.¶ Finally, old models of vaccine equity have not kept pace with changes in discourse and thinking around global health governance, equity and justice. 2021 is not the early 2000s, where new public–private partnerships or funding models were de rigueur. Donor countries are increasingly wary of aid dependency as they pay the cost of continuing high profile health programmes with diminishing strategic returns. Aid-recipient countries are similarly exasperated by funding gaps that lead to delays and materiel shortfalls, the NGO-industrial complex and attendant consultants that rationalise them, and fundamentally, by the notion that their populations only seem to matter when another state can capitalise on them.¶ Conclusion¶ Vaccine apartheid is only one symptom of broader global health inequalities that have their roots in colonialism and persist today because of neocolonial forms of power. As Grosfoguel writes, ‘The heterogeneous and multiple global structures put in place over a period of 450 years did not evaporate with the juridical–political decolonisation of the periphery over the past 50 years. We continue to live under the same ‘colonial power matrix.’ With juridical–political decolonisation we moved from a period of ‘global colonialism’ to the current period of ‘global coloniality.’[33](https://gh.bmj.com/content/6/6/e006504#ref-33) Vaccine justice starts with moving beyond aid models of vaccine donation, in which poorer countries are gifted vaccine leftovers. It demands rapidly achieving global consensus for the IP waiver, democratising vaccine IP and know-how and supporting low-income and middle-income countries to build manufacturing capacity for this pandemic and the next. These steps can mark the start of a reparative justice movement in global health that demands we confront and overturn colonial legacies that continue to devastate the health of low- and middle-income countries.[34](https://gh.bmj.com/content/6/6/e006504#ref-34) A commitment to funding vaccine justice in the face of the COVID-19 pandemic can be a first step in this direction.

**Manufacturing capacity is widespread around the world.**

**Public Citizen 3/29 -** Public Citizen [“Public Citizen is a nonprofit consumer advocacy organization that champions the public interest in the halls of power. We defend democracy, resist corporate power and work to ensure that government works for the people – not for big corporations. Founded in 1971, we now have 500,000 members and supporters throughout the country. We don’t participate in partisan political activities or endorse any candidates for elected office. We take no government or corporate money, which enables us to remain fiercely independent and call out bad actors – no matter who they are or how much power and money they have.”], “Waiver of the WTO’s Intellectual Property Rules: Facts vs. Common Myths,” *Public Citizen Global Trade Watch Series*. March 29, 2021. Accessed Aug. 10, 2021. <https://www.citizen.org/article/waiver-of-the-wtos-intellectual-property-rules-myths-vs-facts/> AT

In the press and on Capitol Hill, Big Pharma is pushing a Big Lie. The claim is that a lack of manufacturing capacity, not pharmaceutical corporation’s monopoly intellectual property (IP) protections, are thwarting greater production of COVID-19 vaccines. A related argument, with decidedly racist overtones, is that COVID-19 vaccines are too complicated for producers in developing countries to make successfully. The reality is that in every region of the world, there are multiple producers that could be greatly increasing global vaccine supplies if the technology and know-how were shared.¶ Just in Africa, “Biovac and Aspen in South Africa, Institute Pasteur in Senegal, and Vacsera in Egypt could rapidly retool factories to make mRNA vaccines,” notes a group of medicine-production experts in a recent Foreign Policy article. Indeed, a former Moderna director of chemistry revealed that with enough technology transfer and know- how-sharing, a modern factory should be able to get mRNA vaccine production online in, at most, three to four months. The Serum Institute in India already is slated to produce the AstraZeneca and Novavax vaccines, while Moderna declined to partner with a qualified Bangladeshi vaccine maker, claiming its engineers were too busy to focus beyond U.S. and EU production. In Latin America, existing facilities in Brazil, Argentina and Mexico under contract to monopoly holders are already pumping out vials, and in countries like Chile and Colombia, the pharmaceutical industry has expressed willingness to kickstart vaccine production.¶ Existing and planned contract manufacturing arrangements prove facilities in developing countries certainly can produce COVID-19 vaccines. But unless technology and know-how are shared more openly, the monopoly holders maintain absolute control over how much can be produced, what the price is and where it will be sold. So, 91% of the Johnson & Johnson vaccine that South African firm Aspen will manufacture must be shipped for sale outside South Africa, according to South Africa’s WTO Counselor. And the Serum Institute is barred from supplying upper- middle-income and high-income countries with the AstraZeneca vaccines it makes, meaning AstraZeneca can artificially segment the global market and ensure that it is the only supplier of the Oxford vaccine in the most profitable national markets, according to Doctors Without Borders.¶ Most critically, there simply is not enough supply to go around now or for every year in the future during which the whole world will need regular COVID vaccination to keep the virus under control. Thankfully, scores of countries are ready to invest in building new or repurposing existing production capacity. That is why more than 100 countries support a waiver of the WTO’s Agreement on Trade-Related Aspects of Intellectual Property (TRIPS). These countries seek certainty that if they adjust their domestic laws and practices to support that investment by providing access to the necessary technology, they will not get dragged into expansive WTO litigation or face retaliatory sanctions from countries claiming WTO violations. The waiver will also serve as a worldwide buffer against the political pressure and legal harassment to which Big Pharma subjects countries that seek to promote affordable access to medicines.¶ In many countries, the regulatory authorities that had to approve domestic use of various vaccines and other COVID-related medical products have significant information from the firms that they could share with skilled teams from local universities, government agencies and pharmaceutical manufacturers — if they were not obliged by WTO rules to guarantee monopoly control of it. And world-class pharmaceutical firms already are making generic versions of new cutting-edge HIV-AIDS medicines and pumping out vaccines based on the platform that, for instance, the Johnson & Johnson vaccine uses.

**Vaccine shortfall causes widespread death and poverty.**

**Public Citizen 3/1 -** Public Citizen [“Public Citizen is a nonprofit consumer advocacy organization that champions the public interest in the halls of power. We defend democracy, resist corporate power and work to ensure that government works for the people – not for big corporations. Founded in 1971, we now have 500,000 members and supporters throughout the country. We don’t participate in partisan political activities or endorse any candidates for elected office. We take no government or corporate money, which enables us to remain fiercely independent and call out bad actors – no matter who they are or how much power and money they have.”], “Backgrounder: WTO-Required Monopolies for Pharmaceutical Corporations Obstruct Global Production of COVID-19 Vaccines & Treatment,” *Public Citizen Global Trade Watch Series*. March 1, 2021. Accessed Aug. 12, 2021. <https://www.citizen.org/article/wto-required-monopolies-for-pharmaceutical-corporations-obstruct-global-production-of-covid-19-vaccines-and-treatments/> AT

It is obvious that current production capacity cannot supply enough vaccines for the entire world. Many people in low- and middle-income countries around the globe will not get vaccinated until at least 2022 unless the world manufactures many more doses, according to the British Medical Journal. The world’s poorest countries may wait until 2024 for mass immunization, if it happens at all, reports the Economist Intelligence Unit.

The global vaccine apartheid unfolding right now could cost millions of lives and push tens of millions more into poverty. The devastation will be felt for a generation. A new International Chamber of Commerce report concluded that the world could face economic losses of more than $9 trillion under the scenario of wealthy nations being fully vaccinated by mid-2021, but poor countries largely shut out. Wealthy countries like the United States would bear nearly half of that hit. Vaccinating just half of low- and middle-income countries’ populations could reduce global losses by $5.5 trillion.

**Poverty and disease are mutually reinforcing, causing staggering suffering and injustice.**

**Hollis & Pogge ’08 -** Aidan Hollis [Associate Professor of Economics, the University of Calgary] and Thomas Pogge [Leitner Professor of Philosophy and International Affairs, Yale University], “The Health Impact Fund Making New Medicines Accessible for All,” *Incentives for Global Health* (2008) AT

In 2004, some 970 million people, around 15 percent of the world’s population, were living below the extreme poverty line of $1 a day (more strictly defi ned, $392.88 annually) in 1993 Purchasing Power Parity (PPP) terms (Chen and Ravallion 2007, 16579).3 Furthermore, those living below this very low poverty line fell on average around 28 percent below it. Th eir average annual purchasing power therefore corresponded to approximately $420 in the US in 2008 dollars.4¶ Th ese are the poorest of the poor. Th e World Bank also uses a somewhat less miserly poverty line, namely $2 dollar a day, or an annual amount of $785.76 PPP 1993. Th e Bank’s data show that around 40 percent of the world’s population, or over 2.5 billion people, lived in income poverty so defi ned in 2004,5 with this population falling on average 41 percent below this higher line.6 Individuals I[];[\p[]p[]\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\n this much larger group could buy, on average, about as much in 2004 as could be bought in the US in 2008 for $690.¶ The Effects of Global Income Poverty on Health¶ The effects of such extreme income poverty are foreseeable and extensively documented. It is estimated that around 13 percent of all human beings (830 million) are chronically undernourished, 17 percent (1.1 billion) lack access to safe water, and 41 percent (2.6 billion) lack access to basic sanitation (UNDP 2006, 174, 33). About 31 percent (2 billion) lack access to crucial drugs and 25 percent (1.6 billion) lack electricity (Fogarty n.d., IEA 2002). Some 780 million adults are illiterate (UNESCO 2006), and 14 percent of children aged between fi ve and 17 (218 million) are child laborers, more than half in hazardous work (ILO 2006, 6).¶ Worldwide, diseases related to poverty, including communicable, maternal, perinatal, and nutritionrelated diseases, comprise over 50 percent of the burden of disease in low-income countries, nearly ten times their relative burden in developed countries (WHO 2006b, 3). If the developed world had its proportional share of poverty-related deaths (onethird of all deaths), severe poverty would kill some 16,000 Americans and 26,000 citizens of the European Union each week.¶ The cycle of mutually reinforcing poverty and disease besetting low income countries, and particularly the poorer communities in these countries, could be broken by signifi cantly reducing severe poverty. But it is also possible to make substantial progress against the global burden of disease more directly by improving health care in developing countries.¶ Poverty does not merely render poor people more vulnerable to disease, but also makes it less likely that they can obtain medical treatment for the diseases they contract. This is because in poor countries medical care is rarely available for free, and poor people are typically unable to buy either the care needed by themselves or their families or the insurance policies that would guarantee them such care. The price of health care in poor countries therefore also plays a crucial role in explaining the catastrophic health situation among the global poor.

## Advantage 2: Global Health inequality

#### The WTO’s Agreement on TRIPS causes massive global health inequality—only eliminating TRIPS solves.

K. M. Gopakumar 15, legal advisor and senior researcher with the Third World Network, “Twenty years of TRIPS agreement and access to medicine: a development perspective,” Indian Journal of International Law 55, 367–404 2015, <https://link.springer.com/article/10.1007%2Fs40901-016-0022-7>

The two decades of TRIPS show clearly that the compulsory product patent regime succeeded in increasing the monopoly of pharmaceutical TNCS in new medicine market. The product patent regime has put curbs on the availability of generic versions of new medicines. The failure of patent system resulted in the call for fresh look at the role of patent and public policy. Two economists argue that ‘‘…public policy should aim to decrease patent monopolies gradually but surely, and ultimate goal should be the abolition of patents.’’107 Another academic notes: ‘‘Even pharmaceutical and biotech companies usually do not need more than about a decade of monopoly power to encourage their very large investments in new drugs.’’108 There is an urgent need to interrogate the international IP regime in general and patent protection for pharmaceuticals in particular, which does not reflect the health and development needs of people, especially those living in developing countries. The Declaration on Patent Protection: Regulatory Sovereignty under TRIPS released in 2014, an initiative of the Max Plank Institute for Innovation and Competition on the occasion of the 20th anniversary of the TRIPS notes four major developments that require accommodating the law to changed circumstances. First, the ‘historically unprecedented numbers of patents filings and grants’ create problems such as backlogs at patent offices, patent thickets, market entry barriers and increased litigation that ultimately generate impediments to research and commercialisation. The result is rising costs of monitoring patents and legal uncertainty, limiting the economic freedom of market participants, which in turn affects consumer welfare and distorts competition. Thus ‘the overall social benefits of innovation are reduced while an imbalance emerges between those able to cope with the resulting insecurities and related costs, such as multinational enterprises with their own patent departments, and those who cannot, such as small and medium sized enterprises or individual inventors.’109 Second, the new technologies like biotechnology, business methods and computer science as well as standard setting, strategic patenting and non-practising entities all affect the functioning of the patent system as a regulatory institution. Third, the role of patents in corporate management has undergone a change from a defensive means to protect research and development outcomes to become strategic assets to influence the conditions of competition. Fourth, the industrialised countries have tilted the balance in the patent regime towards right holders by reducing the burden for the patent applicants such as expanded scope of patentability, lower eligibility standards and reduced fees, as well as extending the rights of patent owners such as longer term of patent, harsher sanctions, strengthened ways for private and public enforcement. Therefore, the Declaration states: ‘the patent system faces increasing friction with ancillary public policy goals, such as protecting the environment, preserving biodiversity or ensuring affordable access to medicines.’110 Against this background there is an urgent need to review the TRIPS patent regime, especially the compulsory product patent protection. The Agreement itself contains provisions to review its implementation. Article 71.1 of the TRIPS Agreement provides mandatory review of the implementation of this Agreement after the expiration of the transitional period referred to in paragraph 2 of Article 65. Hence this review was to initiate in 2010. According to Art.71.1: The Council shall, having regard to the experience gained in its implementation, review it two years after that date, and at identical intervals thereafter. The Council may also undertake reviews in the light of any relevant new developments, which might warrant modification or amendment of this Agreement. There is a fear that the review may result in an opposite result if developed countries use the opportunity of review to push for TRIPS plus amendments using the second sentence of Article 71.1. However, Para 19 of the Doha Ministerial Declaration clearly defines the mandate of the review. It states, ‘‘The Council may also undertake reviews in the light of any relevant new developments, which might warrant modification or amendment of this Agreement.’’111 However, so far no WTO Member State submitted any proposal in this regard. It is important for developing countries to propose amendment of the compulsory product patent protection in the light of experiences under 20 years of TRIPS Patent Regime. Echoing the same sentiment, the UNDP-appointed Global Commission on HIV and the Law observed the ‘TRIPS has failed to encourage and reward the kind of innovation that makes more effective pharmaceutical products available to the poor, including for neglected diseases. Countries must, therefore, develop, agree and invest in new systems that genuinely serve this purpose, prioritising the most promising approaches including a new pharmaceutical R&D treaty and the promotion of open source discovery.’112 Further, the Commission recommended that: The UN Secretary-General must convene a neutral, high-level body to review and assess proposals and recommend a new intellectual property regime for pharmaceutical products. Such a regime should be consistent with international human rights law and public health requirements, while safeguarding the justifiable rights of inventors. Such a body should include representation from the High Commissioner on Human Rights, WHO, WTO, UNDP, UNAIDS and WIPO, as well as the Special Rapporteur on the Right to Health, key technical agencies and experts, and private sector and civil society representatives, including people living with HIV. This re-evaluation, based on human rights, should take into account and build on efforts underway at WHO, such as its Global Strategy and Plan of Action on Public Health, Innovation, and Intellectual Property and the work of its Consultative Expert Working Group. Pending this review, the WTO Members must suspend TRIPS as it relates to essential pharmaceutical products for low- and middle-income countries.113 As part of the implementation of the recommendation UN SecretaryGeneral has established a 16-member High Level Panel on Access to Medicines. This Panel is to review and assess various proposals and make recommendation to ‘‘remedy the policy incoherence between international human rights law and trade rules in the context of access and health technologies.’’114 It is expected to look at a new IP regime, which can ensure both access and innovation as recommended by the Global Commission on HIV/AIDS. The incoherence between trade law and human rights law cannot be addressed by using flexibilities in the TRIPS Agreement. As long as an international obligation to provide product patent protection for pharmaceutical inventions exists, the above-mentioned incoherence is also to exist. Therefore, it is important to restructure the TRIPS and TRIPS plus IP regime, which not only prevent the access to affordable medicine, but also failed to deliver access to R&D needs of developing countries. There is a need to provide enough policy space for countries to design their patent laws, especially to fulfill their human right obligations on right to health and right to science. Scrapping of the compulsory product patent protection under the TRIPS Agreement is critical to serve this purpose.

#### Pharmaceutical monopolies created by TRIPS massively inflate the price of medications and prevent the creation of treatments for diseases that kill millions. Kapczynski 19

Amy Kapczynski [professor of law at Yale Law School, faculty co-director of the Global Health Justice Partnership, and co-founder of the Law and Political Economy Blog], 19 - ("The Right to Medicines in an Age of Neoliberalism," Humanity Journal, 4-26-2019, http://humanityjournal.org/issue10-1/the-right-to-medicines-in-an-age-of-neoliberalism/)//ML

Why are these newer medicines so astronomically costly? Not because they are costly to make, but because producers enjoy monopoly rights. For example, a new breakthrough treatment for hepatitis C can be made for as little as $170, but the company holding the key patents priced it at $84,000 in the United States.85 This is, in fact, one of the core insights that fueled the access to medicines campaign: HIV medicines that were being sold for $10,000 to $15,000 a year (and that must be taken for life) could be sold for as little as $100 in the absence of monopoly.86 The treatment of millions of people with HIV in the global South has been, in fact, predicated on the use of cheaper, high-quality generic medicines, often imported from India or made locally.¶ Another example from Brazil is illustrative. One of the earliest drugs subject to extensive judicialization in Brazil is the anti-HIV drug Kaletra, made by the United States-based multinational firm Abbott.87 Kaletra is essential to basic HIV therapy, but the price was, and continues to be, a major issue for the Brazilian AIDS program. When it was added to the national program, Kaletra quickly came to absorb one third of its total medicines expenditures.88 Generics, though, could have been purchased for substantially less.89 After nearly a decade of sharp negotiations with Abbott, Brazil still paid almost twice the price for Kaletra that it would have paid if it purchased generic versions of the drug.90 Because of the scale of the universal AIDS treatment program, the government could have saved nearly $4 billion over just a few years had it purchased generic medicines.91 But it did not.¶ THE POLITICAL ECONOMY OF EXISTING INTERNATIONAL LAW¶ Why? The answer lies in the contemporary political economy of pharmaceuticals, as it has been shaped by international trade law and by the trade agendas of multinational companies and their affiliated governments, and particularly the United States. When negotiations began to create the new World Trade Organization in the 1980s, a set of multinational companies based in the United States—represented by the CEOs of several powerful pharmaceutical, entertainment, and software companies—joined together to lobby the United States, Europe, and Japan to write intellectual property law into the WTO.92 The proposal was simple and unprecedented: to link obligations on intellectual property to the global trading regime, and in the process, force developing countries to adopt strong IP laws if they wanted entry to the new regime. Because the WTO would have a new and powerful adjudicatory mechanism, developing countries would now also face trade sanctions if they violated their IP commitments. The companies succeeded in their campaign by appealing both to the self-interest of wealthy countries (because intellectual property is one of their main exports and a source of comparative advantage) and to a broader neoliberal account about the need for strong property rights to support the production of global public goods. Strong patent rights, the companies argued, are essential to the development of new medicines. At the time, more than fifty countries in the global South did not permit patents on medicines—as was typical for many northern countries, too, earlier on in their development.¶ The WTO’s Trade-Related Aspects of Intellectual Property Agreement (TRIPS) required all countries to introduce IP protections like those in the global North, including product patents on medicines.93 From the perspective of many economists, this condition was a scandal.94 Rather than following the “win-win” theory of comparative advantage, the logic here seemed to be either a simple rent transfer from South to North, or some kind of commitment to global public goods production. Both were predicted to strain the legitimacy of the global trading order.95¶ These predictions were prescient. Just a few years after the TRIPS Agreement came into effect, the issue of access to HIV/AIDS medicines roared onto the global stage. In 1996, new combination antiretroviral regimens were introduced in the global North, and dramatically decreased AIDS deaths there. But these same medicines were priced out of reach of almost everyone in the rest of the world, where more than 80 per cent of people living with HIV/AIDS lived. Activists mobilized around the issue and urged Indian firms to develop generic versions of anti-HIV drugs at a fraction of the cost of the patented drugs. Only after the patented price (around $25,000 a year) was brought down to the generic price—around $300 then, closer to $100 today—were the AIDS treatment programs that have since saved millions of lives created.96¶ It was in this crucible that health activists came to understand the implications of the TRIPS Agreement for the first time. TRIPS requires drug patents, and also allows countries to override those patents to make use of generic drugs. But the agreement is vague about the permissible conditions for overriding patents. For example, it requires “adequate” compensation and “reasonable” prior negotiation in the absence of emergency.97 Countries have been uncertain about how the terms and exceptions in TRIPS could be interpreted, and were pressured by the United States in particular to avoid any such measures. After intensive technical support and mobilizing by activists, several developing countries have issued compulsory licenses on AIDS medicines, but sometimes at a cost.98 When Thailand recently issued a spate of high-profile compulsory licenses, for example, the U.S. government and companies retaliated sharply—the United States by withdrawing certain trade preferences, and companies by withdrawing medicines from Thailand in protest.¶ The existing political economy of medicines, as this describes, is dominated by powerful pharmaceutical interests that have had a great deal of success in reshaping law and policy around the world. They have done this through a kind of squeeze play: by securing the passage of international agreements that mandate restrictive IP law in most of the world, and leveraging trade pressure from the United States and European Union to punish countries that seek to use flexibilities allowed by these same agreements.99¶ The result might be tolerable if TRIPS had the global public goods results that were claimed for it. But theory and facts suggest otherwise.100 The theory of patent-based R&D is, in essence, that we pay high prices for drugs and we get R&D in return. This system has only ever worked for wealthy countries (insofar as it has—there are problems here too) because a vast proportion of the world’s market resides in these countries and because R&D is expensive and the industry concentrated, leaving little room for small players who might focus on low-profit opportunities such as the diseases of the poor. Sub-Saharan Africa and India each comprises about 1 per cent of the world’s pharmaceutical market.101 All of Latin America makes up less than 5 per cent of the world’s market.102 And about 45 per cent of the world market is located in the United States alone, which has few mechanisms to constrain drug prices.103¶ It is not then a surprise to hear comments like the one recently made by the CEO of Bayer, when addressing the implications of a decision in India to override a patent on a Bayer cancer drug: “Is this going to have a big effect on our business model? No, because we did not develop this product for the Indian market. . . . We developed this product for Western patients who can afford this product, quite honestly.”104 The Onion captured the logic of the prevailing system even better, in a recent headline that reads: “Experts: Ebola Vaccine At Least 50 White People Away.”105 As James Surowiecki recently put it, we should not be surprised that drug companies invested nothing in Ebola for decades:¶ Diseases that mostly affect poor people in poor countries aren’t a research priority, because it’s unlikely that those markets will ever provide a decent return. So diseases like malaria and tuberculosis, which together kill two million people a year, have received less attention from pharmaceutical companies than high cholesterol. Then, there’s what the World Health Organization calls “neglected tropical diseases,” such as Chagas disease and dengue; they affect more than a billion people and kill as many as half a million a year. One study found that of the more than fifteen hundred drugs that came to market between 1975 and 2004 just ten were targeted at these maladies. And when a disease’s victims are both poor and not very numerous that’s a double whammy. On both scores, a drug for Ebola looks like a bad investment: so far, the disease has appeared only in poor countries and has affected a relatively small number of people.106¶ Effective Ebola vaccines and treatments will be the result not of our dynamic private sector, but of substantial investment by government, and by the National Institutes of Health in particular.107 Government, it turns out, is a major funder of not only basic research, but also drugs for neglected diseases, because markets predictably fail to serve the millions who suffer from these diseases.108¶ The conventional theory that supports the exclusive rights approach to information production is based upon the idea that markets will do better than governments in guiding decisions about what to produce, and how much to spend.109 But markets only can do this well if prices are able to adequately track the relevant form of social value. There are deep debates about exactly how to characterize that value when it comes to global health.110 But what is clear is that a market-led system for medicines will not—and cannot, given existing levels of inequality—produce medicines in a way that corresponds to global public health needs, or that redresses the extreme inequality that characterizes health outcomes in our world.111¶ Free markets and strong IP in the domain of global health thus have predictably inequitable results. They link innovation and access to high prices that the poor cannot pay—and that governments are often unwilling to pay for on their behalf. The problems that this model produces for the global poor, moreover, are intensified by domestic inequality, which has intensified in the wake of neoliberalism. One of the reasons that pharmaceutical companies price drugs at very high levels even in relatively poor countries is that high prices in these countries can be profit-maximizing. Charging high prices to a small percentage of wealthy patients will produce greater returns than charging low prices to a large number of the poor, if inequality within a country is high.112 The more unequal a society is, the more likely this is to be the case.113