# Structural Violence Framing

#### I affirm the resolution; The member nations of the World Trade Organization ought to reduce intellectual property protections for medicines.

#### My value is morality, as ought in the resolution implies a moral question.

#### The Value Criterion is mitigating structural violence –

Winter and Leighton 99(Deborah DuNann Winter and Dana C. Leighton. Winter: Psychologist that specializes in Social Psych, Counseling Psych, Historical and Contemporary Issues, Peace Psychology. Leighton: PhD graduate student in the Psychology Department at the University of Arkansas. Knowledgable in the fields of social psychology, peace psychology, and justice and intergroup responses to transgressions of justice) (Peace, conflict, and violence: Peace psychology in the 21st century.  Pg 4-5)

She argues that our normal perceptual cognitive processes divide people into in-groups and out-groups**.** Those outside our group lie outside our scope of justice. Injustice that would be instantaneously confronted if it occurred to someone we love or know is barely noticed if it occurs to strangers or those who are invisible or irrelevant. We do not seem to be able to open our minds and our hearts to everyone, so we draw conceptual lines between those who are in and out of our moral circle. Those who fall outside are morally excluded, and become either invisible, or demeaned in some way so that we do not have to acknowledge the injustice they suffer**.** Moral exclusion is a human failing, but Opotow argues convincingly that it is an outcome of everyday social cognition. To reduce its nefarious effects, we must be vigilant in noticing and listening to oppressed, invisible, outsiders**.** Inclusionary thinking can be fostered by relationships, communication, and appreciation of diversity. Like Opotow, all the authors in this section point out that structural violence is not inevitable if we become aware of its operation, and build systematic ways to mitigate its effects**.** Learning about structural violence may be discouraging, overwhelming, or maddening, but these papers encourage us to step beyond guilt and anger, and begin to think about how to reduce structural violence. All the authors in this section note that the same structures (such as global communication and normal social cognition) which feed structural violence, can also be used to empower citizens to reduce it**.** In the long run, reducing structural violence by reclaiming neighborhoods, demanding social justice and living wages, providing prenatal care, alleviating sexism, and celebrating local cultures, will be our most surefooted path to building lasting peace

#### Prefer –

#### Combatting structural oppression is a prerequisite to all other theories, as there must be total moral inclusion before a theory can be deemed legitimate.

#### Prioritizing oppressed peoples allows us to focus action on those who need it the most, as opposed to generally pursuing goods for all.

#### Ignoring structural oppression in pursuit of abstract theories legitimizes oppression by prioritizing the pursuit of arbitrary moral goods over real world consequences.

#### Oppression is never permissible, regardless of the consequences, because it is incoherent to exercise your rights by oppressing, whilst simultaneously undermining the rights of the oppressed.

#### Answers to this framework assume you have a voice in the first place, which is contingent on you not being oppressed. This means my framework is a lexical prerequisite to theirs.

#### The privilege we have requires us to listen to the oppressed.

Young 90 [Iris Marion Young, Professor in Political Science at the University of Chicago [“Justice and the Politics of Difference”. Princeton University Press, 1990, ]

Group representation, third, encourages the expression of individual and group needs and interests in terms that appeal to justice, that transform an "I want" into an "I am entitled to," in Hannah Pitkin's words. In Chapter 4 I argued that publicity itself encourages this transformation because a condition of the public is that people call one another to account. Group representation adds to such accountability because it serves as an antidote to self-deceiving self-interest masked as an impartial or general interest. Unless confronted with different perspectives on social relations and events, different values and language, most people tend to assert their perspective as universal. When social privilege allows some group perspectives to dominate a public while others are silent, such universalizing of the particular will be reaffirmed by many others. Thus the test of whether a claim upon the public is just or merely an expression of self interest is best made when those making it must confront the opinion of others who have explicitly different, though not necessarily conflicting, experiences, priorities, and needs (cf. Sunstein, 1988, p. 1588). As a person of social privilege, I am more likely to go outside myself and have regard for social justice when I must listen to the voice of those my privilege otherwise tends to silence.

#### 4. Structural Violence is often hidden – causing it to bring about as much damage as direct violence.

Winter & Leighton 99 [Deborah DuNann Winter and Dana C. Leighton, Winter is a Professor at Whitman College and Leighton is a Professor at Texas A&M University, “Peace, Conflict, and Violence: Peace Psychology for the 21st Century” 1999, http://sites.saumag.edu/danaleighton/wp-content/uploads/sites/11/2015/09/SVintro-2.pdf

Direct violence is horrific, but its brutality usually gets our attention: we notice it, and often respond to it. Structural violence, however, is almost always invisible, embedded in ubiquitous social structures, normalized by stable institutions and regular experience. Structural violence occurs whenever people are disadvantaged by political, legal, [and] economic or cultural traditions. Because they are longstanding, structural inequities usually seem ordinary, the way things are and always have been. The chapters in this section teach us about some important but invisible forms of structural violence, and alert us to the powerful cultural mechanisms that create and maintain them over generations. Structured inequities produce suffering and death as often as direct violence does, though the damage is slower, more subtle, more common, and more difficult to repair. Globally, poverty is correlated with infant mortality, infectious disease, and shortened lifespans. Whenever people are denied access to society’s resources, physical and psychological violence exists.

#### Structural violence prohibits people from improving their well-being – turning consequential frameworks

Ansell 17 [David A. Ansell, Ansell is the Professor of Medicine at Rush University Medical Center and holds an M.D. from the State University of New York Upstate Medical University College of Medicine, “American Roulette, The Death Gap: How Inequality Kills”, University of Chicago Press 2017, ISBN 9780226428291]

There are many different kinds of violence. Some are obvious: punches, attacks, gunshots, explosions. These are the kinds of interpersonal violence that we tend to hear about in the news. Other kinds of violence are intimate and emotional. But the deadliest and most thoroughgoing kind of violence is woven into the fabric of American society. It exists when some groups have more access to goods, resources, and opportunities than other groups, including health and life itself. This violence delivers specific blows against particular bodies in particular neighborhoods. This unequal advantage and violence is built into the very rules that govern our society. In the absence of this violence, large numbers of Americans would be able to live fuller and longer lives. This kind of violence is called structural violence, because it is embedded in the very laws, policies, and rules that govern day-to-day life. It is the cumulative impact of laws and social and economic policies and practices that render some Americans less able to access resources and opportunities than others. This inequity of advantage is not a result of the individual’s personal abilities but is built into the systems that govern society. Often it is a product of racism, gender, and income inequality. The diseases and premature mortality that Windora and many of my patients experienced were, in the words of Dr. Paul Farmer, “biological reflections of social fault lines.”9 As a result of these fault lines, a disproportional burden of illness, suffering, and premature mortality falls on certain neighborhoods, like Windora’s. Structural violence can overwhelm an individual’s ability to live a free, unfettered, healthy life. As I ran to evaluate Windora, I knew that her stroke was caused in part by lifelong exposure to suffering, racism, and economic deprivation. Worse, the poverty of West Humboldt Park that contributed to her illness is directly and inextricably related to the massive concentration of wealth and power in other neighborhoods just miles away in Chicago’s Gold Coast and suburbs. That concentration of wealth could not have occurred without laws, policies, and practices that favored some at the expense of others. Those laws, policies, and practices could not have been passed or enforced if access to political and economic power had not been concentrated in the hands of a few. Yet these political and economic structures have become so firmly entrenched (in habits, social relations, economic arrangements, institutional practices, law, and policy) that they have become part of the matrix of American society. The rules that govern day-to-day life were written to benefit a small elite at the expense of people like Windora and her family. These rules and structures are powerful destructive forces. The same structures that render life predictable, secure, comfortable, and pleasant for many destroy the lives of others like Windora through suffering, poverty, ill health, and violence. These structures are neither natural nor neutral. The results of structural violence can be very specific. In Windora’s case, stroke precursors like chronic stress, poverty, and uncontrolled hypertension run rampant in neighborhoods like hers. Windora’s illness was caused by neither her cultural traits nor the failure of her will. Her stroke was caused in part by inequity. She is one of the lucky ones, though, because even while structural violence ravages her neighborhood, it also abets the concentration of expensive stroke- intervention services in certain wealthy teaching hospitals like mine. If I can get to her in time, we can still help her. Income Inequality and Life Inequality Of course, Windora is not the only person struggling on account of structural violence. Countless neighborhoods nationwide are suffering from it, and people are dying needlessly young as a result. The magnitude of this excess mortality is mind-boggling. In 2009 my friend Dr. Steve Whitman asked a simple question, “How many extra black people died in Chicago each year, just because they do not have the same health outcomes as white Chicagoans?” When the Chicago Sun-Times got wind of his results, it ran them on the front page in bold white letters on a black background: “HEALTH CARE GAP KILLS 3200 Black Chicagoans and the Gap is Growing.” The paper styled the headline to look like the declaration of war that it should have been. In fact, we did find ourselves at war not long ago, when almost 3,000 Americans were killed. That was September 11, 2001. That tragedy propelled the country to war. Yet when it comes to the premature deaths of urban Americans, no disaster area has been declared. No federal troops have been called up. No acts of Congress have been passed. Yet this disaster is even worse: those 3,200 black people were in Chicago alone, in just one year. Nationwide each year, more than 60,000 black people die prematurely because of inequality. While blacks suffer the most from this, it is not just an issue of racism, though racism has been a unique and powerful transmitter of violence in America for over four hundred years. Beyond racism, poverty and income inequality perpetuated by exploitative market capitalism are singular agents of transmission of disease and early death. As a result, there is a new and alarming pattern of declining life expectancy among white Americans as well. Deaths from drug overdoses in young white Americans ages 25 to 34 have exploded to levels not seen since the AIDS epidemic. This generation is the first since the Vietnam War era to experience higher death rates than the prior generation.12 White Americans ages 45 to 54 have experienced skyrocketing premature death rates as well, something not seen in any other developed nation.13 White men in some Appalachian towns live on average twenty years less than white men a half-day’s drive away in the suburbs of Washington, DC. Men in McDowell County, West Virginia, can look forward to a life expectancy only slightly better than that of Haitians.14 But those statistics reflect averages, and every death from structural violence is a person. When these illnesses and deaths are occurring one at a time in neighborhoods that society has decided not to care about—neighborhoods populated by poor, black, or brown people—they seem easy to overlook, especially if you are among the fortunate few who are doing incredibly well. The tide of prosperity in America has lifted some boats while others have swamped. Paul Farmer, the physician-anthropologist who founded Partners in Health, an international human rights agency, reflects on the juxtaposition of “unprecedented bounty and untold penury”: “It stands to reason that as beneficiaries of growing inequality, we do not like to be reminded of misery of squalor and failure. Our popular culture provides us with no shortage of anesthesia.”15 That people suffer and die prematurely because of inequality is wrong. It is wrong from an ethical perspective. It is wrong from a fairness perspective. And it is wrong because we have the means to fix it.

#### Prefer Impacts we know are happening today over low chance extinction scenarios – we must solve for current issues in the world right now rather than freeze action over low chance scenarios.

# Case

#### Contention 1 – HIV/AIDS

#### HIV medicine costs are difficult to afford.

Myhre and Sifris 21 -- By [James Myhre & Dennis Sifris, MD](https://www.verywellhealth.com/dennis-sifris-md-and-james-myhre-47512) Updated on February 03, 2021, <https://www.verywellhealth.com/making-hiv-drugs-more-affordable-4120495>,

Affording quality healthcare for the average American is tough enough without the added challenge of a chronic illness. Arguably, for people living with HIV, the challenges are greater given the high cost of HIV drugs, the need for [optimal treatment adherence](https://www.verywellhealth.com/how-much-adherence-is-enough-adherence-49307), and the demand for continual, lifelong medical treatment and care.

Consider, for example, that the average, individual [lifetime cost of HIV](https://www.verywellhealth.com/what-is-the-lifetime-cost-of-hiv-49641) is well over $400,000 —and this for persons who [start treatment early](https://www.verywellhealth.com/hiv-aids-treatment-4014255) and largely avoid the illnesses associated with later-stage (or untreated) disease.

Now add to this the cost of HIV therapy, which carries an [average price tag](https://www.verywellhealth.com/making-hiv-drugs-more-affordable-4120495) of over $2,000 per month, and the obstacles grow even clearer. Even with prescription drug coverage, many of these medications remain unaffordable due to "adverse tiering" practices by which insurers can demand anywhere from 20% to 50% [coinsurance payment](https://www.verywellhealth.com/whats-the-difference-between-copay-and-coinsurance-1738506) for each and every drug prescription.

This means that a person with a "low" 20% coinsurance benefit could easily pay between around $500 per month to get [Triumeq](https://www.verywellhealth.com/ortho-tri-cyclen-lo-906834), an otherwise standard, one-pill option. And that doesn’t even take into account the cost of deductibles and other out-of-pocket expenses that could add up to thousands of dollars before your benefits even kick in.

#### Lack of competition due to patent protections gives rise to high costs.

NBC 13 NBC News, July 2, 2013, 11:49 AM CDT, <https://www.nbcnews.com/healthmain/doctors-patents-keep-hiv-drugs-too-pricey-use-6c10516066>

Doctors Without Borders warned Tuesday that rising intellectual property rights are blocking the generic production of newer drugs to treat HIV and are keeping them out of reach for developing countries.

The medical aid group said at an international AIDS meeting in Kuala Lumpur, Malaysia that prices of older drugs long used to treat patients have fallen sharply as India and other countries make generics. But newer drugs that are more effective against the AIDS virus are too expensive, costing up to 15 times more.

"It's good news that the price of key HIV drugs continues to fall as more generic companies compete for the market, but the newer medicines are still priced far too high," said Jennifer Cohn, medical director for Doctors Without Borders' access campaign. "We need the newer treatments for people that have exhausted all other options, but patents keep them priced beyond reach."

#### HIV disproportionately affects African Americans.

Kaiser 20 Kaiser Family Foundation. "Black Americans And HIV/AIDS: The Basics.” February 07, 2020,<https://www.kff.org/hivaids/fact-sheet/black-americans-and hivaids-the-basics/

Black Americans have been disproportionately affected by HIV/AIDS since the epidemic’s beginning, and that disparity has deepened over time.1,2 Although they represent only 12% of the U.S. population, Blacks account for a much larger share of HIV diagnoses (43%), people estimated to be living with HIV disease (42%), and deaths among people with HIV (44%) than any other racial/ethnic group in the U.S.3,4 Among Black Americans, Black women, youth, and gay and bisexual men have been especially hard hit.5,6 A number of challenges contribute to the epidemic among Blacks, including poverty, lack of access to health care, higher rates of some sexually transmitted infections, smaller sexual networks, lack of awareness of HIV status, and stigma.7 Despite this impact, recent data indicate some encouraging trends, including declining new HIV diagnoses among Blacks overall, especially among women, and a leveling off of new diagnoses among Black gay and bisexual men.8,9 However, given the epidemic’s continued and disproportionate impact among Blacks, a continued focus is critical to addressing HIV in the United States. Overview Today, there are more than 1.1 million people living with HIV/AIDS in the U.S., including 476,100 who are Black.10,11,12 Although Black Americans represent only 12% of the U.S. population,13 they accounted for 43% of new HIV diagnoses in 2018 (see Figure 1) and an estimated 42% of people living with HIV.

#### That affirms – under structural violence, we have a moral obligation to help the oppressed.

#### HIV also disproportionately affects LGBTQ people.

HRC Human Rights Campaign. "How HIV Impacts LGBTQ+ People." Human Rights Campaign. , [How HIV Impacts LGBTQ+ People - HRC](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

#### That affirms again – under structural violence, there is a moral obligation to help these oppressed people.

#### Contention 2 – Insulin

#### Patent exclusivities, which are due to monopolies, leads to excessively high insulin costs, and customers have no choice but to buy.

Barker 20 [Erin M Barker, Executive Editor at the Campbell Law Review with a JD, 2020, "When Market Forces Fail: The Case for Federal Regulation of Insulin Prices," Campbell Law Review, https://heinonline.org/HOL/P?h=hein.journals/camplr42&i=331]/Kankee

A. Economics-Based Justifications Effective federal regulation will alleviate at least two causes of high insulin prices: patents preventing competition from manufacturers of "generic" insulins, and the failure of normal market forces due to the lack of competition.4 5 U.S. patent law provides patent-holders with twenty years of patent exclusivity for the development of new drugs.46 Exclusivity permits patent-holders to set prices and control the market for at least twenty years.4 7 Currently, there are three primary pharmaceutical companies manufacturing insulin in the U.S. market: Eli Lilly, Novo Nordisk, and Sanofi. 4 8 These three pharmaceutical companies "minimize competition by patenting incremental changes" to their insulin formulas, making it extremely difficult for other manufacturers to develop affordable, effective generics known as biosimilars. 49 For example, even though Sanofi's primary patents for the insulin Lantus expired in 2015, Sanofi has filed around seventy patents for incremental changes since 2000.s0 These secondary patents will allow Sanofi to receive patent protection over the formula for Lantus through at least March 2028. Thus, the three pharmaceutical companies that manufacture insulin have developed what is essentially a monopoly over the insulin market through this patent-based barrier to potential competitors. 52 Because it is so difficult for other manufacturers to create biosimilar insulins due to patents, there is currently very little room for competition from other drug manufacturers." In fact, Eli Lily and Sanofi produce the only two biosimilar insulins currently on the market, meaning these manufacturers can maintain the monopoly.54 In a typical market, product price usually falls as time goes on. Common causes of a decrease in market value include competitors entering the market and introducing similar, cheaper alternatives, or a current manufacturer making an advancement that lowers the value of older versions of a product.5 6 Consumers can choose to either purchase a cheaper alternative or upgrade to the newer, more advanced product-either choice would lower demand for the original product, thus lowering the market value of the older version.5 7 Insulin is not a typical consumer product." Not only do patents prevent competitors from entering the market, but type 1 diabetics cannot exert pressure on the pharmaceutical companies to lower prices by simply choosing to not purchase insulin.59 Instead, "[tlype 1 diabetics without adequate insurance coverage are vulnerable to price increases because they can't live without the drug . . . . 'People have to buy insulin no matter what the cost is . .. [giving] a lot of strength to the people selling insulin."' 0 When the marketplace is unable to self-regulate a monopoly through competition, the traditional solution is the passage of regulation rather than leaving the monopoly free within "the unregulated marketplace or to the antitrust laws for correction."61 When determining the most appropriate type of regulation, there are several options available, the most viable of which are discussed below. 6 2 B. Regulations Available to Increase Competition

#### Insulin price increases makes an essential medicine unaffordable – disproportionately affects disabled people.

Barker 20 [Erin M Barker, Executive Editor at the Campbell Law Review with a JD, 2020, "When Market Forces Fail: The Case for Federal Regulation of Insulin Prices," Campbell Law Review, https://heinonline.org/HOL/P?h=hein.journals/camplr42&i=331]/Kankee

INTRODUCTION Today, a single vial of insulin can cost more than $250 in the United States, and most patients use between two and four vials each month.' Consequently, if a diabetic patient is without insurance, or if insurance does not cover a specific brand of insulin, that person could pay upwards of $500 to $1,000 per month out-of-pocket for an essential medication.2 These costs are astronomical and unacceptable-the federal government must step in to regulate pricing. On January 11, 1922, fourteen-year-old Leonard Thompson faced the end stages of a terminal illness: diabetes mellitus, otherwise known as type 1 diabetes.3 Thompson weighed only sixty-five pounds after living with diabetes for three years.' His attempt to control his diabetes with a starvation diet failed to keep him from slipping in and out of a diabetic coma.5 Desperate for any chance to save his son, Thompson's father agreed to let the hospital inject the boy with a recently-discovered drug-insulin.6 Thompson would be the first human subject to receive the injection,' and the results were nothing short of miraculous.' His blood sugar lowered to a normal level, and the glucose and ketones' present in his urine also lowered to a tolerable level.10 Four men discovered this "wonder drug"": Frederick Banting, Charles Best, James Collip, and John Macleod.12 Following Banting's and Best's initial publication of their results,13 the discovery of insulin and its successful application to human subjects landed on the covers of newspapers worldwide.14 Insulin provided life-saving treatment for people who previously faced a death sentence; the drug brought diabetic patients out of comas, allowing them to end their starvation diets and eat carbohydrates." For their discovery, Banting and Macleod won the 1923 Nobel Prize in Physiology or Medicine and split their winnings with Best and Collip.16 Banting, Best, and Collip acquired an American patent on insulin and its method of creation on January 23, 1923.17 When applying for their patent, the trio maintained that "their goal was not profit, but ensuring the speedy and safe availability of their discovery to the public.""8 They then sold their patent rights to the Board of Governors of the University of Toronto for $1.00 each.1 9 In a letter to the University's president, the trio wrote, "The patent would not be used for any other purpose than to prevent the taking out of a patent by other persons. When the details of the method of preparation are published anyone would be free to prepare the extract, but no one could secure a profitable monopoly."20 Banting, Best, and Collip stated a clear goal: their lifesaving invention was to remain available to all. That goal has failed. This Comment analyzes how federal regulation of insulin prices will correct failed market forces, leading to a stabilized market for the indispensable medication. Part I of this Comment will provide a brief overview of the current state of the insulin market in the United States. Part II of this Comment will explain economics-based justifications for adopting federal legislation to regulate the insulin market. It will also provide an overview of the types of regulatory schemes that the government could utilize in this market. Part III of this Comment will describe and critique legislation that two states-Nevada and Colorado-have already acted to regulate the cost of insulin and will then examine currently proposed federal legislation that aims to lower insulin prices. Lastly, Part IV of this Comment offers a solution: the addition of language to the proposed federal legislation, incentivizing competition and positively affecting market prices through the nationalization of patents. I. THE STATE OF THE INSULIN MARKET IN THE UNITED STATES TODAY A. Economic Impact ofRising Insulin Prices From 2002 to 2013, the cost of insulin nearly tripled.21 Then, from 2012 to 2016, the cost of insulin rose dramatically again, nearly doubling. 22 In the first month of 2019 alone, insulin manufacturers Sanofi and Novo Nordisk raised some of their insulin product prices as much as 4.9% and 5.2%, respectively. 23 As of 2017, diabetes treatment and complications cost the United States ("U.S.") more than $327 billion per year, making it the most expensive chronic illness in the country.24 This cost is a combination of $237 billion in direct medical costs, including $15 billion for insulin, and $90 billion in indirect costs. 25 The American Diabetes Association reports: While much of the cost of diabetes appears to fall on insurers (especially Medicare) and employers (in the form of reduced productivity at work, missed work days, and higher employer expenditures for health care), in reality such costs are passed along to all of society in the form of higher insurance premiums and taxes, reduced earnings, and reduced standard of living.26 Government insurance, including Medicare, Medicaid, and insurance through the military, provide for a majority (67.3%) of the cost of diabetes care in this country.27 Private insurance pays for 30.7%, and the uninsured pay for 2% of the cost of diabetes care. 28 Uninsured diabetics visit the doctor 60% less and receive 52% fewer prescriptions than insured diabetics, yet uninsured diabetics account for 168% more emergency department visits than insured diabetics.2 9 Accordingly, because of both the direct and indirect costs of diabetes care, it is not just diabetics who are paying-all of society shoulders the financial burden of the increasing cost of diabetes. 30 B. Social Impact ofRising Insulin Prices Rising insulin prices induce "negative health and financial burdens on the population." 3 1 Of the 30 million diabetic Americans, approximately 7.4 million require daily doses of insulin to survive.32 Rising insulin prices have forced some to cut back on or skip doses of insulin. 3 Others elect to forgo other necessities such as food or rent in order to afford insulin. 3 A 2018 study found that almost 26% of diabetics in the U.S. had rationed their insulin the previous year.35 Recently, poignant stories have emerged detailing the tragic societal consequences of these negative health and financial burdens, including deaths due to an inability to afford insulin. 6 One such story is that of Alec Smith, a twenty-six-year-old who died less than a month after his mother's health insurance plan removed him as a beneficiary.3 7 Smith, who worked a full-time job and earned more than minimum wage, could afford neither new insurance nor the monthly $1,000 out-of-pocket cost of his insulin. 38 Another story is that of Meaghan Carter, a forty-seven-year-old woman who died alone on her sofa on Christmas night because she could not afford insulin.3 9 Carter, a nurse, was between jobs.4 0 She planned to start a new nursing position with health insurance benefits only a week after her death.4 1 Carter's family found empty vials of insulin among Carter's nursing supplies in her home.42 According to Carter's sister-in-law Mindi Patterson, "[s]he had gauze, bandages and all her nursing supplies"-"plenty to take care of others but not enough to take care of herself." 4 3 The stories of Alec Smith and Meaghan Carter demonstrate that there is more than just money at stake here-people's lives are on the line because of insulin prices in the U.S. Almost a hundred years after the discovery of insulin, diabetics should not be forced to ration an essential drug or face death due to excessive costs. Banting, Best, and Collip's goal was to make insulin affordable for all," but that is not the case today. The current price of insulin in the U.S. is unacceptable and must be addressed. II. THE FEDERAL GOVERNMENT SHOULD REGULATE THE INSULIN MARKET BECAUSE OF THE FAILURE OF TYPICAL MARKET FORCES

#### That affirms – under structural violence, we have an obligation to help the oppressed.