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I affirm the resolution, "The member nations of the World Trade Organization ought to reduce intellectual property protections for medicines".

Because we are debating a resolution regarding the World Trade Organization, whose goal and purpose is to facilitate fair and just trade, the value is justice.

In order to uphold justice, we should look towards Rawls' conception of institutional fairness.

First, People have a moral responsibility to reject principles that non mutually constrain others, Christiano 06

Christiano, Tom. "Democracy."*Stanford University*. Stanford University, 27 July 2006. Web.19 Jan. 2015.<http://plato.stanford.edu/entries/democracy/>.

The basic principle seems to be the principle of reasonableness according to **reasonable persons will only offer principles for the regulation of their society that other reasonable persons can reasonably accept.**the notion of the reasonable is meant to be fairly weak on this account. **One can reasonably reject a doctrine to the extent that it is incompatible with one's own doctrine as long as one's doctrine does not imply imposition on others** and it is a doctrine that has survived sustained critical reflection **this** principle **is a** kind of **principle of reciprocity .One only offers principles that others, who restrain themselves in the same way, can accept.** Such a principle implies a kind of principle of restraint which requires that reasonable persons not propose laws and policies on the basis of controversial principles for the regulation of society. When individuals offer proposals for the regulation of their society,they ought not to appeal to the whole truth as they see it but only to that part of the whole truth that others can reasonably accept. To put the matter in the way Rawls puts it: political society must be regulated by principles on which there is an overlapping consensus (Rawls, 1996, Lecture IV). This is meant to obviate the need for a complete consensus on the principles that regulate society.What moral reasons can there be for restraining oneself from offering what one takes to be the best justified proposals for the terms of the society one lives in? One might consider a number of arguments for this principle of reasonableness. One argument is an epistemological one. It is that there is no justification independent of the people or at least reasonable people believe .Hence**,if one cannot provide a justification for principles that others can accept** ~~given their reasonable belief~~ **then those principles are not justified for those persons.Another argument is a moral argument. One fails to respect the reason of the other members of society if one imposes terms of association on them that they cannot accept given their reasonable views. This failure of respect for the reason of the other members of society defeats the value of the principles one is proposing for the society.** A third argument is a specifically democratic argument. One does not genuinely treat others as equals if one insists on imposing principles on them that they cannot reasonably accept, even if this imposition takes place against the background of egalitarian decision making processes

This implies political equality, Christiano 2

The basic principle seems to be the principle of reasonableness according to which reasonable persons will only offer principles for the regulation of their society that other reasonable people can reasonably accept. The notion of the reasonable is meant to be fairly weak on this account. One can reasonably reject a doctrine to the extent that it is incompatible with one's own doctrine as long as one's doctrine does not imply imposition on others and it is a doctrine that has survived sustained critical reflection. So this principle is a kind of principle of reciprocity. One&only offers principles that others, who restrain themselves in the same way, can accept**Such a principle implies a** kind of **principle of restraint which requires that reasonable persons not propose laws and policies on the basis of controversial principles for the regulation of society. When individuals offer proposals for the regulation of their society, They ought not to appeal to the whole truth as they see it**

but only to that part of the whole truth that others can reasonably accept. To put the matter in the way Rawls puts it**, political society must be regulated by principles on which there is an overlapping consensus.** (Rawls, 1996, Lecture IV).This is meant to obviate the need for a complete consensus on the principles that regulate society.

Thus the standard is: Promoting Political Equality

Additionally, prefermy standard for this reason:

It's the most specific to policy; general moral theories applied to policy fail, Rawls 85

Rawls, John. "Justice as Fairness: Political Not Metaphysical."*UCSD.edu*. 1 Jan. 1985. Web. 19 Jan. 2015.<http://philosophyfaculty.ucsd.edu/faculty/rarneson/Courses/RawlsJustice.pdf>.

It should also be stressed that **justice as fairness is not intended as the application of a general moral conception to the basic structure of society, as if this structure were simply another case to which that general moral conception is applied.** In this respect **justice as fairness differs from traditional moral doctrines, for these are widely regarded as such general conceptions. Utilitarianism is a familiar example** since the principle of **utility,** however it is formulated, **is usually said to hold for all kinds of subjects ranging from the actions of individuals to the law of nations.** The essential point is this:**as a practical political matter no general moral conception can provide a** publicly recognized **basis for a conception of justice** in a modern democratic state .The Social and historical conditions of such a state have their origins in the Wars of Religion following the Reformation and the subsequent development of the principle of toleration, and in the growth of constitutional government and the institutions of large industrial market economies. These conditions profoundly affect the requirements of a workable conception of political justice. **Such a conception must allow for a diversity of doctrines and the plurality of conflicting, and indeed incommensurable, conceptions of the good affirmed by the members of** existing democratic **societies.**

In order to support the given value and criterion, I provide the following contentions.

Contention 1- Denial of Access

Stronger Intellectual Property Protections limit developing countries' access to medicine

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

Discussion This study investigated how the national level of IPR is associated with individuals' access to medicines and households' experience of catastrophic expenditure for medicines.. **First, our results show that higher level of [Intellectual Property Rights, or] IPR is associated with low access to prescribed medicines. This adverse relationship between IPR and access to medicines is significant even after controlling for country income level and individuals' socioeconomic status and demographic characteristics.** . Adding other variables, which reflect the characteristics of each country's healthcare system, in the model did not change the significant effect of IPR on access to medicines, although the magnitude of the effect slightly decreased. **These results imply that strengthened IPR for pharmaceuticals is function[s]ing as a barrier to people's access to medicines. Even though each country's policy efforts, such as strengthening the infrastructure of healthcare provision and increasing the public expenditure for healthcare, have contributed to offsetting the negative impact of IPR on medicine utilization to some extent, the effect of IPR was still significant.** Our results also show that IPR exerts an influence on medicine utilization only in countries above a certain income level. We did not observe the significant effect of IPR on access to medicines in low-income countries where GDP per capita is below $1000, whereas it was negatively associated with access to medicines in middleincome countries. These results are more likely to be related with access to healthcare, which is the premise of utilizing the prescription drugs. This study only included the population for whom medicines were prescribed when they visited health care providers, excluding the population who could not see healthcare providers even though they were in need. Given that a greater number of people are suffering from poor access to healthcare in low-income countries than in middle-income ones, no association between IPR and access to 524 International Journal of Health Services 45(3) medicines in low-income countries is more likely to be explained by this kind of sample selection problem. Furthermore, a gap between rules and practice in the enforcement of IPR may contribute to the nonsignificant impact of IPR in low-income countries. As Shadlen and colleagues pointed out,41 low-income countries may have a large gap between rules and reality with regard to IPR, considering their limited resources for implementation and enforcement of IPR. The GP index that we used as an index of IPR in this study was developed by a text-based approach using the existing legal and institutional arrangements for patent systems, so it may not show us the full picture of actual protection level for IPR. Thus, we cannot exclude the possibility of this type of measurement error in low-income countries. We also found that those who live in rural areas have better access to medicines than those who live in urban areas. This may be related to sample selection process. Rural areas are likely to have inferior healthcare infrastructure, so rural residents have more difficulties in utilizing healthcare service. Because rural residents included in this study are those who visit healthcare providers despite this barrier, it is possible that they have more propensity to use healthcare, including prescribed medicines, than urban residents. This possibility is supported by the result that the coefficient of rural residence is bigger and significant in low income countries, but not in middle-income countries, because the difference in healthcare infrastructure between rural and urban areas would be bigger in low-income countries than in middle-income ones. Next, our results show that the effects of the national healthcare system on access to medicines are not the same across countries with different income levels. Although essential medicines lists and the number of doctors had positive significant relationships with access to medicines in low-income countries, only a public share of total health expenditure had a significant impact in middleincome countries. This suggests that the main types of access barrier that countries face are different according to their income level. Middle-income countries tend to suffer from nonaffordable price of medicines rather than availability problems, whereas low availability of essential medicines is a more serious issue for low-income countries. Last, our results show that IPR is not associated with households' catastrophic expenditure for medicines even though it is significantly associated with access to prescribed medicines. This is due to the possibility that many people cannot purchase medicines at all because of their poor purchasing capacity and the high price of medicines. As a result, they are likely to be excluded from the analysis. **Accordingly, the**

results of this study provide strong empirical evidence for the linkage between IPR and access to medicines in developing countries. As we hypothesized, strengthening IPR [leads] to lower access to medicines in developing countries, and particularly lower access for the poorest of the poor. This result of Jung and Kwon 525 supports previous theoretical debate that patent protection may result in welfare loss in developing countries.

Affordability is one of the most significant barriers to developing countries and the patent system is causing significant rise in prices.

Oxfam 01 [Oxfam, Jan 2001, "Patent injustice: how world trade rules threaten the health of poor people," Oxfam, https://www.eldis.org/document/A29216]

The affordability of medicines is only one of the problems facing poor countries. Inadequate and inequitable public spending on health infrastructure, weak planning, failure to prioritise preventative interventions, and ineffective service provision are also contributory factors. **But the price of basic medicines is a vital factor in determining public health. The price of medicines is a critical issue in rich countries as well as in poor. In Britain and the United States, the budget implications of escalating drugs prices are a matter of mounting political concern**. But it is the poorest countries, where budget resources are more limited, and where household poverty is most widespread, that face the gravest threat from rising drugs prices.**. Most health spending in the poorest countries comes directly out of household budgets, rather than through national health budgets or pre-paid insurance schemes. For the poor, the cost of treating sickness is often prohibitive. In Zambia, where two-thirds of rural households live below the poverty line, it costs one such household US$9 to treat a single case of childhood pneumonia - an amount equivalent to half the family's monthly income. The high cost of treatment relative to income can result in poor households either delaying or not seeking treatment**. It can also lead to the diversion of expenditure from other vital areas such as food and education. The WTO and drugs: the rules are loaded against the poor **The WTO's Agreement on Trade Related Intellectual Property Rights (TRIPS) establishes minimum standards for intellectual property protection, including the right to exclusively market a patented product for at least 20 years.**Some Northern governments are using bilateral and regional trade agreements to negotiate even more stringent protection for patents under so-called 'TRIPS plus' agreements. WTO rules recognise the potential conflict between public-health interests and the private interest of patent holders. Under Article 31 of the Agreement, governments can issue compulsory licences to authorise production without the consent of patent holders, subject to adequate compensation. Another measure open to governments is that of parallel importing, whereby governments allow the importation of a patented product which is marketed elsewhere at prices lower than those in the domestic market. These safeguards should be strengthened. There is a need to clarify and broaden the criteria for introducing compulsory licences, and to diminish the burden of proof currently placed on governments seeking to establish public-health threats as grounds for compulsory licensing. In the event of a dispute, patent holders should be required to prove that there is no threat to public health from the strict application of their patent privileges. Even with less onerous conditions for compulsory licensing, countries with limited production capacity or small internal markets will find it impossible to obtain the required drug at an affordable price, unless there is a larger country which is producing it under a compulsory licence and which is willing and able to export it to them. The deeper problem lies in the unwarranted political influence of pharmaceutical corporations which leads to a subordination of trade policy to corporate goals, notably in the USA**. In the course of the past year, a large number of developing countries, which have failed to strengthen patent rules on terms dictated by PhRMA, have been threatened with trade sanctions: India has been placed on the hit list for trade sanctions for failing to include highly restrictive compulsory licensing conditions in national legislation, and for allowing generic companies to export copies of patented drugs. These exports are a major source of basic medicines for low-income developing countries.** . The US has threatened trade sanctions

against the Dominican Republic, including the withdrawal of trade preferences for textiles, for failing to comply with the demands of PhRMA members. Despite the small size of the local market, the country has been targeted by PhRMA, which claims that it represents a bad example that others will follow **WTO disputes have been initiated against Argentina and Brazil. Both countries are accused of failing to incorporate highly restrictive conditions for the granting of compulsory licences into national legislation. In each case, the target has been national legislation authorising production of low-cost equivalents of patented drugs to meet public-health needs** Governments in Europe may have been less public in their threats, but they have silently colluded in supporting the coercive trade diplomacy practised by the United States. PhRMA's political influence comes at a price. Between 1997 and 1999, PhRMA's members spent US$236m lobbying Congress and the executive branch of government. Another US$14m was provided to political parties in 1999 alone. Approximately two-thirds of corporate investment in political lobbying in the USA is directed towards the Republican Party, raising concerns about corporate influence over the new Administration. Various polite formulations and legalistic arguments can be used to explain what is happening in the name of IP protection. But the truth is that corporate self-interest is being placed before people's lives. Patents and prices: the threat to public health **Most developing countries have in the past avoided stringent patent regimes on medicines in the interests of public health.** Highly sophisticated generic industries have emerged with a specialisation in the development of lowcost equivalents of expensive patented medicines for low-income populations. **Countries such as India, Thailand, Egypt, and Brazil have succeeded not just in reducing their dependence on imported medicines, but also in developing their capacity to export them. Across sub-Saharan Africa, most front-line medicines used in the treatment of infectious diseases are imported from generic-drugs suppliers.** These drugs are typically available at prices ranging between one-fifth and one-tenth of those for patented brand-name products. **Because generic-drugs industries are able to market products at a fraction of the costs associated with patented brands, they provide a lifeline to low-income households. The WTO agreement on intellectual property rights threatens to cut that lifeline. Price comparisons between Pakistan, which has traditionally provided strong product patent protection, and India, which has one of the world's strongest generic-drugs industries, are instructive. They show that prices for ciprofloxacin, a safe anti-infective medicine used in the treatment of illnesses such as resistant bloody diarrhoea in children, are up to eight times more costly in Pakistan.** Price increases resulting from the extension of exclusive marketing rights will have grave consequences for public health in developing countries. Infectious diseases that were once relatively easily curable with simple antibiotics are becoming increasingly drug-resistant. Old killers such as malaria, tuberculosis, bloody diarrhoea, and respiratory infections - a group of diseases that cost millions of lives each year - are proving increasingly difficult to treat. Improved access to effective and affordable medicines is essential if these threats are to be addressed. But the danger is that use of the next generation of drugs needed to protect public health will be restricted, either by new patent protection or by the extension of old patent rights.

Breaking the hold that patents have on access to medicine allows for greater treatment of illnesses at the same efficacy

El-Sadr et. al. 12 [Wafaa M. El-Sadr, Columbia University, Mailman School of Public Health, Charles B. Holmes, MD, MPH, Office of US Global AIDS Coordinator, Washington, DC Peter Mugyenyi, MD, Joint Clinical Research Centre, Kampala, Uganda Harsha Thirumurthy, PhD, Department of Health Policy and Management, Gillings School of Global Public Health, University of North Carolina at Chapel Hill, Chapel Hill, NC, Aug. 2012, "Scale-up of HIV Treatment Through PEPFAR: A Historic Public Health Achievement," Journal of Acquired Immune Deficiency Syndromes vol. 60, no. Suppl 3, pp. S96-104, https://doi.org/10.1097/QAI.0b013e31825eb27b]

Improved efficiency in selection and transportation of ARVs, the increasing use of generic drugs and fixed-dose combinations (FDCs), and the transition to preferred ARV regimens has lowered the cost of treatment substantially while improving the overall quality of HIV

treatment in PEPFAR-supported focus countries. PEPFAR's per-patient treatment costs, including drugs and service delivery, have declined to $335 per year, from nearly $1100 just 7 years ago. One key improvement adopted by the Supply Chain Management System (SCMS), established and funded by PEPFAR and supported by the USAID, was the transition from air transport to land- or sea-based shipment.21 It is estimated that using sea freight for major shipments saved up to 85% in transportation costs, and as of December 31, 2010, sea transport had saved PEPFAR $39.8 million in transportation costs.21 SCMS also established regional distribution centers in Ghana, Kenya, and South Africa, increasing commodity availability and reducing the lead time needed for delivery **. PEPFAR has also increased its use of generic drugs and FDCs**.7 **In 2005, only 16% of PEPFAR-procured drugs were generic. This proportion increased to 97% in 2010, resulting in considerable savings compared with branded drugs**(Fig. 1). Between 2008 and 2011 PEPFAR increased purchases of 2- and 3-drug FDCs, as recommended by the WHO (Fig. 2). These regimens are less complex, easier to administer, and may improve patient adherence. Similarly, over the past 4 years since WHO HIV treatment guidelines recommended that countries phase out stavudine in favor of less toxic zidovudine- or tenofovir-based regimens, SCMS orders for stavudine have declined by more than 70%, whereas orders for zidovudine and tenofovir have increased 20-fold (Fig. 3). An external file that holds a picture, illustration, etc. Object name is nihms397419f1.jpg Open in a separate window FIGURE 1 Number of generic versus branded drugs procured (monthly packs, 2005–2010). PEP-FAR increased its use of generic drugs from 16% in 2005 to 97% in 2010. An external file that holds a picture, illustration, etc. Object name is nihms397419f2.jpg Open in a separate window FIGURE 2 Total SCMS orders for 2- and 3-drug ARVs. Between 2008 and 2011, PEPFAR increased its purchases of 2- and 3-drug FDCs, as recommended by WHO. An external file that holds a picture, illustration, etc. Object name is nihms397419f3.jpg Open in a separate window FIGURE 3 SCMS order quantity for zidovudine (AZT), stavudine (d4T), and tenofovir (TDF) in fiscal year (FY) 2008–2011. Since 2008, SCMS orders for stavudine have declined by more than 70%, whereas orders for zidovudine and tenofovir have increased 20-fold. Go to: ACHIEVEMENTS Scale-up of ART Access The number of individuals receiving ART is one metric by which PEPFAR's achievement can be summarized. **PEP-FAR support increased the number of individuals who initiated [treatment] from 66,700 to 3,905,500** (63% women and girls) from 2004 to 2011 (Fig. 4). During the first phase of PEPFAR, there was a rapid increase in the number of patients receiving ART, doubling each year between 2004 and 2007. In addition, during 2008–2011, **PEPFAR increased the number of individuals receiving [treatment] by more than 650,000 patients each year.**. Importantly, while the growth of PMTCT programs has likely reduced the number of infants newly infected with HIV each year, HIV-infected children comprise about 9% of those supported on treatment by PEPFAR, up from 7% earlier in the response. The treatment program's rapid expansion is also reflected in the increase in the number of health facilities providing ART, growing from 300 sites in 2004 to more than 6400 in 2009 (last year this indicator was reported centrally). An external file that holds a picture, illustration, etc. Object name is nihms397419f4.jpg Open in a separate window FIGURE 4 Number of adults and children with HIV infection receiving ART with direct PEPFAR support in fiscal year 2004–2011. PEPFAR support increased the number of individuals who initiated ART from 66,700 to 3,905,500. Although the majority of treatment services are concentrated in 8 countries that collectively account for over half of the global HIV/AIDS epidemic**C**, **PEPFAR has supported treatment programs in more than 30 countries around the world**26 **through contributions to health system's strengthening in the form of policy developments, logistics, protocol or guideline development, advocacy, laboratory support, training, information systems, and capacity building of national HIV/AIDS programs.**. PEPFAR also has had a strong focus on ensuring quality of services and has used a variety of methods to monitor and ensure the quality of its programs,27 including sampled national survey studies28 and other methods, as described in more detail in an article in this journal issue.

As we've seen by the use of generic ARVs by PEPFAR, when the patent system is disregarded and the treatment of illnesses is prioritized, access is expanded for lower costs and treatment quality is improved.

Contention 2- Innovation

Patents pose an obstacle to education and research in medicine

Chen, 10 [Ge Chen, Research Fellow, Institute for International Law and European Law, "Fragmentation of International Law: Its Impact on Access to Knowledge in International Copyright Scenario", World Intellectual Property Organization, May 27th, 2010, https://www.wipo.int/edocs/mdocs/sme/en/wipo_smes_ge_10/wipo_smes_ge_10_ref_topic10_1.pdf]

Under the current international copyright governance, supply of the GPG for developing countries is becoming incrementally difficult due to the need to set standards ex ante to dampen the public good disposition of ideas or creative expressions in favour of the incentive to develop private knowledge goods. 83 **The predatory practices of the global IP regime in the aggregate have moulded the normative pathology of an unbalanced supply of knowledge goods by pre-empting the market monopoly of knowledge in the "Second Enclosure Movement". 84 Although more attention is being paid to the patent system with regard to access to medicines and public health as well as other natural and biological resources, 85 the fortress of copyright remains vulnerable and entails thickets of rights that may constitute obstacles to education and research resources.**

The patent system has normalized an imbalance in knowledge and monopolization of resources. This system provides the right to certain people to block the rest of society from accessing the best education and researching resources, which cannot be afforded when it comes to something essential to the public interest such as medicines.

Developing countries suffer as a result of this. Reduced purchasing power leads to stricter allocation of resources, resulting in developing countries' area-specific diseases not being addressed.

Gubby 20, [Helen Gubby, Barrister and senior lecturer at the Rotterdam School of Management at Erasmus University, September 6th, 2019, "Is the Patent System a Barrier to Inclusive Prosperity? The Biomedical Perspective", Global Policy, https://onlinelibrary.wiley.com/doi/10.1111/1758-5899.12730]

However, perhaps the largest group of patients excluded from the potential benefits of biomedical research are those in developing countries. Exclusion can originate[s] in the very choice of which drugs pharma companies decide to develop. Their research tends to be market orientated. By the end of the twentieth century, only about one percent of newly developed drugs were for tropical diseases, such as African sleeping sickness, dengue fever

and leishmaniasis.s(Maurer et al., 2004). Companies aim to make a profit and satisfy shareholders. It is therefore not surprising that expensive R&D will be more geared up to the types of illnesses prevalent in developed countries, as these countries have more capital resources to pay the price for these drugs. As Stiglitz (2006: p. 1279) observed: '**Poor people cannot afford drugs, and drug companies make investments that yield the highest returns'. Not only does the choice of which drug is developed significantly impact on developing countries: the imposition of stringent requirements for intellectual property protection under the TRIPS agreement is also a factor in access to treatment.** This was made explicit in the World Bank report: Nothing is more controversial in TRIPS. It is conceivable that patent protection will increase incentives for R&D into treatments for diseases of particular concern to poor countries. However **because purchasing power is so limited in the poorest countries, there is little reason to expect a significant boost in such R&D. Accordingly, many developing countries see little potential benefit from introducing patents. In contrast, potential costs could be significant.** (World Bank, 2001, p. 137) The Doha Declaration on the TRIPS Agreement in 2001 did confirm the right of countries to use compulsory licences to gain access to medicines. By issuing a compulsory licence, the government gives permission to a third party to produce the patented product or process without the consent of the patent owner. The drug so produced is much cheaper than the brand name drug at the monopoly price. This right has already been exercised on various occasions, for example by the South African authorities in 2003 in order to create more general access to AIDS medicines.

There will always need to be an allocation of limited resources when developing medicines. The IP system spreads resources even thinner, raising the threshold for making a profit. As long as a monopoly over the system through intellectual property rights is maintained, the price to research and develop will not go down. The only incentive for companies right now to make medicine is profit, which they can only gain by selling to wealthy countries. Less developed countries are not able to develop these medicines on their own, generics are not able to produce cheaper versions of these medicines, and the companies who make the original medicines are only incentivized to produce medicines treating issues which affect wealthy nations because that is the only way they can make a profit. The IP regime denies less wealthy nations access to necessary medicines, again constraining them unequally. The inequality in the treatment of illnesses that results from cumbersome Intellectual Property protections is inherently immoral, thus,

I affirm the resolution, and stand ready for cross examination.