## 1

#### Interp: Debaters must open source or cite all broken constructive positions with highlighting from TOC bid tournaments on the 2021-2022 NDCA LD wiki after they read them in round.

#### Violation: no wiki—screen shot in doc

#### Graphical user interface, text, application Description automatically generated

#### Standards

#### 1] Levels the playing field--

Antonucci 05 [Michael (Debate coach for Georgetown; former coach for Lexington High School); “[eDebate] open source? resp to Morris”; December 8; http://www.ndtceda.com/pipermail/edebate/2005-December/064806.html //]

a. Open source systems are preferable to the various punishment proposals in circulation. It's better to share the wealth than limit production or participation. Various flavors of argument communism appeal to different people, but banning interesting or useful research(ers) seems like the most destructive solution possible. Indeed, open systems may be the only structural, rule-based answer to resource inequities. Every other proposal I've seen obviously fails at the level of enforcement. Revenue sharing (illegal), salary caps (unenforceable and possibly illegal) and personnel restrictions (circumvented faster than you can say 'information is fungible') don't work. This would - for better or worse. b. With the help of a middling competent archivist, an open source system would reduce entry barriers. This is especially true on the novice or JV level. Young teams could plausibly subsist entirely on a diet of scavenged arguments. A novice team might not wish to do so, but the option can't hurt. c. An open source system would fundamentally change the evidence economy without targeting anyone or putting anyone out of a job. It seems much smarter (and less bilious) to change the value of a professional card-cutter's work than send the KGB after specific counter-revolutionary teams.

#### 2] Clash—tests internal links negs get to dig into the aff case and actually understand link scenarios a] K2 neg strat, you cant respond to arguments you don’t understand b] k2 education

#### 3] Evidence ethics—disclosure is the only way to verify ethically cut cards, 4 minutes of prep time is too short, a] ev ethics is part of being a good academic that’s a voter b] miscutting means no limits on lit—affs become unpredictable ruins neg strat

#### 4] Cites don’t cut it a] no highlighting makes positions unpredictable, undermines clash and ev ethics b] new debaters won’t learn by example

#### Voters

#### Education is a voter—it’s the only takeaway from debate

#### Access is a voter—access is k2 fairness, not everyone has a fair shot and equitable education

#### If they make debate impossible drop them, this would just be a waste of time

#### No RVI a] debaters will bait theory for RVI’s making LD worse b] you don’t get a cookie for being fair

#### Competing interps a] Reasonability is arbitrary and requires judge intervention b] competing interps is a race to the top for the best norms

## 2

#### Interpretation: All pieces of evidence read must have a citation or article title that at least lists the url or the title of the article.

#### Violation: they say 25% don’t have meds because the WHO says but there was no link, also look to most of their other ev—there aren’t links

#### That’s a voter for evidence ethics – no way to determnine whether the evidence was made up with an incomplete cite – with the url or title I can trace the article – maintaining ethical ev practices is key to being good academics and we should be able to verify you didn’t cheat

## 3

#### Innovation high and evergreening is false – postdates your ev and we have stats

Ezell 20. Stephen Ezell, July 2020, “Ensuring U.S. Biopharmaceutical Competitiveness,” Information Technology and Innovation Foundation, <http://www2.itif.org/2020-biopharma-competitiveness.pdf> sean!

Medicines are critical to health. Since 2000, the FDA has approved more than 500 new medicines. 2 As of 2020, biopharmaceutical companies in the United States have more than 3,400 drugs under clinical development, accounting for almost half of the estimated 8,000 medicines under development globally (1,100 of which are being developed to treat various forms of cancers).3 And while some have asserted that biotechnology companies focus too often on “me-too” drugs that compete with other treatments already on the market, the reality is that most of the drugs currently under development seek to tackle some of the world’s most intractable diseases, including Alzheimer’s, cancer, and communicable diseases. This includes 130 coronavirus vaccines under development globally as well as 144 active trials of coronavirus therapeutic agents, and another 457 development programs for new therapeutic agents, which the FDA is tracking through its Coronavirus Treatment Acceleration Program.4 Moreover, such arguments miss that many of the drugs developed in recent years have in fact been first of their kind. For instance, in 2014, the FDA’s Center for Drug Evaluation and Research (CDER) approved 41 new medicines (the most since 1996 at that point), many of which were first-in-class medicines, meaning they represent a possible new pharmacological class for treating a medical condition.5 In that year, 28 of the 41 drugs approved were considered biologic or specialty agents, and 41 percent of medicines approved were intended to treat rare diseases. In 2018, CDER approved a record 59 novel drugs, and in 2019, 48 novel drugs, making 2019 the third-largest approval class in the past 25 years.6 As of 2020, 74 percent of medicines in clinical development in the United States are potentially first-in-class medicines, including 86 percent for Alzheimer’s, 70 percent for various forms of cancer, and 73 percent for cardiovascular diseases

#### IP protections motivate innovators to take risks – that means long term development and prolif

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With the belief that medicines should be “public goods,” there is literally no support in some quarters for the application of the WTO TRIPS Agreement to IP rights in medicines. Any protection of the IP rights in such goods is viewed as a violation of human rights and of the overall public interest. This view, though, does not reflect the practical reality of a world in which many medicines would simply not exist if it were not for the existence of IP rights and the protections they are afforded. Technically, IP rights are exceptions to free trade. A long‐​standing general discussion in the WTO has been about when these exceptions to free trade should be allowed and how far they should be extended. The continuing debate over IP rights in medicines is only the most emotional part of this overall conversation. Because developed countries have, historically, been the principal sources of IP rights, this lengthy WTO dispute has largely been between developed countries trying to uphold IP rights and developing countries trying to limit them. The debate over the discovery and the distribution of vaccines for COVID-19 is but the latest global occasion for this ongoing discussion. The primary justification for granting and protecting IP rights is that they are incentives for innovation, which is the main source for long‐​term economic growth and enhancements in the quality of human life. IP rights spark innovation by “enabling innovators to capture enough of the benefits of their own innovative activity to justify taking considerable risks.”18 The knowledge from innovations inspired by IP rights spills over to inspire other innovations. The protection of IP rights promotes the diffusion, domestically and internationally, of innovative technologies and new know‐​how. Historically, the principal factors of production have been land, labor, and capital. In the new pandemic world, perhaps an even more vital factor is the creation of knowledge, which adds enormously to “the wealth of nations.” Digital and other economic growth in the 21st century is increasingly ideas‐​based and knowledge intensive. Without IP rights as incentives, there would be less new knowledge and thus less innovation. In the short term, undermining private IP rights may accelerate distribution of goods and services—where the novel knowledge that went into making them already exists. But in the long term, undermining private IP rights would eliminate the incentives that inspire innovation, thus preventing the discovery and development of knowledge for new goods and services that the world needs. This widespread dismissal of the link between private IP rights and innovation is perhaps best reflected in the fact that although the United Nations Sustainable Development Goals for 2030 aspire to “foster innovation,” they make no mention of IP rights.19

#### Innovation is k2 stopping bioterror

Marjanovic and Fejiao ‘20 Marjanovic, Sonja, and Carolina Feijao. Sonja Marjanovic, Ph.D., Judge Business School, University of Cambridge. Carolina Feijao, Ph.D. in biochemistry, University of Cambridge; M.Sc. in quantitive biology, Imperial College London; B.Sc. in biology, University of Lisbon. "Pharmaceutical Innovation for Infectious Disease Management: From Troubleshooting to Sustainable Models of Engagement." https://www.rand.org/pubs/perspectives/PEA407-1.html (2020). [Quality Control]

As key actors in the healthcare innovation landscape, pharmaceutical and life sci-ences companies have been called on to develop medicines, vaccines and diagnostics for pressing public health challenges. The COVID-19 crisis is one such challenge, but there are many others. For example, MERS, SARS, Ebola, Zika and avian and swine flu are also infectious diseases that represent public health threats. Infectious agents such as anthrax, smallpox and tularemia could present threats in a bioterrorism context.1 The general threat to public health that is posed by antimicrobial resistance is also well recognized as an area in need of pharmaceutical innovation. Innovating in response to these challenges does not always align well with pharmaceutical industry commercial models, shareholder expectations and compe-tition within the industry. However, the expertise, networks and infrastructure that industry has within its reach, as well as public expectations and the moral imperative, make pharmaceutical companies and the wider life sciences sector an indispensable partner in the search for solutions that save lives. This perspective argues for the need to establish more sustainable and scalable ways of incentivising pharmaceu-tical innovation in response to infectious disease threats to public health. It considers both past and current examples of efforts to mobilise pharmaceutical innovation in high commercial risk areas, including in the context of current efforts to respond to the COVID-19 pandemic. In global pandemic crises like COVID-19, the urgency and scale of the crisis – as well as the spotlight placed on pharmaceutical companies – mean that contributing to the search for effective medicines, vaccines or diagnostics is essential for socially responsible companies in the sec-tor.2 It is therefore unsurprising that we are seeing indus-try-wide efforts unfold at unprecedented scale and pace. Whereas there is always scope for more activity, industry is currently contributing in a variety of ways. Examples include pharmaceutical companies donating existing com-pounds to assess their utility in the fight against COVID-19; screening existing compound libraries in-house or with partners to see if they can be repurposed; accelerating tri-als for potentially effective medicine or vaccine candidates; and in some cases rapidly accelerating in-house research and development to discover new treatments or vaccine agents and develop diagnostics tests.3,4 Pharmaceutical companies are collaborating with each other in some of these efforts and participating in global R&D partnerships (such as the Innovative Medicines Initiative effort to accel-erate the development of potential therapies for COVID-19) and supporting national efforts to expand diagnosis and testing capacity and ensure affordable and ready access to potential solutions.3,5,6 The primary purpose of such innovation is to benefit patients and wider population health. Although there are also reputational benefits from involvement that can be realised across the industry, there are likely to be rela-tively few companies that are ‘commercial’ winners. Those who might gain substantial revenues will be under pres-sure not to be seen as profiting from the pandemic. In the United Kingdom for example, GSK has stated that it does not expect to profit from its COVID-19 related activities and that any gains will be invested in supporting research and long-term pandemic preparedness, as well as in developing products that would be affordable in the world’s poorest countries.7 Similarly, in the United States AbbVie has waived intellectual property rights for an existing com-bination product that is being tested for therapeutic poten-tial against COVID-19, which would support affordability and allow for a supply of generics.8,9 Johnson & Johnson has stated that its potential vaccine – which is expected to begin trials – will be available on a not-for-profit basis during the pandemic.10 Pharma is mobilising substantial efforts to rise to the COVID-19 challenge at hand. However, we need to consider how pharmaceutical innovation for responding to emerging infectious diseases can best be enabled beyond the current crisis. Many public health threats (including those associated with other infectious diseases, bioterror-ism agents and antimicrobial resistance) are urgently in need of pharmaceutical innovation, even if their impacts are not as visible to society as COVID-19 is in the imme-diate term. The pharmaceutical industry has responded to previous public health emergencies associated with infec-tious disease in recent times – for example those associated with Ebola and Zika outbreaks.11 However, it has done so to a lesser scale than for COVID-19 and with contribu-tions from fewer companies. Similarly, levels of activity in response to the threat of antimicrobial resistance are still low.12 There are important policy questions as to whether – and how – industry could engage with such public health threats to an even greater extent under improved innova-tion conditions.

#### Bioterror is the largest medical threat—it o/w’s pandemics on probability

Bakerlee ‘21 Chris Bakerlee is a Ph.D. candidate studying evolutionary genetics at Harvard University and a fellow in the Council on Strategic Risks’s Fellowship for Ending Bioweapons Programs. "Mother Nature is not 'the ultimate bioterrorist' - STAT." STAT, 8 Jan. 2021, www.statnews.com/2021/01/08/mother-nature-is-not-the-ultimate-bioterrorist. [Quality Control]

Taken together, these examples show that this meme no longer serves us well. It is undoubtedly a mistake to underestimate the threats from natural pathogens. At the same time, it is equally unwise to wield this 19-year-old expression like a magic wand, intending to briskly banish concerns about people causing harm with biology. We can’t afford to blind ourselves or others to the uncomfortable truth that, with each passing day, humans grow more capable of outdoing nature and harnessing biotechnology to cause harm on a staggering scale, by either cruelty or carelessness. Nature has no interests, motives, or political goals. To the extent it can be said to “want” anything, it is to perpetually enhance populations’ differential reproductive success, which only rarely aligns with causing greater harm to humans. Notably, the trillions of bacteria living in the average human’s colon appear to have adapted toward a peaceful and often mutually beneficial coexistence with their host. And even deadly pathogens may theoretically evolve toward making humans less sick if doing so opens up more opportunities for transmission between hosts. The process of natural selection, for all its power, is highly constrained in its ability to generate “superbugs” possessing a diabolical suite of traits. Like human bioengineers, natural selection must work around stubborn physiological trade-offs between traits, such as genome replication rate and mutation rate. But natural selection is also handicapped by near-sightedness, driving improvements in traits that enhance a population’s fitness in its current environment with no attention to maintaining or improving traits that enhance fitness in other environments. If creating an especially deadly pathogen were like winning a soccer match against a formidable opponent, natural selection would be competing with all the cunning of an especially persistent horde of 5-year-olds, glued to the ball and only ever capable of playing offense, defense, or goalie at any one time. By contrast, modern biologists are gaining the ability to see the whole field, develop an intuition about where the ball will be next, and play multiple positions simultaneously. Through a combination of rational design, directed evolution, breeding, and brute force trial and error, they can increasingly engineer organisms that excel in multiple desired functions at once, such as the ability to grow quickly in a massive industrial fermenter while churning out commercially valuable biomolecules. This growing capability promises tremendous benefits for agriculture, industry, and human health, but its potential application to the creation of pathogens poses serious concerns. It is worth emphasizing that trained biologists — let alone terrorists — still have difficulty one-upping natural selection’s creative output. Our understanding of biology is very much in its infancy. Yet our knowledge and capabilities are maturing rapidly, as evidenced by Twist’s prolific gene synthesis capabilities, along with recent feats in predicting protein structure, gene editing, and genome assembly. We are much closer to this exciting but frightening horizon today than we were in 2001, and this trend will likely persist. It’s also worth noting that, when it comes to weapons-grade biotechnology, states likely pose a greater risk than non-state terrorists. States have vastly more resources to support the development of biological weapons, and about 23 are known or suspected to have maintained biological weapons programs in the 20th century. Some programs, like North Korea’s, likely persist to this day. As countries jockey for advantage, state biological weapons programs remain an ever-present danger, despite the treaties and export controls designed to rein them in. Covid-19, which has exposed countries’ vulnerability to biological threats, has done little to mitigate this danger. Accidental releases pose an additional source of anthropogenic biorisk. Thanks to the U.S. government’s monitoring program, we know that dozens of agents and toxins with the potential to pose a severe threat to public health and agriculture are reported accidentally lost or released from U.S. labs every year. We also know that accidental releases around the world have already caused significant harm. Such risks increase as biotechnology expands across the world and gains in strength. Biotechnology, with all its promise and peril, is moving fast. It’s irresponsible of us to shrug off current and emerging biotechnological threats by reciting “Nature is the ultimate bioterrorist” like some article of faith. As with global warming, the cost of willful ignorance and inaction is high — and increasing. Our health security requires that we engage cautiously but honestly with the full spectrum of evolving biological risks, striving toward solutions with open eyes and moral courage

## 4

#### Text: The International Monetary Fund and the World Bank should pay reparations to indebted nations in the form of debt repudiation and a $650 billion COVID-19 aid package allocated to health infrastructure

#### Redirecting the IMF aid package is key to pulling developing nations out of medical disasters—that solves the aff

Kiderlin 8/3/21

(Sophie Kiderlin, Markets Fellow for Business Insider, PoliSci + IR@University of Bath. “The IMF has approved a $650 billion Covid-19 aid package, mainly going to rich countries - but it's urging them to share.” August 3, 2021. https://markets.businessinsider.com/news/currencies/imf-covid-pandemic-relief-aid-reserves-rich-countries-sdr-support-2021-8)//HW-CC

The International Monetary Fund has given the green light for a COVID-19 aid package worth $650 billion, the majority of which will go to rich countries - but it is encouraging them to share some of the funds. The aid, confirmed on Monday, is the IMF's biggest-ever distribution of monetary reserves and is meant to support countries struggling with debt and other financial fallout related to the pandemic. Members will be given Special Drawing Rights, or SDRs, in line with current quotas of holdings on August 23. Backed by major currencies such as the US dollar and the yen, SDRs are effectively the IMF's reserve assets. "This is a historic decision - the largest SDR allocation in the history of the IMF and a shot in the arm for the global economy at a time of unprecedented crisis," Kristalina Georgieva, managing director of the IMF, said in a statement. Of the $650 billion total package, around $275 billion is earmarked for emerging and developing countries, meaning $375 billion should go to more developed nations. Those richer members in strong economic positions will be able to reallocate parts of their reserves to other countries through the IMF, should they wish to do so. "We will also continue to engage actively with our membership to identify viable options for voluntary channeling of SDRs from wealthier to poorer and more vulnerable member countries to support their pandemic recovery and achieve resilient and sustainable growth," Georgieva said. The Covid-19 pandemic has put a substantial strain on economies worldwide, as productivity suffered and activity fell during lockdown restrictions. Governments faced increased costs in providing healthcare, vaccinations and protecting their citizens from the virus. Global stocks plunged last year as the impact of the pandemic landed, but are staging a recovery as coronavirus-related restrictions ease. Economies have been rebounding at different speeds and to different degrees. Those countries that saw lower COVID-19 caseloads or higher vaccination rates have made quicker progress than those still grappling with rising cases and deaths, where vaccination rates are low. Developed countries with bigger markets and more economic strength tend to fall into the first category, while emerging and developing countries are mainly in the latter.

#### Funding medical programs avoids brain drains and creates innovation

Mantovani and Wermelinger 20

(Iris Mantovani and Martin Wermelinger, march 2020 “Can FDI improve the resilience of health systems?” [https://www.oecd.org/investment/Can-FDI-improve-the-resilience-of-health-systems.pdf) LN](https://www.oecd.org/investment/Can-FDI-improve-the-resilience-of-health-systems.pdf)%20LN)

Despite highly polarised views for and against FDI in healthcare, there remain considerable gaps in the knowledge base underpinning these views. Most of the literature is based on theories, conjectures and anecdotal evidence, precluding a full assessment of the net benefits of FDI in the health sector that puts forward clear and informed policy recommendations (Zimny, 2013[34]; Blouin et al., 2006[35]; Smith, 2004[36]). Nevertheless, examining the key points considered in the literature is useful for raising policy questions and identifying areas for future research. The main risks and opportunities related to FDI in healthcare infrastructure and services can be summarised along three broad and inter-related dimensions: capacity, quality, and equity (Table 4). The most immediate appeal of FDI (and private investment more generally) in the health sector is debt-free investment that increases physical capacity and infrastructure and alleviates pre-existing shortages in the supply of healthcare. This increased capacity may be particularly beneficial in low-income countries that suffer from underinvestment in health infrastructure, as it eases pressures on public finances, and can potentially offer specialised medical services that were previously unavailable locally. Greater domestic capacity can thereby reduce the need for medical travel and reliance on imports of health services. In countries in which highly qualified doctors are underpaid, FDI in health services and infrastructure may further diminish or reverse potential international brain drains of qualified medical staff. Counter to this point, the capacity of public health services maybe suffer, as the presence of foreign investors that offer higher wages and better equipment may entice qualified personnel away from public (and private domestic) facilities, creating or aggravating an internal brain drain (Smith, 2004[36]). For instance, by one estimate, an increase of 100 000 additional foreign patients in private hospitals in Thailand leads to an internal brain drain of 240-700 medical doctors (Arunanondchai and Fink, 2007[37]). In addition to influencing capacity, FDI can affect the overall quality of host country health services through knowledge spillovers. By spreading innovations in medical technology, drugs and health services, as well as superior management techniques, organisational skills and information systems, and by creating employment opportunities that benefit the health sector and the economy at large, FDI provides an impetus to raise the standards and quality of healthcare (Mackintosh, 2003[39]). The flip side of the coin is that, as a result of heightened internal brain drain from lower-pay public facilities to higher-pay multinationals, with fewer resources, the quality of public health services may deteriorate. Moreover, better health technology of private sector providers may distort government incentives to invest in such technology in the public sector at the expense of more pressing social and public health needs (Smith, 2004[36]). While improving quality and increasing choice for nationals of the host country who can afford private health services, FDI can worsen inequality. Healthcare may become a two-tier system, with high-quality care for the rich and low-quality for the poor. This may or may not worsen access to the health system for patients who rely on public provision or public insurance schemes, depending on the structure of the domestic health sector and the safeguards that are in place to ensure accessibility and affordability. As noted in a study on ASEAN countries, existing health systems, with little FDI, already favour more affluent patients who are covered by private health insurance or can pay for treatment out-of-pocket (Arunanondchai and Fink, 2007[37]). Case study evidence of the impact of FDI on Indian hospital services suggests that private investment can play a complementary role in providing tertiary and speciality care but should not be considered as the substitute of public provisioning of healthcare services (Hooda, 2017[40]). The study concludes that the role of the government is to guarantee cost-effective care to the general population across remotest areas of the country. In short, the impact of FDI in health services and infrastructure for equity, access, costs, and quality of services is in large part dependent on the policies and safeguards governments put in place.

If adequate safeguards are in place, FDI can augment the resources available for investment and alleviate the pressure on the healthcare sector by expanding facilities for all (Chanda, 2002[41]). Nevertheless, health is a public good and FDI objectives in the health sector should be compatible with other social objectives like universal access and affordability. Regulation of the health sector is necessary to achieve these social objectives and advance the Sustainable Development Goals (SDGs). FDI promotion in the health sector is therefore not about deregulating, but better regulating, and sometime even regulating more, for instance to adopt higher quality standards for hospitals and clinics (Cattaneo, 2009[38]). Similarly, FDI promotion is not about challenging the public health sector, which often plays a crucial role in the supply of health services, but complementing the public sector by expanding the range of services available and raising their standards and efficiency.

# Case