# **C.B AFF**

# **I Affirm, Resolved: The member nations of the World Trade Organization ought to reduce intellectual property protections for medicines.**

# **AFF**

**My value is morality for two reasons:**

1. **The resolution’s use of the word “ought” implies a moral obligation**
2. **Morality allows us to perceive what is inherently good or bad. It is the value upon which we can conceptualize all other values, thus it must be prioritized.**

**My value criterion is maximising expected well being**

**Government policy is constrained by limitations on resources. Any government decision must account for tradeoffs, which only utilitarian ethics can do.**

**Mack, 2004, Peter Mack (Former U.S. Representative) “Utilitarian Ethics in Healthcare.” International Journal of the Computer, the Internet, and Management Vol. 12, No.3. 2004. Department of Surgery. Singapore General Hospital.]** [**http://www.ijcim.th.org/past\_editions/2004V12N3/ijcimv3n1\_article6.pdf**](http://www.ijcim.th.org/past_editions/2004V12N3/ijcimv3n1_article6.pdf)

**Medicine is a costly science, but of greater concern to the health economist is that it is also a limitless art. Every medical advance created new needs that did not exist until the means of meeting them came into existence. Physicians are reputed to have an infinite capacity to do ever more things, and perform ever more expensive interventions for their patients so long as any of their patients’ health needs remain unfulfilled. The traditional stance of the physician is that each patient is an isolated universe. When confronted with a situation in which his duty involves a competition for scarce medications or treatments, he would plead the patient’s cause by all methods, short of deceit. However, when the physician’s decision involves more than just his own patient, or has some commitment to public health, other issues have to be considered. He then has to recognise that the unbridled advocacy of the patient may not square with what the economist perceives to be the most advantageous policy to society as a whole. Medical professionals characteristically deplore scarcities. Many of them are simply not prepared to modify their intransigent principle of unwavering duty to their patients’ individual interest. However, in decisions involving multiple patients, making available more medication, labour or expenses for one patient will mean leaving less for another. The physician is then compelled by his competing loyalties to enter into a decision mode of one versus many, where the underlying constraint is one of finiteness of the commodities. Although the medical treatment may be simple and inexpensive in many instances, there are situations such as in renal dialysis, where prioritisation of treatment poses a moral dilemma because some patients will be denied the treatment and perish. Ethics and economics share areas of overlap. They both deal with how people should behave, what policies the state should pursue and what obligations citizens owe to their governments. The centrality of the human person in both normative economics and normative ethics is pertinent to this discussion. Economics is the study of human action in the marketplace whereas ethics deals with the “rightness” or “wrongness” of human action in general. Both disciplines are rooted in human reason and human nature and the two disciplines intersect at the human person and the analysis of human action. From the economist’s perspective, ethics is identified with the investigation of rationally justifiable bases for resolving conflict among persons with divergent aims and who share a common world. Because of the scarcity of resources, one’s success is another person’s failure. Therefore ethics search for rationally justifiable standards for the resolution of interpersonal conflict. While the realities of human life have given rise to the concepts of property, justice and scarcity, the management of scarcity requires the exercise of choice, since having more of some goods means having less of others. Exercising choice in turn involves comparisons, and comparisons are based on principles. As ethicists, the meaning of these principles must be sought in the moral basis that implementing them would require. For instance, if the implementation of distributive justice in healthcare is founded on the basis of welfare-based principles, as opposed to say resource-based principles, it means that the health system is motivated by the idea that what is of primary moral importance is the level of welfare of the people. This means that all distributive questions should be settled according to which distribution maximises welfare. Utilitarianism is fundamentally welfarist in its philosophy. Application of the principle to healthcare requires a prior understanding of the welfarist theory as expounded by the economist. Conceptually, welfarist theory is built on four tenets: utility maximisation, consumer sovereignty, consequentialism and welfarism. Utility maximisation embodies the behavioural proposition that individuals choose rationally, but it does not address the morality of rational choice. Consumer sovereignty is the maxim that individuals are the best judge of their own welfare. Consequentialism holds that any action or choice must be judged exclusively in terms of outcomes. Welfarism is the proposition that the “goodness” of the resource allocation be judged solely on the welfare or utility levels in that situation. Taken together these four tenets require that a policy be judged solely in terms of the resulting utilities achieved by individuals as assessed by the individuals themselves. Issues of who receives the utility, the source of the utility and any non-utility aspects of the situation are ignored.**

**Con. 1: COVID-19**

**The global situation is in dire need of help from COVID, restricting IP rights only makes the pandemic worse.**

**Amanda Heidt, 5-10-2021, "Biden Administration Backs Vaccine Intellectual Property Waiver," Scientist Magazine®,** [**https://www.the-scientist.com/news-opinion/biden-administration-backs-vaccine-intellectual-property-waiver-68751**](https://www.the-scientist.com/news-opinion/biden-administration-backs-vaccine-intellectual-property-waiver-68751)

**The proposal at the center of the argument was submitted to the World Trade Organization (WTO) last fall by India and South Africa, two countries currently beset by aggressive SARS-CoV-2 variants. India alone is reporting roughly 300,000 new infections each day, a tally that accounts for roughly half of the world’s new cases, according to The New York Times. Both countries requested a waiver that would exempt WTO member countries from enforcing certain laws related to patents and industry trade secrets that are covered under the organization’s Trade-Related Aspects of Intellectual Property Rights (TRIPS) agreement. If approved unanimously, the waiver would give countries and companies access to vaccine ingredients and manufacturing processes, allowing drug companies worldwide to make generic versions of COVID-19 vaccines for distribution in developing countries that currently do not have access. Anthony Fauci, President Biden’s chief medical adviser, also came out in support of the waiver, although the consensus among the President’s advisers was split, according to the Times. “I always respect the needs of the companies to protect their interests to keep them in business, but we can’t do it completely at the expense of not allowing vaccine that’s lifesaving to get to the people that need it,” Fauci tells the newspaper, adding: “You can’t have people throughout the world dying because they don’t have access to a product that rich people have access to.”**

**Waiving IP Rights can help spread covid-19 vaccines to less wealthy countries.**

**Priti Krishtel, 5-28-2021, "Suspend intellectual property rights for covid-19 vaccines," BMJ,** [**https://www.bmj.com/content/373/bmj.n1344**](https://www.bmj.com/content/373/bmj.n1344)

**Waiving intellectual property rights is essential to tackle serious inequity in the global distribution of covid-19 vaccines, whereby wealthy countries currently control the lion’s share of existing supplies. By the end of April, over 1.3 billion doses had been administered worldwide, but only 0.2% of vaccines had been given in low income countries. More than one year into the pandemic, the situation is at a low point globally. The average number of weekly deaths in April was over 36 000 in just India and Brazil, and variants are proliferating. Experts fear a devastating second wave across Asia and Africa. Voluntary action has not worked— whether timely sharing of doses with low and middle income countries or sharing knowledge through the World Health Organization. It’s time for mandatory rules and legal commitments that can help put an end to this pandemic. The proposed intellectual property waiver is appropriate as vaccine manufacturers have relied heavily on publicly funded research into coronaviruses. Together, companies holding intellectual property rights are estimated to have benefited from government funding of around €93bn (£80bn; $110bn). The Moderna vaccine was funded almost exclusively by the US government. A successfully negotiated intellectual property waiver would ensure manufacturers cannot block production or access to raw materials and finished products for covid-19 technologies worldwide. A waiver would also prevent companies from charging unaffordable prices while insulated from competition. Lack of competition in the vaccines market has a long history. Previously, the two companies with a duopoly for the human papillomavirus (HPV) vaccine8 held patents that prevented competition. According to one estimate, low income countries paid up to 10 times the estimated cost of production for these vaccines. Millions of girls globally are still unable to access this critical protection against cervical cancer. Similarly, Pfizer successfully enforced secondary patents on its pneumococcal vaccine through legal proceedings in India and South Korea, which delayed competition. Pneumonia remains the leading cause of death globally among children under 5 years old. Many middle income countries have low coverage because of the high price of the vaccine, often 5-10 times higher than the lowest price available globally**

**Access to these vaccines are expected to improve if we waiver IP rights.**

**Banri Ito, 8-1-2021, "Impacts of the vaccine intellectual property rights waiver on global supply," No Publication,** [**https://voxeu.org/article/impacts-vaccine-intellectual-property-rights-waiver-global-supply**](https://voxeu.org/article/impacts-vaccine-intellectual-property-rights-waiver-global-supply)

**If technical knowledge regarding patented vaccines is disclosed and if it becomes possible to produce the vaccines in third-party countries, as a general rule, a supply increase would bring benefits to consumers as the elimination of a monopoly lowers prices. Among past cases, we should look at the application of the waiver of the WTO TRIPS agreement to drugs to treat HIV/AIDS in 2001. According to an estimate by Médecins Sans Frontière, the prices of patented drugs dropped to less than a tenth of the previous level in one year, improving access to the drugs around the world. Given that the principle of competition works, access to the COVID-19 vaccines is expected to improve.**

**Con. 2: Healthcare**

**IPR affects the price of essential medicines to the public.**

**Youn Jung, July 2015, The Effects of Intellectual Property Rights on Access to Medicines and Catastrophic Expenditure, PubMed, https://www.researchgate.net/publication/278732481\_The\_Effects\_of\_Intellectual\_Property\_Rights\_on\_Access\_to\_Medicines\_and\_Catastrophic\_Expenditure?enrichId=rgreq-4792930b1f2b01d24d32080100e52ed2-XXX&enrichSource=Y292ZXJQYWdlOzI3ODczMjQ4MTtBUzozNjI3NjU5ODc0MDE3MzRAMTQ2MzUwMTU2MDAwNg%3D%3D&el=1\_x\_2&\_esc=publicationCoverPdf**

**There is growing evidence that stronger protection of IPR for pharmaceuticals may adversely impact medicine prices. Duggan and Goyal found a significant increase in the market share of patented drugs and an increase in average prices after the introduction of stronger product patents by exploring the effects of introducing product patents for central nervous system drugs. Borrell also found that patents shifted drug prices up, through his analysis of sales data on human immunodeficiency virus (HIV) and acquired immune deficiency syndrome (AIDS) drugs in 34 developing countries between 1995 and mid-2000’s. Watal simulated the maximum likely increase in pharmaceutical prices in India when product patents are introduced in the existing 22 patentable pharmaceutical markets after TRIPS agreement (Patentable pharmaceuticals are defined throughout this article as pharmaceuticals that are on product patents elsewhere where such patents are allowed. Following is the list of 22 patentable pharmaceuticals: Cefuroxime sodium, Cefaclor, Netilmicin, Albendazole, Fluoxetine, Aciclovir, Domperidone, Ranitidine, Cefotaxime Sodium, Ketorolac, Norfloxacin, Pefloxacin, Ketoconozole, Famotidine, Enalapril Maleate, Omeprazole, Astemizole, Ceftazidime, Ciprofloxacin, Ofloxacin, and Roxithromycin). This price rise was estimated from 26% up to 242%, depending on demand function. Maskus and Konan and Subramanian estimated maximum price increases up to 67% as a result of the introduction of pharmaceutical product patent rights.**

**IP Rights have blocked people from receiving basic healthcare in the past, and still affects us today.**

**Priti Krishtel, 5-28-2021, "Suspend intellectual property rights for covid-19 vaccines," BMJ,** [**https://www.bmj.com/content/373/bmj.n1344**](https://www.bmj.com/content/373/bmj.n1344)

**A successfully negotiated intellectual property waiver would ensure manufacturers cannot block production or access to raw materials and finished products for covid-19 technologies worldwide. A waiver would also prevent companies from charging unaffordable prices while insulated from competition. Lack of competition in the vaccines market has a long history. Previously, the two companies with a duopoly for the human papillomavirus (HPV) vaccine held patents that prevented competition. According to one estimate, low income countries paid up to 10 times the estimated cost of production for these vaccines. Millions of girls globally are still unable to access this critical protection against cervical cancer. Similarly, Pfizer successfully enforced secondary patents on its pneumococcal vaccine through legal proceedings in India and South Korea, which delayed competition. Pneumonia remains the leading cause of death globally among children under 5 years old. Many middle income countries have low coverage because of the high price of the vaccine, often 5-10 times higher than the lowest price available globally.**

**We must waiver patents for better healthcare globally.**

**Providing A, 2021, "Intellectual property and access to medicine,"Oxfam,** [**https://www.oxfamamerica.org/explore/issues/economic-well-being/intellectual-property-and-access-to-medicine/**](https://www.oxfamamerica.org/explore/issues/economic-well-being/intellectual-property-and-access-to-medicine/) **This trade-off underpins patent systems everywhere. Governments need to maintain an appropriate balance between incentivizing innovation, on the one hand, and, on the other, ensuring that new products are widely available. High levels of IP protection in developing countries exacerbate, rather than help solve, the problem of access to affordable medicines. Extensive patent protection for new medicines delays the onset of generic competition. And because generic competition is the only proven method of reducing medicine prices in a sustainable way, such high levels of IP protection are extremely damaging to public health outcomes. A word on background: The 1994 TRIPS Agreement represented the single greatest expansion of IP protection in history, but it also includes a range of public health safeguards and flexibilities, which were reinforced by the 2001 Doha Declaration on the TRIPS Agreement and Public Health. Yet US trade agreements over the past decade have sought to redefine and even undermine the Doha Declaration, as FTAs have included provisions that curb governments’ ability to use the health safeguards in TRIPS and have mandated higher levels of IP protection. These provisions block or delay the onset of generic competition, keeping medicine prices high. Higher treatment costs are devastating to poor people, and they undermine the sustainability of public health programs—particularly in low- and middle-income countries, where public finance for health care is limited and most patients pay for medicines out of pocket. The reality is that fragile gains in health in developing country TPP partners are at risk from the USTR proposal. For example, Peru is a low- to middle-income country with high levels of poverty and inequality and with a high burden of chronic and noncommunicable diseases that require medicines over the long term. Prices for patented medicines to treat cancer, for example, are unaffordable for households and have exhausted most of the government’s resources available to pay for treatments under the public health system. A 2010 study by a Peruvian government entity (the Director General of Medicines, Supply and Drugs, or DIGEMID) revealed this stark reality: the monthly cost of one key patented medicine needed to treat head and neck cancer is equivalent to 880 times the daily minimum wage in Peru, an amount that would take a worker more than two years to earn, without a single day off. The TPP would not only undermine the efforts of other countries to protect public health, but would also undermine US efforts to improve access to health care around the world. Thanks to the cost savings from use of generics, PEPFAR (the President’s Emergency Plan for AIDS Relief) has successfully initiated treatment for more than three million people worldwide, and saved $380 million in 2010 alone. Stricter patent rules in a few countries may generate greater profits for drug companies, but won’t lead to additional innovation that would meet the public health needs of those countries. And such rules could undermine patients’ access to new treatments. In order to generate greater innovation, changes need to be made within the pharmaceutical industry itself. This is not something that a trade agreement can achieve.**