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

Oppression is created by social systems so only a focus on material conditions can solve.

Johnson no date: Allan Johnson (PhD in sociology, he joined the sociology department at Wesleyan University) http://www.cabrillo.edu/~lroberts/AlanJohnsonWhatCanWeDO001.pdf. RW

Privilege is a feature of social systems, not individuals. People have or don't have privilege depending on the system they're in and the social categories other people put them in. To say, then, that I have race privilege says less about me personally than it does about [how] the society we all live in and how it is organized to assign privilege on the basis of a socially defined set of racial categories that change historically and often overlap. The challenge facing me as an individual has more to do with how I participate in society as a recipient of race privilege and how those choices oppose or support the system itself. In dealing with the problem of privilege, we have to get used to being surrounded by paradox. Very often those who have privilege don't know it, for example, which is a key aspect of privilege. Also paradoxical is the fact that privilege doesn't necessarily lead to a "good life," which can prompt people in privileged groups to deny resentfully that they even have it. But privilege doesn't equate with being happy. It involves having what others don't have and the struggle to hang on to it at their expense, neither of which is a recipe for joy,personal fulfillment, or spiritual contentment.... To be an effective part of the solution, we have to realize that privilege and oppression are not a thing of the past. It's happening right now. It isn't just a collection of wounds inflicted long ago that now need to be healed. **The wounding goes on as I write these words and as you read them, and unless people work to change the system that promotes it, personal healing by itself cannot be the answer. Healing wounds is no more a solution to the oppression that causes the wounding than military hospitals are a solution to war. Healing is a necessary process, but it isn't enough.... Since privilege is rooted primarily in systems—such as families, schools, and workplaces—change isn't simply *a* matter of changing people. People, of course, will have to change in order for systems to change, but the most important point is that changing people isn't enough. The solution also has to include entire systems, such as capitalism, whose paths of least resistance [that] shape how we feel, think, and behave as individuals, how we see ourselves and one another.**

The standard is minimizing structural violence, defined as promoting the material conditions necessary for equality.

Undermining structural violence is necessary for mutual recognition and freedom

Duquette David A. Duquette (Professor of Philosophy St. Norton's College) "Hegel: Social and Political Thought" Internet Encyclopedia of Philosophy

According to Hegel, **the relationship between self and otherness is the fundamental defining characteristic of human awareness and activity,** being **rooted** as it is **in the emotion of desire for objects** as well as in the estrangement from those objects, **which is part of the primordial human experience of the world**. The **otherness that consciousness experiences as a barrier to its goal is the external reality** of the natural and social world, which **prevents individual consciousness from becoming free and independent**. However, that **otherness cannot be abolished or destroyed, without destroying oneself**, and so ideally **there must be reconciliation** between self and other such that consciousness can "universalize" itself through the other. **In the relation of dominance and subservience between two consciousnesses**, say lord and bondsman, **the basic problem for consciousness is the overcoming of its otherness, or put positively, the achieving of integration with itself. The relation between lord and bondsman leads to a sort of provisional, incomplete resolution of the struggle for recognition between distinct consciousnesses.**

Sv First- A) social bias underrepresents its effects B) its effects are exponential C) Turns Util

Nixon '11, Rob. "Slow Violence And The Environmentalism Of The Poor." 2011. Web. August 18, 2021. <https://www.jstor.org/stable/j.ctt2jbsgw>.

Three primary concerns animate this book, chief among them my conviction that **we urgently need to rethink-politically, imaginatively, and theoretically**-what I call "**slow violence." By slow violence I mean a violence that occurs gradually and out of sight, a violence of delayed destruction that is dispersed across time and space, an attritional violence that is typically not viewed as violence at all.** Violence is customarily conceived as an event or action that is immediate in time, explosive and spectacular in space, and as erupting into instant sensational visibility. We need, I believe, to engage a different kind of violence, a violence that is neither spectacular nor instantaneous, but rather incremental and accretive, its calamitous repercussions playing out across a range of temporal scales. In so doing, we also need to engage the representational, narrative, and strategic challenges posed by the relative invisibility of slow violence. Climate change, the thawing cryosphere, toxic drift, biomagnification, deforestation, the radioactive aftermaths of wars, acidifying oceans, and a host of other slowly unfolding environmental catastrophes present formidable representational obstacles that can hinder our efforts to mobilize and act decisively. The long dyings-the staggered and staggeringly discounted casualties, both human and ecological that result from war's toxic aftermaths or climate change-are underrepresented in strategic planning as well as in human memory. Had Summers advocated invading Africa with weapons of mass destruction, his proposal would have fallen under conventional definitions of violence and been perceived as a military or even an imperial invasion. Advocating invading countries with mass forms of slow-motion toxicity, however, requires rethinking our accepted assumptions of violence to include slow violence. Such a rethinking requires that we complicate conventional assumptions about violence as a highly visible act that is newsworthy because it is event focused, time bound, and body bound. We need to account for how the temporal dispersion of slow violence affects the way we perceive and respond to a variety of social afflictions-from domestic abuse to posttraumatic stress and, in particular, environmental calamities. A major challenge is representational: how to devise arresting stories, images, and symbols adequate to the pervasive but elusive violence of delayed effects. Crucially, **slow violence is** often **not just attritional but** also **exponential, operating as a major threat multiplier; it can fuel long-term, proliferating conflicts in situations where the conditions for sustaining life become increasingly but gradually degraded.**

2. Debate is made unsafe when we allow the questioning of
Trust your basic intuitions about oppression—otherwise, debate is made unsafe

Teehan 14 ~Ryan Teehan, NSD staffer and competitor from the Delbarton School~ – NSD Update comment on the student protests at the TOC in 2014.

Honestly, I don't think that 99% of what has been said in this thread so far actually matters**. It doesn't matter whether you think that these types of assumptions should be questioned. It doesn't matter what accepting this intuition could potentially do or not do. It doesn't matter if you see fit to make, incredibly trivializing and misplaced I might add, links between this and the Holocaust**. All of the arguments that talk about how **debate is a unique space for questioning assumptions make an assumption of safety.** They say that this is a space where one is safe to question assumptions and try new perspectives. That is not true for everyone. **When we allow arguments that question the wrongness of racism, sexism, homophobia,** rape, lynching, **etc., we make debate unsafe** for certain people**. The idea that debate is a safe space to question all assumptions is the definition of privilege, it begins with an idea of a debater that can question every assumption. People who face the actual effects of the aforementioned things cannot question those assumptions, and making debate a space built around the idea that they can is hostile.** So, you really have a choice. Either 1) say that you do not want these people to debate so that you can let people question the w rongness of everything I listed before, 2) say that you care more about letting debaters question those things than making debate safe for everyo ne, or 3) make it so that saying things that make debate u nsafe has actual repercussions. On "debate is not the real world". Only for people who ca n separate their existence in "the real world" from their existence in debate. That means privileged,

white, heterosexual males like myself. I don't understand how you can make this sweeping claim whe n some people are clearly harmed by these arguments. **At the end of the day, you have to figure out whether you care about debate being safe for everyone involved.** I don't think anyone has contested that these arguments make debate unsafe for certain people . **If you care at all about the people involved in debate then don't vote on these arguments**. If you care about the safety and wellbeing of competi tors, then don't vote on these arguments. If you don't, then I honestly don't understand why you give up your time to coach and/or j udge . The pay can't be that good. I don't believe that you' re just in it for the money, which is why I ask you to ask yourselves whether you can justify making debate unsa fe for certain people.

Contention One is HIV

HIV drugs are prohibitively expensive.

Vann, Madeline. "Can You Afford Your HIV Treatment?." Everyday Health. May 13, 2009. Web. August 21, 2021. <https://www.everydayhealth.com/hiv-aids/can-you-afford-hiv-treatment.aspx>.

There's no getting around it: **HIV drugs cost a lot of money. In fact, the lifetime cost of care for a person living with HIV can total hundreds of thousands of dollars.** But the good news is that no one living with HIV in the United States has to pay the full cost out of his or her own pocket. "**The average cost of HIV treatment is** $14,000 to **$20,000 a year,"** says Michael Kolber, MD, a professor of medicine and director of the Comprehensive AIDS Program and Adult HIV Services at University of Miami Miller School of Medicine in Florida. "If you're paying $1,000 a month, you're doing really well." **Modern HIV drugs can keep people healthy for decades, but if you take them you could be facing well over $400,000 or more in lifetime costs for HIV treatment. Unfortunately**, real or perceived **cost is a significant barrier to care** — data suggests that only about **half of low-income people living with HIV are receiving the HIV drugs they need because of cost.**

A) HIV disproportionately impacts LGBTQ+ communities.

Human Rights Campaign. '21 "How HIV Impacts LGBTQ+ People." Human Rights Campaign. Web. August 21, 2021. <https://www.hrc.org/resources/hrc-issue-brief-hiv-aids-and-the-lgbt- community>.

HIV disproportionately impacts segments of the LGBTQ community. According to the U.S. Centers for Disease Control and Prevention (**CDC**), there are 1.2 million people living with HIV (PLWH) in the United States, and approximately 40,000 people were diagnosed with HIV in 2015 alone. While the annual number of new diagnoses fell by 19% between 2005 and 2014, progress has been uneven. For example, **gay and bisexual men made up** an estimated **2% of the U.S. population in 2013 but 55% of all PLWH in the United States. If current diagnosis rates continue, 1 in 6 gay and bisexual men will be diagnosed with HIV in their lifetime. For Latino and Black men who have sex with men, the rates are in 1 in 4 and 1 in 2, respectively. Transgender people have also been hit especially hard by the epidemic despite comprising a similarly small percentage of the U.S. population.** While better data is needed to understand the full impact of HIV on the transgender community, **one international analysis found that transgender women in certain communities have 49 times the odds of living with HIV than the general population**. Although HIV prevalence among transgender men is relatively low (0-3%) according to the CDC, some data suggest transgender men may still yet be at elevated risk for HIV acquisition.

**IMPACT

B) HIV is a leading cause of death in sub-Saharan Africa.

WIPO ‘00 “Patent Protection and Access to HIV/AIDS Pharmaceuticals in Sub-Saharan Africa.” the World Intellectual Property Organization (WIPO). 2000. Web. August 21, 2021. <https://www.wipo.int/export/sites/www/about-ip/en/studies/pdf/iipi_hiv.pdf>.

AIDS is now the leading cause of death in sub-Saharan Africa. Since the epidemic began, some 15 million Africans have died from AIDS and there are nearly 25 million adults and children living with HIV/AIDS in African countries south of the Sahara Desert.1 There were 4.0 million new infections in this region during 1999. There are now 16 countries in which more than one-tenth of the adult population is infected with HIV. In seven countries at the southern cone of the continent, the infection rate exceeds 20 percent. 2 Estimates of adult infection rates for the countries hardest hit by the HIV/AIDS epidemic in sub-Saharan Africa, as of the end of 1999, are shown below: BOTSWANA 35.80% KENYA 13.95% SWAZILAND 25.25% CENTRAL AFRICAN REPUBLIC 13.84% ZIMBABWE 25.06% MOZAMBIQUE 13.22% LESOTHO 23.57% DJIBOUTI 11.75% ZAMBIA 19.95% BURUNDI 11.32% SOUTH AFRICA 19.94% RWANDA 11.21% NAMIBIA 19.54% IVORY COAST 10.76% MALAWI 15.96% ETHIOPIA 10.63% The **HIV/AIDS epidemic poses an enormous threat to development in sub-Saharan Africa, which accounts for more than 70 percent of all HIV/AIDS cases globally. HIV/AIDS has reversed social, economic, and political gains made over the past three decades in several countries.**3 As starkly put by the International Partnership Against AIDS in Africa, “[t]he speeds, spread and scope of the epidemic is unprecedented in modern times...By threatening a generation of youthful, productive people, the disease is mortgaging the continent’s future.”4 **The devastating effects of HIV/AIDS in sub-Saharan Africa, predicted since the early 1990s, is now being seen in falling life expectancies, increasing numbers of orphans, and terrible tolls on households, learning, teaching, health systems, agriculture and business sectors across the board.**5 The Worldwatch Institute, a nonprofit public policy research organization dedicated to informing policymakers and the public about emerging global problems and trends, recently published an “Issue Alert” noting the precipitous fall in life expectancies in sub-Saharan Africa.6 Without AIDS, life expectancy in the year 2010 in Zimbabwe would be 70 years, in Botswana 66 years and in Zambia 60 years. With AIDS, these life expectancies are expected to drop to 35 years in Zimbabwe, 33 years in Botswana and 30 years in Zambia, “more akin to those of the Middle Ages than of the modern age.” By 2010, Africa is expected to have 40 million orphans.7 About 95 percent of HIV-infected people live in developing countries, most of them in sub-Saharan Africa. At the same time, African governments together owe more than USD 230 billion in debt, with repayments costing Africa USD 15 billion each year – the equivalent of 5 percent of the region’s income and about 15 percent of its export earnings.8 Despite concerted and intensified efforts to address the HIV/AIDS crisis, however, the epidemic rages on in several sub-Saharan African countries with more devastation than even the worst estimates predicted. In 1991, it was estimated that 9 million people would be infected and 5 million would die from HIV/AIDS in subSaharan Africa by the end of the decade, whereas in reality the figures are almost triple those predicted: 24 million infected and 13.7 million dead.9

Patents are the reason

WIPO ‘00. “Patent Protection and Access to HIV/AIDS Pharmaceuticals in Sub-Saharan Africa.” the World Intellectual Property Organization (WIPO). 2000. Web. August 21, 2021. <https://www.wipo.int/export/sites/www/about-ip/en/studies/pdf/iipi_hiv.pdf>.

In conjunction with the focus on the cost of HIV/AIDS drugs, there has been a heightened awareness of the role that patents play in driving up drug prices. AIDS and health activists contend that **patents and the TRIPS Agreement have the effect of denying access to HIV/AIDS drugs.** The drug companies contend that patent protection is essential to provide a return on their R&D investment and to encourage the development of new drugs. In furtherance of this view, drug companies have fiercely defended their patent rights and generally opposed any efforts by governments to permit parallel imports or issue compulsory licenses. Until recently, the pharmaceutical industry was supported in its efforts by the U.S. government, which had consistently opposed compulsory licensing and parallel importation of drugs under patent in other countries. The U.S. government viewed compulsory licensing as a threat to patent incentives that encourage innovation and it viewed parallel importation as a threat to the cost structures adopted by the pharmaceutical industry. The European Union had expressed similar views. The U.S. government pressured South Africa and Thailand not to permit compulsory licensing or parallel imports. In the case of South Africa, one of the few sub-Saharan African countries where pharmaceutical companies have patents in force, the government had passed the Medicines and Related Substances Control Act, Act No. 90 of 1997 (“the Act”) which allowed parallel imports (section 15C) and local South African companies to produce HIV/AIDS drugs under compulsory license (Section 22C).

More affordable drugs are needed in order to make treatment accessible – current price cuts aren't enough.

WIPO '00 "Patent Protection and Access to HIV/AIDS Pharmaceuticals in Sub-Saharan Africa." the World Intellectual Property Organization (WIPO). 2000. Web. August 21, 2021. <https://www.wipo.int/export/sites/www/about-ip/en/studies/pdf/iipi_hiv.pdf>.

Following the softening of U.S. and EU opposition to compulsory licensing and parallel importation, the drug companies began advancing offers of reduced pricing. **In May 2000, as a result of growing pressure on the pharmaceutical industry from the public organizations concerned with the AIDS crisis and access to HIV/AIDS drugs, five companies** including Bristol- Myers Squibb, Merck & Co, Glaxo Wellcome, Roche, and Boehringer Ingelheim **agreed** with officials of UNAIDS and the World Bank **to sell their drugs in sub-Saharan Africa at greatly reduced prices.** However, a deal was not struck with an African country to secure the discounted drugs until October 2000.46 Senegal has negotiated a reduced price with Bristol- Myers for Zerit and Videx (d4T and ddI) taken together for $1.60 per day, or $584 per year, far below the cost in the U.S.47 **Even at the greatly reduced prices,** however, **the drugs still remain too high for most people suffering from HIV/AIDS.** The reader is referred to the country profiles annexed, which set out the average GDP figures. These figures make it clear that **affordability is a key issue and that the initiative of the pharmaceutical companies may not address the enormous problems facing the poorest populations where HIV/AIDS has become an endemic crisis of the greatest magnitude.** The Joint United Nations Program on HIV/AIDS (UNAIDS) estimates that more than USD 2 billion in annual global investment is necessary. Yet only USD 300 million has been invested in the effort this year. Over the past months, a growing chorus of commentators added their voices to the call for more affordable drugs. As stated in a New York Times editorial: "In recent months, pharmaceutical companies, the World Bank, governments and foundations have promised donations of drugs or new money, in some cases hundreds of millions of dollars' worth. Donated drugs are important, but South Africa is proposing a more sustainable solution – making cheap versions of still-patented drugs or importing them at less than the makers charge. These steps were blocked by Washington – which has since changed its view – and the pharmaceutical industry. Wealthy countries should support South Africa, and help all of Africa to get drugs at the lowest possible prices." 48 Notwithstanding the view expressed by the New York Times, it is not at all clear whether attempts to abrogate patent protection through compulsory licensing and parallel importation will ultimately result in better access to medicines and healthcare. The evidence from the information collected by IIPI from the pharmaceutical companies, ARIPO, OAPI and sub-Saharan countries, dealt with in greater detail below, suggests that in countries where the drugs are not patented, there is still poor access to pharmaceuticals.

C2: Pandemics impacting developing countries

Intellectual property patents slow alleviation efforts during pandemics.

Brink '21. "Why Intellectual Property And Pandemics Don't Mix." Brookings. June 03, 2021. Web. August 18, 2021. <https://www.brookings.edu/blog/up-front/2021/06/03/why- intellectual-property-and-pandemics-dont-mix/>.

For pandemics and other public health emergencies, patents' mix of costs and benefits is misaligned with what is needed for an effective policy response. The basic patent bargain, even when well struck, is to pay for more innovation down the road with slower diffusion of innovation today. In the context of a pandemic, that bargain is a bad one and should be rejected entirely. Here the imperative is to accelerate the diffusion of vaccines and other treatments, not slow it down. **Giving drug companies the power to hold things up by blocking competitors and raising prices pushes in the completely wrong direction.** What approach to encouraging innovation should we take instead? How do we incentivize drug makers to undertake the hefty R&D costs to develop new vaccines without giving them exclusive rights over their production and sale? **The most effective approach during a public health crisis is direct government support: public funding of R&D, advance purchase commitments by the government to buy large numbers of**

doses at set prices, and other, related payouts. And when we pay drug makers, we should not hesitate to pay generously, even extravagantly: we want to offer drug companies big profits so that they prioritize this work above everything else, and so that they are ready and eager to come to the rescue again the next time there's a crisis. It was direct support via Operation Warp Speed that made possible the astonishingly rapid development of COVID-19 vaccines and then facilitated a relatively rapid rollout of vaccine distribution (relative, that is, to most of the rest of the world). And it's worth noting that a major reason for the faster rollout here and in the United Kingdom compared to the European Union was the latter's misguided penny-pinching. The EU bargained hard with firms to keep vaccine prices low, and as a result their citizens ended up in the back of the queue as various supply line kinks were being ironed out. This is particularly ironic since the Pfizer-BioNTech vaccine was developed in Germany. As this fact underscores, the chief advantage of direct support isn't to "get tough" with drug firms and keep a lid on their profits. Instead, it is to accelerate the end of the public health emergency by making sure drug makers profit handsomely from doing the right thing. Patent law and direct support should be seen not as either-or alternatives but as complements that apply different incentives to different circumstances and time horizons. Patent law provides a decentralized system for encouraging innovation. The government doesn't presume to tell the industry which new drugs are needed; it simply incentivizes the development of whatever new drugs that pharmaceutical firms can come up with by offering them a temporary monopoly. It is important to note that patent law's incentives offer no commercial guarantees. Yes, you can block other competitors for a number of years, but that still doesn't ensure enough consumer demand for the new product to make it profitable.

Focusing on long-term improvements is key- a global pandemic will come again.

Brink '21 Lindsey, Brink. "Why Intellectual Property And Pandemics Don't Mix." Brookings. June 03, 2021. Web. August 18, 2021. <https://www.brookings.edu/blog/up-front/2021/06/03/why- intellectual-property-and-pandemics-dont-mix/>.

Although focusing on these immediate constraints is vital, we cannot confine our attention to the short term. First of all, **the COVID-19 pandemic is far from over.** Although Americans can now see the light at the end of the tunnel thanks to the rapid rollout of vaccines, most of the world isn't so lucky. **The virus is currently raging in India and throughout South America, overwhelming health care systems and inflicting suffering and loss on a horrific scale**. And consider the fact that Australia, which has been successful in suppressing the virus, recently announced it was sticking to plans to keep its borders closed until mid-2022. Criticisms of the TRIPS waiver that focus only on the next few months are therefore short-sighted: **this pandemic could well drag on long enough for elimination of patent restrictions to enable new vaccine producers to make a positive difference. Furthermore, and probably even more important, this is almost certainly not the last pandemic we will face. Urbanization, the spread of factory-farming methods, and globalization all combine to increase the odds that a new virus will make the jump from animals to humans and then spread rapidly around the world. Prior to the current pandemic, the 21st century already saw outbreaks of SARS, H1N1, MERS, and Ebola. Everything we do and learn in the current crisis should be viewed from the perspective of getting ready for next time.**

Patents reduce access to medicine and other pharmaceuticals, developing countries face the brunt of these impacts.

Hassan '21, Emmanuel. "Intellectual Property And Developing Countries." RAND. 2010. Web. August 18, 2021. <https://www.rand.org/content/dam/rand/pubs/technical_reports/2010/RAND_TR804. pdf>.

In most developing countries, patent protection for pharmaceuticals is available but not used. Nevertheless, those countries remain affected, because they tend to rely on exports from countries where there is more patent protection. Firms may adopt the view that it is not worth the expense of obtaining and maintaining protection in countries that express small market demand and pose a limited threat of imitation. In a study of 53 African countries and 15 antiretroviral drugs, patenting prevalence was found to be only 21.6 per cent of the possible total (Attaran and GillespieWhite, 2001). On their own, such findings may suggest that patenting does not constrain access. However, the picture changes when one considers that these countries import from others that may have significant market demand of their own, and do have the technological capability to imitate. Patenting in those countries is much more prevalent, such that 13 out of the 15 antiretroviral drugs are patent-protected in South Africa (WHO, 2002a). The ability of countries such as South Africa to imitate and

export to countries that cannot do so for themselves will be curtailed if strong patent rights are tightly enforced there. Thus, even if TRIPS is enforced selectively in only a few key countries, such as South Africa and other imitation (generic) exporters, the immediate outlook is bleak for countries that appear to rely on importing generic drugs as their principal means for addressing public health challenges. They will be forced to seek other channels (discussed below) to reduce the price of accessing medicines.

The major barrier to for a lack of access to medicine in developing countries is unaffordability due to patents

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]/

With as little as $8 to spend on health care per person annually, the governments of most sub-Saharan states cannot afford the $10,000 price tag for a year's supply of name-brand anti-retrovirals. 3 3 **Some patent supporters point to the limited public health resources of these countries to argue that domestic poverty levels alone explain the lack of access to treatment**. 3 " Surely poverty and under-resourced public health infrastructure are major barriers to access to costly medications. **But it is also true that prices remain high, and therefore out of reach, because of patent protection.** In pitting poverty as the sole culprit for the crisis, this "poverty, not patents" argument simultaneously, and paradoxically, urges continued patent protection to ensure further research that will somehow increase availability through the discovery of new treatments. 35 However, the logic of this argument does not add up; these new treatments will likely also enjoy strong patent protection and remain out of reach for the world's poor, making this an empty bargain for the millions of HIV/AIDS patients who cannot even afford existing treatment. Advocates of the "poverty, not patents" perspective point to skeletal public health programs in many AIDS-ravaged countries to argue that even if access to affordable generics, increased, no infrastructure exists for proper disbursement and monitoring. 36 The argument goes as follows: without substantial public health infrastructure, patients will not be able to adhere to the treatment cycle, rendering the drugs ineffective and facilitating drug-resistant viral strains.37 Yet recent studies have concluded otherwise. Patients in Brazil, Kenya, Senegal, and India have adhered to treatment programs as strictly as patients in wealthy western states.3 8 Research has also attested to the quality and efficacy of generically manufactured anti-retrovirals. 39 James Thuo Gathii argues that western governments, in cohort with pharmaceutical corporations, have over-emphasized the role of poverty in restricting access to anti-retrovirals.4 0 The Executive Vice President of Bristol Myers-Squib, which produces the AIDS drug Zerit, for example, denied the impact of patent-based profits on the AIDS crisis, claiming that "[AIDS] is about poverty." 4 1 Such arguments should come as no surprise, as pharmaceutical corporations have a financial interest in framing this humanitarian crisis as one of poverty rather than affordability. They also cast AIDS as a strictly social condition rather than an infectious disease, a notion not unique to pharmaceutical conglomerates. South African President, Thabo Mbeki, for example, misguidedly asserted that "extreme poverty" is the4rimary culprit of sub-Saharan Africa's public health ravages, not the HIV virus. **The circular "poverty, not patents" argument assumes that high prices are a given and that poverty is synonymous with an inability to afford medication. But high prices are not a given; based on the examples of India and Brazil, relaxing patent standards for developing countries by condoning generic manufacture and parallel imports4 3 dramatically lowers prices and increases access to antiretroviral treatment. 44 Instead of poverty, the true barrier to access is unaffordability.** This idea should empower those who are truly concerned with combating the AIDS epidemic because, while poverty is a multidimensional problem with no immediate solution, **current technology already allows for the manufacture of affordable generic treatment. Yet patent protections presently suppress the production of effective generic antiretrovirals, to the detriment of the world's poorest** HIV/AIDS **patients.**

REBUTTAL CARDS:

Even with insurance, HIV medication costs can be insurmountable.

Vann, Madeline. "Can You Afford Your HIV Treatment?." Everyday Health. May 13, 2009. Web. August 21, 2021. <https://www.everydayhealth.com/hiv-aids/can-you-afford-hiv- treatment.aspx>.

Paying for Your HIV Drugs HIV drug costs can be covered in a variety of ways: Private health insurance. Depending on the plan you have, this type of insurance can cover healthcare visits and HIV/AIDS treatment programs and medication. "For people with private insurance there are medications that their insurance company may recommend. Often, there are co-pays for the medications

depending on the type of insurance," says Dr. Hare. **Having private insurance that covers a percentage of the cost of your medications can provide some relief, but co-pays alone can become a substantial burden over time.** Also of note: **Fewer than one in three people with HIV has private health insurance to cover the cost of HIV drugs. Medicaid and Medicare. Almost half of those living with HIV in the United States are covered by one of these federally funded programs. In some states, however, you may not be eligible for Medicaid until you have AIDS or are otherwise disabled by HIV. Medicare part D,** which was developed to cover medications including HIV drugs, **has a restriction in its annual benefit** that's referred to as the "donut hole." **Recipients are required to pay $3,051 out of pocket after their initial, basic coverage benefit is used up and before the catastrophic coverage kicks in to cover the rest of the year's medication needs. This can be a substantial financial burden** for some. AIDS Drug Assistance Programs (ADAP). These programs are federally funded through the 1990 Ryan White Comprehensive Resources Emergency Act and are administered by individual states, which may also contribute to the funding. **People of low income who are living with HIV may qualify for assistance** through these programs. **States often control their costs by limiting the number or type of medications that they will cover** through ADAP, **which may result in shorter life expectancy for people who are depending on these programs to get HIV treatment.** State or community assistance programs. In addition to federally funded coverage programs, many states, communities, and pharmacies have HIV drug assistance programs that can help ease your financial burden. You can find out about these through your treatment clinic or HIV/AIDs organizations. Coping With HIV Costs Houston resident Carl Smith (not his real name) says despite having private insurance that covers the cost of his HIV medications, he is constantly juggling the cost of co-pays with other necessary expenses, such as rent and food.

a/2 innovation: Patents no longer are utilized in order to generate innovation, but rather to create leverage for court cases. This deters new patent launches, with a substantial share of patents not being used for innovation, but merely legal deterrents.

Gubby 20, [Helen Gubby, Barrister and senior lecturer at the Rotterdam School of Management at Erasmus University, September 6th, 2019, "Is the Patent System a Barrier to Inclusive Prosperity? The Biomedical Perspective", Global Policy, https://onlinelibrary.wiley.com/doi/10.1111/1758-5899.12730]

The decision to patent has become in part uncoupled from the original core purpose of the patent: to protect an invention from unfair imitation by other market participants. Larger firms, with the capital assets to pay for the cost of patenting, use their patent portfolios strategically. Patents have become useful as bargaining chips; they provide leverage. Large patent portfolios are a means to get access to important co-operations or cross-licensing arrangements(Blind et al., 2009, p. 431). Yet while building the portfolio requires enormous legal costs, it contributes little to research incentives. Furthermore, these portfolios can be used not just to oblige competitors to take licences, but also the terms of these licences can restrict competitors to certain areas of technology (Barton, 2000). **Larger firms can afford to play the 'wrap around' strategy. Instead of applying for a single patent to cover an invention, other patents are filed around the main patent. These related patents lock down the discrete features of an invention. The tactic hinders entry to the market. Competitors will be put to time, effort and cost to fight their way through all the relevant patents covering the technology.** Furthermore, the chance that the competitor's invention may infringe one of the many claims in one of the many patents is high. Not only can damages be awarded for infringement, but also an injunction. Injunctions prevent the party accused of infringement from producing any products that require the use of the technology covered by the infringed patent and all infringing products are removed from the market. Patents may be used simply to block competitors. Using a patent as a blocking strategy is common practice (Neuhäusler, 2012). Defensive blocking is used to protect a firm's own freedom to operate: it does not want to be shut out by the patents of its rivals. An offensive blocking strategy is where patents are filed to cover products or processes that the firm does not intend to practice itself, but which could be viable alternatives to competitors. By patenting all conceivable alternatives, **research by competitors that might threaten their own technological lead can be thwarted. As in general a patentee is under no obligation to license out its technology to another, the strategy can deter market entry or new product launch**. This offensive blocking of competitors by means of patents, 'is clearly a case of the patent system being used for purposes other than for

which it was originally intended' (Blind, 2009, p. 436). However, both defensive and offensive blocking should be a policy concern, as they can reduce economic efficiency. Defensive patenting increases cost to firms without necessarily producing any benefit and offensive patenting can reduce technological progress and increase consumer costs by reducing competition (Thumm, 2004, p. 533).

Using data from a large-scale survey of patent applications, Torrisi discovered that a substantial share of patents remained unused and **a substantial number of patent applications were filed to block other patents. There were institutional differences; there were more unused patents** in Japan and the EU than in the USA. Although cautious to make generalisations about unused patents, as some unused patents are there to ensure freedom to operate or simply because of management inefficiency, Torrisi et al. did conclude that: '[o]ur results highlight that there might be substantial benefits that patent owners draw from being able to keep patent rights unused. These would have to be balanced against possible harm imposed on other economic agents' (Torrisi et al., 2016; , p. 1384). These strategies show a disconnect with the original purpose of the patent system. Patent strategies impact on innovation, and this in turn impacts on society. Concern was already expressed quite forcibly some years ago by Turner: Surely when the framers of the [US] Constitution empowered Congress to grant monopolies to 'promote the progress of science and the useful arts', they did not envision the beneficiaries of this g

a/2 china: China's vaccine diplomacy is inevitably limited by diversification efforts---countries like India are distributing vaccines abroad precisely to offset any soft power gains for China.

Huang, '21 Yanzhong. "Vaccine Diplomacy Is Paying Off For China." Foreign Affairs. March 11, 2021. Web. August 17, 2021. <https://www.foreignaffairs.com/articles/china/2021-03- 11/vaccine-diplomacy-paying-china>.

China's vaccine diplomacy, for these and other reasons, does not enjoy a totally open field. Rather, **Chinese vaccines must jostle for position among those from India, Russia, and the United States.** The Central Asia Barometer Survey released in early February found that 52 percent of Kazakhstanis, 58 percent of Uzbekistanis, and 76 percent of Kyrgyzstanis believed that Russia would be best able to help their countries, compared with 20 percent of Kazakhstanis, 14 percent of Uzbekistanis, and 8 percent of Kyrgyzstanis who said China would be best able to help their countries. Given China's growing BRI investment in what India considers its sphere of influence, **India has particularly strong incentives to counterbalance China's geopolitical influence by sending desperately needed vaccines to its neighbors**, including Nepal (one million doses), Bangladesh (two million), Sri Lanka (500,000), Bhutan (150,000), Maldives (100,000), Myanmar (1.5 million), Afghanistan (500,000), and Seychelles (50,000). The only country in the region that has not received India's vaccine is its archrival, Pakistan, to which China pledged 1.2 million doses. India's generosity highlights the limits of China's vaccine diplomacy in India's strategic backyard: thus far, China has donated only 500,000 doses to Nepal, 300,000 doses to Sri Lanka, and 300,000 doses to Myanmar. Its vaccine donation to Pakistan, the largest among all BRI countries, covers no more than 0.6 percent of the country's population. Recipients of Chinese largess know that Beijing's vaccine diplomacy is not a one-way street and that vaccines may come at the price of influence down the line. These countries make their own rational calculations in dealing with Beijing. Many seek to diversify their vaccine supply. Some might be happy to see China and its rivals compete with one another to offer vaccines. Seychelles, with a population of 98,000, has received 100,000 doses of vaccines manufactured in either China or India. As a result of "dueling vaccine diplomacy," the island nation now ranks second in the world in the percentage of population vaccinated. Vietnam, which has territorial disputes with China, was the first to preorder a large batch of

Concerns about the reliability of China's vaccines will limit soft power gains.

Marlow '21, Iain. "China Is Winning The Race To Vaccinate The World, For Now." Bloomberg Businessweek. May 19, 2021. Web. August 17, 2021. <https://www.bloomberg.com/news/articles/2021-05-19/china-s-covid-shots-give-beijing-soft-power-lever-around-the-world>.

Another wild card is the reliability of Chinese shots compared with that of the other vaccines. The efficacy of the Sinovac vaccine, for instance, varies wildly—from 50% to 90%—in studies. Global surveys have shown Chinese shots are the least favored in several places. **Even in Hong Kong, only 37% said they'd take a Sinovac jab, compared with 56% for Pfizer** Inc.'s. **Western vaccine diplomacy with more effective shots could easily push back gains by China,** according to Thomas, the Hong Kong academic. The official in New Delhi says India remains a trusted partner for vaccines around the developing world and that Chinese shots haven't lived up to expectations. Across Africa, nations have struggled with vaccine hesitancy, suggesting China's shots m ay languish in storage rather than generate the political goodwill Beijing intended. "Although

some of my workmates have been vaccinated, I am still afraid to do it because of what I've read on social media," says Passmore Mwanza, a 29-year-old supervisor at a candy maker in Zimbabwe.

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1. Structural violence over util becasue consequences are irrelevant under my framework. It is only about consistency with following the rules of the categorical imperative. These rules are justified through the concept of contradiction, not ends states. Consequentialism fails to guide action. It leads to absurd ethical conclusions Empiricist and objectivist theories fail to account for the nuances of each scenario. Finally, the prioritization of the majority leads to racist conclusions being made.
2. We must prioritse keeping debate a space comfortable for