# Meadows Finals Neg vs Orange Lutheran AZ

# 1NC

### 1

#### Interpretation: “intellectual property protections” is a generic bare plural. The aff may not defend WTO member nations reducing a subset of intellectual property protections for medicines.

#### The upward entailment test and adverb test determine the genericity of a bare plural

Leslie and Lerner 16 [Sarah-Jane Leslie, Ph.D., Princeton, 2007. Dean of the Graduate School and Class of 1943 Professor of Philosophy. Served as the vice dean for faculty development in the Office of the Dean of the Faculty, director of the Program in Linguistics, and founding director of the Program in Cognitive Science at Princeton University. Adam Lerner, PhD Philosophy, Postgraduate Research Associate, Princeton 2018. From 2018, Assistant Professor/Faculty Fellow in the Center for Bioethics at New York University. Member of the [Princeton Social Neuroscience Lab](http://psnlab.princeton.edu/).] “Generic Generalizations.” Stanford Encyclopedia of Philosophy. April 24, 2016. <https://plato.stanford.edu/entries/generics/> TG

1. Generics and Logical Form

In English, generics can be expressed using a variety of syntactic forms: bare plurals (e.g., “tigers are striped”), indefinite singulars (e.g., “a tiger is striped”), and definite singulars (“the tiger is striped”). However, none of these syntactic forms is dedicated to expressing generic claims; each can also be used to express existential and/or specific claims. Further, some generics express what appear to be generalizations over individuals (e.g., “tigers are striped”), while others appear to predicate properties directly of the kind (e.g., “dodos are extinct”). These facts and others give rise to a number of questions concerning the logical forms of generic statements.

1.1 Isolating the Generic Interpretation

Consider the following pairs of sentences:

(1)a.Tigers are striped.

b.Tigers are on the front lawn.

(2)a.A tiger is striped.

b.A tiger is on the front lawn.

(3)a.The tiger is striped.

b.The tiger is on the front lawn.

The sentence pairs above are prima facie syntactically parallel—both are subject-predicate sentences whose subjects consist of the same common noun coupled with the same, or no, article. However, the interpretation of first sentence of each pair is intuitively quite different from the interpretation of the second sentence in the pair. In the second sentences, we are talking about some particular tigers: a group of tigers in ([1b](https://plato.stanford.edu/entries/generics/#ex1b)), some individual tiger in ([2b](https://plato.stanford.edu/entries/generics/#ex2b)), and some unique salient or familiar tiger in ([3b](https://plato.stanford.edu/entries/generics/#ex3b))—a beloved pet, perhaps. In the first sentences, however, we are saying something general. There is/are no particular tiger or tigers that we are talking about.

The second sentences of the pairs receive what is called an existential interpretation. The hallmark of the existential interpretation of a sentence containing a bare plural or an indefinite singular is that it may be paraphrased with “some” with little or no change in meaning; hence the terminology “existential reading”. The application of the term “existential interpretation” is perhaps less appropriate when applied to the definite singular, but it is intended there to cover interpretation of the definite singular as referring to a unique contextually salient/familiar particular individual, not to a kind.

There are some tests that are helpful in distinguishing these two readings. For example, the existential interpretation is upward entailing, meaning that the statement will always remain true if we replace the subject term with a more inclusive term. Consider our examples above. In ([1b](https://plato.stanford.edu/entries/generics/#ex1b)), we can replace “tiger” with “animal” salva veritate, but in ([1a](https://plato.stanford.edu/entries/generics/#ex1a)) we cannot. If “tigers are on the lawn” is true, then “animals are on the lawn” must be true. However, “tigers are striped” is true, yet “animals are striped” is false. ([1a](https://plato.stanford.edu/entries/generics/#ex1a)) does not entail that animals are striped, but ([1b](https://plato.stanford.edu/entries/generics/#ex1b)) entails that animals are on the front lawn (Lawler 1973; Laca 1990; Krifka et al. 1995).

Another test concerns whether we can insert an adverb of quantification with minimal change of meaning (Krifka et al. 1995). For example, inserting “usually” in the sentences in ([1a](https://plato.stanford.edu/entries/generics/#ex1a)) (e.g., “tigers are usually striped”) produces only a small change in meaning, while inserting “usually” in ([1b](https://plato.stanford.edu/entries/generics/#ex1b)) dramatically alters the meaning of the sentence (e.g., “tigers are usually on the front lawn”). (For generics such as “mosquitoes carry malaria”, the adverb “sometimes” is perhaps better used than “usually” to mark off the generic reading.)

#### It applies to “IPP” – 1] upward entailment test – “reduce IPP for medicines” doesn’t entail reducing property rights for homes, because it doesn’t prove that we should derestrict broader property protections i.e. physical ones

#### Vote neg:

#### 1] Limits – you can pick anything from patent evergreening to patent delays to data exclusivity to EU trade secrets to copyright and there’s no universal disad since each one has a different function and implication for health, tech, and relations – explodes neg prep and leads to random IP of the week affs which makes cutting stable neg links impossible. PICs don’t solve – it’s absurd to say neg potential abuse justifies the aff being flat out not T, which leads to a race towards abuse. Limits key to reciprocal engagement since they create a caselist for neg prep.

#### 2] TVA – read the aff as an advantage to a whole rez aff.

#### No RVIs – a) illogical – you shouldn’t win for being fair – it’s a litmus test for engaging in substance, b) norming – I can’t concede the counterinterp if I realize I’m wrong which forces me to argue for bad norms

### 2

#### CP: The member nations of the World Trade Organization should allow exclusivity to be extended indefinitely for antimicrobial drugs per Salmieri. The member nations of the World Trade Organization should reduce intellectual property protections for all other medicines by implementing a one-and-done approach for patent protection.

Salmieri 18 “INTELLECTUAL PROPERTY AND THE FREEDOM NEEDED TO SOLVE THE CRISIS OF RESISTANT INFECTIONS” 2018 Gregory Salmieri [Ph.D., Philosophy, 2008, University of Pittsburgh; B.A. 2001, The College of New Jersey. Fellow, The Anthem Foundation for Objectivist Scholarship; Lecturer, Philosophy Department, Rutgers University] <http://georgemasonlawreview.org/wp-content/uploads/2019/04/26-1_7-Salmieri.pdf> SM

This Article suggests another sort of solution, which might be described as a way of incentivizing, by means of a single policy change, both the development of new antimicrobials and the responsible stewardship of these drugs. In its simplest form, the solution is to make the patent terms on these drugs extremely long. The solution has been proposed in this form by Professor John Horowitz and Brian Moehring32 as well as Professor Eric Kades,33 and it is occasionally mentioned in the existing literature.34 However, the case for this broad sort of solution has not been adequately articulated or appreciated. The next part develops the case for a solution of this sort and proposes an alternative version of the solution that is better tailored to the problem and better situated within a theory of IP. Finally, Part III addresses some concerns faced by any solution of this sort.

II. THE RIGHT TO THE VALUE CREATED BY RESPONSIBLE STEWARDSHIP

Consider how the two-fold problem of growing resistance to our current antimicrobial drugs and the dearth of new antimicrobials under development looks once the specifics are omitted. Forget for a moment that the subject is drugs and microbes—or even inventions as opposed to other sorts of property—and just focus on the structure of the predicament.35 There is a resource of immense value that is being used myopically in a way that destroys existing stocks of the resource, and little is being done to find or develop new stocks of it.

This is a pattern one expects to see with unowned resources, but not with owned ones. It is the classic “tragedy of the commons.” When a patch of grazing land is owned in common by everyone—which is just to say it is unowned—everyone has an incentive to make what use of it he can, leading to its overuse and destroying its value. By contrast, an owner can use land judiciously in ways that preserve its value or even to invest in improving the land. This is possible because the owner has exclusive control of the land in the present and therefore can control its uses, and because the owner expects to reap the benefit of the land’s future value. If deeds to land expired after twenty years, with the land reverting to the commons, land owners would have no financial incentives to preserve or enhance the land’s value past the twenty-year window. In this scenario, they could not afford to forgo shortterm gains that came at the expense of the land’s later value. Nor could they afford to invest in long-term improvement projects, such as clearing new land for grazing. This is the predicament with antimicrobial drugs. The profligate use of such drugs in the present destroys their value in a future in which they are unowned.

This suggests the simple solution of extending the patent terms for antimicrobial drugs. So long as the drug remains under patent, the patent holder has both an interest in preserving its usefulness and the ability to control its use so as to preserve its value. How long should the patent term be extended? The five years of extra market exclusivity offered by the GAIN Act is calculated with a view to incentivizing companies to invest in developing new drugs. The aim of the present proposal is different. It is to enable the creators of drugs to profitably exercise their rights over the drugs in a manner that preserves the drugs’ effectiveness over time—ideally into the indefinite future. This requires extending the term of exclusivity not just a few years or decades, but as far into the future as there is reason to hope that the drugs’ effectiveness can be maintained.

There are various ways in which this suggestion could be further developed; perhaps the most promising is simply to allow patents on antimicrobial drugs to be renewed indefinitely, so long as the drugs’ continued effectiveness can be demonstrated. (How exactly continued effectiveness should be demonstrated is a matter of detail, but likely by showing resistance to be below a certain threshold—perhaps 20 percent—in clinical isolates of interest.36) This would allow for a potentially infinite patent term. “Perpetual patents” have occasionally been proposed, 37 but the lack of a fixed term may do violence to the notion of a patent, so it may be better to conceive of this as a proposal for a new type of IP right that combines features of patents and trademarks. Conceptualizing the relevant right in this way highlights its basis. Like a patent, the right would pertain to an invention and would confer market exclusivity; like a trademark, however, it would be renewable in perpetuity on the grounds that the continued value of the property depends on the owner taking continuous action to maintain it. In the case of the right under consideration, the relevant actions would be those of stewarding the drug in such a manner as to prolong its continued effectiveness in the face of resistance.

This new sort of property right could, in principle, be applied to drugs that are already off patent or otherwise ineligible for patent protection. The Chatham House Working Group proposes granting “delinkage rewards” to “firms registering a new antibiotic without patent protection (such as new uses for old drugs),”38 and it may be that the sort of IP protection proposed here would be applicable in such cases as well. If so, the right would be justified by the discovery of the new use for the drug and by the fact that intelligent management of this use is required for it to retain its value. A more difficult case is granting such rights to already known antibiotics that have gone off patent and are now available as generics. Removing these drugs from the commons would make it possible for an owner to profit by stewarding them responsibly. The difficulty here is determining who would own them. Professor Kades considers the possibility of granting a new patent to the original patent holder, but suggests “auctioning the patent rights [to such drugs] to the highest bidder.”39 Both are plausible solutions. Another option, in light of the issue of cross-resistance (which will be discussed in Part III) would be to apportion the IP rights to the relevant drugs among the owners of other drugs with similar mechanisms of action.

Instituting the sort of property right described here (whether or not it is extended to drugs that are currently unpatentable and/or in the public domain) would create an environment in which pharmaceutical companies and other private entities can compete to develop new policies and business models that maximize the total value derived from antimicrobial drugs over time. An important advantage of this proposal is that it does not require policymakers (or authors of law review articles) to know in advance which specific practices would have this auspicious effect. However, some obvious possibilities suggest themselves.

Pharmaceutical companies could sell new antimicrobials at a price high enough to make it prohibitive to use them as anything other than treatments of last resort. In addition to extending the drugs’ useful lives, the high prices would compensate for the lower initial volume of sales, and the drugs could eventually be repriced for wider use as second- and then first-line treatments. This repricing would have to be paced both to the growth of the resistant bacterial population and to the development of new antimicrobial drugs to take their predecessors’ place as treatments of last resort. One can imagine many variations of this strategy with different price points and development cycles.

Pharmaceutical companies could also extend the effective lifespan of their antimicrobials through contractual arrangements with healthcare providers, which restrict the latter’s use of the drugs to certain protocols or best practices. Imagine the new business practices whereby pharmaceutical companies might profit from drugs that are never or hardly ever used. Licensing plans like the one proposed by Commissioner Gottlieb might be employed in innovative ways.40 For example, healthcare providers or insurance companies might pay a monthly fee for the right to use these drugs should it ever become necessary to do so. Or the various parties might negotiate a system whereby a pharmaceutical company (or an entity that has licensed drugs from multiple companies) charges a fixed price for treatment in accordance with a proprietary antimicrobial protocol that makes use of several of their drugs, specifying which drugs can used under which conditions.

The suggestions in the last paragraph all amount to ways in which revenues from the creation of a new drug might be “delinked” from sales volume. In principle, this delinkage could occur simply through market forces, without any additional policy interventions, but since governments and multinational organizations account for most of the spending in the healthcare sector in much of the world, their adopting policies favoring delinkage would likely stimulate the development of these sorts of business models under an IP regime of the sort suggested. Indeed, such delinkage–promoting policies would likely fare better under the proposed IP regime than under the current IP system because, as The Chatham House Working Group observes, “patent expiry” creates some difficulties for such policies.

Obligations for responsible use can be carefully crafted and functional when monopoly rights are in place, but are likely to fail once generic antibiotics are introduced upon the termination of the period of exclusivity. Generic manufacturers ordinarily rely on volume-based rewards, and low prices and large volume of sales without appropriate measures to conserve the antibiotics may be an important driver of indiscriminate use and resistance. A sustainable system will require controls on market entry after termination of the patent, and regulation of the way the generic products are marketed and prescribed.41

It bears emphasizing at this point that the best stewardship policies for antimicrobial drugs remain to be discovered. The Chatham House Working Group report (quoted several times above) represents the cutting edge of research on this issue, and it offers precious few details about the new “delinked” business model it says “needs to be developed.” Successful business models are rarely if ever specified from on high by public policy makers. Securing a long-range IP right to antimicrobial drugs would create the conditions in which the healthcare industry as a whole could invest the resources required to discover the practices, protocols, and business models that maximize the value of these substances. In addition, the ability to capture this value as profit would create an incentive to develop new drugs as needed.

IP rights, and patents in particular, are sometimes understood as bargains between creators and society. The proposal under consideration grants a lot more to the developers of any new antimicrobial drugs than they are granted under current law, but it asks a lot of these developers in return—for it requires them to become good stewards of their drugs by discovering and implementing the means necessary to preserve the drugs’ value over time, so that the maximum potential benefit from them is realized.42 This is work that needs to be done by someone, and the sort of IP regime proposed here would enable those people and firms most qualified to do this work to profit by doing it.

This leads to a deeper point. Although IP rights are often understood as special privileges granted by government and justified on utilitarian grounds, the dominant strand in early American jurisprudence, taking its inspiration from John Locke, regards all property rights as securing to a creator the fruits of his productive work.43 Among the reasons why patents and copyrights are finite in duration, whereas rights to chattels or land can be passed on from generation to generation indefinitely, is that chattels and land generally need to be maintained in order to retain their economic value over time, whereas this is not true of the economic value of an artwork or a method.44 But the case under consideration reveals that the continued economic value of certain methods does depend on an ongoing process of intelligent management by which one uses the method sparingly. It is this very fact that (according to the argument of this Part) justifies extending the IP right to the drug indefinitely. This raises the question of whether there are structurally similar cases in other fields, where the continued commercial value of a potential invention depends on its judicious use. If so, it may be that there are other values being destroyed (or never created) because of tragedies of the commons that could be rectified by policies analogous to the one suggested here.

#### Even if the aff incentivizes innovation they cannot incentivize innovation in anti-microbial research – the problem right now is lack of profit incentives for innovation and responsible stewardship.

Salmieri 18 “INTELLECTUAL PROPERTY AND THE FREEDOM NEEDED TO SOLVE THE CRISIS OF RESISTANT INFECTIONS” 2018 Gregory Salmieri [Ph.D., Philosophy, 2008, University of Pittsburgh; B.A. 2001, The College of New Jersey. Fellow, The Anthem Foundation for Objectivist Scholarship; Lecturer, Philosophy Department, Rutgers University] <http://georgemasonlawreview.org/wp-content/uploads/2019/04/26-1_7-Salmieri.pdf> SM

According to a 2013 report by the Center for Disease Control (“CDC”), two million people in the United States annually contract infections that are “resistant to one or more of the antibiotics designed to treat those infections”; the result is at least 23,000 deaths and (direct and indirect) economic losses that have been estimated at $55 billion (in 2008 dollars).2 The United Kingdom’s Antimicrobial Resistance Review estimates that, worldwide, there will be as many as ten million deaths annually from such infections by 2050.3 A 2017 report by the World Bank Group anticipates the financial toll:

In the optimistic case of low AMR [antimicrobial resistance] impacts, the simulations found that, by 2050, annual global gross domestic product (GDP) would likely fall by 1.1 percent, relative to a base-case scenario with no AMR effects; the GDP shortfall would exceed $1 trillion annually after 2030. In the high AMR-impact scenario, the world will lose 3.8 percent of its annual GDP by 2050, with an annual shortfall of $3.4 trillion by 2030.4

There are two related aspects to this crisis: (1) bacterial populations are evolving resistance to the antimicrobial drugs currently in use, and (2) there are few new drugs in the developmental pipeline that promise to be effective against these bacteria.5 It is widely understood that both aspects are caused or exacerbated by the economic incentives faced by the pharmaceutical industry and the healthcare industry more broadly.6

The eventual obsolescence of any conventional antimicrobial drug is inherent in its use, but it is hastened when the drug is liberally prescribed.7 Such liberal prescription is driven by incentives for both physicians and pharmaceutical companies. Patients’ expectations for prompt treatment sometimes lead doctors to prescribe broad-spectrum antibiotics in cases where it would be more prudent to await testing and prescribe a more targeted antimicrobial—or to prescribe antibiotics for viral infections where they are ineffective. 8 Pharmaceutical companies have an incentive to sell as much volume as possible in the period between the drug’s Food and Drug Administration (“FDA”) approval and the end of its twenty-year patent term.

The problem of liberal prescription of antibiotics has been much discussed in medical and policy circles. 9 It is widely agreed that an important part of the solution is antimicrobial stewardship, which the Infectious Diseases Society of America defines as follows:

Antimicrobial stewardship refers to coordinated interventions designed to improve and measure the appropriate use of antimicrobials by promoting the selection of the optimal antimicrobial drug regimen, dose, duration of therapy, and route of administration. The major objectives of antimicrobial stewardship are to achieve optimal clinical outcomes related to antimicrobial use, to minimize toxicity and other adverse events, to reduce the costs of health care for infections, and to limit the selection for antimicrobial resistant strains.10

The most dramatic outcome thus far of the policy discussion, in the United States at least, is that the Centers for Medicare and Medicaid Services updated its “Conditions of Participation.”11 These updated “Conditions of Participation” (issued as a result of an executive order by President Obama in 2014) require all hospitals participating in Medicare and Medicaid to establish and maintain “antibiotic stewardship programs.”12 These conditions are already in effect for acute care hospitals and are expected to go into effect generally by the end of 2018.13

An additional incentive for too liberal use of antibiotics comes from outside of the healthcare industry. These drugs are useful as a growth promoter for livestock, and it has been shown that this use can lead to the growth of resistant bacteria, which can then infect human beings. 14 Such use of most antibiotics is now banned in the European Union member states, Mexico, New Zealand, and South Korea.15 In the United States and Canada, regulatory agencies have issued guidelines against this use of antibiotics that are deemed medically important.16

The second aspect of the crisis is the dearth of new antimicrobial drugs in development. A 2017 World Health Organization report projects that approximately ten new antibiotics and biologicals will be approved in the next ten years but warns that “these new treatments will add little to the already existing arsenal” because most of them will be “modifications of existing antibiotic classes,” which are “only short term solutions as they usually cannot overcome multiple existing resistance mechanisms and do not control the growing number of pan-resistant pathogens.”17

Few new antimicrobial drugs are in development because there is a low return on the investment needed to discover such drugs and shepherd them through the approval process. This is the reason why Aventis, Bristol-Myers, Squibb, Eli Lilly, Glaxo SmithKline, Proctor and Gamble, Roche, and Wyeth all “greatly curtailed, wholly eliminated or spun off their antibacterial research” between 1999 and 2003.18 The already low return on investment will dwindle as stewardship guidelines are adopted and the drugs are prescribed more judiciously.19

The Chatham House Working Group on New Antibiotic Business Models summarizes the situation thusly:

Today, few large pharmaceutical companies retain active antibacterial drug discovery programmes. One reason is that it is scientifically challenging to discover new antibiotics that are active against the antibiotic-resistant bacterial species of current clinical concern. Another core issue, however, is diminishing economic incentives. Increasingly, there are calls to conserve the use of truly novel antibiotics, which might limit sales severely and discourage greater investment in R&D. Meanwhile, unless they see evidence of superiority, healthcare payers are unwilling to pay prices that would directly support the cost of development, provide a competitive return on investment and reflect the value to society of maintaining a portfolio of antibiotics adequate to overcome growing resistance.

A principal reason for this is the mismatch between the current business model for drugs and combating resistance. The current business model requires high levels of antibiotic use in order to recover the costs of R&D. But mitigating the spread of resistance demands just the opposite: restrictions on the use of antibiotics. Economic incentives play a key role in the global resistance problem, leading to overuse of these precious drugs at the same time as companies are abandoning the field; and the increasing restrictions on inappropriate use of antibiotics make them relatively unprofitable compared with other disease areas.20

### 3

#### CP: The member nations of the World Trade Organization ought to reduce intellectual property protections for medicines except for orphan drugs.

#### Only exclusive patent protection rights paired with incentives can solve malaria, leprosy, and initially rare diseases

Henry Grabowski 2, Patents, Innovation and Access to New Pharmaceuticals, *Journal of International Economic Law*, Volume 5, Issue 4, December 2002, Pages 849–860, <https://doi.org/10.1093/jiel/5.4.849>

* defined in a subsequent law as diseases or medical conditions which affect fewer than 200,000 patients

In 1983, Congress passed the Orphan Drug Act, which provided a variety of incentives to undertake R&D on orphan drug indications (defined in a subsequent law as diseases or medical conditions which affect fewer than 200,000 patients).37 The economic incentives included in the Act involved R&D tax credits, a clinical research grants programme, accelerated reviews at the FDA, and a guaranteed market exclusivity period of 7 years from the date of FDA approval (this was separate from any normal patent protection that might also apply to these products). Funding for R&D has also been provided by various non-profit foundations focused on particular rare illnesses. The effect of these incentives on the development of new orphan drugs has been impressive. In the period between 1983 and 1999, more than 200 drugs and biologicals for rare diseases have been introduced.38 This represents more than a 12-fold annual increase compared to the decade prior to the enactment of the law, when fewer than 10 such products came to the market for the entire 10-year period. In a recent paper, Professor Frank Lichtenberg has shown that the Act has had a favourable effect on mortality from rare illnesses. While the number of deaths from rare diseases had been increasing faster than those from other diseases in the 5-year period prior to 1983, the number of deaths from rare diseases declined, both in absolute terms and relative to other deaths, in the post-1983 period.39 To attack the ‘orphan disease’ problem confronting third world countries for diseases like malaria and leprosy, one needs an international counterpart to the US Orphan Drug Act. From a scientific standpoint, it is an auspicious time to proceed with such a programme, given the recent advances in genom- ics which enhance the possibility of developing significant new vaccines and therapies for infectious diseases prevalent in less affluent countries. As in the case of the Orphan Drug Act, a multifaceted approach is necessary including R&D subsidies to firms with promising new technologies. These could be funded through government as well as non-profit charitable entities and public-private partnerships. Given the low-income base of third world mar- kets, success of these programmes might well hinge upon guarantees to pur- chase amounts of economically sustainable products that are successfully developed. The purchase agreements could be tied to up-front commitments from the firms on the product’s price within third-world markets. Michael Kremer has characterized R&D incentive programmes based on purchase guarantees as ‘pull’ programmes and analyzed how they could be designed in the context of new vaccines for third-world diseases.40 A variety of risk- and reward-sharing arrangements between pharmaceutical firms and funding sponsors could be envisioned. The objectives would be to provide incentives for new R&D programmes for diseases in developing countries. For example, under the Gates Foundation-sponsored International AIDS Vaccine Initiative (IAVI), firms have received grants to partially sup- port development of AIDS vaccines targeted to African strains of the disease. The firms retain international patent rights to the technology, but have agreed to supply any approved vaccines developed from this programme at a small margin over cost to developing countries. Such terms can be particularly attractive to earlier stage biotech firms seeking funding for proof of principle for a new technology with multiple applications. Similarly, the Global Alli- ance for TB Drug Development has recently announced a memorandum of understanding with Chiron for the development of a new TB drug for which no royalties would be due on sales in less-developed countries.41 In summary, the success of the US Orphan Drug Act in stimulating R&D investment and innovation for diseases with low expected market potential provides a useful model for the orphan disease problem confronting less indus- trialized countries. While the characteristics of particular programmes may differ significantly from those employed in the case of the US Orphan Drug Act, the basic principle of public and private risk sharing within the context of a system of market incentives would appear to be a fruitful guiding principle.

#### Orphan drug targeting has prevented hundreds of thousands of deaths and is k2 combating HIV mortality

Lichtenberg 1, Frank R. "The effect of new drugs on mortality from rare diseases and HIV." (2001). <https://www.nber.org/papers/w8677>

I have investigated the effect of large increases in the number of drugs available to treat rare diseases and HIV on mortality associated with them. Figure 9 indicates that mortality from both diseases declined dramatically following increases in drug approvals. Before the Orphan Drug Act went into effect (between 1979 and 1984), mortality from (initially) rare diseases grew at the same rate as mortality from other diseases. In contrast, during the next five years, mortality from (initially) rare diseases grew more slowly than mortality from other diseases. I estimate that one additional orphan drug approval in year t prevents 211 deaths in year t+1 and ultimately prevents 499 deaths, and that about 108 thousand deaths from rare diseases will ultimately be prevented by all of the 216 orphan drugs that have been approved since 1983. Deaths are more closely related to the number of orphan product designations than they are to the number of approvals. Consistent with previous patient-level studies of HIV, I find that new drugs played a key role in the post-1995 decline in HIV mortality. I estimate that one additional HIV drug approval in year t will prevent 5986 HIV deaths in year t+1 and ultimately prevent 33,819 HIV deaths. HIV drug approvals have reduced mortality both directly and indirectly (via increased drug consumption). HIV mortality depends on both 15 the quality and the quantity of medications consumed, and new drug approvals have a sizeable impact on drug consumption: one additional HIV drug approval in year t results in 1.2 million additional HIV drug units consumed in year t+1 and ultimately result in 3.6 million additional HIV drug units consumed.

#### AMR superbugs cause 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

### 4

#### CP: The member nations of the World Trade Organization except for the Republic of India should reduce intellectual property protections for medicines. The Republic of India should reduce intellectual property protections for medicines excluding traditional medicine.

#### Traditional medicine protections key for sustaining communities – India is a key leader

WIPO 11 (WIPOMAGAZINE, [WIPO is the global forum for intellectual property (IP) services, policy, information and cooperation, self-funding agency of the United Nations, with 193 member states.], June 2011, “Protecting India’s Traditional Knowledge“, No Publication, accessed: 8-8-2021, https://www.wipo.int/wipo\_magazine/en/2011/03/article\_0002.html) ajs

In just under two years, in Europe alone, India has succeeded in bringing about the cancellation or withdrawal of 36 applications to patent traditionally known medicinal formulations. The key to this success has been its Traditional Knowledge Digital Library (TKDL), a database containing 34 million pages of formatted information on some 2,260,000 medicinal formulations in multiple languages. Designed as a tool to assist patent examiners of major intellectual property (IP) offices in carrying out prior art1 searches, the TKDL is a unique repository of India’s traditional medical wisdom. It bridges the linguistic gap between traditional knowledge expressed in languages such as Sanskrit, Arabic, Persian, Urdu and Tamil, and those used by patent examiners of major IP offices. India’s TKDL is proving a powerful weapon in the country’s fight against erroneous patents, sometimes referred to as “biopiracy”. In this article, Dr. V.K. Gupta2, the author and architect of India’s TKDL, explains the critical role that this unique tool plays in protecting India’s traditional knowledge.

The significance of traditional knowledge

Traditional knowledge (TK) is integral to the identity of most local communities. It is a key constituent of a community’s social and physical environment and, as such, its preservation is of paramount importance. Attempts to exploit TK for industrial or commercial benefit can lead to its misappropriation and can prejudice the interests of its rightful custodians. In the face of such risks, there is a need to develop ways and means to protect and nurture TK for sustainable development in line with the interests of TK holders. The preservation, protection and promotion of the TK-based innovations and practices of local communities are particularly important for developing countries. Their rich endowment of TK and biodiversity plays a critical role in their health care, food security, culture, religion, identity, environment, trade and development. Yet, this valuable asset is under threat in many parts of the world.

There are concerns that this knowledge is being used and patented by third parties without the prior informed consent of TK holders and that few, if any, of the derived benefits are shared with the communities in which this knowledge originated and exists. Such concerns have pushed TK to the forefront of the international agenda, triggering lively debate about ways to preserve, protect, further develop and sustainably use TK. Documenting and digitizing TK-related information in the form of a TKDL is proving to be an effective means of preserving TK and of preventing its misappropriation by third parties. India is a pioneer in this field.

#### It’s key to health

Sen and Chakraborty 17 (Saikat Sen[] and Raja Chakraborty [], 06-28-2017, “Revival, modernization and integration of Indian traditional herbal medicine in clinical practice: Importance, challenges and future“, PubMed Central (PMC), accessed: 8-8-2021, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5388083/) ajs

Plants are always the key source of drug or treatment strategy in different traditional medicinal systems. In recent years, many people are choosing to plant based medicines or products to improve their health conditions or as curative substance either alone or in combination with others. According to the WHO, herbs or herbal products are used by the large number of populations for basic healthcare needs. Herbal medicine includes herbs, herbal materials (like plant parts) or preparations, processed and finished herbal products, active ingredients.20, 21 In recent years, a huge resurgence of the use of herbal product due to the side effects of modern drugs, failure of modern therapies for against chronic diseases, and microbial resistance. It is estimated that nearly 75% of the plant based therapeutic entities used worldwide were included from traditional/folk medicine. In India, approximately 70% of modern drug are discovered from natural resources and number of other synthetic analogues have been prepared from prototype compounds isolated from plants.20, 22, 23 It was reported that more than 60% of cancer drug available in market or in testing are based on natural products. Currently, about 80% of antimicrobial, immunosuppressive, cardiovascular, and anticancer drugs are derived from plant sources. More than 70% entities among 177 anticancer drugs approved are based on natural products or mimetic. About 25% prescription drug found globally are derived from plant sources, and nearly 121 such drugs entity are in use. Thirteen drugs of natural origin are approved in United States between 2005 and 2007, and clinical trials are going on more than 100 natural product-based drugs. It was also estimated that 11% of the total 252 drugs found in essential medicine list of WHO are exclusively of plant origin.24, 25 In Indian traditional medicine a large number of plants are used. It was estimated that Ayurveda uses 1200–1800 plants, Siddha medicine includes 500–900 plants, Unani utilize 400–700 medicinal plants and Amchi medicine uses nearly 300 plants while folk healers of India use more than 7500 medicinal plants in different medicine. Three classical Ayurvedic literature Charaka Samhita, Sushruta Samhita and Astanga Hridaya mentioned about 526,573 and 902 number of plants.17, 26, 27

#### 1AR theory is skewed towards the aff –

#### a) the 2NR must cover substance and over-cover theory, since they get the collapse and persuasive spin advantage of the 3min 2AR,

#### b) their responses to my counter interp will be new, which means 1AR theory necessitates intervention,

#### c) they have a 7-6 advantage on all 1AR offs.

#### Implications –

#### a) drop the arg to minimize the chance the round is decided unfairly,

#### b) use reasonability with a bar of defense or the aff always wins since the 2AR can line by line the whole 2NR without winning real abuse

#### c) multiple 1AR shells bad – they can collapse to one and generate a 3:1 skew in ballot access

#### Condo –

#### 1] Experimentation – lack of condo means negs never experiment with new args, which results in stale debates where each neg reads the same position every round since they know how to win it – our model incentivizes research for new options which o/w since research skills are the only portable impact

#### 2] Neg flex – affs choose the advocacy and have infinite prep for frontlines and hell 1AR’s – negs need to prep every aff but affs can go deep on 1 or 2 affs – condo balances this by allowing negs many options. Neg flex internal link turns their fairness impact – aff bias because of first and last speech, picking the focal point of the debate and this limitless topic without any core neg generic makes it try or die for the neg

#### PICs –

#### 1] Topic lit – the cards on it prove they destroy core neg ground, the PIC is part of the literature and a core controversy – that solves predictability and link turns ground cuz its in the lit and you should’ve seen it when writing the biggest aff on the topic – if you weren’t able to answer this, it means you need to cut a better aff and do research

#### 2] Research skills and depth – PICs incentivize exploring the bounds of the topic and developing good research skills – our model incentivizes diving deep to find new options which o/w cuz research skills are the only portable impact – independently, in depth research is good and o/w breadth – a) real world policymakers talk about one proposal being good or bad to resolve an issue –

#### 3] cross apply neg flex

### Case

#### Focus on large scale catastrophes is good and they outweigh – appeals to social costs, moral rules, and securitization play into cognitive biases and flawed risk calculus – 2020 is living proof

Weber 20 (ELKE U. WEBER is Gerhard R. Andlinger Professor in Energy and the Environment and Professor of Psychology and Public Affairs at Princeton University.), November-December 2020 Issue, "Heads in the Sand," Foreign Affairs, <https://www.foreignaffairs.com/articles/2020-10-13/heads-sand> mvp

We are living in a time of crisis. From the immediate challenge of the COVID-19 pandemic to the looming existential threat of climate change, the world is grappling with massive global dangers—to say nothing of countless problems within countries, such as inequality, cyberattacks, unemployment, systemic racism, and obesity. In any given crisis, the right response is often clear. Wear a mask and keep away from other people. Burn less fossil fuel. Redistribute income. Protect digital infrastructure. The answers are out there. What’s lacking are governments that can translate them into actual policy. As a result, the crises continue. The death toll from the pandemic skyrockets, and the world makes dangerously slow progress on climate change, and so on.

It’s no secret how governments should react in times of crisis. First, they need to be nimble. Nimble means moving quickly, because problems often grow at exponential rates: a contagious virus, for example, or greenhouse gas emissions. That makes early action crucial and procrastination disastrous. Nimble also means adaptive. Policymakers need to continuously adjust their responses to crises as they learn from their own experience and from the work of scientists. Second, governments need to act wisely. That means incorporating the full range of scientific knowledge available about the problem at hand. It means embracing uncertainty, rather than willfully ignoring it. And it means thinking in terms of a long time horizon, rather than merely until the next election. But so often, policymakers are anything but nimble and wise. They are slow, inflexible, uninformed, overconfident, and myopic.

Why is everyone doing so badly? Part of the explanation lies in the inherent qualities of crises. Crises typically require navigating between risks. In the COVID-19 pandemic, policymakers want to save lives and jobs. With climate change, they seek a balance between avoiding extreme weather and allowing economic growth. Such tradeoffs are hard as it is, and they are further complicated by the fact that costs and benefits are not evenly distributed among stakeholders, making conflict a seemingly unavoidable part of any policy choice. Vested interests attempt to forestall needed action, using their money to influence decision-makers and the media. To make matters worse, policymakers must pay sustained attention to multiple issues and multiple constituencies over time. They must accept large amounts of uncertainty. Often, then, the easiest response is to stick with the status quo. But that can be a singularly dangerous response to many new hazards. After all, with the pandemic, business as usual would mean no social distancing. With climate change, it would mean continuing to burn fossil fuels.

But the explanation for humanity’s woeful response to crises goes beyond politics and incentives. To truly understand the failure to act, one must turn to human psychology. It is there that one can grasp the full impediments to proper decision-making—the cognitive biases, emotional reactions, and suboptimal shortcuts that hold policymakers back—and the tools to overcome them.

AVOIDING THE UNCOMFORTABLE

People are singularly bad at predicting and preparing for catastrophes. Many of these events are “black swans,” rare and unpredictable occurrences that most people find difficult to imagine, seemingly falling into the realm of science fiction. Others are “gray rhinos,” large and not uncommon threats that are still neglected until they stare you in the face (such as a coronavirus outbreak). Then there are “invisible gorillas,” threats in full view that should be noticed but aren’t—so named for a psychological experiment in which subjects watching a clip of a basketball game were so fixated on the players that they missed a person in a gorilla costume walking through the frame. Even professional forecasters, including security analysts, have a poor track record when it comes to accurately anticipating events. The COVID-19 crisis, in which a dystopic science-fiction narrative came to life and took everyone by surprise, serves as a cautionary tale about humans’ inability to foresee important events.

Not only do humans fail to anticipate crises; they also fail to respond rationally to them. At best, people display “bounded rationality,” the idea that instead of carefully considering their options and making perfectly rational decisions that optimize their preferences, humans in the real world act quickly and imperfectly, limited as they are by time and cognitive capacity. Add in the stress generated by crises, and their performance gets even worse.

Because humans don’t have enough time, information, or processing power to deliberate rationally, they have evolved easier ways of making decisions. They rely on their emotions, which serve as an early warning system of sorts: alerting people that they are in a positive context that can be explored and exploited or in a negative context where fight or flight is the appropriate response. They also rely on rules. To simplify decision-making, they might follow standard operating procedures or abide by some sort of moral code. They might decide to imitate the action taken by other people whom they trust or admire. They might follow what they perceive to be widespread norms. Out of habit, they might continue to do what they have been doing unless there is overwhelming evidence against it.

Not only do humans fail to anticipate crises; they also fail to respond rationally to them.

Humans evolved these shortcuts because they require little effort and work well in a broad range of situations. Without access to a real-time map of prey in different hunting grounds, for example, a prehistoric hunter might have resorted to a simple rule of thumb: look for animals where his fellow tribesmen found them yesterday. But in times of crisis, emotions and rules are not always helpful drivers of decision-making. High stakes, uncertainty, tradeoffs, and conflict—all elicit negative emotions, which can impede wise responses. Uncertainty is scary, as it signals an inability to predict what will happen, and what cannot be predicted might be deadly. The vast majority of people are already risk averse under normal circumstances. Under stress, they become even more so, and they retreat to the familiar comfort of the status quo. From gun laws to fossil fuel subsidies, once a piece of legislation is in place, it is hard to dislodge it, even when cost-benefit analysis argues for change.

#### Their args:

#### 1] We agree with Kessler than extinction doesn’t have infinite impact just a really really big one – that means that when the probably goes to like 0.00001% we can disregard it but there’s zero way they’re getting the DA anywhere near that which means defaulting to probability times magnitude is the only objective metric for impact calc

#### 2] A. Weber flips cognitive bias or at least means it’s a wash B. Winter and Leighton just proves slow violence is deprioritized but that should justify objective impact calculus, not an egregious overcorrection that discounts all other impacts

#### 3] A. there isn’t a 1-1 coorelation to positions defended in round and our actions and epistemology outside of debate – they haven’t won spillover

#### 4] Memmi is hyperbole – Racism is awful because it causes massive amounts of unjust suffering, not because it’s the root cause of every conflict which is a ridiculous claim that needs empirical warrants or the only end line evil – you should reject impact justified preclusive framing mechanisms that elevate certain forms of oppression as they will always marginalize others – only objective utilitarianism solves

#### 5] AC Sell just proves big pharma sucks which is facts but that’s not a reason the aff can suddenly overcome global capitalism or solve impacts that operate on a higher layer – avoiding complicity in neoliberalism only matters under a framework that care about something other than consequences which they haven’t justified

#### Squo solves – plan increases price of scarce materials and results in costly, ineffective facilities

Mcmurry-Heath 8/18 (Michelle Mcmurry-Heath, [physician-scientist and president and CEO of the Biotechnology Innovation Organization.], 8-18-2021, “Waiving intellectual property rights would harm global vaccination“, STAT, accessed: 8-19-2021, https://www.statnews.com/2021/08/18/waiving-intellectual-property-rights-compromise-global-vaccination-efforts/) ajs

Covid-19 vaccines are already remarkably cheap, and companies are offering them at low or no cost to low-income countries. Poor access to clinics and transportation are barriers in some countries, but the expense of the shot itself is not. In fact, if the World Trade Organization grants the IP waiver, it could make these vaccines more expensive.

Here’s why. Before Covid-19 emerged, the world produced at most [5.5 billion doses](https://www.barrons.com/articles/a-plan-to-break-the-vaccine-manufacturing-bottleneck-51621952245) of various vaccines every year. Now the world needs an additional [11 billion doses](https://www.who.int/director-general/speeches/detail/director-general-s-opening-remarks-at-the-g7-summit---12-june-2021) — including billions of doses of mRNA vaccines that no one had ever mass-manufactured before — to fully vaccinate every eligible person on the planet against the new disease.

Even as Covid-19 vaccines were still being developed, pharmaceutical companies began retrofitting and upgrading existing facilities to produce Covid-19 vaccines, at a cost of $40 to $100 million each. Vaccine developers also licensed their technologies to well-established manufacturers, like the Serum Institute of India, to further increase production. As a result, almost every facility in the world that can quickly and safely make Covid-19 vaccines is already doing so, or will be in the next few months.

The cutting-edge mRNA vaccines from Moderna and Pfizer-BioNTech face an even bigger capacity issue. Since the underlying technology is new, there are no mRNA manufacturing facilities sitting idle with operators just waiting for licensing agreements to turn on the machines. Nor are there trained personnel to run them or ensure safety and quality control. Embedding delicate mRNA vaccine molecules inside lipid nanoparticle shells at temperatures colder than Antarctica isn’t as easy as following a recipe from Bon Appetit.

Another big barrier to producing more shots is a shortage of raw materials. Suspending intellectual property protections and allowing any manufacturer to try to produce these vaccines, regardless of preparedness or experience, would increase the demand for scarce raw materials, driving up prices and impeding production.

Nor could all companies that suddenly get a green light due to suspended intellectual property rights produce vaccines as cheaply or quickly as existing manufacturers. Building a new vaccine manufacturing facility costs about $700 million, takes many months — if not years — to build and, once opened, requires another [four to six months](https://www.americanprogress.org/issues/healthcare/reports/2020/07/28/488196/comprehensive-covid-19-vaccine-plan/) to start producing vaccine doses. And because negotiations surrounding the WTO waiver, which began this summer, could take until December before they are completed, it wouldn’t be until well into 2023 or later that any additional doses would become available.

That’s slower than our current production rate. According to a report from Duke University’s [Global Health Innovation Center](https://launchandscalefaster.org/covid-19/vaccinemanufacturing), companies are on track to manufacture enough shots in 2021 to fully vaccinate at least 70% of the global population against Covid-19 — the level required to achieve herd immunity.

Covid-19 vaccines are saving millions of lives and protecting trillions of dollars of economic activity for an exceptionally low cost. Israel, for example, which has one of the world’s highest vaccination rates, paid [$23.50 per dose](https://www.timesofisrael.com/israel-said-to-be-paying-average-of-47-per-person-for-pfizer-moderna-vaccines/) for early shipments, for a total of about $315 million. That’s approximately equal to the gross domestic productivity losses incurred during [just two days of shutdowns](https://www.bmj.com/content/372/bmj.n281) in the country.

Many countries are buying shots for under $10 per dose. India and South Africa — the two countries leading the petition to gut IP rights — are paying just $8 and $5.25 per dose, respectively. For reference, a regular flu shot costs about $14 in the United States, and pediatric vaccines average about $55 per dose.

Meanwhile, low-income countries that can’t afford even modest prices are getting their vaccines at no charge. [COVAX](https://www.who.int/initiatives/act-accelerator/covax), the international nonprofit vaccine distributor, aims to deliver 2 billion doses to developing nations by the end of the year.

President Biden vowed to make America the world’s [“arsenal of vaccines.”](https://www.whitehouse.gov/briefing-room/speeches-remarks/2021/05/17/remarks-by-president-biden-on-the-covid-19-response-and-the-vaccination-program-4/) The U.S. has already committed $4 billion to COVAX, has donated more than 100 million vaccine doses abroad, and is on track to donate [500 million more](https://www.npr.org/sections/goatsandsoda/2021/08/03/1023822839/biden-is-sending-110-million-vaccines-to-nations-in-need-thats-just-a-first-step) by the end of summer. Other countries are following the administration’s leadership and ramping up their donations.