I affirm resolved: The member nations of the World Trade Organization ought to reduce intellectual property protections for medicines.

#### Util is the only moral system available to policymakers, because of the degree of uncertainty which they exist under

Robert Goodin 90, fellow in philosophy, Australian National Defense University, THE UTILITARIAN RESPONSE, 1990, p. 141-2

My larger argument turns on the proposition that there is something special about the situation of public officials that makes utilitarianism more probable for them than private individuals. Before proceeding with the large argument, I must therefore say what it is that makes it so special about public officials and their situations that make it both more necessary and more desirable for them to adopt a more credible form of utilitarianism. Consider, first, the argument from necessity. Public officials are obliged to make their choices under uncertainty, and uncertainty of a very special sort at that. All choices – public and private alike – are made under some degree of uncertainty, of course. But in the nature of things, private individuals will usually have more complete information on the peculiarities of their own circumstances and on the ramifications that alternative possible choices might have for them. Public officials, in contrast, [they] are relatively poorly informed as to the effects that their choices will have on individuals, one by one. What they typically do know are generalities: averages and aggregates. They know what will happen most often to most people as a result of their various possible choices, but that is all. That is enough to allow[s] public policy-makers to usethe utilitarian calculus – assuming they want to use it at all – to chose general rules or conduct

# Contention 1: Reducing intellectual property protections for medicines would help at risk groups.

### Stronger IPP limits developing country access to medicine

**Jung and Kwon 15** [Jung, Youn, Institute of Health and Environment, Seoul National University, Seoul, Republic of Korea and Soonman Kwon, School of Public Health, Seoul National University, Seoul, Republic of Korea, July 2015, “The Effects of Intellectual Property Rights on Access to Medicines and Catastrophic Expenditure,” *International Journal of Health Services, vol. 45*, no. 3, pp. 507–29. DOI.org (Crossref), doi:10.1177/0020731415584560]/ Triumph Debate

\*IPR = Intellectual Property Rights

Discussion This study investigated how the national level of IPR is associated with individuals’ access to medicines and households’ experience of catastrophic expenditure for medicines. First, our results show that higher level of IPR is associated with low access to prescribed medicines. This adverse relationship between IPR and access to medicines is significant even after controlling for country income level and individuals’ socioeconomic status and demographic characteristics. Adding other variables, which reflect the characteristics of each country’s healthcare system, in the model did not change the significant effect of IPR on access to medicines, although the magnitude of the effect slightly decreased. These results imply that strengthened IPR for pharmaceuticals is functioning as a barrier to people’s access to medicines. Even though each country’s policy efforts, such as strengthening the infrastructure of healthcare provision and increasing the public expenditure for healthcare, have contributed to offsetting the negative impact of IPR on medicine utilization to some extent, the effect of IPR was still significant. Our results also show that IPR exerts an influence on medicine utilization only in countries above a certain income level. We did not observe the significant effect of IPR on access to medicines in low-income countries where GDP per capita is below $1000, whereas it was negatively associated with access to medicines in middle-income countries. These results are more likely to be related with access to healthcare, which is the premise of utilizing the prescription drugs. This study only included the population for whom medicines were prescribed when they visited health care providers, excluding the population who could not see healthcare providers even though they were in need. Given that a greater number of people are suffering from poor access to healthcare in low-income countries than in middle-income ones, no association between IPR and access to 524 International Journal of Health Services 45(3) medicines in low-income countries is more likely to be explained by this kind of sample selection problem. Furthermore, a gap between rules and practice in the enforcement of IPR may contribute to the non-significant impact of IPR in low-income countries. As Shadlen and colleagues pointed out,41 low-income countries may have a large gap between rules and reality with regard to IPR, considering their limited resources for implementation and enforcement of IPR. The GP index that we used as an index of IPR in this study was developed by a text-based approach using the existing legal and institutional arrangements for patent systems, so it may not show us the full picture of actual protection level for IPR. Thus, we cannot exclude the possibility of this type of measurement error in low-income countries. We also found that those who live in rural areas have better access to medicines than those who live in urban areas. This may be related to sample selection process. Rural areas are likely to have inferior healthcare infrastructure, so rural residents have more difficulties in utilizing healthcare service. Because rural residents included in this study are those who visit healthcare providers despite this barrier, it is possible that they have more propensity to use healthcare, including prescribed medicines, than urban residents. This possibility is supported by the result that the coefficient of rural residence is bigger and significant in lowincome countries, but not in middle-income countries, because the difference in healthcare infrastructure between rural and urban areas would be bigger in low-income countries than in middle-income ones. Next, our results show that the effects of the national healthcare system on access to medicines are not the same across countries with different income levels. Although essential medicines lists and the number of doctors had positive significant relationships with access to medicines in low-income countries, only a public share of total health expenditure had a significant impact in middleincome countries. This suggests that the main types of access barrier that countries face are different according to their income level. Middle-income countries tend to suffer from nonaffordable price of medicines rather than availability problems, whereas low availability of essential medicines is a more serious issue for low-income countries. Last, our results show that IPR is not associated with households’ catastrophic expenditure for medicines even though it is significantly associated with access to prescribed medicines. This is due to the possibility that many people cannot purchase medicines at all because of their poor purchasing capacity and the high price of medicines. As a result, they are likely to be excluded from the analysis. Accordingly, the results of this study provide strong empirical evidence for the linkage between IPR and access to medicines in developing countries. As we hypothesized, strengthening IPR led to lower access to medicines in developing countries, and particularly lower access for the poorest of the poor. This result Jung and Kwon 525 supports previous theoretical debate that patent protection may result in welfare loss in developing countries.6,18,42

### Once PEPFAR switched to generic ARVs they were able to dramatically increase patient output

**El-Sadr et al 12** [Wafaa M. El-Sadr, Columbia University, Mailman School of Public Health, Charles B. Holmes, MD, MPH, Office of US Global AIDS Coordinator, Washington, DC Peter Mugyenyi, MD, Joint Clinical Research Centre, Kampala, Uganda Harsha Thirumurthy, PhD, Department of Health Policy and Management, Gillings School of Global Public Health, University of North Carolina at Chapel Hill, Chapel Hill, NC, Aug. 2012, “Scale-up of HIV Treatment Through PEPFAR: A Historic Public Health Achievement*,” Journal of Acquired Immune Deficiency Syndromes* *vol. 60*, no. Suppl 3, pp. S96-104, [https://doi.org/10.1097/QAI.0b013e31825eb27b]/](https://doi.org/10.1097/QAI.0b013e31825eb27b%5d/) Triumph Debate

\*ARV = Antiretroviral  
\*PEPFAR = U.S. President’s Emergency Plan for AIDS-Relief

Improved efficiency in selection and transportation of ARVs, the increasing use of generic drugs and fixed-dose combinations (FDCs), and the transition to preferred ARV regimens has lowered the cost of treatment substantially while improving the overall quality of HIV treatment in PEPFAR-supported focus countries. PEPFAR’s per-patient treatment costs, including drugs and service delivery, have declined to $335 per year, from nearly $1100 just 7 years ago.20 One key improvement adopted by the Supply Chain Management System (SCMS), established and funded by PEPFAR and supported by the USAID, was the transition from air transport to land- or sea-based shipment.21 It is estimated that using sea freight for major shipments saved up to 85% in transportation costs, and as of December 31, 2010, sea transport had saved PEPFAR $39.8 million in transportation costs.21 SCMS also established regional distribution centers in Ghana, Kenya, and South Africa, increasing commodity availability and reducing the lead time needed for delivery. PEPFAR has also increased its use of generic drugs and FDCs.7 In 2005, only 16% of PEPFAR-procured drugs were generic. This proportion increased to 97% in 2010, resulting in considerable savings compared with branded drugs (Fig. 1). Between 2008 and 2011 PEPFAR increased purchases of 2- and 3-drug FDCs, as recommended by the WHO (Fig. 2). These regimens are less complex, easier to administer, and may improve patient adherence. Similarly, over the past 4 years since WHO HIV treatment guidelines recommended that countries phase out stavudine in favor of less toxic zidovudine- or tenofovir-based regimens, SCMS orders for stavudine have declined by more than 70%, whereas orders for zidovudine and tenofovir have increased 20-fold (Fig. 3). An external file that holds a picture, illustration, etc. Object name is nihms397419f1.jpg Open in a separate window FIGURE 1 Number of generic versus branded drugs procured (monthly packs, 2005–2010). PEP-FAR increased its use of generic drugs from 16% in 2005 to 97% in 2010. An external file that holds a picture, illustration, etc. Object name is nihms397419f2.jpg Open in a separate window FIGURE 2 Total SCMS orders for 2- and 3-drug ARVs. Between 2008 and 2011, PEPFAR increased its purchases of 2- and 3-drug FDCs, as recommended by WHO. An external file that holds a picture, illustration, etc. Object name is nihms397419f3.jpg Open in a separate window FIGURE 3 SCMS order quantity for zidovudine (AZT), stavudine (d4T), and tenofovir (TDF) in fiscal year (FY) 2008–2011. Since 2008, SCMS orders for stavudine have declined by more than 70%, whereas orders for zidovudine and tenofovir have increased 20-fold. Go to: ACHIEVEMENTS Scale-up of ART Access The number of individuals receiving ART is one metric by which PEPFAR’s achievement can be summarized. PEP-FAR support increased the number of individuals who initiated ART from 66,700 to 3,905,500 (63% women and girls) from 2004 to 2011 (Fig. 4). During the first phase of PEPFAR, there was a rapid increase in the number of patients receiving ART, doubling each year between 2004 and 2007. In addition, during 2008–2011, PEPFAR increased the number of individuals receiving ART by more than 650,000 patients each year. Importantly, while the growth of PMTCT programs has likely reduced the number of infants newly infected with HIV each year, HIV-infected children comprise about 9% of those supported on treatment by PEPFAR, up from 7% earlier in the response. The treatment program’s rapid expansion is also reflected in the increase in the number of health facilities providing ART, growing from 300 sites in 2004 to more than 6400 in 2009 (last year this indicator was reported centrally). An external file that holds a picture, illustration, etc. Object name is nihms397419f4.jpg Open in a separate window FIGURE 4 Number of adults and children with HIV infection receiving ART with direct PEPFAR support in fiscal year 2004–2011. PEPFAR support increased the number of individuals who initiated ART from 66,700 to 3,905,500. Although the majority of treatment services are concentrated in 8 countries that collectively account for over half of the global HIV/AIDS epidemic, PEPFAR has supported treatment programs in more than 30 countries around the world26 through contributions to health system’s strengthening in the form of policy developments, logistics, protocol or guideline development, advocacy, laboratory support, training, information systems, and capacity building of national HIV/AIDS programs. PEPFAR also has had a strong focus on ensuring quality of services and has used a variety of methods to monitor and ensure the quality of its programs,27 including sampled national survey studies28 and other methods, as described in more detail in an article in this journal issue.

### 1.6 million Africans died of malaria, tuberculosis, and HIV in 2015, due to patent law preventing generic drug import

**Pheage 16** [Tefo Pheage- journalist for African Renewal, December 2016, “Dying from lack of medicines,” United Nations Africa Renewal, [https://www.un.org/africarenewal/magazine/december-2016-march-2017/dying-lack-medicines]/](https://www.un.org/africarenewal/magazine/december-2016-march-2017/dying-lack-medicines%5d/) Triumph Debate

Approximately 1.6 million Africans died of malaria, tuberculosis and HIV-related illnesses in 2015. These diseases can be prevented or treated with timely access to appropriate and affordable medicines, vaccines and other health services. But less than 2% of drugs consumed in Africa are produced on the continent, meaning that many sick patients do not have access to locally produced drugs and may not afford to buy the imported ones. Without access to medicines, Africans are susceptible to the three big killer diseases on the continent: malaria, tuberculosis and HIV/AIDS. Globally, 50% of children under five who die of pneumonia, diarrhoea, measles, HIV, tuberculosis and malaria are in Africa, according to the World Health Organisation (WHO). The organisation defines having access to medicine as having medicines continuously available and affordable at health facilities that are within one hour’s walk of the population. In some parts of Zimbabwe, for example, some nurses give painkillers to sick patients as a “treat-all drug,” says Charles Ndlovu, a Zimbabwean living in Botswana. Some of his family members have been treated in hospitals in Zimbabwe. With most medicines unavailable, the nurses have little choice. Dave Puo, from Mpumalanga in South Africa, says that in his country, “when you seek medical attention, you are often informed that there is no medication and advised to go to the big hospitals,” which the majority of the poor cannot afford. “The system does not care about your [empty] pockets.” Inhibiting factors About 80% of Africans, mostly those in the middle-income bracket and below, rely on public health facilities, reported the World Bank in 2013. With public health facilities suffering chronic shortages of critical drugs, many patients die of easily curable diseases. Several factors inhibit access to medicines, but the major ones, according to the WHO, are the shortage of resources and the lack of skilled personnel. “Low-income countries experience poor availability of essential medicines in health facilities, substandard-quality treatments, frequent stock-outs and suboptimal prescription and use of medicines,” says the world health body. Africa’s inefficient and bureaucratic public sector supply system is often plagued by poor procurement practices that make drugs very costly or unavailable. Added to these are the poor transportation system, a lack of storage facilities for pharmaceutical products and a weak manufacturing capacity. Africa’s capacity for pharmaceutical research and development (R & D) and local drug production still has a long way to go, say experts. Only 37 out of 54 African states have some level of pharmaceutical production. Except South Africa, which boasts some active local pharmaceutical ingredients, most countries rely on imported ingredients. The result is that Africa imports 70% of its pharmaceutical products, with India alone accounting for nearly 18% of imports in 2011. Pharmaceutical imports in Africa include up to 80% of the antiretroviral drugs (ARVs) used to treat HIV/AIDS, according to trade data. “Many African governments spend a disproportionate amount of their scarce resources on procuring medicines,” writes Carlos Lopes, former executive secretary of the United Nations Economic Commission for Africa. To produce medicines, a country must abide by Current Good Manufacturing Practices (CGMP), which are enforced by the United States and other governments to ensure the quality of manufacturing processes and facilities. Many African countries do not have the technical, financial or human resources required for high-scale drug production. But Egypt, Morocco, South Africa and Tunisia have made progress in local pharmaceutical productions. Morocco is Africa’s second-largest pharmaceutical producer (after South Africa), and has 40 pharmaceutical manufacturing companies that supply 70% of products for local consumption and also exports to neighbouring countries. Countries such as Ghana, Kenya, Nigeria and Tanzania are currently developing production capacity. Suspicions Many African political leaders and development experts believe that the world’s biggest pharmaceutical companies are reluctant to offer technical support to African manufacturers. For example, in 2001, 39 international pharmaceutical companies dragged the South African government to court to challenge its plans to manufacture and import cheap, generic HIV/AIDS drugs. The companies claimed that South Africa’s plans breached their patent rights. Although they later withdrew the matter from court following pressure from groups that advocate for international access to medicines, South Africa’s late president Nelson Mandela accused the companies of exploiting the developing world by charging exorbitant fees for HIV/AIDS drugs. “That is completely wrong and must be condemned,” he said at the time. There is evidence, however, that local production improves access and brings down the cost of medicines. “Ever since the high-tech generic drug production [facility], Cinpharm-Cameroon, was set up, it is relatively easier for Cameroonians to have access to medicines,” says Mr. Lopes. “Now a low-wage earner can access a course of antibiotics at a lower price than a Kenyan counterpart.” Worth $24 million, Cinpharm-Cameroon produces 40 different drugs. The Trade Related Aspects of Intellectual Property Rights (TRIPS) regulation of the World Trade Organization (WTO), in force since 1986, curtails the right of companies to manufacture generic drugs, forcing countries to rely on brand-name products. However, the WTO in 2006 granted developing countries a 10-year waiver to manufacture generic drugs using the intellectual property rights of big pharmaceutical companies overseas. Despite US objections, the waiver, which expired this year, was extended until two-thirds of WTO members decide to remove it. Experts believe that is unlikely to happen, as the US appears to be the only big country insisting on its removal. WHO director-general Dr. Margaret Chan remarked in 2010 that the debate on access to medicine is often clouded by suspicions: “Suspicions that the rules governing international trade in pharmaceutical products are rigged to favour the rich and powerful; that economic interests will trump health concerns.”

### Due to Patent Protections less than 1% of South African’s were able to get ARVs

**Crook 05** [Jamie Crook- director of litigation for the Center for Gender and Refugee Studies, 2005, “Balancing Intellectual Property Protection with the Human Right to Health,” *Berkeley Journal of International Law* *23*(3), 524-550, [https://lawcat.berkeley.edu/record/1119803?ln=en]/](https://lawcat.berkeley.edu/record/1119803?ln=en%5d/) Triumph Debate  
  
\*ARV = Antiretroviral

In 2003, the Human Immunodeficiency Virus (HIV) newly infected an estimated five million people worldwide; three million died of complications related to Acquired Immunodeficiency Syndrome (AIDS). 2 Since its discovery in the 1980s, AIDS has killed twenty-two million people worldwide, leaving thirteen million AIDS orphans. 3 The Joint United Nations Programme on HIV/AIDS (UNAIDS) estimates that between thirty-four and forty-six million people around the world are living with the condition.4 While sub-Saharan African states have suffered the worst epidemics to date, UNAIDS and the World Health Organization (WHO) predict new outbreaks in North Africa, India, China, states in Central Asia, and the Baltic states.5 HLV/AIDS rates in Latin America are also rising.6 Globally, costly anti-retroviral drugs that prolong the lives and improve the health of infected individuals do not reach the almost 90% of HIV/AIDS patients living in the poorest 10% of the world's countries. South Africa's experience with the AIDS crisis provides a representative example of the deadly combination of poverty and patent protection in the context of public health disasters. With less than 2% of the global population, South Africa is home to 30% of the world's HIV/AIDS-infected people and to 80% of those patients who cannot afford their own healthcare. 8 Though effective generic anti-retroviral drug therapies can sell for as little as $140 for one year's supply, patent protections prevent their sale in most developing countries.9 According to a lawyer for South Africa's Aids Law Project, "[i]n South Africa, tens of thousands of people are dying every year because excessive prices are charged for life-saving anti-retroviral medicines." 10 The worst is probably yet to come for South Africa, where lack of access to effective medication will facilitate the rapid spread of AIDS-related deaths over the next five years.1 1 In 2003, UNAIDS and the WHO determined that the immediate implementation of a national anti-retroviral program in South Africa would "significantly cushion the country against the impact" of the AIDS crisis. 12 Nevertheless, as of October 2003, no generic anti-retrovirals were available in South Africa, desrite the plentitude of successful generic versions produced in India and Brazil.' , HIV/AIDS patients in South Africa and throughout the global South would substantially benefit from the increased affordability of generic anti-retroviral drug therapies. Yet in 2002, out of an estimated twenty-eight million people in sub-Saharan Africa living with HIV/AIDS, only 50,000 people, or less than 0.2%, had access to such treatment. 14 This limited access largely results from patent protections held by multinational pharmaceutical corporations that maintain inflated drug prices and severely restrict the geneiric manufacture of anti-retrovirals. 1 Drug-patent supporters argue that patents guarantee profit returns, which in turn enable continuing research and development. Public health advocates counter that the unfolding AIDS catastrophe requires a more immeda te palliative than the distant hope of discovering a cure or treatment, neither of which would likely be any more accessible to infected populations than current patented drug therapies. Tensions between intellectual property protection and the health needs of their impoverished people plague the leaders of developing states, who fear endangering trade relations with wealthy states should they violate the patent rights enforced through various international agreements. 16 This paper will explore whether existing international law creates a right to health that includes a right to generic, or at least affordable, anti-retroviral treatment, enforceable against state and non-state actors seeking to maintain patent protection. It will further consider whether relaxing patent protection is a feasible means toward the ultimate goal of substantially increasing access to anti-retroviral treatment. AIDS is a global threat with unique impacts on many regions; this paper will focus Iprimarily on the impact of U.S. patent-protection policy in sub-Saharan Africa. 1 ' Part I presents the need for increased access to anti-retroviral treatment. Part II examines patent-related barriers to access. Part III summarizes sources of international law that suggest the existence of a right to health that would be enforceable against both domestic governments and third parties, such as other states and multinational corporations. Part IV turns to policy arguments that might encourage wealthier states to take proactive measures to increase access, even at the expense of patent protection. Part V suggests methods for easing patent restrictions that would be consistent with the goal of immediately increasing access to anti-retroviral drug therapy for the world's poorest and most vulnerable HIV/AIDS victims.

### Rwanda had substantial time delays getting ARVs due to the barriers of TRIPS

**D’Angelo et al 21** [Alexa B. D’Angelo, Department of Community Health and Social Sciences, CUNY Graduate School of Public Health and Health Policy Christian Grov, Department of Community Health and Social Sciences, CUNY Graduate School of Public Health and Health Policy Jeremiah Johnson, Treatment Action Group, New York, NY, USA& Nicholas Freudenberg, Department of Community Health and Social Sciences, CUNY Graduate School of Public Health and Health Policy, May 2021, “Breaking Bad Patents: Learning from HIV/AIDS to Make COVID-19 Treatments Accessible,” Global Public Health, www.tandfonline.com, [https://www.tandfonline.com/doi/full/10.1080/17441692.2021.1924223]/](https://www.tandfonline.com/doi/full/10.1080/17441692.2021.1924223%5d/) Triumph Debate

\*TRIPS = Trade-Related Aspects of Intellectual Property Rights  
\*ARV = Antiretroviral

In 2006, Rwanda utilised TRIPS flexibilities to begin the process of exporting a compulsory license to manufacture and import ARVs from Canada into Rwanda through the generic manufacturer Apotex (Kohler et al., 2010). In this case, the Rwandan government was forced to comply not only with TRIPS articles, but also with Canadian patent law. The exchange was marred by constant delays, a result of bureaucratic complexities built into TRIPS and Canadian patent law (Kohler et al., 2010). The first delay came from a missed formality wherein the Rwandan government did not complete a ‘formal’ request to begin the importation process. The second delay, a result of Canadian law, forced Apotex to negotiate with the patent holding companies for 30 days to come to a ‘reasonable’ royalty deal, before they were permitted to apply for a compulsory license from the World Trade Organization (Kohler et al., 2010). After failed negations with the patent holders, Apotex was cleared to pursue a compulsory license with the World Trade Organization. This entire process took thirteen months, followed by five months to manufacture the ARVs for importation (Kohler et al., 2010). Further, Canadian law stipulated that the importation agreement was valid for two years, and could only be extended if the agreed upon number of pills were not imported during the two-year window. During the twoyear license period, seven million ARVs were imported into Rwanda (Chami & Wasswa-Kintu, 2011). Due to bureaucratic and legal hurdles, Apotex was unwilling to participate in compulsory licensing and importation following this experience (Chami & Wasswa-Kintu, 2011). Additionally, the Rwanda/Canada case revealed to other generic manufacturers how difficult the process was, discouraging other firms from participating in similar efforts (Kohler et al., 2010). This case highlights some of the challenges that arise when additional patent laws are layered on top of the existing barriers inherent to TRIPS.

### Patents leave minority communities more at risk of price gouging

**ACRE 20** [Action Center on Race and the Economy, August 2020, “Poi$on: How Big Pharma’s Racist Price Gouging Kills Black and Brown Folks,” Action Center on Race and the Economy, [https://acrecampaigns.org/wp-content/uploads/2020/08/new-poison-final.pdf]/](https://acrecampaigns.org/wp-content/uploads/2020/08/new-poison-final.pdf%5d/) Triumph Debate

As this report goes to press, Gilead’s decision to charge over $3,000 for remdesivir, a COVID-19 drug that was jointly developed by Gilead and federal research agencies, is reigniting debate about drug pricing in the United States.ii At the same time, COVID-19 itself has brought structural racism in the U.S. health care system to the foreground as Black and Brown communities bear vastly disproportionate levels of COVID-19 infections and death. Systemic race-based exclusion, discrimination, and violence in employment, housing, policing, and health care have created greater risk for COVID-19 exposure, infection, complications, and death in Black and Brown communities.iii Under the U.S. model of monopoly drug patents, Black and Brown people have also been exposed to more concentrated risk of price gouging by pharmaceutical companies. This report confronts the complicity of price gouging by pharmaceutical companies in racial and ethnic health inequities by bringing together two sets of research: data analysis showing that Black and Latinx patients are forced to ration medications at higher rates than white patients and historical analysis of the monopoly patent model, which gives private, for-profit pharmaceutical companies power over drug pricing. Price gouging excludes Black and Brown communities from access to medications for the chronic diseases that put patients at higher risk of death from COVID-19. Drug-pricing debates often focus on what prices pharmaceutical companies should charge rather than whether pharmaceutical companies should have the power to set prices for medicine. The public interest in government-regulated pharmaceutical pricing is undeniable: $33 billion in government-funded drug research makes most new drug discoveries possible; price gouging adds significant costs to public programs, like Medicare and Medicaid; and medication rationing due to high cost leads to avoidable complications and premature death, defeating the fundamental public health goals of prevention and health equity. The decision to rely on a monopoly patent model that cedes pricing power completely to pharmaceutical companies has always been motivated by neoliberal ideology. Medical innovation, the stated rationale for monopoly patents and inflated prices, is stymied by the maze of intellectual property protections that protect private pricing power. The profits that ostensibly incentivize research and development for breakthrough medicines actually flow directly to Wall Street in the form of stock buybacks and dividend payments. A steady stream of political contributions and payments to researchers and medical providers props up the narrative of private profits as “the price of progress.” This rationale dismisses the damage, disproportionately afflicting Black and Brown communities, that results from price gouging essential medications. Our Preexisting Condition: Race COVID-19 has shined a light on long-standing health inequities that harm Black and Latinx communities. The higher prevalence and mortality rates of Black and Latinx COVID-19 patients mirror the heightened incidence of diabetes, hypertension, heart disease, and other illnesses that put Black and Brown people at greater risk for COVID-19 complications and death. At the root of the United States’ social and economic system is the plunder of wealth and health from Black and Indigenous people and other people of color to enrich wealthy white individuals and institutions. The much-discussed economic and health disparities experienced by these communities are the result of this targeted racial discrimination. Yet the disproportionate effect of prescription drug price gouging on Black and Latinx communities is rarely mentioned, even as the competition for COVID-19 vaccines and cures puts pharmaceutical companies at the center of attention. Across insurance status, age, and disease type, Black and Latinx patients report higher rates of medication rationing—forgoing or delaying filling a prescription, skipping doses, and reducing doses below the prescribed amount due to cost.iv Even before the current pandemic, medication rationing due to inflated prices was contributing to unconscionable levels of preventable disease and death in Black and Latinx communities. This should be a forewarning of the likely barriers to access to COVID-19 vaccines and medicine and of the empty promises of pharmaceutical companies to mitigate the harm of their own practices. Consider diabetes and hypertension, two conditions that appear to be strongly associated with COVID-19 mortality and that disproportionately afflict Black and Latinx people. Black people are twice as likely as whites to have hypertension, are more likely to experience the onset of hypertension at younger ages,v and are more likely to experience severe complicationsvi Latinx hypertension patients are less likely than white people to have their blood pressure controlled, and Mexican Americans are more likely to die from hypertensionvii Black and Latinx people are both more likely than whites to have diabetes and more likely to die from diabetes Latinx patients have higher rates of diabetes-related kidney failure and vision lossviii Black people with diabetes have higher rates of kidney failure and amputationsix A strong body of evidence shows that high levels of stress due to racial and ethnic discrimination, including that involving police encounters, are associated with elevated blood pressure and high levels of inflammation (which is a characteristic of diabetes, hypertension, and COVID-19) in Black and Latinx people. The heightened vigilance and 8 anticipatory stress that characterize Black and Latinx people’s attempts to cope with persistent but unpredictable threats of racism in their daily lives trigger stress responses that over time can cause or worsen cardiovascular and cardiometabolic disease.x Racism contributes to the development of hypertension and diabetes, and price gouging blocks Black and Latinx patients from accessing treatment. Diabetes and hypertension are manageable chronic diseases for which the standard of care includes prescription medications to control symptoms and avoid complications. In surveys of medication use, Black hypertension patients report more medication rationing due to cost than do white patients.xi Analysis of pharmacy claims and patient registry data confirms that Black and Latinx patients experience more barriers to either filling or routinely refilling prescriptions for diabetes and hypertension medications.xii Price gouging that restricts access to medications literally costs Black and Brown people their lives and limbs. Whereas taking the proper doses of anti-hypertensive medications has been shown to reduce cardiovascular mortality,xiii medication rationing is “a leading cause of inadequate hypertension management leading to cardiovascular disease, stroke, and chronic kidney disease.”xiv Restricted access to affordable hypertension medication is one reason that overall decreases in cardiovascular disease mortality in the U.S. have not been equally seen by Black, Latinx, and white people.xv Diabetes medications are among the most expensive among all chronic disease medications, and insulin users in particular are most likely to report medication rationing.xvi Black and Latinx diabetics are more likely than whites to use insulinxvii and more likely to report that they skip or reduce doses of diabetic medications due to cost.xviii Underusing necessary diabetes medications is a major cause of poor glycemic control, which is, in turn, a cause of vascular disease that can (though, with proper and timely treatment, usually should not) lead to amputations, kidney failure, and blindness.xix A ProPublica investigative report on racism in U.S. diabetes care documents a systemwide disinvestment in diabetes-related vascular disease prevention that drives the “epidemic of amputations” in Black communities. The same racist policies and practices also increase the risks of other diabetes-related vascular complications, such as kidney disease, retinopathy, and blindness, all of which disproportionately afflict Black and Latinx patients.xx This pattern of treatment amounts to systemic neglect of and inhumanity for the health of these patients. 9 But the academic literature on racial disparities generally discusses “race” rather than racism and avoids the topic of price gouging by pharmaceutical companies altogether. Too often, researchers shift responsibility for medication access onto Black and Latinx patients.xxi The language of medication “nonadherence” and “underuse” conveys this assumption of individual failings and echoes the Trump administration’s victim blaming that attributes susceptibility to COVID-19 to the unhealthy “culture” of immigrant Latinx meat plant workers and the individual behavior of Black people.xxii Yet, mainstream research does recognize the high stakes of medication rationing. One study acknowledged that racial inequities in health outcomes are due at least in part to “persistent problems in getting necessary medications that eventually lead to the most debilitating effects of unmanaged chronic illness.”xxiii Researchers tend to identify at the root of these persistent problems some version of the “financial wherewithal to pay for prescription medications.”xxiv This explanation obscures the fundamental factor of wealth extraction from Black and Brown communities. Most notably, the history of residential segregation and racial and ethnic discrimination in employment, wages, and access to basic goods and services in the U.S. drives a racial wealth gap that gives white households greater “financial wherewithal.”xxv Structural barriers to Black and Brown wealth attainment and intergenerational progress expose Black and Brown households to greater economic insecurity, which makes them more vulnerable to the price-gouging tactics of pharmaceutical companies.xxvi As a mechanism to maximize profit and enrich pharmaceutical company investors at the expense of Black and Brown health and wealth, drug price gouging is itself another instance of the same process of wealth extraction. The profits accumulated from price gouging further enrich wealthy investors, feeding the cycle of wealth extraction and exploitation. The History and Politics of the Pharmaceutical Patent Monopoly Model Along with attention to racial and ethnic health inequities, the COVID-19 pandemic has directed public awareness to the complexity of the health care supply chain. The complexity of the pharmaceutical industry, from research and manufacturing to regulatory approval and insurance negotiations, has been used to muddy the waters of debate over medication access for decades. What appears plainly as price gouging— triple-digit-percentage increases in lifesaving drugs that have existed for years or astronomical markups from the cost of drug production—are explained away as one piece of a complex process that leads to innovative medicine that would otherwise be undiscovered and unavailable to treat sick people around the globe. The unstated assumption behind the “myth of the price of progress”xxvii is that the current pharmaceutical pricing regime arose naturally, as the best possible solution to produce 10 the best possible medicines to meet the most pressing health care needs. Demands for changes to the status quo to make drugs affordable are greeted with patronizing explanations of how such well-meaning policies would inevitably result in the opposite: higher prices for more people and fewer medical breakthroughs for everyone. Such demands “represent an easy but wrongheaded way to avoid the messy work of constructing a system to incentivize medical breakthroughs and make them widely available in the context of 21st century economic realities,” according to one such admonishment.xxviii The actual political history of the U.S. pharmaceutical industry and its complicity in racial health inequities is obscured in the heroic tales of market-driven discovery and in the scolding dished out to its critics. So, too, is the racism embedded in “21st century economic realities” hidden in plain sight. The pricing power of private pharmaceutical companies was deliberately created by free-market ideologues, not to incentivize medical breakthroughs but to empower private corporations as a counterforce to public-sector regulations and consumer protections.xxix Apologists for unchecked corporate power repeat the myth of the price of progress more loudly as the evidence accumulates that the “innovation” that high drug prices are purportedly paying for amounts mostly to stock buybacks, executive compensation, and a flood of expensive new drugs with no demonstrated efficacy over established standards of care.xxx The Origins of Patent Monopolies in the Pharmaceutical Industry The history of patent monopolies in the pharmaceutical industry is a history of the gradual ceding of public control of public goods—drugs developed by government-funded research—to private companies. Drug patents granted to private entities were rare before 1968, when the Institutional Patent Agreement gave universities the right to own patents on federally funded drug discoveries.xxxi Those universities were then free to sell the licenses to manufacture new drugs to the highest bidder.xxxii The New Deal agencies that originally boosted U.S. medical research and vaccine development had required private contractors to assign intellectual property rights from publicly funded research back to the government.xxxiii Since 1968, freemarket ideologues have cast aside New Deal–era concerns about the corruption of medical research by “undue concentration of economic power in the hands of few large corporations”xxxiv and doubled down on the maximization of private profit from public research by 11 Expanding private patent rights for drugs developed with federal funds to all private contractors in the Bayh-Dole Act of 1980;xxxv Extending licenses and granting tax breaks for “rare diseases” in the 1983 Orphan Drug Act, under which remdesivir, Gilead’s treatment candidate for COVID-19 (perhaps the least rare disease ever), briefly qualified for seven-year market exclusivity and federal grants and tax credits to reimburse clinical testing costs;xxxvi Extending drug patents from 17 to 20 years in the 1995 Uruguay Round Agreements Act;xxxvii Prohibiting Medicare from negotiating lower drug prices in the Medicare Modernization Act of 2003;xxxviii and Facilitating direct-to-consumer drug marketing in the Food and Drug Administration (FDA) Modernization Act of 1997.xxxix This is not a history of abandoning a just system for an unjust one, however. There is no golden age of truly equitable U.S. drug policy, and the development of pharmaceutical drugs is marked by racist and gendered exploitation. In the 1940s and ’50s, when U.S. government officials were strongly insisting on “public control over patents”xl on vaccines and other medicines, Black and Brown people were excluded from “the public” by laws restricting every aspect of their lives and by the racial violence that enforced segregation and exclusion. The government’s commitment to publicly funded and controlled medical research included medical experiments on Black and Brown bodies, like the deliberate withholding of medication in the U.S. Public Health Service–funded Tuskegee syphilis experiments on Black men from 1932 to 1972 and the deliberate, sometimes fatal, infection of healthy Guatemalan men, women, and children in experiments from 1946 to 1953.xli While some in the federal government fretted over the misuse of patented medical breakthroughs, a private surgeon was surreptitiously removing cancer cells from the body of Henrietta Lacks, without informing Lacks or her family.xlii The cells have been used for decades thereafter to develop profit-making drugs to treat cancer and other diseases.xliii This history must be the interpretive lens for understanding victimblaming statements attributing medication rationing and poor health in Black and Brown communities to “noncompliance” with medical experts and mistrust of medical authority. It must also guide a forwardthinking, explicitly antiracist solution to pharmaceutical price gouging that recognizes the racism in the New Deal–era public drug development system. 12 Maximizing Profit Extraction: Abuses of the Patent System Economic historian Edward Nik-Khah sums up the ideological roots of the monopoly patent model by noting, “Pharma was the perfect test case for a neoliberal project that celebrates markets, but is fine with large concentrations of power and monopoly.”xliv Patents grant a temporary monopoly, but corporate power, once concentrated, rarely accepts such limits. The decision to transfer public knowledge to private profit-making corporations also transferred power. Pharmaceutical companies have used that power to extend patent monopolies far beyond the 20 years originally granted, all while maintaining the $33 billion in annual governmentfunded drug research that makes new discoveries possible.xlv Every drug approved in the U.S. between 2010 and 2016 was based on National Institutes of Health– funded research.xlvi The patent system privatizes the return from this public investment, and pharmaceutical companies further abuse patent law to perpetuate their monopoly power and continue profit-maximizing price gouging. The Initiative for Medicines, Access, and Knowledge (I-MAK) submitted public comments to the Federal Trade Commission in 2018 warning that “people worldwide—including in the United States—are not receiving the lifesaving treatment they need due to skyrocketing prices based on the abuse of the patent system.”xlvii I-MAK outlines the abusive practices that the pharmaceutical industry uses to “secure the market on entire diseases and artificially inflate the price of treatment.”xlviii By obtaining multiple patents, pharmaceutical companies delay or block generic competition for decades, keeping cheaper medications off the market without improving treatment in any way. I-MAK found that the 12 best-selling drugs in the U.S. have an average of 135 patent applications and 71 approved patents per drug. A member of I-MAK, Tahir Amin, pointed out that the decline of pharmaceutical industry investment in new antibiotics to treat drug-resistant infections, an urgent global health crisis, coincides with pharmaceutical companies’ strategic decision to “spend more time finding ways to keep existing drug franchises profitable.”xlix We could say the same about the indifference to preventing diabetesrelated amputations and avoidable deaths from chronic disease in Black and Brown communities in the United States. In a familiar trend, the financialized pharmaceutical sector directs more of its profits toward enriching shareholders and building “a tangle of IP protections”l to block access to the discoveries it already owns than to produ

# Contention 2: Reducing intellectual property protections increases innovation and access

### Global IP imbalances harm everyone, and fail to accommodate the needs of developing countries. We must take into consideration the ways in which global differences affect access to medicines.

Chen, 10 [Ge Chen, Research Fellow, Institute for International Law and European Law, “Fragmentation of International Law: Its Impact on Access to Knowledge in International Copyright Scenario”, World Intellectual Property Organization, May 27th, 2010, <https://www.wipo.int/edocs/mdocs/sme/en/wipo_smes_ge_10/wipo_smes_ge_10_ref_topic10_1.pdf> ] /TriumphDebate

Under the institutional lens, the redistributive value of knowledge goods is likewise relatively unheeded, though it has been embraced as GPG indispensable to the common progress of the human society. 99 In terms of neoclassical economics public goods are necessitated by the market failure to satisfy certain basic human needs which shall be in turn accommodated by government regulation in its policy of social welfare. 100 However, access rights in IP regimes have immanently covered up the complexity of the redistributive uncertainties entailed in welfare disposition of knowledge goods. 101 In fact, how to ensure that the social benefits of recouping momentum for cumulative innovation from the current system are not diluted or offset by the social costs of deterring free riders with the relentless ratcheting up of IP standards constitutes a critical question which might otherwise adversely impinge on the provision and distribution of other public goods such as education and scientific research. In particular, when the imbalance is magnified on the global scale, the stakes will be considerably higher. 102 Presumably, by disentangling the unnecessarily fettered access to copyrighted works, the legislator could redefine the GPG and help the modern media like the Internet become an open marketplace for ideas and business transactions. 103 While ideas and information should then be used as a resource and management tool that allows the maximization of the value of processes and transactions, 104 an open market in the global trade sphere that distributes knowledge goods shall enable all nations including those with poor financial and innovative capacities to benefit from knowledge transfer. 105 It is the very vision of even distribution of sufficient GPG that has bolstered the uniform pursuit of optimal level of IP protection. 106 Unfortunately, however, the current paradigm of GPG governance fails to accommodate the needs of access to knowledge in developing countries due to the lack of a legitimate and effective regulatory regime that provides institutional backup to centralize and distribute all these global public resources on a uniform scale, which amounts to the “governance gap” on the international plane. 107 While developed countries have always treated knowledge in the form of creative expressions accomplished by their nationals as their exclusive natural resource worthy of strong legal protection, 108 knowledge cartels representing unilateral pursuit of private interests have manoeuvred into the centre of IP decision-making with their poignant lobbying capacities at the domestic level. 109 Moreover, these countries have endeavoured to exert great influence on global norm-setting in copyright fields and managed to impose a universally high standard comparable to their domestic level upon other nations as well. 110 In contrast, developing countries with limited innovation capacities and financial resources often claim that the benefits virtually accrue to consumers and users in other countries and postulate that divergent social and economic contingencies must be taken into consideration if global coordination in knowledge governance is to be made. 111

### Patent strategies have focused on stifling competition and potential innovation, not incentivizing it. Companies are seeking the broadest patents available to successful preclude other companies from advancing.

Gurgula & Lee, 21 [Olga Gurgula, lecturer in intellectual property law at the Brunel Law School, Wen Hwa Lee, co-director of the Oxford Martin Schoool Programme on Affordable Medicines, University of Oxford, June 6th, 2021, “Covid-19 IP and access: Will the current system of medical innovation and access to medicines meet global expectations?”, Journal of Generic Medicines: The Business Journal for the Generic Medicines Sector, <https://journals.sagepub.com/doi/full/10.1177/1741134321993182> ]

While patents often lead to unaffordably high drug prices,[24](https://journals.sagepub.com/doi/full/10.1177/1741134321993182) pharmaceutical companies claim that they need strong patent protection to secure their investments in R&D.[25](https://journals.sagepub.com/doi/full/10.1177/1741134321993182),[26](https://journals.sagepub.com/doi/full/10.1177/1741134321993182) Therefore, the current legal framework has developed around the model of proprietary research conducted by private pharmaceutical companies, the outcomes of which are typically protected by multiple patents.[24](https://journals.sagepub.com/doi/full/10.1177/1741134321993182) Such proprietary research has several negative consequences. First, it can lead to a waste of significant time and resources due to duplicative research activities by numerous pharmaceutical companies and the fragmentation of knowledge. Second, these companies typically seek to obtain the broadest and strongest patent protection for the results of their research to achieve market exclusivity, which allows them to set the price of their products. In turn, this often leads to problems of accessing these products due to high prices. However, the proprietary system of pharmaceutical innovation as we know it today has taken shape fairly recently. In the past, countries were free to develop their national IP-related policies to combat high prices and facilitate access to medicines in accordance with their local needs. Many countries denied patent protection on medicines or provided only limited protection to the process of their manufacture. Such an approach was based on the fear that patents would create monopolies over such an essential product as medicines.[27](https://journals.sagepub.com/doi/full/10.1177/1741134321993182),[28](https://journals.sagepub.com/doi/full/10.1177/1741134321993182) This, however, changed in 1995 when the WTO Agreement on Trade-Related Aspects of IP Rights (‘TRIPS’) came into force, which obliged all WTO members to provide patent protection to all types of technologies, including medicines.[29](https://journals.sagepub.com/doi/full/10.1177/1741134321993182) These new global rules, coupled with bilateral treaties that strengthen the protection even further,[30](https://journals.sagepub.com/doi/full/10.1177/1741134321993182) and patent-related strategies by pharmaceutical companies directed at ‘evergreening’ their market monopoly,[31](https://journals.sagepub.com/doi/full/10.1177/1741134321993182) resulted in many countries not being able to provide sufficient access to essential medicines for their populations. As was stated in the Report prepared by the UN High-Level Panel on Access to Medicines in 2016, diseases such as HIV, which have become manageable chronic conditions in developed countries, continue to kill millions of people in low- and middle-income countries because of the unaffordably high prices of patented medicines.[22](https://journals.sagepub.com/doi/full/10.1177/1741134321993182) Moreover, developed countries are also increasingly suffering from high drug prices, which put significant pressure on national healthcare budgets, forcing governments to reconsider their policies in this field. For example, in 2019 the US FDA approved Zolgensma, a gene therapy developed by Novartis for spinal muscular atrophy, the leading genetic cause of death in infants. The price of the one-time treatment has been set by Novartis at a record $2.125 million, triggering debates about the escalating costs of prescription drugs and access to them.[32](https://journals.sagepub.com/doi/full/10.1177/1741134321993182) The ‘skyrocketing’ prices of patented medicines in the US have prompted an investigation by the House Committee on Oversight and Reform,[33](https://journals.sagepub.com/doi/full/10.1177/1741134321993182) which has recently held hearings with top executives of major drug companies to examine their pricing practices for some of the costliest drugs in the United States.[34](https://journals.sagepub.com/doi/full/10.1177/1741134321993182) Realising the deficiencies of the current system, various calls from governments, international organisations, civil society and academics have been put forward aiming at controlling prices, facilitating access and stimulating genuine innovation.[22](https://journals.sagepub.com/doi/full/10.1177/1741134321993182) Despite this no tangible changes in the operation of this system have occurred.

### Patents ignore the way innovation truly occurs, which is through public knowledge generation and the avoidance of legal strategies that deter such cumulation of knowledge.

Pénin & Neicu, 18 [Julien Pénin, Professor at University of Strasbourg, Daniel Neicu, Professor at University of Strasbourg, 2018, “Patents and Open innovation: Bad Fences Do Not Make Good Neighbors”, Journal of Innovation Economics & Management, <https://www.cairn.info/revue-journal-of-innovation-economics-2018-1-page-57.htm?contenu=article> ]

Why do we need patents? The usual argument, which we shall call the “second best” theory of patents, argues that patents are needed to solve a double problem: a problem of incentives, on the one hand, and a problem of knowledge diffusion, on the other hand (the so-called Arrow dilemma, 1962, which highlights the difficulty to achieve both optimal incentives to produce knowledge, and optimal level of dissemination of the knowledge produced [[3]](https://www.cairn.info/revue-journal-of-innovation-economics-2018-1-page-57.htm#no3)). First, patents induce firms to invest in R&D and in the economic valorization of inventions (Nordhaus, 1969; Kitch, 1977); second, they encourage firms to disclose their inventions, i.e. disseminate technical knowledge within the economy and fight secrecy (Encaoua et al., 2006). Yet, in the short run, patents give market power to inventors, thus creating monopoly deadweight loss and static inefficiency. Consequently, patents are not a “first best”, but only a “second best” option. As reminded by Schumpeter (1942), static inefficiency is the price to pay in order to induce innovation and dynamic efficiency. f this vision of patents has the merit of consistency and simplicity, a growing number of researchers tend to oppose it more or less head-on (Kingston, 2001; Bessen, Meurer, 2008; Boldrin, Levine, 2008; Hilaire-Pérez et al., 2013). First, this standard interpretation relies on an unrealistic view of the innovation process. It is based on the traditional Arrovian framework, which considers innovation as an individual and isolated act to produce a public good (knowledge is reduced to information, i.e. is easy to reproduce). This view emphasizes incentives and the importance of patents to exclude imitators. It largely neglects the properties of knowledge (its tacit dimension), and of the innovation process (which is largely a collective process requiring collaborations and interactions). As suggested by Cohendet and Pénin (2011), when these properties are taken into account, the main source of market failure might not be a problem of incentives but of coordination, and the main role of the patent system might not be to exclude others but to include all the different stakeholders in the innovation process. Second, the standard view is not confirmed by most empirical studies, which put forward three important insights (Levin et al., 1987; Cohen et al., 2000; Sakakibara, Branstetter, 2001; Arundel, 2001). First, patents are not the most efficient instrument to protect an invention (secrecy, lead time, complementarity with other assets, are usually preferred). Second, except for the pharmaceutical industry, patents are not necessary to increase incentives to innovate (most firms would invest a similar amount in R&D without the existence of the patent system). Third, the use of patents is strategic (defensive use, signaling, knowledge management, etc.). In conclusion, most empirical studies question the global positive effect of patents on incentives to innovate (see Bessen, Meurer, 2008, for a survey) . This conclusion is robust according to the different methodologies used, such as a questionnaire-based inquiry (Mansfield, 1986; Levin et al., 1987; Cohen et al., 2000), natural experiments (Sakakibara, Branstetter, 2001; Lerner, 2002), or, more recently, lab experiments (Meloso et al., 2009).

# LARP Theory

## Conditional CPs Bad

**A-Interpretation:** Debaters must run unconditional counterplans.

**B-Violation:** In cross-x he said he can kick the CP at any time

**C-Standards:**

1. **Turn Ground –** I literally have ZERO turn ground on his case because once I make a turn he can drop CP making my turn useless. Turn Ground is uniquely key to fairness because the ability to generate offense in multiple place is integral to create a coherent impact story, which thus dictates our ability to win the round
2. **Strategy Skew** – Since the CP is conditional it can be kicked at any point in time, meaning that the neg is a moving target and there is no way to pinpoint their advocacy. I have to defend one stable position whereas they get to shift their advocacy throughout the round, creating a fundamental strategic skew. Equal strategy is key to fairness since our ability to make strategic in-round decisions constitutes our ability to win.

**D-Voter**: Fairness is a **voter** because unfair arguments arbitrarily skew your evaluation of the round and it precedes substance because it frames its evaluation. Drop the debater **a)** to set a precedent for the best norms of debate, **b)** to deter future abuse, **c)** to rectify time lost running theory, and **d)** the round has been irreversibly skewed so we can’t return to substance fairly. Use **competing interps** because **a)** what is reasonably fair is arbitrary and **b)** reasonability encourages debaters to get away with increasingly unfair strategies through defense on theory. And, don’t vote on the RVI **a)** both debaters have the burden of being fair, and no one deserves to win for just meeting that burden, **b)** to prevent the deterrence of legitimate theory, and **c)** to prevent abusive debaters from winning with huge scripts.

## Plans Bad

**A-Interpretation**: The aff must prove the resolution true as a general principle; aff offense must uniquely prove the general case of the topic true, not just a particular case.

**B-Violation:** They only defend [x] scenario [and disads to other scenarios].

**C-Standards**:

1. **Predictability:** There’s no way for me to predict what plan they’ll run, since there are an infinite number of scenarios, so a) I don’t know what counts as topic lit before the round and b) it explodes my research burden because I have to be prepped on every single scenario to have a chance while they only need to prep one. [It doesn’t matter how predictable the plan is—the fact that they have the ability to pick one scenario is abusive.] Predictability is key to fairness since it’s necessary to preparing arguments and winning, and key to education since better arguments lead to more depth of argumentation and clash.
2. **Ground:** They destroy my ground because **a**) they present a narrow advocacy, so I have very little ground to clash with the AC, and, **b**) they have the ability to pick instances that are clearly aff biased, putting the neg at a structural disadvantage and taking away key neg positions. Ground is key to fairness because it’s the basis on which we make arguments, and key to education because more ground leads to more breadth of argumentation.
3. **Text:** Their advocacy only conditionally affirms. The only way to justify their interp would be to insert words in to the resolution, which is blatantly non-textual. Text is the most important standard because it's the sole basis of pre-round prep.

**D-Voter**: Fairness is a **voter** because unfair arguments arbitrarily skew your evaluation of the round and it precedes substance because it frames its evaluation. Drop the debater **a)** to set a precedent for the best norms of debate **b)** to deter future abuse and **c)** to rectify time lost running theory. Use **competing interps** because **a)** what is reasonably fair is arbitrary and **b)** reasonability encourages debaters to get away with increasingly unfair strategies through defense on theory. And, don’t vote on the RVI **a)** both debaters have the burden of being fair, and no one deserves to win for just meeting that burden and **b)** to prevent the deterrence of legitimate theory.