#### I affirm the member nations of the World Trade Organization ought to reduce intellectual property protections for medicine.

#### Standard- maximizing the amount of lives.

**Framing- util**

***Only* pleasure and pain are intrinsically valuable. People consistently regard pleasure and pain as good reasons for action, all other values can be explained in relation.**

**Moen 16** [Ole Martin Moen, Research Fellow in Philosophy at University of Oslo “An Argument for Hedonism” Journal of Value Inquiry (Springer), 50 (2) 2016: 267–281] SJDI

Let us start by observing, empirically, that **a widely shared judgment about intrinsic value and disvalue is that pleasure is intrinsically valuable and pain is intrinsically disvaluable.** **On virtually any proposed list of intrinsic values and disvalues (we will look at some of them below), pleasure is included among the intrinsic values and pain among the intrinsic disvalues.** This inclusion makes intuitive sense, moreover, for **there is something undeniably good about the way pleasure feels and something undeniably bad about the way pain feels, and neither the goodness of pleasure nor the badness of pain seems to be exhausted by the further effects that these experiences might have.** “Pleasure” and “pain” are here understood inclusively, as encompassing anything hedonically positive and anything hedonically negative.2 **The special value statuses of pleasure and pain are manifested in how we treat these experiences in our everyday reasoning about values.** If you tell me that you are heading for the convenience store, **I might ask: “What for?” This is a reasonable question, for when you go to the convenience store you usually do so**, not merely for the sake of going to the convenience store, but **for the sake of achieving something further that you deem to be valuable.** You might answer, for example: “To buy soda.” This answer makes sense, for soda is a nice thing and you can get it at the convenience store. I might further inquire, however: “What is buying the soda good for?” This further question can also be a reasonable one, for it need not be obvious why you want the soda. You might answer: “Well, I want it for the pleasure of drinking it.” **If I then proceed by asking “But what is the pleasure of drinking the soda good for?” the discussion is likely to reach an awkward end. The reason is that the pleasure is not good for anything further; it is simply that for which going to the convenience store and buying the soda is good.**3 As Aristotle observes**: “We never ask [a man] what his end is in being pleased, because we assume that pleasure is choice worthy in itself.**”4 Presumably, a similar story can be told in the case of pains, for if someone says “This is painful!” we never respond by asking: “And why is that a problem?” We take for granted that if something is painful, we have a sufficient explanation of why it is bad. If we are onto something in our everyday reasoning about values, it seems that **pleasure and pain are both places where we reach the end of the line in matters of value.**

**Prefer for bindingness – if I put my hand on a hot stove I have a biological imperative to pull it back – proves avoiding pain is intrinsic to actions – anything that isn’t binding lets people say why not.**

**Thus, the standard is maximizing expected well-being. Prefer additionally:**

**1] Lexical Prerequisite – suffering creates lifelong conditions and threats on life that**

**preclude the ability of actors being able to engage in other ethical evaluations since**

**they are in a constant state of crisis.**

**2] Actor specificity:**

**A] Governments must aggregate since every policy benefits some and harms others,**

**which also means side constraints freeze action.**

**B] States lack wills or intentions since policies are collective actions. Actor-specificity**

**comes first since different agents have different ethical standings. Link turns calc**

**indites because the alt would be no action.**

**3] No act-omission distinction – governments are responsible for everything in the**

**public sphere so inaction is implicit authorization of action: they have yes/no bills,**

**which means everything collapses to aggregation.**

**4] No intent-foresight distinction— If we foresee a consequence, then it becomes part**

**of our deliberation which makes it intrinsic to our action since we intend it to happen.**

**Contention 1- COVID**

**COVID is a serious problem, and third world countries aren’t getting access to vaccines because first world countries bought excess doses from companies. Banerjee et. al 21 discuss,**

The World Bank, 08/03/21, <https://www.worldbank.org/en/news/podcast/2021/07/30/-absolutely-unacceptable-vaccination-rates-in-developing-countries-the-development-podcast>

Raka Banerjee: Hello, and welcome to The Development Podcast coming to you from the World Bank Group in the United States and around the world. I'm Raka Banerjee alongside Paul Blake. Paul Blake: Today, the race to vaccinate the world against COVID-19. We're examining why many low-income countries are struggling to vaccinate their populations and what's being done to help. Mamta Murthi (Clip): The situation that we see right now is absolutely unacceptable because a large part of the world remains unvaccinated**,** and this is a danger for all of us. Paul Blake: And from Addis Ababa, the steps being taken to accelerate vaccination rates across the African continent. Ahmed Ogwell (Clip): What we want are vaccines now**.** We don't want vaccines in 2022**, 2023.** And those vaccines that would be made available now have already been bought up**. It means that even though we have the money,** we can't be able to buy because there's nothing to buy**.** Paul Blake: All that and more over the next few minutes, but first let's take a look at some data. Paul Blake: All right, Raka. So you've been digging into the data and when it comes to COVID-19 vaccination rates around the world, what are you finding? Raka Banerjee: So I was looking at data that's available from the Our World in Data website, which is updated daily based on the latest official statistics from governments and health ministries around the world. And what has become painfully clear is that the main story when it comes to vaccines is inequality. Paul Blake: And what are some of those sort of major discrepancies? Raka Banerjee: So worldwide, almost 4 billion vaccine doses have been administered globally. And 27.6% of the world's population has received at least one dose of a vaccine at this point. So that sounds pretty good. But then if you break it down by country income groups, **1.**1% Of people living in low income countries have received even one dose of a vaccine. Paul Blake: And 1.1% Is a very low number. Can you break it down and further? Raka Banerjee: So that's in terms of percentage of population, but then if you look at the breakdown when it comes to the percentage of doses to date, and this is as of July 28th, 84% of all doses that have been administered so far have all gone to people in high and upper middle-income countries. And in comparison, looking at the percentage of doses that have been administered in low-income countries, it's a shockingly low 0.3%. Paul Blake: I mean, that's a huge difference. Do things look any better if you start to compare across regions? Raka Banerjee: Honestly, not really. So in terms of doses administered per every 100 people, Europe and North America come in at 84 and 82 doses respectively, and keep in mind that most of the vaccines are two dose regimens, right? Paul Blake: Right. Raka Banerjee: And then right from there, it drops really starkly. So South America has administered only 59 doses per 100 people, Asia 54, and then across Africa the rate is fewer than five doses for every 100 people. Paul Blake: And is it a question of problems with production or with making the vaccines? Or is this an issue with doses being sort of held in surplus and not being made available to people who need them in other locations? And I guess if it's about that second point, like excess doses, where are they and why aren't they being released? Raka Banerjee: So a big part of the problem is that many wealthy countries actually pre-ordered far more vaccine doses than they even needed to vaccinate their populations. Looking at data coming from Duke University, just for example, the US paid for enough vaccines for twice its population**, the UK paid for enough for four times its population,** and Canada for five times its population. So even though the world will have created 11 billion total doses by the end of this year, almost 9.9 billion of those doses have already been promised to higher and upper middle-income countries. Paul Blake: And so what's happening now in countries where the vaccine supply exceeds the demand for the vaccine? Raka Banerjee: Well, some countries have started to donate some of their excess supply, but it's hard to find data on exactly what's happening. Last month, the G7 agreed to donate 1 billion COVID-19 doses to poorer countries, so that's a start. But given that the World Health Organization has stated that vaccinating most of the world's population will take 11 billion doses, a lot of people have felt that this contribution was not nearly as substantial enough to make the difference that we need to actually stop the pandemic. Paul Blake: And you mentioned that it was hard to find data around excess doses. Do you have any thoughts about why that is? Why it's hard to find data? Is it a matter of the research not being done? Is it a matter of sort of transparency? What's behind that? Raka Banerjee: Well the thing is when it comes to data, it's so important to have transparency so that people can hold governments to account. And since much of this information is not publicly available, it's really hard to advocate for the equitable distribution that is really needed to make sure that people in poorer countries aren't just being left to fend for themselves. Paul Blake: All right. So one last question. Is vaccine production a factor here? And is there any good news on that front in terms of getting shots into arms? Raka Banerjee: So many of the major vaccine manufacturers have ramped up production. So for example, Pfizer and BioNTech are planning to produce 3 billion doses by the end of the year. And a third of those are intended to go directly to COVAX or low and middle-income countries. Paul Blake: All right. Well, thanks so much for sharing all this background and context. Really appreciate it. Raka Banerjee: My pleasure. Thanks, Paul. Raka Banerjee: This is The Development Podcast from the World Bank Group. Paul Blake: Now, March 2020 may feel like it was a different era, but it was just about 17 months ago that the World Health Organization declared COVID-19 a global pandemic. With developing countries bracing for the virus to arrive on their shores, **one region that was of particular concern was Africa.** Many countries across the continent have long suffered from fragile health systems that were already stretched by outbreaks in years past. Raka Banerjee: To understand how African countries were pulling together and preparing for the pandemic. We spoke last year to the Africa Centers for Disease Control's Deputy Director, Dr. Ahmed Ogwell. Ahmed Ogwell (Clip from March 2020): The mood I would say is one of uncertainty because this thing is new, what images available online, and the media is not very encouraging. And of course there's quite some anxiety what that mean if it came onto the continent. Paul Blake: Well, that was March 2020. Let's fast forward to today. Just what has the virus meant for the continent? What about vaccination efforts and what challenges are on the horizon Raka Banerjee: To get answers to these questions and more, we had the opportunity to talk once again with Dr. Ahmed Ogwell. He joined us down the line from Addis Ababa. Paul Blake: Well, thank you so much for joining us. When we last spoke, which was in early March of 2020, before I think much of the world realized just how serious this pandemic was going to be, we asked you how serious the pandemic seemed at the time to you and what those kinds of early signs look like to you in your kind of professional opinion relative to previous outbreaks of diseases. And let's just, real quick before we jump into some questions, take a listen to that clip. Ahmed Ogwell (Clip from March 2020): This one is looking a lot more serious than the earlier ones. If you look at COVID-19, it's transmissibility is quite high**.** It's easy to transmit from person to person**.** And then the level of illness that it causes particularly to the older folk is quite much higher than what SARS and MERS has shown us to be able to do. Paul Blake: So that was a really prescient answer there from early March 2020. How has the African continent fared since then? Ahmed Ogwell: There are three things that I think stand out for us on the continent, and thank you very much for having me on the show. Paul Blake: My pleasure. Ahmed Ogwell: The three things. One is that when knowledge is shared with the public**,** they tend to respond largely in positive ways**.** And that is- Ahmed Ogwell: ... largely in positive ways. And that is why, in the beginning of the pandemic, we saw low numbers in Africa, not just because there was leadership from many levels, the Africa Union, the Africa CDC, the member states, but also because the public listened to evidence and science and they responded. Second, is that when the chips are really down, that Africa is on its own and we've struggled to handle things that will have been a lot easier if there was more solidarity globally. Third, is the spread of the virus does not really respect modeling. It does not respond to discussions amongst the professionals and politicians. It does what it does, and that's how the variants have ripped across the world. We knew variants were coming, but we were not entirely prepared globally speaking. We were not entirely prepared for the large number of variants. And of course, Delta variant just waking up and becoming the real problem really during the whole pandemic so far. Raka Banerjee: When we spoke last, you had said that one of your main concerns at that time was that across the continent of Africa, health systems are not the strongest, that they might be overwhelmed. Where those fears realized to any extent, or can you give us an update on that? Ahmed Ogwell: Africa is very diverse and there are parts of Africa that the systems were not completely overrun, but heavily stretched. It really is heavily dependent on how much prevention and the community engagement our country does because that then reflects on not the overall numbers of cases, and then the numbers of those that really need hospitalization. And those that need hospitalization are the ones that would put a huge strain on the health system. And the knock-on effects include other areas**, malaria, TB, childhood illnesses,** will then get affected because the staff are quite stretched.

#### Global vaccine inequality threatens progress in overcoming Covid 19. Fink 21 7-30-21

(Jenni, https://www.newsweek.com/who-warns-world-blind-understanding-covid-spread-hurting-ability-end-pandemic-1614722)

A lack of testing for COVID-19 in parts of the world is preventing countries from having a clear picture of how the virus is spreading and therefore hurting the world's chances at *fighting the virus and ending the pandemic*, according to the World Health Organization. *Health inequities* throughout the world have plagued the global response to COVID-19 from the outset and WHO has pushed higher income countries to help lower income countries in the interest of ending the pandemic. Along with restricted access to vaccines, lower income countries have struggled to have sufficient testing, meaning the virus is likely going undetected in certain areas, further enabling its ability to spread. Low testing rates is "leaving the world blind to understanding where the disease is and how it's changing," Dr. Tedros Adhanom Ghebreyesus, director general of the WHO said on Friday during a press briefing. Without improving global testing rates, Ghebreyesus said the world can't "fight the disease" or mitigate the risk it poses to people around the globe. who blind covid spread cases On Friday, the World Health Organization warned the world is "blind" to how COVID-19 is spreading because of a lack of testing in certain places. WHO Director-General Tedros Adhanom Ghebreyesus attends a daily press briefing on the new coronavirus dubbed COVID-19, at the WHO headquaters on March 2, 2020, in Geneva. FABRICE COFFRINI//AFP/GETTY IMAGES NEWSWEEK NEWSLETTER SIGN-UP > One of Ghebreyesus' biggest frustrations with the pandemic response is the failure to *evenly distribute the vaccine* around the world. In some countries, like the United States and other higher-income nations, significant portions of the population have been vaccinated. While those large vaccinated populations help reduce the spread of the virus in some areas, other countries, especially those in Africa, haven't been able to vaccinate even 10 percent of their population. This puts the entire world at risk because when the virus is able to spread throughout communities it *has the ability to mutate*, thereby increasing the possibility that a mutation could *evade the vaccines*. It's a scenario public health officials have been warning about for months and Ghebreyesus said on Friday that "hard won *gains are in jeopardy*" or have already been lost because the virus has been able to spread. Nearly 30 countries have high or rising oxygen needs and the shortage of life-saving oxygen could lead to increased deaths. More than 196 million cases of COVID-19 have been reported around the world, according to a Johns Hopkins University tracker, and more than 4.2 million people have died. Ghebreyesus suspected the number of cases would top 200 million within the next two weeks and warned that health systems in many countries *are being overwhelmed.* Preventing hospitals from exceeding capacity was a massive concern when the pandemic first broke out and a year later, parts of the U.S. are having their health systems strained as the more transmissible Delta variant spreads. On Thursday, Arkansas Governor Asa Hutchinson declared a public health emergency that allows the state to bring in health care workers from outside Arkansas and makes it easier for retired health care workers and medical students to become licensed. The goal is to help alleviate stress on health care systems and Hutchinson said they've had people waiting in ambulances because there wasn't an open spot in a hospital. That strain will only become more exacerbated if a mutation occurs that evades the vaccine, as inoculations have proven effective at helping to keep people out of the hospital. Ghebreyesus warned that more variants will emerge if global access to vaccines and testing doesn't improve. "The pandemic will end when the world chooses to end it. It is in our hands. We have all the tools we need. We can prevent this disease. We can test for it and we can treat it," Ghebreyesus said.

**Delta variant will accelerate the pandemic.**

**Katella 21** Kathy Katella is an award-winning writer who has specialized in health and medicine for more than 15 years. She is a senior clinical writer for Yale Medicine, producing content about the practice’s services in anesthesiology, ophthalmology, orthopaedics and surgery. Kathy previously served as communications manager, a position that included handling internal communications for Yale Medicine, producing newsletters and year-end reports, and providing general support for the CEO and other senior administrators. Before joining the Yale School of Medicine, Kathy was a general assignment feature reporter and later an editor for two daily newspapers in Connecticut. She published articles in the New York Times, Yale Medicine magazine and other publications, and wrote two books for middle-schoolers. She also provided freelance editorial services for a variety of clients, including Yale New Haven Hospital., https://www.yalemedicine.org/news/5-things-to-know-delta-variant-covid

**Even as people began to feel some hope—or at least cautious optimism—early this summer that the pandemic could recede to the background, there was still the threat that new mutations of the COVID-19 virus could bring it back, and it might be even stronger.**

**A major worry right now is Delta, a highly contagious SARS-CoV-2 virus strain,** which was first identified in India in December. It swept rapidly through that country and Great Britain before reaching the U.S., where it is now the predominant variant.

**The Centers for Disease Control and Prevention (CDC) described Delta as more transmissible than the common cold and influenza, as well as the viruses that cause smallpox, MERS, SARS, and Ebola—and called it as contagious as chickenpox** in an internal document, a copy of which was obtained by and reported on in The New York Times. **The highest spread of cases and severe outcomes is happening in places with low vaccination rates, and virtually all hospitalizations and deaths have been among the unvaccinated, the CDC says.** But the CDC released data in July that showed **vaccinated people also can transmit Delta,///////** which officials did not believe to be the case with other variants, and which led the agency to make a prompt revision to its masking guidelines.

Inci Yildirim, MD, PhD, a Yale Medicine **pediatric infectious diseases specialist and a vaccinologist, isn’t surprised by what’s happening. “All viruses evolve over time and undergo changes as they spread and replicate,” she says.** From what we know so far, people who are fully vaccinated against the coronavirus continue to have strong protection against COVID-19 compared to those who aren’t. But anyone who is unvaccinated and not practicing preventive strategies is at high risk for infection by the new variant, doctors say. Here are five things you need to know about the Delta variant.

**One thing that is unique about Delta is how quickly it is spreading,** says F. Perry Wilson, MD, a Yale Medicine epidemiologist. Around the world, he says, “**Delta will certainly accelerate the pandemic.**” The first Delta case was identified in December 2020, and the variant soon became the predominant strain of the virus in both India and then Great Britain. By the end of July, Delta was the cause of more than 80% of new U.S. COVID-19 cases, according to CDC estimates.The July CDC report on Delta's transmissibility came after an outbreak that occurred in Provincetown, Mass., after a crowded July 4 weekend, which quickly turned into a cluster of at least 470 cases. While the number of reported breakthrough cases in general has been very low in the U.S., three quarters of those infected in Provincetown were people who had been immunized. According to the CDC, even people with “breakthrough cases” carry tremendous amounts of virus in their nose and throat, and, according to preliminary reports, can spread the virus to others whether or not they have symptoms.

**India is suffering because of the Delta variant**

**Pradhan and Chaudhary 21**

**India’s actual death toll from Covid-19 could range between 1.3 million to a staggering 5 million,** with even the most conservative estimate **putting its tally at more than double the U.S., the highest recorded in the world so far.**

The numbers, derived from research models and local authority data, range from three to 10 times the country’s official count, adding to evidence that **the true cost of India’s outbreak has been massively under-reported.**

**As corpses floated in the Ganges, a river sacred to millions of Hindus, and crematoriums and graveyards were overwhelmed, skepticism grew over the death toll of around 420,000** recorded by Prime Minister Narendra Modi’s government, which has used the ostensibly low mortality rate to defend India’s Covid track record.

The findings dovetail with estimates from researchers around the world. Bhramar Mukherjee, a professor at the School of Public Health at the University of Michigan, has devoted much of the past year to modeling India’s pandemic. **Her studies suggest the death toll is around 1.3 million up to June 15.**

Rukmini S, a **leading data journalist[s],** has written that the numbers she’s **gathered suggest a death toll closer to 2.5 million.**

**Cases in Africa are rising at unprecedented rates, slow vaccination strains the area. Princewill 21**

<https://www.cnn.com/2021/08/03/africa/delta-variant-covid-africa-intl/index.html>

**Coronavirus deaths in Africa rose rapidly over the past month,** as fatalities surged by 80 percent within the last four weeks, the World Health Organization has said. WHO's Vaccine Introduction Officer for the African Region, Phionah Atuhebwe, told CNN on Monday that **the continent was witnessing an unprecedented rise in coronavirus fatalities. "COVID-19 death rates have increased across Africa, with the highest weekly rate (6,343) to date reported during the week starting 19 July 2021,**" said Atuhebwe. "**Deaths increased by 89%, from 13,242 to 24,987, in the last 28 days, when compared against statistics for the previous 28 days,**" she added. WHO Director-General Tedros Adhanom Ghebreyesus told a news conference Friday that **the pandemic's worsening death toll and rapid infection rate are "being driven by the highly transmissible Delta variant,"** which is considered to be more deadly than the original strain of coronavirus. Ghebreyesus said the Delta variant — so far "detected in at least 132 countries" — has also spiked Covid-19 infections globally by 80 percent within the past four weeks. "Almost 4 million cases were reported to WHO last week, and on current trends, we expect the total number of cases to pass 200 million within the next two weeks," Ghebreyesus added. Atuhebwe explained that most new deaths in the last 28 days were reported from **Southern Africa**, which she said **accounts for 64 percent of the burgeoning death rate** with 16,019, **while North Africa accounts for 24 percent with 6036 deaths. Both subregions accounted for 88 percent of all reported deaths in the past month**, the WHO official added. Atuhebwe said **at least 15 African countries are currently recording an upward trend in weekly deaths associated with COVID-19. "The 15 countries are Algeria, Botswana, DRC, Eswatini, Lesotho, Malawi, Mauritania, Mozambique, Rwanda, Senegal, South Africa, Zimbabwe, Libya, Tunisia, and Morocco**," she said, attributing the surge in Covid fatality rates to increased transmission rates of the virus. **In West Africa, a resurgence of cases is overwhelming the already stretched healthcare systems of affected countries in the region. Less than one million of Senegal's 16 million people have received Covid-19 vaccination, setting the country up for a devastating third wave of infections, which saw more than 15,000 new Covid cases last month.** While in Nigeria, a rise in the number of Covid deaths is also causing concern. Lagos State Governor Babajide Sanwo-Olu, said Monday that there has been a daily average of six deaths at its isolation centers in the past week. Sanwo-Olu added that there had been an eight-fold increase in infection rate in Lagos, resulting in 4,300 confirmed cases in July alone, while 352 patients were admitted into the state-run isolation centers. **Only around 1.5 percent of Africa's more than one billion people have been fully vaccinated against Covid-19.** Much of the continent relies on donations from the global vaccine sharing scheme COVAX, as well as donations from China, India, and the US. **Africa's slow vaccination rate has been largely hinged on global vaccine inequality as wealthier countries in the West stockpile more Covid shots than they need.** Ghebreyesus described the global distribution of vaccines as "unjust" while expressing worry that Africa was at higher risk of being overrun by the pandemic due to vaccine shortages. "**All regions are at risk, but none more so than Africa... Many African countries have prepared well to roll out vaccines, but the vaccines have not arrived,"** he said. "This is a very serious problem if we're going to take action against this pandemic and end it." Vaccination efforts are ramping up as donations trickle in. The US this week sent millions of doses to countries including Senegal, South Africa and Nigeria. Over the weekend Nigeria received delivery of 4 million doses of the Moderna vaccine on Sunday, this is in addition to more than 4 million doses of the Oxford/AstraZeneca earlier received from COVAX in March, the country's vaccination agency said Monday. More than 2 million people have so far received a vaccination shot in Nigeria, with more than one million fully vaccinated. South Africa took delivery of 2.8 million out of an expected 5.6 million Pfizer vaccines donated by the US government. The country has recorded more than 2 million Covid cases and 72,000 deaths — the highest in Africa.

**Arguments against the TRIPS waiver are short sighted, and slow down incentives to improve the situation of the pandemic**

**Lindsey 21 (Brink Lindsey is Vice President and Director of the Open Society Project at the Niskanen Center. Previously he was the Cato Institute's vice president for research. “Why intellectual property and pandemics don’t mix”** [**https://www.brookings.edu/blog/up-front/2021/06/03/why-intellectual-property-and-pandemics-dont-mix/**](https://www.brookings.edu/blog/up-front/2021/06/03/why-intellectual-property-and-pandemics-dont-mix/) **)**

Although focusing on these immediate constraints is vital, we cannot confine our attention to the short term. First of all, **the COVID-19 pandemic is far from over**. Although Americans can now see the light at the end of the tunnel thanks to the rapid rollout of vaccines, most of the world isn’t so lucky**. The virus is** [**currently raging in India and throughout South America**](https://www.nytimes.com/interactive/2021/world/covid-cases.html), overwhelming health care systems and inflicting suffering and loss on a horrific scale. And consider the fact that Australia, which has been successful in suppressing the virus, recently announced it was sticking to plans to keep its borders closed until mid-2022**. Criticisms of the TRIPS waiver that focus only on the next few months are therefore short-sighted:** this pandemic could well drag on long enough for elimination of patent restrictions to enable new vaccine producers to make a positive difference. Furthermore, and probably even more important, **this is almost certainly not the last pandemic we will face.** Urbanization, **the spread of factory-farming methods, and globalization all combine to increase the odds that a new virus will** make the jump from animals to humans and then **spread rapidly around the world.** Prior to the current pandemic, the 21st century already saw outbreaks of SARS, H1N1, MERS, and Ebola. Everything we do and learn in the current crisis should be viewed from the perspective of getting ready for next time. When we take the longer view, we can see a fundamental mismatch between the policy design of intellectual property protection and the policy requirements of effective pandemic response. Although **patent law**, properly restrained, constitutes one important element of a well-designed national innovation system, the way it goes about **encouraging technological progress is singularly ill-suited to the emergency conditions of a pandemic or other public health crisis**. **Securing a TRIPS waiver** for COVID-19 vaccines and treatments would thus establish a salutary precedent that, in emergencies of this kind, governments should employ other, more direct means to **incentivize the development of new drugs.** Here is the basic bargain offered by patent law: encourage the creation of useful new ideas for the long run by slowing the diffusion of useful new ideas in the short run. The second half of the bargain, the half that imposes costs on society, comes from the temporary exclusive rights, or monopoly privileges, that a patent holder enjoys. Under U.S. patent law, for a period of 20 years nobody else can manufacture or sell the patented product without the permission of the patent holder. This allows the patent holder to block competitors from the market, or extract licensing fees before allowing them to enter, and consequently charge above-market prices to its customers. **Patent rights thus slow the diffusion of a new invention by restricting output and raising prices. The imposition of these short-run costs, however, can bring net long-term benefits by sharpening the incentives to invent new products.** In the absence of patent protection, the prospect of easy imitation by later market entrants can deter would-be innovators from incurring the up-front fixed costs of research and development. **But with a guaranteed period of market exclusivity, inventors can proceed with greater confidence that they will be able to recoup their investment**. For the tradeoff between costs and benefits to come out positive on net, patent law must strike the right balance. Exclusive rights should be valuable enough to encourage greater innovation, but not so easily granted or extensive in scope or term that this encouragement is outweighed by output restrictions on the patented product and discouragement of downstream innovations dependent on access to the patented technology.

**IP protections are the key internal link to resolve vaccine deficiencies. Kumar 21**

Kumar, PhD, 7-12-21

(Rajeesh, Associate Fellow Manohar Parrikar Institute for Defence Studies and Analysis, https://www.idsa.in/issuebrief/wto-trips-waiver-covid-vaccine-rkumar-120721)

In October 2020, India and South Africa had submitted a proposal to the World Trade Organization (WTO), suggesting a waiver of certain provisions of the Trade-Related Aspects of Intellectual Property Rights (TRIPS) Agreement for the “prevention, containment and treatment of COVID-19”. The proposal seeks the waiver of “the implementation, application, and enforcement of sections 1, 4, 5 and 7 of part II of the TRIPS agreement”, which are stipulations referring to copyright, industrial design, patents, and undisclosed information (trade secrets).1 The proponents of the proposal argue that a waiver will *enable timely and equitable access* to affordable health products and technologies, including vaccines. Though many member countries had supported and co-sponsored the proposal, a small but influential group of countries, mainly Australia, Canada, the European Union (EU), Japan, the United Kingdom (UK) and the United States (US), opposed it. They argued that existing exceptions under the TRIPS Agreement are sufficient to address the concerns mentioned in the proposal. This resulted in sidelining of the waiver proposal for months. However, on 5 May 2021, the Joseph Biden administration announced its support for waiving intellectual property protections for COVID-19 vaccines.2 It was a significant step towards breaking the seven-month gridlock, and led to many more countries modifying their position on the waiver proposal. On 25 May 2021, the co-sponsors of the waiver proposal submitted a revised proposal that specified the scope of the waiver as applying to “health products and technologies” and also added a section on the proposed duration of the waiver, i.e., three years.3 At present, more than 100 countries, including the US and China support this proposal. The principal opponent of the waiver is the EU and in June 2021, it submitted an alternative proposal to the TRIPS Council, which requested to keep TRIPS’ provisions intact and focuse[s] on compulsory licensing and removing vaccine export restrictions to address the concerns raised by India and South Africa.4 The EU proposal also stated that the TRIPS Agreement does not prevent countries from taking measures to protect public health.5 At the meeting of the TRIPS Council on 8–9 June 2021, the member states agreed to text-based negotiations focusing on two proposals tabled by members. The members also decided to hold a series of meetings till the end of July 2021 to take stock of the text-based negotiations. However, the latest developments show that the waiver discussions hit a hurdle due to a split between the developed and developing countries over the negotiation text. This brief discusses how TRIPS becomes a barrier to the equitable access of COVID-19 vaccines. It also examines how a waiver will help India in its fight against COVID-19 at home and abroad. TRIPS and its Exceptions TRIPS, a comprehensive multilateral agreement on Intellectual Property (IP), was an outcome of the Uruguay Round (1986–94) of negotiations of the General Agreement on Tariffs and Trade (GATT). The Agreement came into force on 1 January 1995 and offers a minimum standard of protection for Intellectual Property Rights (IPR).6 In WTO, IPR are divided into two main categories. First, copyright and related rights (Articles 9 to 14, Part II of the TRIPS Agreement). Second, industrial property that includes trademarks, geographical indications, industrial designs, patents, integrated circuit layout designs, and undisclosed information (Articles 15 to 38, Part II of the TRIPS Agreement).7 Article IX.3 and IX.4 of the Marrakesh Agreement Establishing the WTO deals with TRIPS waivers. Article IX.3 says that in “exceptional circumstances” the Ministerial Conference may waive off an obligation imposed on WTO member countries.8 Such a decision requires the support of three-fourths of the WTO membership. According to Article IX.4, any waiver granted for more than one year will be reviewed by the Ministerial Conference. Based on the annual review, the Conference may extend, modify, or terminate the waiver. The TRIPS Agreement provides some flexibility primarily in the form of compulsory licensing and research exceptions through Articles 30 and 31. While Article 30 permits WTO members to make limited exceptions to patent rights, Article 31 provides a detailed exception, provided certain conditions are met. Compulsory licensing is the process of granting a license by a government to use a patent without the patent holder's consent. Article 31 permits granting compulsory license under circumstances such as “national emergencies”, “other circumstances of extreme urgency”, “public noncommercial use”, or against “anti-competitive” practices.9 In addition to these original waivers, the Declaration on the TRIPS Agreement and Public Health, adopted at the 2001 Doha Ministerial Meeting, also recognises some exceptions, for instance, in situations of a public health emergency, member countries have the freedom to determine the grounds upon which compulsory licenses are granted. Similarly, under Article 66.1, the least developed countries (LDCs) are given waivers for implementing TRIPS on pharmaceuticals till 1 January 2033. COVID-19 and TRIPS Waiver Two significant factors rekindled the debate on TRIPS waiver for essential medical products—first, vaccine inequity, and second, the insufficiency of existing waiver provisions in fighting the COVID-19 pandemic. COVID-19 is an *exceptional circumstance*, and *equitable global access* to the vaccine is necessary to *bring the pandemic under control*. However, the world is witnessing quite the reverse, i.e., *vaccine nationalism*. Vaccine nationalism is “my nation first” approach to securing and stockpiling vaccines before making them available in other countries. A TRIPS waiver would be instrumental in addressing the *growing inequality in the production*, distribution, and pricing of the COVID-19 vaccines. Vaccine Inequity According to Duke Global Health Innovation Center, which monitors COVID-19 vaccine purchases, rich nations representing just 14 per cent of the world population have bought up to 53 per cent of the most promising vaccines so far. As of 4 July 2021, the high-income countries (HICs) purchased more than half (6.16 billion) vaccine doses sold globally. At the same time, the low-income countries (LICs) received only 0.3 per cent of the vaccines produced.///// The low and middle-income countries (LMICs), which account for 81 per cent of the global adult population, purchased 33 per cent, and COVAX (COVID-19 Vaccines Global Access) has received 13 per cent.10 Many HICs bought enough doses to vaccinate their populations several times over. For instance, Canada procured 10.45 doses per person, while the UK, EU and the US procured 8.18, 6.89, and 4.60 doses per inhabitant, respectively.11 Source:“Tracking COVID-19 Vaccine Purchases Across the Globe”, Duke Global Health Innovation Center, Updated 9 July 2021. Consequently, there is a significant disparity between HICs and LICs in vaccine administration as well. As of 8 July 2021, 3.32 billion vaccine doses had been administered globally.12 Nonetheless, *only one per cent* of people in LICs have been given at least one dose. While in HICs almost one in four people have received the vaccine, in LICs, it is one in more than 500. The World Health Organization (WHO) notes that about 90 per cent of African countries will miss the September target to vaccinate at least 10 per cent of their populations as a third wave looms on the continent.13 South Africa, the most affected African country, for instance, has vaccinated less than two per cent of its population of about 59 million. This is in contrast with the US where almost 47.5 per cent of the population of more than 330 million has been fully vaccinated. In Sub-Saharan Africa, vaccine rollout remains the slowest in the world. According to the International Monetary Fund (IMF), at current rates, by the end of 2021, a massive global inequity will continue to exist, with Africa still experiencing meagre vaccination rates while other parts of the world move much closer to complete vaccination.14 This vaccine inequity is not only morally indefensible but also *clinically counter-productive*. If this situation prevails, LICs could be waiting until 2025 for vaccinating half of their people. Allowing most of the world’s population to go unvaccinated will also *spawn new virus mutations, more contagious viruses* leading to a steep rise in COVID-19 cases. Such a scenario could cause *twice as many deaths* as against distributing them globally, on a priority basis. Preventing this humanitarian catastrophe requires *removing all barriers* to the production and distribution of vaccines. TRIPS is one such barrier that prevents vaccine production in LMICs and hence its equitable distribution. TRIPS: Barrier to Equitable Health Care Access The opponents of the waiver proposal argue that IPR are not a significant barrier to equitable access to health care, and existing TRIPS flexibilities are sufficient to address the COVID-19 pandemic. *However, history suggests the contrary.* For instance, when South Africa passed the Medicines and Related Substances Act of 1997 to address the HIV/AIDS public health crisis, nearly 40 of world’s largest and influential pharma companies took the South African government to court over the violation of TRIPS. The Act, which invoked the compulsory licensing provision, allowed South Africa to produce affordable generic drugs.15 The Big Pharma also lobbied developed countries, particularly the US, to put bilateral trade sanctions against South Africa.16 Similarly, when Indian company Cipla decided to provide generic antiretrovirals (ARVs) to the African market at a lower cost, Big Pharma retaliated through patent litigations in Indian and international trade courts and branded Indian drug companies as thieves.17 Another instance was when Swiss company Roche initiated patent infringement proceedings against Cipla’s decision to launch a generic version of cancer drug, “erlotinib”. Though the Delhi High Court initially dismissed Roche's appeal by citing “public interest” and “affordability of medicines,” the continued to pressure the generic pharma companies over IPR. 18 Likewise, Pfizer’s aggressive patenting strategy prevented South Korea in developing pneumonia vaccines for children.19 A recent document by Médecins Sans Frontières (MSF), or Doctors Without Borders, highlights various instances of how *IP hinders manufacturing and supply of diagnostics,* medical equipment, treatments and vaccines during the COVID-19 pandemic. For instance, during the peak of the COVID-19 first wave in Europe, Roche rejected a request from the Netherlands to release the recipe of key chemical reagents needed to increase the production of diagnostic kits. Another example was patent holders threatening producers of 3D printing ventilators with patent infringement lawsuits in Italy.20 The MSF also found that patents pose a severe threat to access to affordable versions of newer vaccines.21 Source:“COVID-19 Vaccine R&D Investments”, Global Health Centre, Graduate Institute, Geneva, Updated 9 July 2021. The opponents of the TRIPS waiver also argue that *IP is the incentive for innovation* and if it is undermined, future innovation will suffer. However, most of the COVID-19 medical innovations, particularly vaccines, are developed with *public financing assistance*. Governments spent billions of dollars for COVID-19 vaccine research. Notably, out of $6.1 billion in investment tracked up to July 2021*, 98.12* per cent was public funding.22 The US and Germany are the largest investors in vaccine R&D with $2.2 billion and $1.5 billion funding. Source:“COVID-19 Vaccine R&D Investments”, Global Health Centre, Graduate Institute, Geneva, Updated 9 July 2021. Private companies received 94.6 per cent of this funding; Moderna received the highest $956.3 million and Janssen $910.6 million. Moreover, governments also invested $50.9 billion for advance purchase agreements (APAs) as an incentive for vaccine development. A recent IMF working paper also notes that public research institutions were a key driver of the COVID-19 R&D effort—accounting for 70 per cent of all COVID-19 clinical trials globally.23 The argument is that vaccines are developed with the support of substantial public financing, hence there is a public right to the scientific achievements. Moreover, private companies reaped billions in profits from COVID-19 vaccines. Source: Katharina Buchholz, “COVID-19 Vaccines Lift Pharma Company Profits”, Statista, 17 May 2021. One could argue that since the US, Germany and other HICs are spending money, their citizens are entitled to get vaccines first, hence vaccine nationalism is morally defensible. Nonetheless*, it is not the case*. The TRIPS Agreement includes several provisions which mandates promotion of technology transfer from developed countries to LDCs. For instance, Article 7 states that "the protection and enforcement of IP rights should contribute to the promotion of technological innovation and the transfer and dissemination of technology, to the mutual advantage of producers and users of technical knowledge and in a manner conducive to social and economic welfare, and to a balance of rights and obligations."24 Similarly, Article 66.2 also mandates the developed countries to transfer technologies to LDCs to enable them to create a sound and viable technological base. The LMICs opened their markets and amended domestic patent laws favouring developing countries’ products against this promise of technology transfer. Another argument against the proposed TRIPS waiver is that a waiver would not increase the manufacturing of COVID-19 vaccines. Indeed, one of the significant factors contributing to vaccine inequity is the lack of manufacturing capacity in the global south. Further, a TRIPS waiver will not automatically translate into improved manufacturing capacity. *However, a waiver would be the first but essential step to increase manufacturing capacity worldwid*e. For instance, to export COVID-19 vaccine-related products, countries need to ensure that there are no IP restrictions at both ends – exporting and importing. The market for vaccine materials includes consumables, single-use reactors bags, filters, culture media, and vaccine ingredients. Export blockages on raw materials, equipment and finished products harm the overall output of the vaccine supply chain. If there is no TRIPS restriction, more governments and companies will invest in repurposing their facilities. Similarly, the arguments such as that no other manufacturers can carry out the complex manufacturing process of COVID-19 vaccines and generic manufacturing as that *would jeopardise quality*, have also been *proven wrong in the past*. For instance, in the early 1990s, when Indian company Shantha Biotechnics approached a Western firm for a technology transfer of Hepatitis B vaccine, the firm responded that “India cannot afford such high technology vaccines… And even if you can afford to buy the technology, your scientists cannot understand recombinant technology in the least.”25 Later, Shantha Biotechnics developed its own vaccine at $1 per dose, and the UNICEF (United Nations Children’s Emergency Fund) mass inoculation programme uses this vaccine against Hepatitis B. In 2009, Shantha sold over 120 million doses of vaccines globally. India also produces high-quality generic drugs for HIV/AIDS and cancer treatment and markets them across the globe. Now, a couple of Indian companies are in the last stage of producing mRNA (Messenger RNA) vaccines.26 Similarly, Bangladesh and Indonesia claimed that they could manufacture millions of COVID-19 vaccine doses a year if pharmaceutical companies share the know-how.27 Recently, Vietnam also said that the country could satisfy COVID-19 vaccine production requirements once it obtains vaccine patents.28 Countries like the United Arab Emirates (UAE), Turkey, Cuba, Brazil, Argentina and South Korea have the capacity to produce high-quality vaccines but lack technologies and know-how. However, Africa, Egypt, Morocco, Senegal, South Africa and Tunisia have limited manufacturing capacities, which could also produce COVID-19 vaccines after repurposing. Moreover, COVID-19 vaccine IPR runs across the entire value chain – vaccine development, production, use, etc. A mere patent waiver may not be enough to address the issues related to its production and distribution. What is more important here is to share the technical know-how and information such as trade secrets. Therefore, **the existing TRIPS flexibilities, such as compulsory and voluntary licensing, are insufficient to address this crisis**. Further, compulsory licensing and the domestic legal procedures it requires is cumbersome and not expedient in a public health crisis like the COVID-19 pandemic.