## 1 (3)

#### 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.

### Bioterror

#### 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.

#### 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.

#### Bioterror causes extinction---early response key

Farmer 17 (“Bioterrorism could kill more people than nuclear war, Bill Gates to warn world leaders” http://www.telegraph.co.uk/news/2017/02/17/biological-terrorism-could-kill-people-nuclear-attacks-bill/)

Bioterrorists could one day kill hundreds of millions of people in an attack more deadly than nuclear war, Bill Gates will warn world leaders. Rapid advances in genetic engineering have opened the door for small terrorism groups to tailor and easily turn biological viruses into weapons. A resulting disease pandemic is currently one of the most deadly threats faced by the world, he believes, yet governments are complacent about the scale of the risk. Speaking ahead of an address to the Munich Security Conference, the richest man in the world said that while governments are concerned with the proliferation of nuclear and chemical weapons, they are overlooking the threat of biological warfare. Mr Gates, whose charitable foundationis funding research into quickly spotting outbreaks and speeding up vaccine production, said the defence and security establishment “have not been following biology and I’m here to bring them a little bit of bad news”. Mr Gates will today (Saturday) tell an audience of international leaders and senior officers that the world’s next deadly pandemic “could originate on the computer screen of a terrorist”. He told the Telegraph: “Natural epidemics can be extremely large. Intentionally caused epidemics, bioterrorism, would be the largest of all. “With nuclear weapons, you’d think you would probably stop after killing 100million. Smallpox won’t stop. Because the population is naïve, and there are no real preparations. That, if it got out and spread, would be a larger number.” He said developments in genetic engineering were proceeding at a “mind-blowing rate”. Biological warfare ambitions once limited to a handful of nation states are now open to small groups with limited resources and skills. He said: “They make it much easier for a non-state person. It doesn’t take much biology expertise nowadays to assemble a smallpox virus. Biology is making it way easier to create these things.” The increasingly common use of gene editing technology would make it difficult to spot any potential terrorist conspiracy. Technologies which have made it easy to read DNA sequences and tinker with them to rewrite or tweak genes have many legitimate uses. He said: “It’s not like when someone says, ‘Hey I’d like some Plutonium’ and you start saying ‘Hmmm.. I wonder why he wants Plutonium?’” Mr Gates said the potential death toll from a disease outbreak could be higher than other threats such as climate change or nuclear war. He said: “This is like earthquakes, you should think in order of magnitudes. If you can kill 10 people that’s a one, 100 people that’s a two... Bioterrorism is the thing that can give you not just sixes, but sevens, eights and nines. “With nuclear war, once you have got a six, or a seven, or eight, you’d think it would probably stop. [With bioterrorism] it’s just unbounded if you are not there to stop the spread of it.” By tailoring the genes of a virus, it would be possible to manipulate its ability to spread and its ability to harm people. Mr Gates said one of the most potentially deadly outbreaks could involve the humble flu virus. It would be relatively easy to engineer a new flu strain combining qualities from varieties that spread like wildfire with varieties that were deadly. The last time that happened naturally was the 1918 Spanish Influenza pandemic, which went on to kill more than 50 million people – or nearly three times the death toll from the First World War. By comparison, the recent Ebola outbreak in West Africa which killed just over 11,000 was “a Richter Scale three, it’s a nothing,” he said. But despite the potential, the founder of Microsoft said that world leaders and their militaries could not see beyond the more recognised risks. He said: “Should the world be serious about this? It is somewhat serious about normal classic warfare and nuclear warfare, but today it is not very serious about bio-defence or natural epidemics.” He went on: “They do tend to say ‘How easy is it to get fissile material and how accurate are the plans out on the internet for dirty bombs, plutonium bombs and hydrogen bombs?’ “They have some people that do that. What I am suggesting is that the number of people that look at bio-defence is worth increasing.” Whether naturally occurring, or deliberately started, it is almost certain that a highly lethal global pandemic will occur within our lifetimes, he believes. But the good news for those contemplating the potential damage is that the same biotechnology can prevent epidemics spreading out of control. Mr Gates will say in his speech that most of the things needed to protect against a naturally occurring pandemic are the same things needed to prepare for an intentional biological attack. Nations must amass an arsenal of new weapons to fight such a disease outbreak, including vaccines, drugs and diagnostic techniques. Being able to develop a vaccine as soon as possible against a new outbreak is particularly important and could save huge numbers of lives, scientists working at his foundation believe.

### Econ

#### Economic crisis undermines disease surveillance – turns outbreaks

Beauté, 14 - (J. Beaute with European Centre for Disease Prevention and Control, "Impact of the economic crisis on infectious disease surveillance in Europe: Julien Beauté," OUP Academic, 10-1-2014, https://academic.oup.com/eurpub/article/2839693/Impact-of-the-economic-crisis-on-infectious) //HR

Established in 2005, the European Centre for Disease Prevention and Control (ECDC) is an EU agency involved in the surveillance of infectious diseases in Europe. Surveillance is classically described as the process of collecting, managing, analysing, interpreting and reporting information on diseases. Ultimately, the main goal of surveillance is to monitor trends and detect events that may prompt action (e.g. outbreaks), help evaluate interventions, or simply better describe the epidemiology of diseases. Financial cuts may impact surveillance systems at different levels, such as the population under surveillance, frequency of reporting or the depth of the analyses performed. In addition, surveillance data could be affected by financial cuts both quantitatively and qualitatively. To assess the potential impact of the current crisis on infectious disease transmission in Europe, EU/EEA countries were asked to complete a survey in late 2013. In addition, European surveillance data held at ECDC were investigated for any changes in recent years which may be linked to the economic crisis. Results Nineteen countries participated in the survey. Of these, eight reported that the economic crisis had negatively impacted national disease surveillance programmes, mostly related to cuts in human resources at national public health institutes. Two countries anticipated increased disease incidence in the long term, four expected mixed effects, five no difference while the rest did not feel confident enough to make any prediction. Hitherto, no substantial impact could be detected in the surveillance data reported to ECDC, although links between increases in HIV case reports among people who inject drugs in a number of EU countries and the economic crisis are being explored.

## Universal healthcare CP

#### **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.**

#### Implementing a UHC system gets medicine to the uninsured

Goozner PhD 20

Merril Goozner (PhD and literally wrote the book on overpriced drugs, called “The 800$ pill), Winter 2020, "Insulin Should Be Free. Yes, Free.," Democracy Journal, <https://democracyjournal.org/magazine/55/insulin-should-be-free-yes-free/> // AW

Later in the year, on the eve of the second Democratic Party debate, Senator Bernie Sanders, who has made Medicare-for-All his signature policy proposal, took a busload of diabetics to Canada to purchase insulin that is one-tenth the United States price. **Sanders’s single-payer system would go beyond negotiating lower prices** as is done in Canada and other industrialized nations. **It would completely eliminate the copays and deductibles that stand in the way of many patients**—including some who are well-insured—getting the medications they need. That our health-care system fails to provide essential medicines to people who face immediate death or injury without them is morally outrageous. The pricing and access policies of profit-seeking drug companies also make that failure quite literally a human rights violation. Those companies—and the government that fails to control them—are flagrantly ignoring the World Health Organization’s constitution, which calls “the highest attainable standard of health a fundamental right of every human being.” The document, which the United States signed in 1946, also says that “understanding health as a human right creates a legal obligation on states to ensure access to timely, acceptable, and affordable health care of appropriate quality.”

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>

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 ¶

# Case

#### Behind the Veil of Ignorance, we would choose util because it’s the only one that regards all people as equal.

#### Preventing extinction is the most ethical outcome – a just society can’t exist if we’re all dead

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.

#### The veil of ignorance may be a fun thought experiment- but in the real world, people are biased towards communities that they are part of. Communitarianism is part of human nature, and if you strip people of that, you are destroying identities. Under the veil of ignorance, anyone would choose the version of the world where a majority of the population wasn’t dead.

#### Ceballos says the root of disease is environmental issue which the aff can’t solve. Mean’s that unless they address climate change they’ll never be able to stop disease.

#### Presume neg – they have no card that says what the aff actually does – what exactly are they reducing? How much? – there are multiple inconsistent ways the aff could be implemented so give 0 weight to their solvency

#### Moszynski- this card flows neg and turns case. The card says nothing on dependency or innovation, just that substandard drugs mean that even expanded access doesn’t solve in the Global South.

#### Crook- no solvency—there are already generic versions of HIV/AIDS drugs. The problem isn’t price; it’s distribution. 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.¶

#### Turn- TRIPS reduces global health inequality

Samir Raheem Alsoodani 15, “"The WTO Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) may offered an access to essential pharmaceutical drugs for developing countries,” Journal Of the College of law /Al-Nahrain University 2015, Volume 17, Issue 2, Pages 393-410, <https://www.iasj.net/iasj/article/109180>

To conclude, it is beyond doubt that the TRIPS Agreement and its later, permanent amendment of 2005 attempted in good faith to address an urgent issue faced by many developing countries with regards to accessing essential medicine. To a certain extent in its basic tenets, it has had a profound and positive effect on the system, as it has made permanently possible the opportunity for the poorest countries to obtain medications more cheaply through manufacture in developing countries under a compulsory licensing system. Certain positive outcomes arguably include the fact that disputes have been brought under the jurisdiction of one regulatory body, and the least developed Members have found some redress in the power balance regarding costs paid to the pharmaceutical industries based in the wealthier, developed countries (even if this redress has only been to the extent of facilitating increased bargaining capability). This can be considered a triumph from the perspective of universal human rights.

#### Turn- TRIPS enhances human rights

Samir Raheem Alsoodani 15, “"The WTO Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) may offered an access to essential pharmaceutical drugs for developing countries,” Journal Of the College of law /Al-Nahrain University 2015, Volume 17, Issue 2, Pages 393-410, <https://www.iasj.net/iasj/article/109180>

In contrast, Anderson and Wager (2006) believe that the TRIPS Agreement provisions enhanced human rights principles, because of the many features throughout the TRIPS Agreement, such as the emphasis on the need for a balance between the advantages, the commitments, and the rights for both the users and the producers of the invention. Other examples include nondiscrimination treatment, and the stipulation that all disputes must be settled under the WTO system, which secures the rule of law governing international trade. The TRIPS Agreement has favoured the least developed countries with distinctive and more lenient treatment, as these countries have until 2016 to enforce protection of patent rights with regards to undisclosed data relating to pharmaceutical products.

#### Non-unique- Global health inequality is decreasing

Davidson R Gwatkin 17, Senior Associate at the Johns Hopkins Bloomberg School of Public Health, “Trends in health inequalities in developing countries,” February 23rd, 2017, <https://www.thelancet.com/pdfs/journals/langlo/PIIS2214-109X(17)30080-3.pdf>

A similar picture emerges from several other studies that have been done in the past few years. The only study of child mortality, for which trends are especially difficult to assess because of the large sample sizes required, was done by Eran Bendavid,2 who reported faster declines in child mortality among poor populations than among wealthier populations overall and in 61 of the 85 countries he studied between 2002 and 2012. The remaining studies focused on health-service coverage. Two covered several types of reproductive, maternal, newborn, and child health interventions: Sarah Alkenbrack and colleagues3 reported overall inequality declines for the four intervention types that they examined, and Victora and colleagues4 noted a similar trend for the several interventions that they studied. Others have focused on specific types of reproductive, maternal, newborn, and child health intervention. For example, John Ross5 showed that the poor–rich disparity in terms of contraceptive prevalence fell overall and in three-quarters of 46 countries followed. Similarly, two multicountry investigations6,7 of changes in immunisation inequalities showed overall reductions but wide intercountry variations. The findings of all these studies are remarkably similar. To some degree, such similarity is unsurprising, because all the investigators used the same—and only—sources of suitable information: household survey data from the well known Demographic and Health Survey and Multiple Indicator Cluster Survey programmes. But in other respects, the approaches taken vary substantially— for example, the investigators look at many different health indicators, use many different definitions of inequality, and measure change in many different ways. The similarity of results despite such difference in approach makes the results mutually reinforcing and produces an unusually distinct picture of a glass that is clearly more than half full, but still well over a quarter empty.

#### No solvency – There is no IP barrier in most countries. The fact that they are not manufacturing vaccine shows that they *can’t* without compulsory licensing.

**Mercurio 21**

Mercurio 2/12 - Bryan Mercurio; Chinese University of Hong Kong - Faculty of Law, ; 2-12-2021; "Wto Waiver From Intellectual Property Protection For Covid-19 Vaccines And Treatments: A Critical Review (February 12, 2021)”; Virginia Journal Of International Law Online (Forthcoming 2021), Available At Ssrn: Https://Ssrn.Com/Abstract=3789820 Or Http://Dx.Doi.Org/10.2139/Ssrn.3789820"; https://papers.ssrn.com/sol3/papers.cfm?abstract\_id=3789820, accessed 7-21-2021; JPark

Second, the proposed waiver will do nothing to address the problem of lack of capacity or the transfer of technology and goodwill. Pharmaceutical companies have not applied for patents in the majority of developing countries – in such countries, any manufacturer is free to produce and market the vaccine inside the territory of that country or to export the vaccine to other countries where patents have not been filed.33 Patents cannot be the problem in the countries where no patent applications have been filed, but the lack of production in such countries points to the real problem – these countries lack manufacturing capacity and capability. While advanced pharmaceutical companies will have the technology, know-how and readiness to manufacture, store and transport complex vaccine formulations, such factories and logistics exist in only a handful of countries.34 Regardless of whether an IP waiver is granted,

the remaining countries will be left without enhanced vaccine access and still reliant on imported supplies. With prices for the vaccine already very low, it is doubtful that generic suppliers will be able to provide the vaccine at significantly lower prices. Under such a scenario, the benefit of the waiver would go not to the countries in need but to the generic supplier who would not need to pay the licence fee or royalty to the innovator. Thus, the waiver would simply serve to benefit advanced generic manufacturers, most of which are located in a handful of countries, including China and Brazil as well as (unsurprisingly) India and South Africa. Countries would perhaps be better off obtaining the vaccine from suppliers that have negotiated a voluntary licence from the patent holder, as such licences include provisions for the transfer of technology, know-how and ongoing quality assurance support.