### Framework

#### Because the resolution asks what we *ought* to do, my value is Morality.

#### Debaters shouldn’t have to prove oppression is bad.

Alston & Timmons 14, Jonathan Alston and Aaron Timmons, 4-28-2014, “Nobody Knows the Trouble I See” (And In National Circuit Lincoln-Douglas Debate, Does Anyone Really Care?), https://www.vbriefly.com/2014/04/28/20144nobody-knows-the-trouble-i-see-and-in-national-circuit-lincoln-douglas-debate-does-anyone-really-care/, 8-10-2021

Above are statements that we and our students have heard from judges. There are many other equally offensive statements that can be shared. It seems like the statements above, and similar comments, have become more frequent. Recently the National Symposium on Debate featured a strategy article by Emily Massey, Geoffrey Kristoff and Grant Reiter that inadvertently—I do not believe that they fully understand the implication of their words—perpetuates the hateful and hostile atmosphere that exists in high school Lincoln-Douglas debate. Hundreds of students around the country are coached to say that oppression, rape, genocide, and lynching are not inherently bad. “You have to explain why they’re bad,” say many respected leaders in the community. Instead of engaging in a debate about the best methods to prevent, reduce, mitigate, eradicate oppression, too many adults, coaches, and judges in high school Lincoln-Douglas debate believe a more “strategic” conversation is to talk about the philosophy that justifies why such things are bad. But doesn’t having to prove rape is bad open up the possibility that it is not?

#### Mitigating structural violence is necessary to prevent flawed moral exclusion.

Opotow 11 (Susan Opotow is a social psychologist and justice researcher at the City University of New York. Her research examines the scope of justice over time, as well as exclusionary and inclusionary change in a range of contexts that include: environmental degradation, societal changes after the USA Civil War and World War II, and museums that represent past injustice. She was Editor of Peace and Conflict: Journal of Peace Psychology) “Social Injustice,” Peace, Conflict, and Violence: Peace Psychology for the 21st century, Englewood Cliffs, New Jersey: Prentice-Hall, 2001, BE)

Both structural and direct violence result[s] from moral justifications and rationalizations. Morals are the norms, rights, entitlements, obligations, responsibilities, and duties that shape our sense of justice and guide our behavior with others (Deutsch, 1985). Morals operationalize our sense of justice by identifying what we owe to whom, whose needs, views, and well-being count, and whose do not. Our morals apply to people we value, which define who is inside our scope of justice (or “moral community”), such as family members, friends, compatriots, and coreligionists (Deutsch, 1974, 1985; Opotow, 1990; Staub, 1989). We extend considerations of fairness to them, share community resources with them, and make sacrifices for them that foster their wellbeing (Opotow, 1987, 1993). We see other kinds of people such as enemies or strangers outside our scope of justice; they are morally excluded. Gender, ethnicity, religious identity, age, mental capacity, sexual orientation, and political affiliation are some criteria used to define moral exclusion. Excluded people can be hated and viewed as “vermin” or “plague” or they can be seen as expendable non-entities. In either case, disadvantage, hardship, and exploitation inflicted on them seems normal, acceptable, and just—as “the way things are” or the way they “ought to be.” Fairness and deserving seem irrelevant when applied to them and harm befalling them elicits neither remorse, outrage, nor demands for restitution; instead, harm inflicted on them can inspire celebration. Many social issues and controversies, such as aid to school drop-outs, illegal immigrants, “welfare moms,” people who are homeless, substance abusers, and those infected with HIV are essentially moral debates about who deserves public resources, and thus, ultimately, about moral inclusion. When we see other people’s circumstances to be a result of their moral failings, moral exclusion seems warranted. But when we see others’ circumstances as a result of structural vio- 4 lence, moral exclusion seems unwarranted and unjust. Psychological Bases for Moral Exclusion While it is psychologically more comfortable to perceive harm-doers to be evil or demented, we each have boundaries for justice. Our moral obligations are stronger toward those close to us and weaker toward those who are distant. When the media reports suffering and death in Cambodia, El Salvador, Nicaragua, the former Yugoslavia, and Rwanda, we often fail—as a nation, as communities, and as individuals—to protest or to provide aid. Rationalizations include insufficient knowledge of the political dynamics, the futility of doing much of use, and not knowing where to begin. Our tendency to exclude people is fostered by a number of normal perceptual tendencies: 1. Social categorization. Our tendency to group and classify objects, including social categories, is ordinarily innocuous, facilitating acquisition of information and memory (Tajfel & Wilkes, 1963). Social categorizations can become invidious, however, when they serve as a basis for rationalizing structural inequality and social injustice. For example, race is a neutral physical characteristic, but it often becomes a value-loaded label, which generates unequal treatment and outcomes (Archer, 1985; Tajfel, 1978). 2. Evaluative judgments. Our tendency to make simple, evaluative, dichotomous judgments (e.g., good and bad, like and dislike) is a fundamental feature of human perception. Evaluative judgments have cognitive, affective, and moral components.

#### Your ballot should be oriented toward minimizing Structural Violence:

#### The logic of “any risk” util collapses on itself

Santos 3 2003, Boaventura de Souza Santos is a Professor of Sociology at the University of Coimbra, “Collective Suicide?”, Bad Subjects, Issue # 63 , http://www.ces.fe.uc.pt/opiniao/bss/072en.php

According to Franz Hinkelammert, the West has repeatedly been under the illusion that it should try to save humanity by destroying part of it. This is a salvific and sacrificial destruction, committed in the name of the need to radically materialize all the possibilities opened up by a given social and political reality over which it is supposed to have total power. This is how it was in colonialism, with the genocide of indigenous peoples, and the African slaves. This is how it was in the period of imperialist struggles, which caused millions of deaths in two world wars and many other colonial wars. This is how it was in Stalinism, with the Gulag and in Nazism, with the holocaust. And now today, this is how it is in neoliberalism, with the collective sacrifice of the periphery and even the semiperiphery of the world system. With the war against Iraq, it is fitting to ask whether what is in progress is a new genocidal and sacrificial illusion, and what its scope might be. It is above all appropriate to ask if the new illusion will not herald the radicalization and the ultimate perversion of the western illusion: destroying all of humanity in the illusion of saving it. Sacrificial genocide arises from a totalitarian illusion that is manifested in the belief that there are no alternatives to the present-day reality and that the problems and difficulties confronting it arise from failing to take its logic of development to its ultimate consequences. If there is unemployment, hunger and death in the Third World, this is not the result of market failures; instead, it is the outcome of the market laws not having been fully applied. If there is terrorism, this is not due to the violence of the conditions that generate it; it is due, rather, to the fact that total violence has not been employed to physically eradicate all terrorists and potential terrorists. This political logic is based on the supposition of total power and knowledge, and on the radical rejection of alternatives; it is ultra-conservative in that it aims to infinitely reproduce the status quo. Inherent to it is the notion of the end of history. During the last hundred years, the West has experienced three versions of this logic, and, therefore, seen three versions of the end of history: Stalinism, with its logic of insuperable efficiency of the plan; Nazism, with its logic of racial superiority; and neoliberalism, with its logic of insuperable efficiency of the market. The first two periods involved the destruction of democracy. The last one trivializes democracy, disarming it in the face of social actors sufficiently powerful to be able to privatize the State and international institutions in their favour. I have described this situation as a combination of political democracy and social fascism. One current manifestation of this combination resides in the fact that intensely strong public opinion, worldwide, against the war is found to be incapable of halting the war machine set in motion by supposedly democratic rulers. At all these moments, a death drive, a catastrophic heroism, predominates, the idea of a looming collective suicide, only preventable by the massive destruction of the other. Paradoxically, the broader the definition of the other and the efficacy of its destruction, the more likely collective suicide becomes. In its sacrificial genocide version, neoliberalism is a mixture of market radicalization, neoconservatism and Christian fundamentalism. Its death drive takes a number of forms, from the idea of "discardable populations", referring to citizens of the Third World not capable of being exploited as workers and consumers, to the concept of "collateral damage", to refer to the deaths, as a result of war, of thousands of innocent civilians. The last, catastrophic heroism, is quite clear on two facts: according to reliable calculations by the Non-Governmental Organization MEDACT, in London, between 48 and 260 thousand civilians will die during the war and in the three months after (this is without there being civil war or a nuclear attack); the war will cost 100 billion dollars, enough to pay the health costs of the world's poorest countries for four years. Is it possible to fight this death drive? We must bear in mind that, historically, sacrificial destruction has always been linked to the economic pillage of natural resources and the labor force, to the imperial design of radically changing the terms of economic, social, political and cultural exchanges in the face of falling efficiency rates postulated by the maximalist logic of the totalitarian illusion in operation. It is as though hegemonic powers, both when they are on the rise and when they are in decline, repeatedly go through times of primitive accumulation, legitimizing the most shameful violence in the name of futures where, by definition, there is no room for what must be destroyed. In today's version, the period of primitive accumulation consists of combining neoliberal economic globalization with the globalization of war. The machine of democracy and liberty turns into a machine of horror and destruction.

### Plan

#### The member nations of the World Trade Organization ought to reduce intellectual property protections for medicines.

### Advantage

#### IPRs are uniquely harmful during a pandemic: three internal links.

#### incentivise companies to block global vaccination during pandemics.

Lindsey 21 [Brink Lindsey, Vice President and Director of the Open Society Project at the Niskanen Center. “Why intellectual property and pandemics don’t mix”. 6-3-2021. Brookings. https://www.brookings.edu/blog/up-front/2021/06/03/why-intellectual-property-and-pandemics-dont-mix/. Accessed 8-9-2021; MJen]

For pandemics and other public health emergencies, patents’ mix of costs and benefits is misaligned with what is needed for an effective policy response. The basic patent bargain, even when well struck, is to pay for more innovation down the road with slower diffusion of innovation today. In the context of a pandemic, that bargain is a bad one and should be rejected entirely. Here the imperative is to accelerate the diffusion of vaccines and other treatments, not slow it down. Giving drug companies the power to hold things up by blocking competitors and raising prices pushes in the completely wrong direction. What approach to encouraging innovation should we take instead? How do we incentivize drug makers to undertake the hefty R&D costs to develop new vaccines without giving them exclusive rights over their production and sale? The most effective approach during a public health crisis is direct government support: public funding of R&D, advance purchase commitments by the government to buy large numbers of doses at set prices, and other, related payouts. And when we pay drug makers, we should not hesitate to pay generously, even extravagantly: we want to offer drug companies big profits so that they prioritize this work above everything else, and so that they are ready and eager to come to the rescue again the next time there’s a crisis. It was direct support via Operation Warp Speed that made possible the astonishingly rapid development of COVID-19 vaccines and then facilitated a relatively rapid rollout of vaccine distribution (relative, that is, to most of the rest of the world). And it’s worth noting that a major reason for the faster rollout here and in the United Kingdom compared to the European Union was the latter’s [misguided penny-pinching](https://www.nytimes.com/2021/05/17/opinion/europe-vaccines-commission.html?smid=tw-share). The EU bargained hard with firms to keep vaccine prices low, and as a result their citizens ended up in the back of the queue as various supply line kinks were being ironed out. This is particularly ironic since the Pfizer-BioNTech vaccine was developed in Germany. As this fact underscores, the chief advantage of direct support isn’t to “get tough” with drug firms and keep a lid on their profits. Instead, it is to accelerate the end of the public health emergency by making sure drug makers profit handsomely from doing the right thing. Patent law and direct support should be seen not as either-or alternatives but as complements that apply different incentives to different circumstances and time horizons. Patent law provides a decentralized system for encouraging innovation. The government doesn’t presume to tell the industry which new drugs are needed; it simply incentivizes the development of whatever new drugs that pharmaceutical firms can come up with by offering them a temporary monopoly. It is important to note that patent law’s incentives offer no commercial guarantees. Yes, you can block other competitors for a number of years, but that still doesn’t ensure enough consumer demand for the new product to make it profitable. What matters isn’t the existence or size of the profits, but how they are earned. We have good reason to want drug makers to profit from vaccinating the world: the comparative price is minuscule, and the incentive effects are a vital safeguard of public health in the event of future crises. What we want to avoid at all costs is putting drug makers in the position where drug companies can profit from standing in the way of rapid global vaccination. That is why intellectual property rights need to be taken out of the equation. Vaccinating the world in any kind of reasonable time frame will require large-scale technology transfer to drug firms in other countries and rapid expansion of their production capacity. And looking beyond the current pandemic to the longer term, we need [ample, redundant global vaccine production capacity](https://www.vox.com/future-perfect/22397914/vaccine-mrna-adenovirus-manufacturing-process-investment) that is widely distributed around the planet. To achieve these goals as rapidly as possible will require the active cooperation of the U.S. pharmaceutical industry, which is why the direct support model now needs to be extended. What is needed now is an Operation Warp Speed for the world, in which we make it worth current vaccine producers’ while to share their know-how broadly and ramp up global capacity. Here again, we must recognize that the choice isn’t between people on the one hand and profits on the other. Rather, the key to good pandemic response policy is ensuring that incentives are structured so that drug company profit-seeking and global public health are well aligned. That means opting out of the default, decentralized patent bargain in favor of generous but well-focused direct government support. **DIRECT SUPPORT MAKES PATENTS REDUNDANT** The situation is different in a pandemic. Here the government knows exactly what it wants to incentivize: the creation of vaccines to prevent the spread of a specific virus and other drugs to treat that virus. Under these circumstances, the decentralized approach isn’t good enough. There is no time to sit back and let drug makers take the initiative on their own timeline. Instead, the government needs to be more involved to incentivize specific innovations now. As recompense for letting it call the shots (pardon the pun), the government sweetens the deal for drug companies by insulating them from commercial risk. If pharmaceutical firms develop effective vaccines and therapies, the government will buy large, predetermined quantities at prices set high enough to guarantee a healthy return.

#### Protections favour rich countries at the expense of low income countries.

Baker ‘04 (Brook K. Baker; Professor at Northeastern School of Law, member of the Health Global Access Project; 01-03-2004; "View of Arthritic Flexibilities for Accessing Medicines: Analysis of WTO Action Regarding Paragraph 6 of the Doha Declaration on the TRIPS Agreement and Public Health"; https://journals.iupui.edu/index.php/iiclr/article/view/17822/17992, Indiana International and Comparative Law Review; Vol. 14 No. 3, accessed 7-22-2021; JPark)

It is against this backdrop of millions of lives lost needlessly every year that one must judge the world's hesitant and often counter-productive response to the AIDS pandemic and other health problems in developing countries and applaud the growing movement to catalyze a robust trade in low-cost generic medicines. The enormous gap between the need for access to affordable patented medicines and its realization reflects a disconnect between the perceived interests of rich countries in the global North, including the highly profitable proprietary pharmaceutical companies6 that research, develop, and produce patented medicines, and the interests of developing countries in the global South that require life-saving medicines to fight HIV/AIDS and other pandemics that are decimating their poverty-stricken populations. This disconnect occurs at the juncture of national and international intellectual property regimes, especially the World Trade Organization (WTO) Agreement on the Trade Related Aspects of Intellectual Property Rights (TRIPS),7 national and regional capacities to manufacture and market pharmaceutical products efficiently, and global patterns of income inequality and poverty. While rich, developed countries continue to pursue intellectual property protections and trade rules designed to guarantee incentives for innovation by and profits for the proprietary pharmaceutical industry, there is a critical lack of access to medicines essential to counteract disease and to lower the body count of poor people in Africa, Asia, South America, and other developing regions. Developed countries often promote enhanced intellectual property rights, including those of pharmaceutical producers, as important to development, where the rising tide of import-export economies will rehabilitate failed public health sectors and intellectual property protection will promote local research and development of medicines for diseases primarily found in Africa, South America, and Asia. An alternative solution, pursued by developing countries and treatment activists internationally, is the promotion of efficient generic production by a sufficient number of manufacturers at meaningful economiesof-scale so that medicines can be accessed at lowest cost. To enable trade in generic medicines, developing countries and pro-public health activists have launched a broad-based attack on intellectual property rights that hamstring developing countries' ability to respond proportionately to their urgent crises and more prosaic public health needs by making treatment costs prohibitive.

#### Patent protections enable big pharma to keep medicine inaccessible which is terrible for developing nations.

Gurgula 21 Gurgula, Olga(Brunel University London - Brunel Law School; University of Oxford - Oxford Martin School) Drug Prices, Patents and Access to Life-Saving Medicines: Changes Are Urgently Needed in the COVID-19 Era (February 6, 2021). Forthcoming in the European Intellectual Property Review (EIPR) , Available at SSRN: <https://ssrn.com/abstract=3780630> or [http://dx.doi.org/10.2139/ssrn.3780630](https://dx.doi.org/10.2139/ssrn.3780630)

The ability to charge high prices on medicines stems from the legal protection provided by intellectual property rights, and patents in particular. Patents provide exclusive rights to their owners. This means that patent holders have the right to prevent others from using their patent-protected invention, and thus control the manufacture and distribution of such products, including their prices.12 While patents often lead to unaffordably high prices, pharmaceutical companies claim that they need strong patent protection to recoup their investments in R&D.13 The traditional argument put forward by pharmaceutical companies is that there will be no incentives to engage in R&D of important life-saving drugs if there is no strong patent protection.14 To support this claim they typically refer to industry figures placing the cost of developing a single drug above $2.6 billion.15 To incentivise pharmaceutical companies to innovate, the patent system in Europe and the US provides a broad opportunity for strong patent protection by setting a low bar for patentability.16 This enables them to procure numerous patents around a single medicine, thus prolonging its protection well beyond the expiration of a primary patent that protects its active ingredient.17 While relying on patents to extract a competitive edge is not a new practice,18 Walsh et al., reviewing the studies in the field of strategic patenting, argue that the last several decades have shown a significant increase in patenting, 19 with a growing emphasis on strategic or pre-emptive patents. Such patents are filed with strategic purposes to block competitors, creating protection around a technology.20 This could be observed in the pharmaceutical industry, where a low bar for patentability coupled with the strategic motives by pharmaceutical companies has led to a significant increase in patenting in the pharmaceutical industry.21 The European Commission found during its Pharmaceutical Sector Inquiry that while before the 1980s pharmaceutical companies tended to protect their products by one patent,22 nowadays they move towards broader and more numerous patents23 ‘surrounding the first patents of a successful compound and its product in order to protect their position’.24 Several recent studies provide evidence of the abusive nature of strategic patenting by pharmaceutical companies. The IMAK analysis of the top blockbusters in the US reveals that ‘[f]our of the top twelve drugs have already been on the market for 20 years and have pending patent applications seeking to extend patent life to 2033 (Herceptin, Genentech), 2030 (Rituxan, Biogen/Genentech), 2029 (Enbrel, Amgen), and 2025 (Remicade, Janssen)’.25 They conclude that ‘patents are used by drug makers for the purpose of forestalling generic competition while continuing to increase the price of these drugs’.26 Another study found that ‘pharmaceutical companies are recycling and repurposing old [drugs].27 On average, ‘78% of the drugs associated with new patents were not new drugs coming on the market, but existing drugs’ and that ‘[a]dding new patents and exclusivities to extend the protection cliff is particularly pronounced among blockbuster drugs. Of the roughly 100 best-selling drugs, almost 80% extended their protection at least once, with almost 50% extending the protection cliff more than once’.28 Such extensive patent protection enables pharmaceutical companies to prevent competition for a significant period and to continue charging monopoly prices for their products, making them inaccessible for many patients.29 To date, a lack of transparency as to how the pharmaceutical profits are spent has not allowed us to fully examine the justifications for such strong patent protection put forward by pharmaceutical companies With the COVID-19 pandemic threatening the lives of thousands of people every day, our pervasive dependence on private pharmaceutical companies has become apparent. It is clear today that the current system requires fundamental changes in the way medicinal innovation is conducted, as well as how access to life-saving medicines is secured. Therefore, structural and comprehensive changes will help to facilitate genuine innovation and access to affordable medicines to all. This should include a rigorous investigation into pharmaceutical pricing and patenting practices, ensuring adequate access to the drugs developed with public funds, as well as assuming the responsibility for public health by governments, making pharmaceutical business part of the solution, rather than the only solution. 68 Olga Gurgula and Wen Hwa Lee (n 59). This preprint research paper has not been peer reviewed. Electronic copy available at: https://ssrn.com/abstract=3780630 Preprint no

#### This problem can’t be solved - price regulations fail.

Laforgia et al 07 [Laforgia, Francesco, graduated in Economics and Social Sciences at the Bocconi University in 2002, specializing in innovation economics; Montobbio, Fabio, Economics of Innovations. Economics of Science, Intellectual Property Rights, and Orsenigo, Luigi. RM Phillips Professor of Economics of Innovation at SPRU - Science Policy Research Unit at the University of Sussex “IPRs, technological and industrial development and growth: the case of the pharmaceutical industry”. October 2007. Centre for Research on Innovation and Internationalization. http://oro.open.ac.uk/10107/1/Laforgia\_Montobbio\_Orsenigo\_wp206.pdf. Accessed 8-9-2021; MJen]

Once again, it is very hard to evaluate in general the effects of TRIPs on drug prices. Scarcity of data and the extreme difficulties in computing comparable price indexes (Danzon, 1997; Danzon and Kim 1998) prevent systematic analysis. Clearly such effect will be different across countries. The evidence surveyed by Maskus (2001), suggests, however, a substantial impact. Price increases after introduction of patents were estimated by Watal (2000) and Fink (2000) to range from 50 percent to 200 percent in India, while Baker and Chatani (2002) suggest that the average increase in price for pharmaceuticals due to patent protection is probably close to 400 percent. More specific analyses of specific drugs report that in Brazil free market version of AIDS drugs were available at $200 against $10,000 a year for patent-protected versions (Coriat et al. 2006). Two issues deserve specific attention. First, price regulations certainly have a large role to play in limiting price increases. However, patent holders may choose not to supply the local market at the regulated prices. Moreover, when price regulations are based on “cost-plus” formula, firms are encouraged to set high transfer prices on imported ingredients, leading to potentially higher prices (Lanjouw, 1998). Conversely, when prices are defined on the basis of reference indexes of prices in other markets, firms have an incentive to bargain for the highest possible prices in the lowprice economies in order to gain a higher set of global reference prices (Maskus, 2001). Second, price discrimination is often considered as a possible counter- balance to unaffordable drug prices in poor countries. However, this implies banning parallel imports, an important source of low price drugs in many countries (and a source of exports for producers in developing countries). Further, price discrimination is often viewed as anticompetitive because it allows firms to set prices according to market power in each country. Indeed, Maskus (2001) shows that that prices are often higher in developing nations than would be expected under a simple price discrimination equilibrium and, indeed, are at times higher than in the rich nations.

#### Developing Countries are forced to campaign in order to protect their people.

Shah '20 (Saeed Shah; ; 9-17-2020; "Developing Countries Push to Limit Patent Protections for Covid-19 Vaccines"; <https://www.wsj.com/articles/developing-countries-push-to-limit-patent-protections-for-covid-vaccines-11600355170>; Wall Street Journal; accessed 7-21-2021; JPark)

A group of developing countries, backed by United Nations agencies and activist groups, is pushing to limit patent protections for Covid-19 vaccines being tested by some of the world’s biggest pharmaceutical companies so that inexpensive copies can be produced for poorer nations. South Africa, Ghana, Senegal, Pakistan and others argue they won’t be able to afford to protect their people without lower-cost, generic alternatives to the vaccines now being tested by companies such as Pfizer Inc., AstraZeneca PLC and Moderna Inc. That stance puts the countries at odds with the pharmaceutical industry, which says it supports wide distribution of the vaccines but warns that allowing drugs to be copied would undermine innovation and raise the risk of unsafe vaccines. Albert Bourla, chief executive of Pfizer, has said calls to sidestep patent protections for Covid-19 vaccine are nonsense, and dangerous. The developing countries’ campaign is part of an intense global race to secure supplies of Covid-19 vaccines. Even before the drugs are fully tested, richer countries have struck deals worth billions of dollars to buy up much of the known manufacturing capacity. It is an effort that echoes moves in the late 1990s to reduce the price of drugs used to treat AIDS. After years of being criticized, drugmakers allowed inexpensive generic copies of AIDS drugs to be distributed in some countries. International law permits countries to eliminate patent restrictions in some emergency situations and issue “compulsory licenses” to allow domestic industry to copy a medicine and even export it to other nations in need. South Africa has already called for the intellectual property barriers for Covid-19 vaccines to be lifted at the World Trade Organization. At the United Nations General Assembly this month, the World Health Organization plans to set out operational details of a voluntary patents pool where Covid-19 technology can be shared. Companies would be paid a royalty for the use of their vaccine, but one well below what they could earn otherwise. “We cannot afford to have a monopolistic approach to intellectual property for treatments and vaccines, nor maintain a system which puts profits before the lives of people,” said Winnie Byanyima, executive director of UNAIDS, a U.N. agency set up to combat HIV.

#### Risk of infection is tied to poverty and disproportionately affects marginalized populations

Demenech et al 20 [Lauro Miranda Demenech, Center for Studies on Risk and Health,

Samuel de Carvalho Dumith, Graduate Program in Health Sciences, Maria Eduarda Centena Duarte Vieira, School of Medicine, Lucas Neiva-Silva, Center for Studies on Risk and Health. . “Income inequality and risk of infection and death by COVID-19 in Brazil”. 6-7-2020. Scielo Journal. https://www.scielosp.org/article/rbepid/2020.v23/e200095/en/. Accessed 8-10-2021; MJen]

The unequal distribution of opportunities can allocate individuals in different socioeconomic positions according to their social group, sex, gender, and ethnicity, creating cascading difficulties in the access to education, work, and income**28** . People at greater socioeconomic disadvantage tend to have differential exposure to the virus (because they have poor housing conditions, live with a larger number of people in smaller residences, use public transport with greater agglomeration, and have job insecurity, which makes social distancing difficult); differential susceptibility (due to food insecurity and poorer nutritional quality, increased psychological stress, and difficulty of access to healthcare professionals); and differential consequence (less social capital and reduced options of primary prevention and treatment)7,28,29,30,31,32. Altogether, differential exposure, susceptibility, and consequence can produce higher rates of illness and death in these subgroups. Such an effect has already been observed in the National Household Sample Survey (PNAD) to assess the impact of COVID-19, which showed that black and mixed-race, poor and uneducated people, in addition to being more likely to be infected, were also more severely affected by the pandemic in terms of economy33. It is estimated that the risk of dying from COVID-19 may be up to 10 times higher among individuals living in the most vulnerable neighborhoods in the same city, and that black people are 62% more likely to be victims of the virus34. These contextual effects, which impact everyone by the degradation of the public structure, but affect poorest individuals in a more severe way, can be a plausible explanation for the greater increase in incidence and mortality rates in more unequal states in the evaluated period (and in less unequal states, this increase was smaller or almost stable).

#### Access to vaccines are human rights Gostin et al. 20

Gostin, Lawrence O., Safura Abdool Karim, and Benjamin Mason Meier. "Facilitating access to a COVID-19 vaccine through global health law." The Journal of Law, Medicine & Ethics 48.3 (2020): 622-626. (https://journals.sagepub.com/doi/epub/10.1177/1073110520958892)

Human rights law provides an international legal foundation for the progressive realization of vaccine access. COVID-19 not only endangers health and longevity, but does so inequitably — burdening the poor, the sick, the disadvantaged, and the marginalized. Recognizing the equal dignity of all persons, human rights law requires equitable access to essential vaccines for disease prevention and health promotion.7 A growing anti-vaccination movement is already mobilizing under “rights” discourse to oppose a prospective COVID-19 vaccine;8 however, this co-optation of human rights rhetoric does not obviate human rights obligations to ensure access to essential medicines. In realizing the highest attainable standard of health through vaccination, human rights law provides an international obligation to progressively realize the prevention, treatment, and control of prevalent diseases. Access to an essential lifesaving vaccine is a core human rights obligation. Immunization is science’s best prevention tool and remains a quint-essentially important element of the right to the highest attainable standard of health.9 The United Nations Special Rapporteur on the right to health concluded that states are obligated to “do all they reasonably can to make sure that existing medicines are available in sufficient quantities.”10 The widespread provision of a COVID-19 vaccination also finds support under the human right to the benefits of scientific progress, requiring that states provide resources for the distribution of scientific progress, remove discriminatory barriers, and ensure access to the “most advanced, up-to-date, and verifiable science available.”11 In realizing these rights, a COVID-19 vaccination, similar to life saving antiretrovirals for HIV, will almost certainly be classified by WHO as an “essential medicine,” raising national and international obligations to ensure access.12

### Solvency

#### **Local production significantly improves access especially for locally important drugs**

WHO, 11, Local Production for Access to Medical Products: Developing a Framework to Improve Public Health, <https://www.who.int/phi/publications/Local_Production_Policy_Framework.pdf> (accessed 8/2/2021)

**Local** production can offers price-based competition in the market and improve affordability:**.** Firms in Bangladesh, Argentina and Indonesia demonstrate this well, by catering to between 60% (Argentina) and over 87% (Bangladesh) of the total local market. Clearly, market participation of local firms is not a direct indicator of improved access, and the key question is whether the local firms make a difference in terms of availability and affordability of medical products. **This is important for all poor countries, where the majority of the population is unable to afford medicaments imported from developed countries. The Bangladesh study found in this case that** **local** firms make a significant difference in promoting access to medicines for the local populations in both urban and rural areas. In Argentina and Indonesia, **there is market segmentation between locally produced generics and branded medicines from multinational companies, offering wide availability of a variety of drugs**. To support access, these governments source their public medicine procurement from local companies due to comparative cost advantages. Price comparisons in the diagnostics market are more difficult to interpret, as the quality of goods varies widely, with some products being ineffectual and misleading (e.g. see WHO & Special Programme for Research and Training in Tropical Diseases, 2011). **• Local production has catered to local health needs:** **Firms** in all the case studies catered to specific health needs by producing medicines for which there was local demand. These included antibiotics, anti-infectives, vaccines, antimalarials and ARVs. Firms in Bangladesh, Argentina, Indonesia and Uganda produce ARVs and antimalarials. Firms in Bangladesh are beginning to venture into vaccines for rabies, typhoid, tetanus and polio. Indonesian firms are specifically engaged in producing vaccines and heatresistant ARVs. The firms in Jordan and Argentina are expanding into product categories (including diagnostics), which resulted in incremental adaptations and improvements to existing products. • Local firms can produce products for local needs that either are not produced at all by the multinational companies or are in short supply: In these cases, **such** products address diseases that disproportionately affect developing countries. **Examples include production of paediatric ARVs by Indian companies, and production of the meningitis A vaccine by the Serum Institute of India. The Bangladesh firm Beximco is engaged in production of chlorofluorocarbon inhalers, which it also supplies to global procurement agencies. In Brazil, Bio-Manguinhos (Immunobiological Technology Institute), a unit of the Oswaldo Cruz Foundation (Fiocruz), supplies the public sector with diagnostic reagents and kits for HIV, leptospirosis, leishmaniasis, Chagas disease, dengue fever, hepatitis and rubella**. • Local firms can be more adept at creating distribution networks that cater to the needs of poor people in remote areas: The existence of distribution networks and pharmaceutical supply chains is a starting point for the development of formulation capabilities in countries and expansion into other niche areas. Quality Chemicals, a Ugandan firm producing ARVs, was a distributor for Cipla’s medicinal products and has extensive distribution networks in rural Uganda. Similarly, most local companies are adept at using context-relevant strengths for distributing their products and in creating newer modes of distribution for their medicinal products. Historical narratives of the pharmaceutical sector show that many pharmaceutical firms in developing countries, including Bangladesh, Kenya and India, are offshoots of distribution companies.

#### A pandemic is the best time to modify patent law.

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The Chilean parliament and Ecuador’s National Assembly have also adopted resolutions that would pave the way for the issuance of compulsory licences to tackle the coronavirus outbreak. Meanwhile, the German government has started plans to limit patent rights in view of the pandemic. And Canada is making similar moves. In the face of an unprecedented global health emergency like the coronavirus pandemic, it has never been more necessary for researchers to work together in the search for better testing and treatment. This in turn may very well require companies to give up their monopoly rights on new treatments and technology. In the past we have seen similar conflicts. In 1998, a group of pharmaceutical companies brought a legal case against the South African government to stop it introducing laws aimed at making various medicine more affordable, especially HIV and AIDS drugs. The main objection was that local laws reduced patent protection. The case provoked a lot of criticism worldwide and increased public awareness about the (sometimes) negative impact of patent rights on public health. The companies eventually abandoned the legal action.