### 1AC: Evergreening

#### Contention 1 is Drug Prices

#### Evergreening keeps Drug Prices high.

Amin 18 Tahir Amin 6-27-2018 "The problem with high drug prices isn't 'foreign freeloading,' it's the patent system" [High drug prices caused by US patent system, not 'foreign freeloaders' (cnbc.com)](https://www.cnbc.com/2018/06/25/high-drug-prices-caused-by-us-patent-system.html) <https://www.cnbc.com/2018/06/25/high-drug-prices-caused-by-us-patent-system.html> (co-founder of nonprofit I-MAK.org)//Elmer

**'Evergreening'** Instead of going to new medicines, the study finds that 74 percent of new patents during the decade went to drugs that already existed. It found that 80 percent of the nearly 100 best-selling drugs extended their exclusivity protections at least once, and 50 percent extended their patents more than once—with the effect of **prolonging** the **time before generics** could reach the market **as drug prices continued to rise**. The strategy is called “evergreening”: drug makers add on new patents to prolong a drug’s exclusivity, even when the additions aren’t fundamentally new, non-obvious, and useful as the law requires. One of the most expensive cancer drugs on the market, **Revlimid**®, is a case in point: **priced at** over $**125,000** per year of treatment, Celgene has sought **105 patents** on Revlimid®, many of which have been granted, extending its monopoly until the end of 2036. That gives the Revlimid® patent portfolio a lifespan of 40 years, which is being used to block or deter generic competitors from entering the market. But a recent I-MAK analysis finds that several of Celgene’s patents are mere add-ons—not fundamentally new to deserve a patent. And because of the thicket of patents around Revlimid®, **payers** are **projected to spend $45 billion** **in excess costs** on that drug alone as compared to what they could be paying if generic competitors were to enter when the first patent expires in 2019. Meanwhile, Celgene is also among the pharmaceuticals that have been recently scolded by the FDA for refusing to share samples with generic makers so they can test their own products against the brands in order to attain FDA approval. **In the absence of** genuine **competition** in the U.S. prescription drug market, **monopolies are yielding reckless pricing schemes and prohibitively expensive drugs** for Americans (and people around the world) who need them. In 2015, for example, U.S. Senators Wyden and Grassley found after an 18-month bipartisan investigation that the notorious $84,000 price tag for the hepatitis C drug made by Gilead was based on “a pricing and marketing strategy designed to maximize revenue with little concern for access or affordability.” Gilead’s subsequent hepatitis C drug Harvoni® was introduced to the market at a still higher cost of $94,500. Who benefits when drugs are priced so high? Not the 85 percent of Americans with hepatitis C who are still not able to afford treatment.

#### High Drug Prices forces patients to go underground for drugs.

* AT Medicare CP – won’t cover Drugs – CP can’t fiat coverage

Bryant 11 Clifton Bryant 2011 “The Routledge Handbook of Deviant Behaviour” (former professor of sociology at VA Tech)//Elmer

Now, the field of medicine is able to achieve seemingly miraculous results, through organ transplantation, reviving patients who have been "clinically" dead, and curing supposedly "incurable diseases." Medical miracles are not cheap, however, and the costs of medical care and drugs have risen (and continue to rise) at a near-astronomical rate. Consequently, neither private medical insurance plans nor Medicare will now cover certain procedures, treatments, and medicines. In the future, with continuing reform of the US healthcare system, even fewer procedures, treatments, and medications might will be covered. Certainly, some medical treatment will be "rationed," and particular categories of people (such as the elderly) may be systematically denied the coverage they need. As a result of all this, medical- and health-related crime and deviance will inevitably rise. Medical insurance, Medicare, and Medicaid fraud, which is already prevalent today, will increase exponentially. Smugglers will "bootleg" ever more pharmaceuticals into the US, and a large, thriving, nationwide black market will develop for those who cannot afford to buy uncovered medications. More medicines and diagnostic equipment will be stolen, and back- street medical procedures using such stolen equipment may well be offered for cash with no questions asked. Armed robberies of valuable pharmaceuticals from drug stores and super- markets will increase, too. Bribery to obtain insurance-uncovered or rationed medical care (or, indeed, any kind of medical care where demand exceeds supply) will likely mushroom. This is actually common in some countries around the world. Counterfeiting expensive pharmaceuticals will be prevalent, and medical frauds of all kinds will be very widespread. Many of these frauds will be directed at the elderly population as it continues to increase in size. The elderly will be particularly vulnerable because they are most likely to be denied coverage for certain medical procedures or treatments. For instance, private health insurance and Medicare will both refuse to cover a woman in her mid-80s for potentially life-saving heart-bypass surgery. As a result, she will be a prime candidate for victimization by medical fraud that offers her affordable, but bogus, treatment. There is already a thriving international black market in human organs (Schepper-Hughes 2009). Kidneys are obtained from poor individuals in impoverished countries for relatively modest sums of money. This cash allows the donors to purchase luxuries, such as a small automobile, educate their children, or simply sustain their families for a few months. The organs are sometimes transferred quickly to a hospital in the donor's own country for transplant surgery. But on other occasions they are transported to the US or another Western country. In the US, obtaining an organ for transplantation in this fashion is illegal. Nevertheless, the practice will undoubtedly increase greatly in the future. Where medical care and medicines become exorbitantly expensive, cheaper ways to obtain them, even when these are illicit, will be sought. Where there are shortages of medical care or medicines, perhaps because of rationing, other means of obtaining them, even if deviant, will surely be employed. As the cost and the difficulty of obtaining medical care and medicines increase, the implications for increased crime and deviance become almost limitless.

#### That kills Millions.

Greenberger 20 Phyllis E. Greenberger 12-3-2020 "Counterfeit Medicines Kill People" <https://www.healthywomen.org/health-care-policy/counterfeit-medicines-kill-people/who-suffers-because-of-counterfeit-drugs> (HealthWomen’s Senior Vice President of Science & Health Policy)//Elmer

**Over 1 million people die each year from fake drugs**. COVID-19 Have you ever had a hard time getting a prescription filled? Or maybe you've had to wrestle with your insurance provider to get them to pay for a medication vital for your health? Worse, maybe you're one of the 27.5 million uninsured Americans who find it difficult to get health care, let alone obtain the prescription drugs you may need. If you've had any of these experiences, then perhaps you've turned to the internet to buy medications that would require a prescription. While legal online pharmacies do exist, many online pharmacies are fraudulent, selling counterfeit medications, and millions of people have fallen victim to these scammers. Make no mistake: **Counterfeit medicine is not real**. The **active ingredients** that help you stay healthy may be **missing** **or diluted** to levels that are no longer potent. This **can be dangerous and even life-threatening**, as people rely on their medications to keep them well, and sometimes even alive. Many counterfeit medicines aren't even drugs at all, but rather **snake oil cures that make people sick** — they may even **contain** **dangerous ingredients such as heavy metals, highway paint or even rat poison.** The World Health Organization (WHO) estimates that over 1 million people die each year from these substandard drugs. It's estimated that more than 10% of all pharmaceuticals in the global supply chain are counterfeit in normal times, and during COVID-19, the increased use of telehealth and the appearance of fraudulent doctors has led to a surge in drug fraud. In October of this year, Peter Pitts, president of the Center for Medicine in the Public Interest, a nonpartisan research organization, said pharmaceutical fakery was a "spreading cancer." Counterfeiting is a major problem that requires the federal government to step up to slow — and eventually prevent — its spread. It's also vital that consumers know exactly what's at stake when taking these fake drugs. Who suffers because of counterfeit drugs? Expensive prescription medications and generic drugs in nearly every therapeutic class may be counterfeited. Out of $4.3 billion worth of counterfeit medications seized between 2014 and 2016, 35% were marked as antibiotics. Some of the other most common culprits in counterfeit medicine are used to "treat" HIV/AIDS, erectile dysfunction and weight loss. No matter what condition or disease the counterfeit medication is intending to treat, the outcome can be disastrous. **Counterfeit medications exacerbate other existing health crises**. The United States, for example, is in the midst of an opioid epidemic that is killing 130 people per day. As of 2018, counterfeit drugs containing illegally imported fentanyl (a powerful opioid) had contributed to this tragedy by causing deaths in 26 states. The U.S. Department of Justice found that, in at least one case, these counterfeit drugs had been sold through a fraudulent online pharmacy.

#### Counterfeit Drugs cause Anti-Biotic Resistance.

Jahnke 19 Art Jahnke 1-14-2019 "How Bad Drugs Turn Treatable Diseases Deadly" <https://www.bu.edu/articles/2019/how-bad-drugs-turn-treatable-diseases-deadly/> (Senior editor Art Jahnke began his career at the Real Paper, a Boston area alternative weekly. He has worked as a writer and editor at Boston Magazine, web editorial director at CXO Media, and executive editor in Marketing & Communications at Boston University, where his work was honored with many awards. Art has served on the editorial board of the Boston Review and has taught at Harvard University summer school and Emerson College.)//Elmer

Four decades later as a Boston University professor of biomedical engineering and materials science and engineering, Zaman was reminded of the dangers of low-quality drugs in his native country when he learned that **more than 200 people in the city of Lahore died after being treated with an adulterated version of a hypertension drug.** That event, in 2012, altered the course of Zaman’s research. Now, he focuses on the global problem of “**substandard drugs**,” poorly made medicines containing ingredients that are either ineffective or toxic. His most recent discovery has startling implications for our understanding of drug resistance: a low-quality version of rifampin, a broad spectrum antibiotic typically used as the first line of defense to treat tuberculosis, **can** greatly **contribute to the development of drug-resistant infections**. The findings, published in Antimicrobial Agents and Chemotherapy, are particularly pressing because **drug-resistant TB** is **an increasing** **problem worldwide**. Of the **10 million new cases** of tuberculosis in 2016, about 600,000 were rifampin resistant, requiring second-line treatments which come with increased toxicity. “**There had not been a definitive study** showing that lack of [antibiotic] quality leads to resistance,” says Zaman, who is also a Howard Hughes Medical Institute Professor of Biomedical Engineering and International Health. “**Now we are sure that it does**, and it does with TB, **a** global **problem that has become stubbornly hard to resolve**.” “We had always thought of this a scientific issue, but now it is also an ethical issue.”Muhammad Zaman Zaman says substandard drugs, as well as drugs that are **deliberate counterfeits**, are all too common in developing nations. A recent survey by the World Health Organization found that in low- and middle-income countries, **one in ten medicines is substandard or falsified**. One contributing factor could be that government enforcement of safe manufacturing practices is feeble or nonexistent. In Pakistan, for example, a country of nearly 200 million people, only a handful of federal inspectors monitor the quality of drug manufacturing.

#### Extinction - generic defense doesn’t apply.

Srivatsa 17 Kadiyali Srivatsa 1-12-2017 “Superbug Pandemics and How to Prevent Them” <https://www.the-american-interest.com/2017/01/12/superbug-pandemics-and-how-to-prevent-them/> (doctor, inventor, and publisher. He worked in acute and intensive pediatric care in British hospitals)//Elmer

It is by now no secret that the human species is locked in a race of its own making with “superbugs.” Indeed, if popular science fiction is a measure of awareness, the theme has pervaded English-language literature from Michael Crichton’s 1969 Andromeda Strain all the way to Emily St. John Mandel’s 2014 Station Eleven and beyond. By a combination of massive inadvertence and what can only be called stupidity, we must now invent new and effective antibiotics faster than deadly bacteria evolve—and regrettably, they are rapidly doing so with our help. I do not exclude the possibility that bad actors might deliberately engineer deadly superbugs.1 But even if that does not happen, humanity faces an existential threat largely of its own making in the absence of malign intentions. As threats go, this one is entirely predictable. The concept of a “black swan,” Nassim Nicholas Taleb’s term for low-probability but high-impact events, has become widely known in recent years. Taleb did not invent the concept; he only gave it a catchy name to help mainly business executives who know little of statistics or probability. Many have embraced the “black swan” label the way children embrace holiday gifts, which are often bobbles of little value, except to them. But the threat of inadvertent pandemics is not a “black swan” because its probability is not low. If one likes catchy labels, it better fits the term “gray rhino,” which, explains Michele Wucker, is a high-probability, high-impact event that people manage to ignore anyway for a raft of social-psychological reasons.2 A pandemic is a quintessential gray rhino, for it is no longer a matter of if but of when it will challenge us—and of how prepared we are to deal with it when it happens. We have certainly been warned. The curse we have created was understood as a possibility from the very outset, when seventy years ago Sir Alexander Fleming, the discoverer of penicillin, predicted antibiotic resistance. When interviewed for a 2015 article, “The Most Predictable Disaster in the History of the Human Race, ” Bill Gates pointed out that one of the costliest disasters of the 20th century, worse even than World War I, was the Spanish Flu pandemic of 1918-19. As the author of the article, Ezra Klein, put it: “No one can say we weren’t warned. And warned. And warned. A pandemic disease is the most predictable catastrophe in the history of the human race, if only because it has happened to the human race so many, many times before.”3 Even with effective new medicines, if we can devise them, we must contain outbreaks of bacterial disease fast, lest they get out of control. In other words, we have a social-organizational challenge before us as well as a strictly medical one. That means getting sufficient amounts of medicine into the right hands and in the right places, but it also means educating people and enabling them to communicate with each other to prevent any outbreak from spreading widely. Responsible governments and cooperative organizations have options in that regard, but even individuals can contribute something. To that end, as a medical doctor I have created a computer app that promises to be useful in that regard—of which more in a moment. But first let us review the situation, for while it has become well known to many people, there is a general resistance to acknowledging the severity and imminence of the danger. What Are the Problems? Bacteria are among the oldest living things on the planet. They are masters of survival and can be found everywhere. Billions of them live on and in every one of us, many of them helping our bodies to run smoothly and stay healthy. Most bacteria that are not helpful to us are at least harmless, but some are not. They invade our cells, spread quickly, and cause havoc that we refer to generically as disease. Millions of people used to die every year as a result of bacterial infections, until we developed antibiotics. These wonder drugs revolutionized medicine, but one can have too much of a good thing. Doctors have used antibiotics recklessly, prescribing them for just about everything, and in the process helped to create strains of bacteria that are resistant to the medicines we have. We even give antibiotics to cattle that are not sick and use them to fatten chickens. Companies large and small still mindlessly market antimicrobial products for hands and home, claiming that they kill bacteria and viruses. They do more harm than good because the low concentrations of antimicrobials that these products contain tend to kill friendly bacteria (not viruses at all), and so clear the way for the mass multiplication of surviving unfriendly bacteria. Perhaps even worse, hospitals have deployed antimicrobial products on an industrial scale for a long time now, the result being a sharp rise in iatrogenic bacterial illnesses. Overuse of antibiotics and commercial products containing them has helped superbugs to evolve. We now increasingly face microorganisms that cannot be killed by antibiotics, antifungals, antivirals, or any other chemical weapon we throw at them. Pandemics are the major risk we run as a result, but it is not the only one. Overuse of antibiotics by doctors, homemakers, and hospital managers could mean that, in the not-too-distant future, something as simple as a minor cut could again become life-threatening if it becomes infected. Few non-medical professionals are aware that antibiotics are the foundation on which nearly all of modern medicine rests. Cancer therapy, organ transplants, surgeries minor and major, and even childbirth all rely on antibiotics to prevent infections. If infections become untreatable we stand to lose most of the medical advances we have made over the past fifty years. And the problem is already here. In the summer of 2011, a 43-year-old woman with complications from a lung transplant was transferred from a New York City hospital to the Clinical Center at the National Institutes of Health (NIH), in Bethesda, Maryland. She had a highly resistant superbug known as Klebsiella pneumoniae carbapenemase (KPC). The patient was treated and eventually discharged after doctors concluded that they had contained the infection. A few weeks later, a 34-year-old man with a tumor and no known link to the woman contracted KPC while at the hospital. During the course of the next few months, several more NIH patients presented with KPC. Doctors attacked the outbreak with combinations of antibiotics, including a supposedly powerful experimental drug. A separate intensive care unit for KPC patients was set up and robots disinfected empty rooms, but the infection still spread beyond the intensive care area. Several patients died and then suddenly all was silent on the KPC front, with doctors convinced they had seen the last of the dangerous bacterium. They couldn’t have been more mistaken. A year later, a young man with complications from a bone marrow transplant arrived at NIH. He became infected with KPC and died. This superbug is now present in hospitals in most, if not all U.S. states. This is not good. This past year an outbreak of CRE (carbapenem-resistant enterobacteriaceae) linked to contaminated medical equipment infected 11 patients and killed two in Los Angeles area hospitals. This family of bacteria has evolved resistance to all antibiotics, including the powerful carbapenem antibiotics that are often used as a last resort against serious infections. They are now so resilient that it is virtually impossible to remove them from medical tools such as catheters and breathing tubes placed into the body, even after cleaning. Then we have gonorrhea, chlamydia, and other sexually transmitted diseases that we cannot treat and that are spreading all over the world. Anyone who has sex can catch these infections, and because most people may not exhibit any symptoms they spread infections without anyone knowing about it. Sexually transmitted diseases used to be treatable with antibiotics, but in recent years we have witnessed the rise of multi-drug resistant STDs. Untreated gonorrhea can lead to infertility in men and women and blindness and other congenital defect in babies. As is well known, too, we have witnessed many cases of drug-resistant pneumonia. These problems have arisen in part because of simple mistakes healthcare professionals repeatedly make. Let me explain. Neither superbugs nor common bacterial infections produce any special symptoms indicative of their cause. Rashes, fevers, sneezing, runny noses, ear pain, diarrhea, vomiting, coughing, fatigue, and weakness are signs of common and minor illnesses as well as uncommonly deadly ones. Therefore, the major problem for clinicians is to identify a common symptom that may potentially be an early sign of a major infection that could result in an epidemic. We know that dangerous infections in any given geographical area do not start at the same time. They start with one victim and gradually spread. But that victim is only one among hundreds of patients a doctor will typically see, so many doctors will miss patients presenting with infections that are serious. They will probably identify diseases that kill fast, but slow-spreading infections such as skin infections that can lead to septicemia are rarely diagnosed early. In addition, I have seen doctors treating eczema with antibiotic cream, even though they know that bacteria are resistant to the majority of these drugs. This sort of action encourages simple infections to spread locally, because patients are therefore not instructed to take other, more useful precautions. On top of that, some people are frivolous about infections and assume doctors are exaggerating the threat. And some people are selfish. Once I was called to see a passenger during a flight who had symptoms consistent with infection. He boarded the plane with these symptoms, but began to feel much worse during the flight. I was scared, knowing how infections such as Ebola can spread. This made me think about a way to screen passengers before they board a flight. Airlines could refund a traveler’s ticket, or issue a replacement, in case of sickness—which is not the policy now. We currently have no method to block infectious travelers from boarding flights, and there are no changes in the incentive system to enable conscientious passengers to avoid losing their money if they responsibly miss a flight because of illness. Speaking of selfishness, I once saw a mother drop her daughter off at school with a serious bout of impetigo on her face. When I asked her why she had brought her daughter to school with a contagious infection, she said she could not spare the time to keep her at home or take her to the doctor. By allowing this child to contact other children, a simple infection can become a major threat. Fortunately, I could see the rash on the girl’s face, but other kids in schools may have rashes we cannot see. Incorrect diagnosis of skin problems and mistaken use of antibiotics to treat them is common all over the world, and so we are continually creating superbugs in our communities. Similarly, chest infections, sore throats, and illnesses diagnosed as colds that unnecessarily treated with antibiotics are also a major threat. By prescribing antibiotics for viral infections, we are not only helping bacteria develop resistance, but we are also polluting the environment when these drugs are passed in urine and feces. All of this helps resistant bacteria to spread in the community and become an epidemic. Ebola is very difficult to transmit because people who are contagious have visible and unusual symptoms. However, the emerging infections and pandemics of the future may not have visible symptoms, and they could break out in highly populous countries such as India and China that send thousands of travelers all over the world every day. When a person is infected with a contagious disease, he or she can expect to pass the illness on to an average of two people. This is called the “reproduction number.” Two is not that high a number as these things go; some diseases have far greater rates of infection. The SARS virus had a reproduction number of four. Measles has a reproduction number of 18. One person traveling as an airplane passenger and carrying an infection similar to Ebola can infect three to five people sitting nearby, ten if he or she walks to the toilet. The study that highlighted this was published in a medical journal a few years ago, but the airline industry has not implemented any changes or introduced screening to prevent the spread of infections by air travel passengers, a major vehicle for the rapid spread of disease. It is scary to think that nobody knows what will happen when the world faces a lethal disease we’re not used to, perhaps with a reproduction number of five or eight or even ten. What if it starts in a megacity? What if, unlike Ebola, it’s contagious before patients show obvious symptoms? Past experience isn’t comforting. In 2009, H1N1 flu spread around the world before we even knew it existed. The Questions Remains Why do seemingly intelligent people repeatedly do such collectively stupid things? How did we allow this to happen? The answer is disarmingly simple. It is because people are incentivized to prioritize short-term benefits over long-term considerations. It is what social scientists have called a “logic of collective action” problem. Everyone has his or her specialized niche interest: doctors their patients’ approval, business and airline executives their shareholders’ earnings, hospitals their reputations for best-practice hygienics, homemakers their obligation to keep their own families from illness. But no one owns the longer-term consequences for hundreds of millions of people who are irrelevant to satisfying these short-term concerns. Here is an example. At a recent Superbug Super Drug conference in London that I attended, scientists, health agencies, and pharmaceutical companies were vastly more concerned with investing millions of dollars in efforts to invent another antibiotic, claiming that this has to be the way forward. Money was the most pressing issue because, as everyone at the conference knew, for many years pharmaceutical companies have been pulling back from antibiotics research because they can’t see a profit in it. Development costs run into billions of dollars, yet there is no guarantee that any new drug will successfully fight infections. At the same conference Dr. Lloyd Czaplewski spoke about alternatives to antibiotics, in case we cannot come up with new ones fast enough to outrun superbug evolution. But he omitted mention of preventive strategies that use the internet or communication software to help reduce the spread of infections among families, communities, and countries. It is madness that we don’t have a concrete second-best alternative to new antibiotics, because we need them and we need them quickly. Of course, this is why we have governments, which have been known occasionally in the past as commonwealths. Governments are supposed to look out for the wider, common interests of society that niche-interested professionals take no responsibility for, and that includes public health. It is why nearly every nation’s government has an official who is analogous to the U.S. Surgeon General, and nearly every one has a public health service of some kind. Alas, national governments do not always function as they should. Several years ago physician and former Republican Senator Bill Frist submitted a proposal to the Senate for a U.S. Medical Expeditionary Corps. This would have been a specialized organization that could coordinate and execute rapid responses to global health emergencies such as Ebola. Nothing came of it, because Dr. Frist’s fellow politicians were either too shortsighted or too dimwitted to understand why it was a good idea. Or perhaps they simply realized that they could not benefit politically from supporting it. Plenty of mistakes continue to be made. In 2015, a particularly infectious form of bird flu ripped through 14 U.S. states, leading farmers to preventively slaughter nearly 40 million birds. The result of such callous and unnecessary acts is that, instead of exhausting themselves in the host population of birds, the viruses quickly find alternative hosts in which to survive, and could therefore easily mutate into a form that can infect humans. Earlier, during the 1980s, AIDS garnered more public attention because a handful of rich and famous people were infected, and because the campaign to eradicate it dovetailed with and boosted the political campaign on behalf of homosexual rights. Methicillin resistant Staphylococcus aureus (MRSA) in hospitals, by far the bigger threat at the time, was virtually ignored. Some doctors knew that MRSA would bring us to our knees and kill millions of people worldwide, but pharmaceutical companies and device and equipment manufacturers ignored these doctors and the thousands of patients dying in hospitals as a result of MRSA. They prioritized the wrong thing, and government did not correct the error. And that is partly how antibiotic-resistant infection went from an obscure hospital problem to an incipient global pandemic. Politics well outside the United States plays several other roles in the budding problem that we are confronting. Countries often will not admit they have a problem and request help because of the possible financial implications in terms of investment and travel. Guinea did not declare the Ebola epidemic early on and Chinese leaders, worried about trade and tourism, lied for months in 2002 about the presence of the SARS virus. In 2004, when avian influenza first surfaced in Thailand, officials there displayed a similar reluctance to release information. Hospitals in some countries, including India, are managed and often owned by doctors. They refuse to share information about existing infections and often categorically deny they have a problem. Reporting infections to public health authorities is not mandatory, and so hospitals that fail to say anything are not penalized. Even now, the WHO and the CDC do not have accurate and up-to-date information about the spread of E. coli or other infections, and part of the reason is that for-profit hospitals are reluctant to do anything to diminish their bottom line. Syria and Yemen are among those countries that are so weak and fragmented that they cannot effectively coordinate public healthcare. But their governments are also hostile to external organizations that offer relief. Part of the reason is xenophobia, but part is that this makes the government look bad. Relatedly, most poor-nation governments do not trust the efficacy of international institutions, and think that cooperating with them amounts to a re-importation of imperialism. They would rather their own people suffer and die than ask for needed help. That brings us to the level of international public health governance. Alas, sometimes poor-country governments estimate the efficacy of international institutions accurately. The WHO’s Ebola response in 2014-15 was a disaster. The organization was slow to declare a public health emergency even after public warnings from Médecins Sans Frontières, some of whose doctors had already died on the front line. The outbreak killed more than 28,000 people, far more than would have been the case had it been quickly identified. This isn’t just an issue of bureaucratic incompetence. The WHO is under-resourced for the problems it is meant to solve. Funding comes from voluntary donations, and there is no mechanism by which it can quickly scale up its efforts during an emergency. The result is that its response to the next major disease outbreak is likely to be as inadequate as were its responses to Ebola, H1N1, and SARS. Stakeholders admit that we need another mechanism, and most experts agree that the world needs some kind of emergency response team for dangerous diseases. But no one knows how to set one up amid the dysfunctional global governance structures that presently exist. Maybe they should turn to Bill Frist, whose basic concept was sound; if the U.S. government will not act, perhaps some other governments will, and use the UN system to do so. But as things stand, we lack a health equivalent of the military reserve. Neither government leaders nor doctors can mobilize a team of experts to contain infections. People who want to volunteer, whether for government or NGO efforts, are not paid and the rules, if any, are sketchy about what we do with them when they return from a mission. Are employers going to take them back? What are the quarantine rules? It is all completely ad hoc, meaning that humanity lacks the tools it needs to protect itself. And note, by the way, the contrast between how governments prepare for facing pandemics and how they prepare for making war. War is not more deadly to the human race than pandemics, but national defense against armed aggression is much better planned for than defense against threats to public health. There is a wealth of rules regarding it, too. Human beings study and plan for war, which kills people both deliberately and accidentally, but they do not invest comparable effort planning for pandemics, which are liable to kill orders of magnitude more people. To the mind of a medical doctor, this is strange. Creating Conditions for Infections to Spread Superbug infections spread for several interlocking reasons. Some are medical-epidemiological. Most of the infections of the past thirty years have started in one place and in one family. As already noted, they spread because many infectious diseases are highly contagious before the onset of symptoms, and because it is difficult to prevent patients who know they are sick from going to hospitals, work, and school, or from traveling further afield. But again, one reason for the problem is political, not medical. Many governments have no strategies in place to prevent pandemics because they are unwilling to tell their people how infections spread. They don’t want to worry people with such talk; it will make them, they fear, unpopular. So governments may have mountains of bureaucracy with great heaps of rules and regulations concerning public health, but they are generally unwilling to trust their own citizens to use common sense on their own behalf. This, too, seems very strange. Until now, no one has come forward to help us develop strategies to educate people how to identify and prevent the spread of infection to their families and communities. The majority of stakeholders have also been oblivious to the use of new technologies to help reduce the spread of these infections. There are some exceptions. In a fun blog post called Preparedness 101: Zombie Apocalypse, the CDC uses the threat of a zombie outbreak as a metaphor to encourage people to prepare for emergencies, including pandemics. It is well meaning and insightful, yet when my colleagues and I try to discuss ways of scaling up the CDC’s example with doctors and nurses, they shut down. Nobody plans for an actual crisis partly because it is too scary and hence paralyzing to think about. But it is also because it is not most health professionals’ job; it is not what they are trained and paid to do. It is always someone else’s job, except that it has turned out to be nobody’s job. Worse, the situation is not static. While we sit paralyzed, superbugs are evolving. Epidemiological models now predict how an algorithmic process of disease spread will move through the modern world. All urban centers around the entire globe can become infected within sixty days because we move around and cross borders much more than our ancestors did, thanks to air travel. A new pandemic could start crossing borders before we even know it exists. A flu-like disease could kill more than 33 million people in 250 days.3

#### High Drug Prices pushes people into poverty – our internal is causal.

Hoban 10 Rose Hoban 9-13-2010 "High Cost of Medicine Pushes More People into Poverty" <https://www.voanews.com/science-health/high-cost-medicine-pushes-more-people-poverty> (spent more than six years as the health reporter for North Carolina Public Radio – WUNC, where she covered health care, state health policy, science and research with a focus on public health issues. She left to start North Carolina Health News after watching many of her professional peers leave or be laid off of their jobs, leaving NC with few people to cover this complicated and important topic. ALSO cites Laurens Niens who is a Health Researcher at Erasmus University Rotterdam)//Elmer

Health economist Laurens Niëns found that drugs needed to treat chronic diseases could be considered unaffordable **for many people in poor countries**. Medicines can be expensive and often make up a large portion of any family's health care budget. And the burden can be even greater for people in poor countries, where the **cost of vital medicines can push them into poverty**. The problem is growing as more people around the world are diagnosed with chronic diseases such as high blood pressure and diabetes. Being diagnosed with a chronic disease usually compells patients to seek treatment for a prolonged period of time. That increases the eventual price tag for health, says health economist Laurens Niëns at Erasmus University in the Netherlands. Niëns examined medication pricing data from the World Health Organization and also looked at data from the World Bank on household income in many countries. Using the data, he calculated how much people need to spend on necessities such as food, housing, education and medicines. "The medicines we looked at are medicines for patients who suffer from asthma, diabetes, hypertension and we looked at an adult respiratory infection," Niëns says. "Three conditions are for chronic diseases, which basically means that people need to procure those medicines each and every day." Niëns focused on the cost of medicine for those conditions. He found the essential drugs could be considered unaffordable for many people in poor countries - so much so that their cost often pushes people into abject poverty. "The proportion of the population that is living below the poverty line, plus the people that are being pushed below the poverty line, can **reach up to 80 percent** in some countries for some medicines," Niëns says. He points out that generic medicines - which are more affordable than brand-name medications - are often **not available in the marketplace**. And, according to Niëns, poor government policies can drive up the cost of medications. "For instance, a lot of governments actually tax medicines when they come into the country," he says. "[They] have no standard for the markups on medicines through the distribution chain. So often, governments think they pay a good price for the medicines when they procure them from the producer. However, before such a medicine reaches a patient, markups are sometimes up to 1,000 percent."

#### This is a form of pharmaceutical capitalism – exploiting marginalized groups in the third world.

Lift Mode 17 3-10-2017 "Pharmaceutical Colonialism” <https://medium.com/@liftmode/pharmaceutical-colonialism-3-ways-that-western-medicine-takes-from-indigenous-communities-3a9339b4f24f> (We at Liftmode.com are a team of professionals from a variety of backgrounds, dedicated to the mission of providing the highest quality and highest purity nutritional health supplements on the market. We look specifically for the latest and most promising research in the fields of cognition enhancement, neuroscience and alternative health supplements, and develop commercial strategies to bring these technologies to the marketplace.)//Elmer

3. **Cost of medicine as a form of debt** **One of the biggest methods of extracting money from rural and indigenous communities is through increased costs of medication**. Pharmaceutical colonialism often uses the premise of providing cheap medication for the world’s neediest to acquire local knowledge and natural resources. This premise is pushed into society through advertising campaigns and processes like lobbying. However, those who benefit most are often the shareholders, and not the people who need help. An example was the 2009 Reuters report which found that nearly **a million people** were **dying from malaria** dying every year **due to overly expensive medication**. According to the report, Artemisinin combination therapies (ACTs) can cost up to 65 times the daily minimum wage in countries that are most affected by malaria. These high prices **come after the government subsidies** which push them down as low as possible.[19] Another famous and recent example was the businessman Martin Shkreli, who pushed the cost of an AIDS drug up from $13.50 to over $700 per pill. This created an outrage on social media and it highlighted the underlying mindset behind most pharmaceutical companies — profit above all. An interesting and disturbing source of information about this is the film Fire in the Blood, which documents how **western pharmaceutical companies** **blocked the sale of cheap antiretroviral drugs to AIDS patients** **in Sub-Saharan Africa**.[20] “There is indeed a sense in which all modern **medicine** is **engaged in a colonizing process**… It can be seen in **the** increasing **professionalization of medicine and the exclusion of ‘folk’ practitioners**, in the close and often symbiotic relationship between medicine and the modern state, in the far-reaching claims made by medical science for its ability to prevent, control, and even eradicate human diseases.”[21] — D Arnold, Colonizing the Body, 1993 Pharmaceutical companies have been responsible for saving millions of lives due to their advances in medicine. However, the number of lives that have been lost due to the lack of affordability of medicine and the lack of equity and sharing of profits is estimated to be extremely high. **Western capitalism** has the **potential to act as a new form of colonialism**, and the modern medical method is one great way to extend the branches of capitalism into developing countries. The slums in Brazil highlight the blatant inequality between nations and people.

#### The Alternative to the Aff isn’t no medicine but exploitive medicine – the Plan’s orientation is a sequencing strategy to resistance.

Ahmed 20 A Kavum Ahmed 6-24-2020 "Decolonizing the vaccine" <https://africasacountry.com/2020/06/decolonizing-the-vaccine> (A. Kayum Ahmed is Division Director for Access and Accountability at the Open Society Public Health Program in New York and teaches at Columbia University Law School.)//Duong+Elmer

Reflecting on a potential COVID-19 vaccine trial during a television interview in April, a French doctor stated, “If I can be provocative, shouldn’t we be doing this study in Africa, where there are no masks, no treatments, no resuscitation?” These remarks reflect a colonial view of Africa, reinforcing the idea that Africans are non-humans whose black bodies can be experimented on. This colonial perspective is also clearly articulated in the alliance between France, The Netherlands, Germany and Italy to negotiate priority access to the COVID-19 vaccine for themselves and the rest of Europe. In the Dutch government’s announcement of the European vaccine coalition, they indicate that, “… the alliance is also working to make a portion of vaccines available to low-income countries, including in Africa.” In the collective imagination of these European nations, Africa is portrayed as a site of redemption—a place where you can absolve yourself from the sins of “vaccine sovereignty,” by offering a “portion of the vaccines” to the continent. Vaccine sovereignty reflects how European and American governments use public funding, supported by the pharmaceutical industry and research universities, to obtain priority access to potential COVID-19 vaccines. The concept symbolizes the COVID-19 **vaccine** (when it eventually becomes available) as **an instrument of power deployed to exercise control** **over who will live and who must die**. In order to counter vaccine sovereignty, we must decolonize the vaccine. Africans have a particular role to play in leading this decolonization process as subjects of colonialism and as objects of domination through coloniality. Colonialism, as an expansion of territorial dominance, and coloniality, as the continued expression of Western imperialism after colonization, play out in the vaccine development space, most notably on the African continent. So what does decolonizing the vaccine look like? And how do we decolonize something that does not yet exist? For Frantz Fanon, “**Decolonization**, which sets out to change the order of the world, **is**, obviously, a program of **complete disorder**.” **Acknowledging** **that the** COVID-19 **vaccine has been weaponized** **as an instrument of power** by wealthy nations, **decolonization** **requires** a Fanonian program of **radical re-ordering.** In the context of vaccine sovereignty, this re-ordering **necessitates** the **dismantling** of the **profit-driven biomedical system**. This program starts with **de-linking from** **Euro-American constructions of knowledge and power** that reinforce vaccine sovereignty through the profit-driven biomedical system. Advocacy campaigns such as the “People’s Vaccine”, which calls for guaranteed free access to COVID-19 vaccines, diagnostics and treatments to everyone, everywhere, are a good start. Other mechanisms, such as the World Health Organization’s COVID-19 Technology Access Pool, similarly supports universal access to COVID-19 health technologies as global public goods. Since less than 1% of vaccines consumed in Africa are manufactured on the continent, regional efforts to develop vaccine manufacturing capacity such as those led by the Africa Center for Disease Control and Prevention, as well as the Alliance of African Research Universities, must be supported. These efforts collectively advance delinking and move us closer toward the re-ordering of systems of power. The opportunity for disorder is paradoxically enabled by the COVID-19 pandemic, which has permitted moments of existential reflection in the midst of the crisis. A few months ago, a press release announcing the distribution of “a portion of the vaccines” to Africans, may have been lauded as European benevolence. But in the context of a pandemic that is more likely to kill black people, Africa’s reliance on Europe for vaccine handouts is untenable, necessitating a re-examination of the systems of power that hold this colonial relationship in place. The Black African body appears to be good enough to be experimented on, but not worthy of receiving simultaneous access to the COVID-19 vaccine as Europeans. Consequently, Africans continue to feel the effects of colonialism and white supremacy, and understand the pernicious nature of European altruism. By reinforcing the current system of vaccine research, development and manufacturing, it has become apparent that European governments want to retain their colonial power over life and death in Africa through the COVID-19 vaccine. Resistance to this colonial power requires the decolonization of the vaccine.

### 1AC: Plan

#### Plan – The member nations of the World Trade Organization ought to reduce intellectual property protections for medicines by implementing a one-and-done approach for patent protection.

#### Contention 2 is Solvency

#### The Plan solves Evergreening.

Feldman 3 Robin Feldman 2-11-2019 "‘One-and-done’ for new drugs could cut patent thickets and boost generic competition" <https://www.statnews.com/2019/02/11/drug-patent-protection-one-done/> (Arthur J. Goldberg Distinguished Professor of Law, Albert Abramson ’54 Distinguished Professor of Law Chair, and Director of the Center for Innovation)//SidK + Elmer

I believe that one period of protection **should be enough**. We should make the legal changes necessary to prevent companies **from building patent walls** and piling up mountains of rights. This could be accomplished **by a “one-and-done” approach** for patent protection. Under it, a drug would receive just one period of exclusivity, and no more. The choice of which “one” could be left entirely in the hands of the pharmaceutical company, with the election made when the FDA approves the drug. Perhaps development of the drug went swiftly and smoothly, so the remaining life of one of the drug’s patents is of greatest value. Perhaps development languished, so designation as an orphan drug or some other benefit would bring greater reward. The choice would be up to the company itself, based on its own calculation of the maximum benefit. The result, however, is that a pharmaceutical company chooses whether its period of exclusivity would be a patent, an orphan drug designation, a period of data exclusivity (in which no generic is allowed to use the original drug’s safety and effectiveness data), or something else — but **not all of the above** and more. Consider Suboxone, a combination of buprenorphine and naloxone for treating opioid addiction. The drug’s maker has extended its protection cliff eight times, including obtaining an orphan drug designation, which is intended for drugs that serve only a small number of patients. The drug’s first period of exclusivity ended in 2005, but with the additions its protection now lasts until 2024. That makes almost two additional decades in which the public has borne the burden of monopoly pricing, and access to the medicine may have been constrained. Implementing a one-and-done approach in conjunction with FDA approval underscores the fact that these problems and solutions are designed for pharmaceuticals, not for all types of technologies. That way, one-and-done could be implemented through **legislative changes to the FDA’s drug approval system**, and would apply to patents granted going forward. One-and-done would apply to both patents and exclusivities. A more limited approach, a baby step if you will, would be to invigorate the existing patent obviousness doctrine as a way to cut back on patent tinkering. Obviousness, one of the five standards for patent eligibility, says that inventions that are obvious to an expert or the general public can’t be patented. Either by congressional clarification or judicial interpretation, many pile-on patents could be eliminated with a ruling that the core concept of the additional patent is nothing more than the original formulation. Anything else is merely an obvious adaptation of the core invention, modified with existing technology. As such, the patent would fail for being perfectly obvious. Even without congressional action, a more vigorous and robust application of the existing obviousness doctrine could significantly improve the problem of piled-up patents and patent walls. Pharmaceutical companies have become adept at maneuvering through the system of patent and non-patent rights to create mountains of rights that can be applied, one after another. This behavior lets drug companies keep competitors out of the market and beat them back when they get there. We shouldn’t be surprised at this. Pharmaceutical companies are profit-making entities, after all, that face pressure from their shareholders to produce ever-better results. If we want to change the system, we must change the incentives driving the system. And right now, the incentives for creating patent walls are just too great.

### FW

#### The standard is maximizing expected well-being. – we will spec – Hedonistic act Utilitarianism

#### Prefer:

#### 1] Pleasure and pain are intrinsic value and disvalue – everything else regresses. Evolutionary knowledge is reliable – broad consensus and robust neuroscience prove.

Blum et al. 18

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**Pleasure** is not only one of the three primary reward functions but it also **defines reward.** As homeostasis explains the functions of only a limited number of rewards, the principal reason why particular stimuli, objects, events, situations, and activities are rewarding may be due to pleasure. This applies first of all to sex and to the primary homeostatic rewards of food and liquid and extends to money, taste, beauty, social encounters and nonmaterial, internally set, and intrinsic rewards. Pleasure, as the primary effect of rewards, drives the prime reward functions of learning, approach behavior, and decision making and provides the **basis for hedonic theories** of reward function. We are attracted by most rewards and exert intense efforts to obtain them, just because they are enjoyable [10]. Pleasure is a passive reaction that derives from the experience or prediction of reward and may lead to a long-lasting state of happiness. The word happiness is difficult to define. In fact, just obtaining physical pleasure may not be enough. One key to happiness involves a network of good friends. However, it is not obvious how the higher forms of satisfaction and pleasure are related to an ice cream cone, or to your team winning a sporting event. Recent multidisciplinary research, using both humans and detailed invasive brain analysis of animals has discovered some critical ways that the brain processes pleasure [14]. Pleasure as a hallmark of reward is sufficient for defining a reward, but it may not be necessary. A reward may generate positive learning and approach behavior simply because it contains substances that are essential for body function. When we are hungry, we may eat bad and unpleasant meals. A monkey who receives hundreds of small drops of water every morning in the laboratory is unlikely to feel a rush of pleasure every time it gets the 0.1 ml. Nevertheless, with these precautions in mind, we may define any stimulus, object, event, activity, or situation that has the potential to produce pleasure as a reward. In the context of reward deficiency or for disorders of addiction, homeostasis pursues pharmacological treatments: drugs to treat drug addiction, obesity, and other compulsive behaviors. The theory of allostasis suggests broader approaches - such as re-expanding the range of possible pleasures and providing opportunities to expend effort in their pursuit. [15]. It is noteworthy, the first animal studies eliciting approach behavior by electrical brain stimulation interpreted their findings as a discovery of the brain’s pleasure centers [16] which were later partly associated with midbrain dopamine neurons [17–19] despite the notorious difficulties of identifying emotions in animals. Evolutionary theories of pleasure: The love connection BO:D Charles Darwin and other biological scientists that have examined the biological evolution and its basic principles found various mechanisms that steer behavior and biological development. Besides their theory on natural selection, it was particularly the sexual selection process that gained significance in the latter context over the last century, especially when it comes to the question of what makes us “what we are,” i.e., human. However, the capacity to sexually select and evolve is not at all a human accomplishment alone or a sign of our uniqueness; yet, we humans, as it seems, are ingenious in fooling ourselves and others–when we are in love or desperately search for it. It is well established that modern biological theory conjectures that **organisms are** the **result of evolutionary competition.** In fact, Richard Dawkins stresses gene survival and propagation as the basic mechanism of life [20]. Only genes that lead to the fittest phenotype will make it. It is noteworthy that the phenotype is selected based on behavior that maximizes gene propagation. To do so, the phenotype must survive and generate offspring, and be better at it than its competitors. Thus, the ultimate, distal function of rewards is to increase evolutionary fitness by ensuring the survival of the organism and reproduction. It is agreed that learning, approach, economic decisions, and positive emotions are the proximal functions through which phenotypes obtain other necessary nutrients for survival, mating, and care for offspring. Behavioral reward functions have evolved to help individuals to survive and propagate their genes. Apparently, people need to live well and long enough to reproduce. Most would agree that homo-sapiens do so by ingesting the substances that make their bodies function properly. For this reason, foods and drinks are rewards. Additional rewards, including those used for economic exchanges, ensure sufficient palatable food and drink supply. Mating and gene propagation is supported by powerful sexual attraction. Additional properties, like body form, augment the chance to mate and nourish and defend offspring and are therefore also rewards. Care for offspring until they can reproduce themselves helps gene propagation and is rewarding; otherwise, many believe mating is useless. According to David E Comings, as any small edge will ultimately result in evolutionary advantage [21], additional reward mechanisms like novelty seeking and exploration widen the spectrum of available rewards and thus enhance the chance for survival, reproduction, and ultimate gene propagation. These functions may help us to obtain the benefits of distant rewards that are determined by our own interests and not immediately available in the environment. Thus the distal reward function in gene propagation and evolutionary fitness defines the proximal reward functions that we see in everyday behavior. That is why foods, drinks, mates, and offspring are rewarding. There have been theories linking pleasure as a required component of health benefits salutogenesis, (salugenesis). In essence, under these terms, pleasure is described as a state or feeling of happiness and satisfaction resulting from an experience that one enjoys. Regarding pleasure, it is a double-edged sword, on the one hand, it promotes positive feelings (like mindfulness) and even better cognition, possibly through the release of dopamine [22]. But on the other hand, pleasure simultaneously encourages addiction and other negative behaviors, i.e., motivational toxicity. It is a complex neurobiological phenomenon, relying on reward circuitry or limbic activity. It is important to realize that through the “Brain Reward Cascade” (BRC) endorphin and endogenous morphinergic mechanisms may play a role [23]. While natural rewards are essential for survival and appetitive motivation leading to beneficial biological behaviors like eating, sex, and reproduction, crucial social interactions seem to further facilitate the positive effects exerted by pleasurable experiences. Indeed, experimentation with addictive drugs is capable of directly acting on reward pathways and causing deterioration of these systems promoting hypodopaminergia [24]. Most would agree that pleasurable activities can stimulate personal growth and may help to induce healthy behavioral changes, including stress management [25]. The work of Esch and Stefano [26] concerning the link between compassion and love implicate the brain reward system, and pleasure induction suggests that social contact in general, i.e., love, attachment, and compassion, can be highly effective in stress reduction, survival, and overall health. Understanding the role of neurotransmission and pleasurable states both positive and negative have been adequately studied over many decades [26–37], but comparative anatomical and neurobiological function between animals and homo sapiens appear to be required and seem to be in an infancy stage. Finding happiness is different between apes and humans As stated earlier in this expert opinion one key to happiness involves a network of good friends [38]. However, it is not entirely clear exactly how the higher forms of satisfaction and pleasure are related to a sugar rush, winning a sports event or even sky diving, all of which augment dopamine release at the reward brain site. Recent multidisciplinary research, using both humans and detailed invasive brain analysis of animals has discovered some critical ways that the brain processes pleasure. Remarkably, there are pathways for ordinary liking and pleasure, which are limited in scope as described above in this commentary. However, there are **many brain regions**, often termed hot and cold spots, that significantly **modulate** (increase or decrease) our **pleasure or** even **produce the opposite** of pleasure— that is disgust and fear [39]. One specific region of the nucleus accumbens is organized like a computer keyboard, with particular stimulus triggers in rows— producing an increase and decrease of pleasure and disgust. Moreover, the cortex has unique roles in the cognitive evaluation of our feelings of pleasure [40]. Importantly, the interplay of these multiple triggers and the higher brain centers in the prefrontal cortex are very intricate and are just being uncovered. Desire and reward centers It is surprising that many different sources of pleasure activate the same circuits between the mesocorticolimbic regions (Figure 1). Reward and desire are two aspects pleasure induction and have a very widespread, large circuit. Some part of this circuit distinguishes between desire and dread. The so-called pleasure circuitry called “REWARD” involves a well-known dopamine pathway in the mesolimbic system that can influence both pleasure and motivation. In simplest terms, the well-established mesolimbic system is a dopamine circuit for reward. It starts in the ventral tegmental area (VTA) of the midbrain and travels to the nucleus accumbens (Figure 2). It is the cornerstone target to all addictions. The VTA is encompassed with neurons using glutamate, GABA, and dopamine. The nucleus accumbens (NAc) is located within the ventral striatum and is divided into two sub-regions—the motor and limbic regions associated with its core and shell, respectively. The NAc has spiny neurons that receive dopamine from the VTA and glutamate (a dopamine driver) from the hippocampus, amygdala and medial prefrontal cortex. Subsequently, the NAc projects GABA signals to an area termed the ventral pallidum (VP). The region is a relay station in the limbic loop of the basal ganglia, critical for motivation, behavior, emotions and the “Feel Good” response. This defined system of the brain is involved in all addictions –substance, and non –substance related. In 1995, our laboratory coined the term “Reward Deficiency Syndrome” (RDS) to describe genetic and epigenetic induced hypodopaminergia in the “Brain Reward Cascade” that contribute to addiction and compulsive behaviors [3,6,41]. Furthermore, ordinary “liking” of something, or pure pleasure, is represented by small regions mainly in the limbic system (old reptilian part of the brain). These may be part of larger neural circuits. In Latin, hedus is the term for “sweet”; and in Greek, hodone is the term for “pleasure.” Thus, the word Hedonic is now referring to various subcomponents of pleasure: some associated with purely sensory and others with more complex emotions involving morals, aesthetics, and social interactions. The capacity to have pleasure is part of being healthy and may even extend life, especially if linked to optimism as a dopaminergic response [42]. Psychiatric illness often includes symptoms of an abnormal inability to experience pleasure, referred to as anhedonia. A negative feeling state is called dysphoria, which can consist of many emotions such as pain, depression, anxiety, fear, and disgust. Previously many scientists used animal research to uncover the complex mechanisms of pleasure, liking, motivation and even emotions like panic and fear, as discussed above [43]. However, as a significant amount of related research about the specific brain regions of pleasure/reward circuitry has been derived from invasive studies of animals, these cannot be directly compared with subjective states experienced by humans. In an attempt to resolve the controversy regarding the causal contributions of mesolimbic dopamine systems to reward, we have previously evaluated the three-main competing explanatory categories: “liking,” “learning,” and “wanting” [3]. That is, dopamine may mediate (a) liking: the hedonic impact of reward, (b) learning: learned predictions about rewarding effects, or (c) wanting: the pursuit of rewards by attributing incentive salience to reward-related stimuli [44]. We have evaluated these hypotheses, especially as they relate to the RDS, and we find that the incentive salience or “wanting” hypothesis of dopaminergic functioning is supported by a majority of the scientific evidence. Various neuroimaging studies have shown that anticipated behaviors such as sex and gaming, delicious foods and drugs of abuse all affect brain regions associated with reward networks, and may not be unidirectional. Drugs of abuse enhance dopamine signaling which sensitizes mesolimbic brain mechanisms that apparently evolved explicitly to attribute incentive salience to various rewards [45]. Addictive substances are voluntarily self-administered, and they enhance (directly or indirectly) dopaminergic synaptic function in the NAc. This activation of the brain reward networks (producing the ecstatic “high” that users seek). Although these circuits were initially thought to encode a set point of hedonic tone, it is now being considered to be far more complicated in function, also encoding attention, reward expectancy, disconfirmation of reward expectancy, and incentive motivation [46]. The argument about addiction as a disease may be confused with a predisposition to substance and nonsubstance rewards relative to the extreme effect of drugs of abuse on brain neurochemistry. The former sets up an individual to be at high risk through both genetic polymorphisms in reward genes as well as harmful epigenetic insult. Some Psychologists, even with all the data, still infer that addiction is not a disease [47]. Elevated stress levels, together with polymorphisms (genetic variations) of various dopaminergic genes and the genes related to other neurotransmitters (and their genetic variants), and may have an additive effect on vulnerability to various addictions [48]. In this regard, Vanyukov, et al. [48] suggested based on review that whereas the gateway hypothesis does not specify mechanistic connections between “stages,” and does not extend to the risks for addictions the concept of common liability to addictions may be more parsimonious. The latter theory is grounded in genetic theory and supported by data identifying common sources of variation in the risk for specific addictions (e.g., RDS). This commonality has identifiable neurobiological substrate and plausible evolutionary explanations. Over many years the controversy of dopamine involvement in especially “pleasure” has led to confusion concerning separating motivation from actual pleasure (wanting versus liking) [49]. We take the position that animal studies cannot provide real clinical information as described by self-reports in humans. As mentioned earlier and in the abstract, on November 23rd, 2017, evidence for our concerns was discovered [50] In essence, although nonhuman primate brains are similar to our own, the disparity between other primates and those of human cognitive abilities tells us that surface similarity is not the whole story. Sousa et al. [50] small case found various differentially expressed genes, to associate with pleasure related systems. Furthermore, the dopaminergic interneurons located in the human neocortex were absent from the neocortex of nonhuman African apes. Such differences in neuronal transcriptional programs may underlie a variety of neurodevelopmental disorders. In simpler terms, the system controls the production of dopamine, a chemical messenger that plays a significant role in pleasure and rewards. The senior author, Dr. Nenad Sestan from Yale, stated: “Humans have evolved a dopamine system that is different than the one in chimpanzees.” This may explain why the behavior of humans is so unique from that of non-human primates, even though our brains are so surprisingly similar, Sestan said: “It might also shed light on why people are vulnerable to mental disorders such as autism (possibly even addiction).” Remarkably, this research finding emerged from an extensive, multicenter collaboration to compare the brains across several species. These researchers examined 247 specimens of neural tissue from six humans, five chimpanzees, and five macaque monkeys. Moreover, these investigators analyzed which genes were turned on or off in 16 regions of the brain. While the differences among species were subtle, **there was** a **remarkable contrast in** the **neocortices**, specifically in an area of the brain that is much more developed in humans than in chimpanzees. In fact, these researchers found that a gene called tyrosine hydroxylase (TH) for the enzyme, responsible for the production of dopamine, was expressed in the neocortex of humans, but not chimpanzees. As discussed earlier, dopamine is best known for its essential role within the brain’s reward system; the very system that responds to everything from sex, to gambling, to food, and to addictive drugs. However, dopamine also assists in regulating emotional responses, memory, and movement. Notably, abnormal dopamine levels have been linked to disorders including Parkinson’s, schizophrenia and spectrum disorders such as autism and addiction or RDS. Nora Volkow, the director of NIDA, pointed out that one alluring possibility is that the neurotransmitter dopamine plays a substantial role in humans’ ability to pursue various rewards that are perhaps months or even years away in the future. This same idea has been suggested by Dr. Robert Sapolsky, a professor of biology and neurology at Stanford University. Dr. Sapolsky cited evidence that dopamine levels rise dramatically in humans when we anticipate potential rewards that are uncertain and even far off in our futures, such as retirement or even the possible alterlife. This may explain what often motivates people to work for things that have no apparent short-term benefit [51]. In similar work, Volkow and Bale [52] proposed a model in which dopamine can favor NOW processes through phasic signaling in reward circuits or LATER processes through tonic signaling in control circuits. Specifically, they suggest that through its modulation of the orbitofrontal cortex, which processes salience attribution, dopamine also enables shilting from NOW to LATER, while its modulation of the insula, which processes interoceptive information, influences the probability of selecting NOW versus LATER actions based on an individual’s physiological state. This hypothesis further supports the concept that disruptions along these circuits contribute to diverse pathologies, including obesity and addiction or RDS.

#### [2] Only natural observable moral facts exist:

#### Papineau 07, David Papineau, “Naturalism,” Stanford Encyclopedia of Philosophy, 2007//SS Moore took this argument to show that moral facts comprise a distinct species of non-natural fact. However, any such non-naturalist view of morality faces immediate difficulties, deriving ultimately from the kind of causal closure thesis discussed above. If all physical effects are due to a limited range of natural causes, and if moral facts lie outside this range, then it follow that moral facts can never make any difference to what happens in the physical world (Harman, 1986). At first sight this may seem tolerable (perhaps moral facts indeed don't have any physical effects). But it has very awkward epistemological consequences. For beings like us, knowledge of the spatiotemporal world is mediated by physical processes involving our sense organs and cognitive systems. If moral facts cannot influence the physical world, then it is hard to see how we can have any knowledge of them

#### Two implications: A) Substantively affirms since we need the natural world to derive moral facts from it, so environmental destruction eliminates our ability to perceive and interact with those facts to create morality. B) Proves Util since we physically know the pleasure is good and pain is bad.

#### 3] 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.

#### 4] Actor specificity:

#### A] Governments must aggregate since every policy benefit 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.

#### 5] No act-omission distinction—governments are responsible for everything in the public sphere, so inaction is implicit authorization of action: they have to yes/no bills, which means everything collapse to aggregation.

#### 6] 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.

**[7] Use epistemic modesty for evaluating the framework debate: that means compare the probability of the framework times the magnitude of the impact under a framework. Prefer:**

**[A] Clash—disincentives debaters from going all in for framework which means we get the ideal balance between topic ed and phil ed—it’s important to talk about contention-level offense**

**[C] Action under one framework isn’t exclusive of action under another.**

Enoch ‘11, David. "Giving Practical Reasons." Philosophers Imprint. The Hebrew University, Mar. 2011. Web. <https://quod.lib.umich.edu/cgi/p/pod/dod-idx/giving-practical-reasons.pdf?c=phimp;idno=3521354.0011.004>.

I should also note something it does not take for the role played by the given reason in the receiver’s practical reasoning to be appropriate. **It is not required that the role be**, as it were, **ultimate**. In other words, it is perfectly consistent with robust reason-giving thus understood that there be a further, fuller, perhaps more basic story of why it is that B does and should take A’s relevant intentions as reason-giving. **Perhaps**, for instance, **B is a simple utilitarian**, and let’s further assume that simple utilitarianism is indeed the true fundamental story about all reasons for action. **If so, B will take A’s request as a reason to [act] if** and only if, and because, **doing so will maximize utility**. But this does not mean that she doesn’t take, in those cases, A’s request to be a (nonultimate) reason. The crucial question is whether the ultimate (or perhaps just more basic) story here is one that goes through the reasongiver’s special intentions identified above (and the receiver’s recognition thereof), as in the case of the utilitarian request-receiver, in which case we may have a case of robust reason-giving; or whether the more basic story here works directly, leaving no role for the specific intentions that make reason-giving robust (as is the case in the dictator’s child example). Cases of this latter type are not, on the account I’m suggesting here, cases of robust reason-giving. And **this seems to me the independently plausible result** here. Notice that the intentions mentioned above do not include something like the intention that B actually Φs. This is so because **A can give B a reason to [act] Φ knowing well that other reasons may be relevant, including possibly stronger reasons not to [act] Φ**.52 Indeed, it seems to me A can make a genuine request that B Φs, all the time acknowledging that if certain other considerations bear on the case, B should not (all things considered) Φ. We do not want to restrict robust reason-giving to just the cases in which the reason-giver intends the given reason to outweigh all others. For similar reasons, **A need not intend that the given reason be the only reason** for which B Φs.

#### Extinction first –

#### 1 – Forecloses future improvement – we can never improve society because our impact is irreversible

#### 2 – Turns suffering – mass death causes suffering because people can’t get access to resources and basic necessities

#### 3 – Moral obligation – allowing people to die is unethical and should be prevented because it creates ethics towards other people

#### 4 – Objectivity – body count is the most objective way to calculate impacts because comparing suffering is unethical

#### 5 – Moral uncertainty – if we’re unsure about which interpretation of the world is true – we ought to preserve the world to keep debating about it

### Underview

#### 1. AFF theory is no RVI, Drop the debater, competing interps, under an interp that aff theory is legit regardless of voters a) infinite abuse since otherwise it would be impossible to check NC abuse b) it would justify the aff never getting to read theory which is a reciprocity issue c) Time crunched 1ar means it becomes impossible to justify paradigm issues and win the shell. And, all neg interps are counter interps since the aff takes an implicit stance on every issue which means any neg theory interp requires an RVI to become offensive.

#### 2. No new 2n arguments and paradigm issues. a) overloads the 2AR with a massive clarification burden b) it becomes impossible to check NC abuse if you can dump on reasons the shell doesn't matter in the 2n. And, neg has access to bidirectional shells which makes neg shells impossible to meet and impact turns your reading of the shells since I’ll always lose on an interpretation. . Fairness is a side constraint since a) your arguments presume they will be evaluated fairly so they concede it’s authority b) It’s a priori question to enaging in the substance debate since it is impossible to objectively evaluate. If they win a reason fairness or the flow doesn’t matter hack against them since they justify an arbitrary decision.

#### 3. And, alternative advocacies don’t negate – a) Resistance strategies exist in relation to agents which means different solutions for different people solves all your offense and justifies the perm b) Doesn’t disprove our general thesis – just because other things are also good doesn’t mean our strategy is bad.

#### 4. Vote against them if I win a response to their arguments – a) Using to justify tricks and theory obfuscate the discussion of actual violence and proves commodification of oppression that turns it into a tool for the ballot b) Turns to reps voters mean you lose since if inclusion is a voter it flows both ways – you causing more is a reason you also lose.

#### 5. The role of the ballot is to weigh the consequences of the plan vs negative argumentation A] anything else moots 6 minutes of AC offense – that ow since fairness is a meta constraint on the evaluation of arguments B] Not weighing the case prevents necessary critical clash and limits their theory to a form of dogmatism.

#### 6. Reject IVI A] no brightline for what an IVI is 2] There are an infinite number of things we could do that are wrong so its unpredictable 3] trivialization disad – calling out small examples of these things in debate makes us used to the violence

#### 7. Since ought entails following a practice, the resolution presupposes that a practice exists Denying that there exists a practice proves the truth of the resolution because simple propositional logic mandates that if the antecedent of a conditional statement is false, then the statement as a whole is trivially held to be true. **SEP**[[1]](#footnote-1), A conditional asserts that if its antecedent is true, its consequent is also true; any conditional [statement] with a true [condition] antecedent and a false consequent must be false. For any other combination of true and false [conditions] antecedents and consequents, the conditional statement is true.

Implications: a) Skep and Pess affirms since denying the conditional that morality exists proves the resolution true b) **If aff is winning I get the ballot, even if the aff isn’t winning I get the ballot c) The aff is a logical syllogism, which means denying any conditional without denying each one and their consequent proves the aff is still true.**

#### 8. If the affirmative framework is “act utilitarianism”, the negative must concede the affirmative framework. A] Strat Scew: New framing forces a 1ar restart, but the 2N can dump for 6 minutes, framing out all my substantive offense B] Resolvability: If the judge didn’t have radical freedom, they couldn’t chose to vote for either debate. That means you should auto vote aff since I spoke first. C] Reading theory on why the particular framework chosen is bad, checks against arguments that auto affirm E] Switch Side Debate solves back all of your offense since you can discuss what you want when you affirm

#### Reject pessimism ks:

#### 1] Ontology just proves we live in a world that is currently ableist, not that the world 5,000 years from now must be anti-black.

#### 2] Phenomology of disability; Only objects have ontology IE a table exists and is red. ableist is a social construct and idea, not something that can have physical properties.

#### 3] Pascals wager – 1% risk things can get better means we should try instead of doing nothing.

#### 4] Materialism doublebind: Either material events can effect ontology so material progress can make things better, or material events can’t so the slave trade didn’t put blackness in an ontological position.

### Method

#### Disparities within health are not ontological but formed and maintained by social norms upheld by legal indifference – solving the discriminatory practices of public health is uniquely key as a starting point

Matthew 18, Dayna Bowen. Just medicine: A cure for racial inequality in American health care. NYU Press, 2018. (Resident senior fellow in the Center for Health Policy, who works at the University of Colorado School of Law, the Colorado School of Public Health, and the Center for Bioethics and Humanities at the University of Colorado Health Sciences Center specializes in health and behavioral sciences and her research interests include public health law, poverty, and ethics in health professions)//Elmer

For the past thirty years, medical doctors, social scientists, psychologists, policy analysts, jurists, and a wide spectrum of health care providers have been studying and discussing health inequality in America. Meanwhile, by one estimate, 83,570 minority patients die annually due to health care disparities. Black and brown patients consistently receive inferior medical treatment—fewer angiographies, bypass surgeries, organ transplants, cancer tests, and resections, less access to pain treatment, rehabilitative services, asthma remedies, and nearly every other form of medical care—than their white counterparts. Yet minority patients are sicker and more likely to die than whites from a wide range of diseases and illnesses for which we have data. Certainly, this picture is complicated. For example, health and illness for all racial and ethnic groups follow a social gradient so that minority populations, which disproportionately occupy low socioeconomic strata, also predictably suffer relatively worse health outcomes than whites do. Although it is popular to blame the poor for the their poor healthy by pointing to risky health behaviors, careful studies of nationally representative populations conclude that the significantly higher prevalence of cigarette smoking, alcohol consumption, obesity, and physical inactivity are only one aspect of the relationship between lower socioeconomic status and poor health. Moreover, behavioral disparities must not be taken out of their societal context where unequal exposure to the stress of discrimination, inequitable access to healthy food and built environments, and inferior access to resources generally are integrally associated with many racial and ethnic differences in health behavior. In fact, racial and ethnic differences in health treatment and outcomes persist in multiple studies even after controlling for differences in insurance status, income, education, geography, and socioeconomic status. Researchers have identified numerous structural and individual determinants of these disparities at all levels. These include socioeconomic circumstances such as poverty, inferior education, and segregated housing conditions along with lack of access to healthy food choices or recreational facilities; systemic and organizational contributors such as medical practice settings and sources of insurance; and geographic proximity to care. The economic and social conditions called “social determinants of health” often drive patient-specific contributors to poor health such as poor family health history, diet, and low physical activity. All have been shown to contribute to the disparity of health outcomes experience by ethnic and racial minority patients in the United States. However, this book is about the single most important determinant of health disparities that is not being widely discussed in straightforward terms: this determinant is racial and ethnic discrimination against minority patient populations, an uncontrovertibly significant contributor to health inequality. The evidence that the majority of Americans involuntarily harbor anti-minority prejudices makes it impossible, even immoral, not to examine the impact of unconscious racism on health and health care. Therefore, this book makes a thorough examination of the scientific evidence that does exist to confirm that providers discriminate against patients and patients discriminate against providers. This cycle of discrimination produces inequality throughout the health care system. The inequality itself is not news. But the fact that it is avoidable challenges the complacency that allows the racial and ethnic discrimination that produces them to persist. This book calls for providers, patients, scientists, and jurists to face the uncomfortable truth that although overt racism, prejudice, and bigotry may have subsided in America, racial and ethnic injustice, unfairness, and even segregation in American health care have not. The most tragic proof that racial and ethnic injustice is alive and well is the phenomenon we politely call “health disparities.” The message of this book is that a significant cause of these health disparities is the unconscious racial and ethnic bias that infects our delivery system. Implicit racial and ethnic biases in health care are harmful, avoidable, and unjust. This book charts a way to deal with health and health care disparities as injustices, not merely as inevitable byproducts of human nature or a phenomenon subordinate to biological and social differences. Instead, the argument made here is that health inequality due to unconscious discrimination is a structural malady in need of a system cure. This book lays bare a disturbing contradiction. On one hand, injustice and inequality are anathema to our professed national identity. Yet on the other hand, unconscious bias has become an entrenched and acceptable social norm, empirically demonstrated to control decision-makers not only in health care, but in civil and criminal justice proceedings, law enforcement, employment, media, and education. Unconscious racism has become the new normal. Thus, to defeat inequality due to unconscious racism in health care, individuals as well as institutions must realign themselves away from this social norm that is incongruous with the core underlying values to which our nation’s doctors, patients, and health care professionals expressly aspire. The solutions this book proposes are comprehensive; they have their origin in law, and to some this may seem radical. But they are solutions grounded in a historical and empirical record. The solutions are further supported by original, qualitative interviews reported here. These narratives allow doctors, nurses, and patients to bring their voices and real-life experiences to bear on a worthy cause: achieving justice and equity in American health care. Chapter 1 recounts the historical origins of legally enforced discrimination that have laid the structural foundations for African, Asian, Hispanic, and Native Americans to suffer inferior health outcomes in the United States since this country’s inception. I argue that law has directly influenced the differences in health and health care experiences between minorities and whites throughout our nation’s history. When laws enforced slavery, segregations, and nationalism, minority health fared poorly. During the periods of our history when civil rights laws were effectively used to desegregate health care and promote equal access, health care disparities improved. Today, however, traditional civil rights laws have become irrelevant in the effort to bring justice to health care. Those antidiscrimination laws punish only outright bigotry and the most virulent forms of racism. Now that these forms of overt racism are out of vogue and mostly absent from the health care system, the rule of law has been neutralized and no longer controls racial discrimination. Therefore, the great American traditional of running two separate and unequal medical systems for white and non-white patients is back. Chapter 2 explains the nature and evidence of discrimination in contemporary health care. The quantitative and qualitative data gathered in this chapter explain that health care providers unintentionally discriminate against racial and ethnic minority patients—and that their unintentional discrimination directly and substantially contributes to ethnic and racial health care disparities. Moreover, the evidence also shows that patients hold implicit biases and thus react to providers discrimination through the lens of their own experiences with race bias and inequity. The result is a viciously reciprocal cycle of miscommunication between doctors and patients that ultimately harms patients’ health. When patients perceive or experience discrimination arising from implicit biases, they often respond rationally by seeking to minimize the reoccurrence of the offense. Thus, minority patients are more likely to switch providers, less likely to follow up on or adhere to their doctors’ advice, and more likely to generally distrust their providers. Decreased patient satisfaction and decreased continuity of care follow, to the detriment of minority health outcomes. Much of the current discourse on health disparities “blames the victim,” charging patients with non-adherence and with poor diet and living choices or alleging the existence of biologically based justifications for inequality. My analysis of patient bias does not belong to this genre. Instead, I employ the evidence that patients unconsciously react negatively to unconscious racism to explain how implicit bias is a culprit on both sides of the clinical encounter, which occurs within a structurally unsound environment that in turn reinforces bias. Chapter 3 presents a preponderance of evidence showing that providers’ disparate treatment of their minority patients is closely associated with their implicit racial and ethnic biases. This chapter identifies physicians’ unconscious racism as a primary contributor to health disparities. Chapters 4, 5, and 6 present the Biased Care Model, one of this book’s core contributions to advance our understanding of health and health care disparities. The Biased Care Model organizes the best social science literature on implicit bias into a conceptual framework to answer important, but hitherto unresolved questions raised by the Institute of Medicine in its landmark 2003 report on American health disparities. Specifically, the Biased Care Model identifies the mechanisms by which implicit biases affect disparate health outcomes. The model explains how health providers continue to discriminate against minority patients even as polls and surveys tell us that most Americans, especially doctors, are decidedly not racists. The model’s mechanisms are grounded in empirical literature and are supported by the voices of doctors and patients whose interviews confirm the presence and influences of implicit biases in their clinical experiences. Thus, the rich qualitative and quantitative data that supports the Biased Care Model spans three chapters. Chapter 4 describes the impact implicit biases have before a physician and patient meet, chapter 5 discusses the role of implicit biases during the clinical encounter, and chapter 6 examines the mechanisms that permit implicit biases to continue contributing to health disparities even after the clinical encounter ends. The questions these chapters confront are tough, and the facts are uncomfortable. The answers the Biased Care Model provides fill an important void in our understanding of the way health inequalities evolve, and thus they lay the foundation for fashioning evidence-based policy solutions. Chapter 7 introduces an evidentiary “game changer” in the discourse about addressing implicit bias in health care. This chapter explains the social science evidence that implicit racial and ethnic biases are malleable. Contrary to popular fiction, unconscious racism is neither inevitable nor unalterable. This chapter is full of evidence that confirms that the habit of acting out of one’s implicit racial biases can be changed. Therefore, the chapter concludes, health care providers and the institutions that employ them can be held morally responsible for addressing the inequities these biases cause. This chapter opens the way for structural responses to the health disparity crisis. The next chapter explains why responding to this crisis is not only a moral responsibility, but also appropriately a legal one. Chapter 8 answers the question that will plague many health care providers who read this book, especially those who are sympathetic to the cause of justice and equality in health care: Why do we need a law to deal with implicit bias? The short answer is that other avenues will simply not work. Political efforts at universalizing access, regulatory efforts at enforcing cultural competency, and private efforts at “doing the right thing” have all failed. At best, these well-intentioned efforts have only reinforced the culture in which it is assumed that explicit racial motives have little remaining influence on health disparities today. Implicit biases are not entirely impervious to these programs and policies, but the public health policy literature helps to explain why they are insufficient solutions. The more complete answer is that health care disparities are rooted in structural inequities and therefore require a structural solution. Consequently, the legal reforms I propose will change the context in which health care is delivered and shift the social norm that has tolerated health inequality for far too long. The policy problem presented by health care disparities has both the good and bad fortune to be a late-comer to the list of complex practical conundrums that fundamentally challenge broad constitutionally protected American values such as racial equality and justice, but require interventions at the intersection of law and science to solve. For example, law has joined with scientific expertise to help regulate the evolving challenges presented by climate change, genetically modified foods. and pharmacogenomics just to name a few examples. Accordingly, chapter 8 makes the case for strengthening legal interventions to promote health equality. Chapter 9 proposes concrete reforms founded on legal and scientific solutions to the problem of racial and ethnic health disparities. This chapter challenges current antidiscrimination law’s “naive” assumption that humans act solely in accordance with their explicit and conscious intentions. In fact, the scientific evidence indicates that we all act much more consistently with our unconscious and implicit intentions. I compare the assumptions about human behavior that underlie the current law to what we know about real human behavior as it impacts health and health care, and I argue that antidiscrimination law should better match reality. I conclude with an appeal for action directed towards the four stakeholder groups I hope to impact most: social scientists, health care providers, law and policy-makers, and patients. I ask each group to consider its role in eradicating health inequality and to consider this book’s broader implications for the fight for racial and ethnic equality beyond health care. While my focus here is on unconscious racism, I do not overlook other determinants of health disparities that will not succumb to legal remedies. Changing only the law will not solve the socioeconomic disparities that lie at the foundation of our society and produce the poor health experienced by many poor people. Yet neither do I use the complexity of the problem and its causes as an excuse to avoid forthrightly addressing the pervasiveness of discriminatory health care. I also cannot shrink from confronting implicit racial bias due to a seemingly paralyzing fear that doing so is the equivalent of charging health care providers with outright racism and bigotry. The cure for this paralysis is an accurate understanding that implicit and unconscious biases are facts of American life that contradict and work against most Americans’ true intentions. Physicians are no exception; they need not be racist to discriminate against racial minorities. Nevertheless, discrimination due to implicit bias must be addressed because it unnecessarily decreases the quality and length of life of people in this country who are not white. Distinguishing overt from unconscious racism frees us to honestly and candidly address the problem of providers’ implicit bias. In the process. we will see that the scientific evidence is legally sufficient to warrant or even mandate reform of antidiscrimination law. I reach one primary conclusion in this book. It is that the presently available social science evidence associating implicit racial and ethnic bias with health disparities provides a morally compelling and legally sufficient basis for legal action. A sufficient stack of “further research” –the social scientist’s beloved refrain—could not be generated fast enough to slow the devastating effects of implicit bias on the lives of tens of thousands of minority patients each year. Ignoring health disparities due to discrimination is costly. In addition to the nearly 84,000 people of color who needlessly lose their lives annually due to health disparities, there are significant economic burdens imposed by health care discrimination. A 2009 report by the Joint Center for Political and Economic Studies estimated that eliminating health disparities would have reduced direct medical care expenditures by $229.4 billion and indirect costs due to illness and premature death by approximately $1 trillion during 2003-2006. Therefore, the pages that follow unite the medical, neuroscientific, psychological, and sociological expertise on the issue of implicit bias and health disparities with the powerful influence of explicit and enforceable rules of law to devise an effective and innovative plan to reduce implicit biases in health care and eliminate the inequity they cause so that all in America can enjoy a just, humane health care system, regardless of color, race, or national origin.

#### Debates surrounding health policies are good.

Shelton 17, Rachel C., Derek M. Griffith, and Michelle C. Kegler. "The promise of qualitative research to inform theory to address health equity." Health Education & Behavior 44.5 (2017): 815-819. (Assistant Professor, Sociomedical Sciences, Columbia University)//Elmer

In the 30 years since the 1985 Secretary’s Task Force Report on Black and Minority Health was released (Heckler, 1985), the 20 years since Society of Public Health Education (SOPHE) published its first research agenda (Clark & McLeroy, 1995), and the decade since the Inaugural SOPHE Summit on Eliminating Racial and Ethnic Health Disparities (Airhihenbuwa, 2006), the patterns of health and illness in the United States continue to tell a story of societal inequity. Whether implicit or explicit, theory is critical in that it serves as a lens through which we can view the contours of health issues and inequities. Given our modest progress in reducing health disparities over the past 20 years, it is possible that our current theories are not directing us to the priority determinants, which, if modified, could enable us make significant progress in achieving health equity. It is also plausible that the theory-based change strategies and interventions that researchers and practitioners typically implement fall short of what is needed to create significant changes to redress structural, social, and historical injustices that have contributed to health disparities. Qualitative methods are uniquely poised to offer insight into not just the theory of the problem but insight into the principles and theories that may be the best candidates on which to build an intervention (McLeroy et al., 1993). Yet qualitative methods (used on their own or in the context of mixed-methods research) tend to be perceived within the scientific community as less valuable and important than quantitative methods in the context of health disparities research. To understand the perspectives, context, and daily lives and experiences that shape health, qualitative research is essential. Particularly in the context of health education and health promotion, qualitative research has provided critical insights into the factors that shape modifiable determinants of health across all levels of the ecological model (McLeroy, Bibeau, Steckler, & Glanz, 1988). Previously, there has been little critical or systematic consideration of how qualitative research could be used to advance research on health disparities or health equity in our field. In this commentary, we reflect on some of the theoretical and conceptual challenges facing health disparities and health equity research and highlight how qualitative methods provide important and unique insights that inform future research and practice. Role of Theory In health education and health promotion, we discuss the theory of the problem and change theories or theories of action (Glanz, Rimer, & Viswanath, 2015). Theories of the problem are explanatory and help identify and describe determinants of a problem and identify modifiable factors that can be prioritized for change (Glanz et al., 2015). Theories of change inform how to design intervention strategies that will influence priority determinants and also help pinpoint logical short-term and intermediate outcomes for logic models and evaluation efforts (Bartholomew, Parcel, Kok, Gottlieb, & Fernandez, 2011; Crosby, Kegler, & DiClemente, 2009; Eldredge, Markham, Ruiter, Kok, & Parcel, 2016; Glanz et al., 2015). Thus, theories provide an organizing framework for our research and practice by systematically guiding us toward constructs to target with our interventions and organize our evaluation and research results. Despite growing recognition of the importance of broader organizational, community, and policy-related factors in shaping health and health disparities, our field’s tendency to use theories at the individual and interpersonal levels is well documented (Golden & Earp, 2012; Painter, Borba, Hynes, Mays, & Glanz, 2008). Even our program and intervention planning models, which allow for selection of constructs from a range of theories depending on the identified determinants (Airhihenbuwa, 1995; Bartholomew et al., 2011; Green & Kreuter, 2005; Iwelunmor, Newsome, & Airhihenbuwa, 2014), largely rely on our existing theories to shape the questions we ask and how we go about addressing the identified determinants. In the context of informing efforts to pursue health equity, however, the challenge is that few of our theories specify how constructs intersect and interact across levels, and which of these are most powerful in explaining behavior and the environmental conditions that create, maintain, or exacerbate disparities. Moreover, our theories **generally** **do not provide guidance** as to which causal pathways are most likely to specifically reduce disparities and in which populations (Diez Roux, 2012). Additionally, theories at the higher levels of the social ecology are less likely to be operationalized and measured in a manner consistent with our quantitative research methods, which may present barriers to more widespread application. Furthermore, with some rare exceptions (e.g., critical race theory/public health critical race praxis; Ford & Airhihenbuwa, 2010a, 2010b), our existing theories in health behavior and health education neither critically examine nor address the important fundamental causes of health, including the social and political determinants that may be at the root of health inequities. Given the nature of short-term grant and budget cycles (and prohibitions on lobbying with federal funds), it is not surprising that the theories most typically pursued in our field focus on proximal or short-term outcomes and what is perceived as more easily addressable determinants of health. Therefore, as a field, we do not typically recognize or attempt to address historical and ongoing societal factors that have implications for health disparities like racism and power. The Promise of Qualitative Methods In considering how qualitative research might advance theory pertinent to health equity, it is first important to recognize that experts approach the application of theory in research from a variety of perspectives. Hennink, Hutter, and Bailey (2011) describe an interplay between deductive and inductive reasoning in their approach and describe how theory is central in the design phase with a clear role in framing research questions and informing conceptual models and frameworks (Hennink et al., 2011). Depending on the goal and context of the research, the analytic process can involve developing inductive theory or applying deductive codes from the research questions, existing theory, or conceptual frameworks. Hennink et al. (2011) argue there is always a theory underlying research and making it explicit is essential, typically in the form of a conceptual framework to guide the research (e.g., categories of questions asked, coding, organization of data, and results; Hennink et al., 2011). Patton (2015) describes theory primarily within the context of sampling and analysis. For example, he describes deductive theoretical sampling for deepening or verifying theory-derived constructs, giving examples such as resilience, trauma, and respect. He also describes inductive grounded theory sampling in which the sample is constructed as the emerging theory begins to take shape and evolves from exploratory to verification. These examples highlight that there is a vast array of opportunities for theory to inform disparities-oriented research. To date, however, there has been relatively little attention paid to the use of qualitative research to advance theory in the area of health disparities and health equity. The volume of literature describing health disparities and discussing strategies to eliminate health disparities has not made strong conceptual or empirical distinctions between minority health promotion and health disparities elimination (Srinivasan & Williams, 2014). While both outcomes are important and deserve attention, it is likely that each has different determinants and intervention strategies that matter most; as such, the theoretical and conceptual frameworks used to study them may also be different. Furthermore, there are some limitations to relying predominately on a comparative approach that has become the cornerstone of health disparities research in recent years (Bediako & Griffith, 2007). In this context, qualitative methods can play an important role in how we understand and describe the problem of health inequities and their determinants. Not only can these approaches help illuminate social, cultural, and political factors that may underlie health disparities, but qualitative approaches are also uniquely positioned to document and contextualize how these factors affect health across levels of the social–ecological framework in a more nuanced and in-depth way. Qualitative methods also have the potential to illuminate new theories of change, particularly those that operate at higher levels of the social ecological framework, as well as interactions between constructs at varying levels of the framework. Providing insight into how well-accepted theoretical constructs should be operationalized or adapted for specific subpopulations (e.g., social norms, social capital, intention, or attitudes; Burke, Bird, et al., 2009; Pasick, Barker, et al., 2009; Pasick, Burke, et al., 2009) is another potential strength of a qualitative approach. By acknowledging the complex interplay of factors that influence and underlie health disparities, social ecologic approaches that have been informed by qualitative methodologies may provide a good blueprint for moving toward health equity. While qualitative methods offer these possibilities, according to Hennink et al. (2011), without theory development of some kind, qualitative research ends purely in description, which does not explain a phenomenon and neglects to answer “how” and “why” questions (Hennink et al., 2011). Similarly, Patton (2015) states that “much qualitative inquiry stops at reporting the explanations of the people studied” (p. 583) without attempting further qualitative causal analysis. He further acknowledges that asserting that qualitative analysis can yield causal explanations remains controversial, and this is undoubtedly true in health education and health promotion as well. This may relate in part to the tendency by qualitative researchers to downplay or minimize the generalizability of findings, often due to relatively small sample sizes, which is in sharp contrast to quantitative research that seeks to highlight the generalizability and reproducibility of its findings. However, we encourage our fellow qualitative researchers to go further with our studies and make a concerted (and well-documented) effort to develop, extend, or refine theory within the context of trying to figure out how to reduce health disparities, and when appropriate, to highlight any insights that are consistent with prior work and could be scaled up and tested on a broader scale. Moving Forward To make real progress in addressing health disparities and moving toward health equity will require a renewed commitment to and deeper understanding of qualitative research on the part of health disparities researchers in our field. In particular, we encourage researchers to move beyond only descriptive documentation of disparities toward thinking about mechanisms and theory building and refining, with an eye toward informing interventions, strategies, and health promotion messaging in public health and clinical contexts. Through this process, it will be important that researchers refrain from relying only on individual and interpersonal theories, and begin explicitly incorporating behavior change theories with theories at the social, organizational, community, and policy levels, and consider how factors interact synergistically across levels. While we agree that the field should be selective and parsimonious with respect to the development of new theories (Glanz et al., 2015), we also assert that with respect to promoting health equity, there is room for the development of new theories and refinement of theoretical constructs, particularly for those pertaining to the social, organizational, community, and policy levels. Building theoretical and conceptual frameworks and models that can be applied across multiple levels is highly pertinent to disparities research in several ways. First, these theories are more likely to address the larger societal and social factors that shape disparities and can help researchers identify which factors matter most across levels (e.g., what is most relevant and meaningful for a population), and should therefore be prioritized as intervention or policy targets. While most research to date has focused on using qualitative research to provide insight into the populations experiencing inequities, we recommend researchers use qualitative research to advance understanding of “behaviors in context,” and the settings and social context in which disparities arise (Burke, Joseph, Pasick, & Barker, 2009; Okechukwu, Davison, & Emmons, 2014). This includes investigating the contexts in which interventions to address disparities are implemented, with an eye toward theory building and theory refinement. Second, we encourage researchers to move beyond approaching health disparities largely as a single dimension toward considering the possible intersectionality of social dimensions that have implications for health equity (Bauer, 2014; Bowleg, 2008). Using qualitative research that is grounded in the daily experiences of people’s lives may help address the methodological challenges of thinking about social categories as additive and instead frame them as related and intersecting social structures that create and recreate social disadvantage and health inequity. There are also many opportunities for researchers to use more community-engaged, participatory, and action-oriented theories and frameworks that not only focus narrowly on health disparities but also encourage an assets-based approach that focuses on promoting health equity (Grieb, Smith, Calhoun, & Tandon, 2015; Wallerstein & Duran, 2006). This Commen-tary is consistent with Bowleg’s (2017) Perspective in Health Education & Behavior, which advocates for the wider use of critical theoretical frameworks in health equity research. In making advances in this area, it is also clear that we have much to learn from other disciplines that have rich histories in both theory and qualitative research, including anthropology, history, and sociology (Chowkwanyun, 2011; Hirsch, Wardlow, & Smith, 2009; Livingood et al., 2011; Livingood, Allegrante, & Green, 2016; Nathanson, 2007; Pasick & Burke, 2008). Of note, these fields have also incorporated a much broader range of qualitative approaches in their research (e.g., textual analysis, comparative ethnography) that we encourage researchers to explore and embrace. Finally, we recommend that in examining health disparity issues, researchers in this area be thoughtful and detailed in the social dimension and lenses through which they are grouping “disparity” populations, as there is tremendous diversity and heterogeneity within groups (e.g., documented differences among Latinos in health disparities and determinants of health by country of origin; Shelton, Jandorf, Thelemaque, King, & Erwin, 2012). This will help increase the likelihood that interventions will be developed or adapted with cultural specificity when needed (e.g., when the determinants are unique to that population) or will help identify when there are commonalities across social groups that can be addressed across disparity populations (Emmons, Barbeau, Gutheil, Stryker, & Stoddard, 2007; Goldman et al., 2003). In addition, qualitative research can be used to inform the operationalization and measurement of constructs that may be newly identified within a social context and/or are culturally specific (Airhihenbuwa, 2006; Airhihenbuwa & Liburd, 2006). In conclusion, we believe there is much work to do to make progress in both eliminating health disparities and promoting health equity. In fact, in examining qualitative research focused on promoting health equity, the majority of research, including the rich scholarship featured in this special issue, focuses on the methodological and intervention implications of their research findings. However, we also believe that there are tremendous opportunities for qualitative and health equity scholars to advance research and practice in this area through the expansion and application of rigorous, theoretically informed qualitative research. We hope researchers will recognize and seize this challenging, but critically important opportunity.

1. STANFORD PHILOSOPHY <http://www.stanford.edu/~bobonicha/dictionary/dictionary.html> Abbreviated Dictionary of Philosophical Terminology An introduction to philosophy Stanford University [↑](#footnote-ref-1)