### Innovation DA

#### Pharma innovation is high now – profit incentive is the biggest factor.

**Swagel 21** Phillip L. Swagel, Director of the Congressional budget office 4-xx-2021, "Research and Development in the Pharmaceutical Industry," Congressional Budget Office, <https://www.cbo.goc/publication/57126#_idTextAnchor020> SJ//DA

**Every year, the U.S. pharmaceutical industry develops a variety of new drugs that provide valuable medical benefits. Many of those drugs are expensive and contribute to rising health care costs for the private sector and the federal government. Policymakers have considered policies that would lower drug prices and reduce federal drug expenditures. Such policies would probably reduce the industry’s incentive to develop new drugs.** In this report, the Congressional Budget Office assesses trends in spending for drug research and development (R&D) and the introduction of new drugs. CBO also examines factors that determine how much drug companies spend on R&D: expected global revenues from a new drug; cost to develop a new drug; and federal policies that affect the demand for drug therapies, the supply of new drugs, or both. What Are Recent Trends in Pharmaceutical R&D and New Drug Approvals? T**he pharmaceutical industry devoted $83 billion to R&D expenditures in 2019. Those expenditures covered a variety of activities, including discovering and testing new drugs, developing incremental innovations such as product extensions**, and clinical testing for **safety-monitoring or marketing purposes. That amount is about 10 times what the industry spent per year in the 1980s, after adjusting for the effects of inflation.** The share of revenues that drug companies devote to R&D has also grown: **On average, pharmaceutical companies spent about one-quarter of their revenues (net of expenses and buyer rebates) on R&D expenses** in 2019, which is **almost twice as large a share of revenues as they spent in 2000.** That revenue share is larger than that for other knowledge-based industries, such as semiconductors, technology hardware, and software. The number of new drugs approved each year has also grown over the past decade. On averace, the Food and Drug Administration (FDA) approved 38 new drugs per year from 2010 through 2019 (with a peak of 59 in 2018), which is 60 percent more than the yearly average over the previous decade. **Many of the drugs that have been approved in recent years are “specialty drugs.” Specialty drugs generally treat chronic, complex, or rare conditions, and they may also require special handling or monitoring of patients**. Many specialty drugs are biologics (large-molecule drugs based on living cell lines), **which are costly to develop, hard to imitate, and frequently have high prices.** Previously, most drugs were small-molecule drugs based on chemical compounds. Even while they were under patent, those drugs had lower prices than recent specialty drugs have. Information about the kinds of drugs in current clinical trials indicates that much of the industry’s innovative activity is focused on specialty drugs that would provide new cancer therapies and treatments for nervous-system disorders, such as Alzheimer’s disease and Parkinson’s disease. **What Factors Influence Spending for R&D?** Drug companies’ R&D spending decisions depend on three main factors: Anticipated lifetime global revenues from a new drug, **Expected costs to develop a new drug**, and Policies and programs that influence the supply of and demand for prescription drugs. Various considerations inform companies’ expectations about a drug’s revenue stream, including the anticipated prices it could command in different markets around the world and the expected global sales volume at those prices (given the number of people who might use the drug). The prices and sales volumes of existing drugs provide information about consumers’ and insurance plans’ willingness to pay for drug treatments. Importantly, when drug companies set the prices of a new drug, they do so to maximize future revenues net of manufacturing and distribution costs. A drug’s sunk R&D costs—that is, the costs already incurred in developing that drug—do not influence its price. **Developing new drugs is a costly and uncertain process, and many potential drugs never make it to market. Only about 12 percent of drugs entering clinical trials are ultimately approved for introduction by the FDA. In recent studies, estimates of the average R&D cost per new drug range from less than $1 billion to more than $2 billion per drug**. Those estimates include the costs of both laboratory research and clinical trials of successful new drugs as well as expenditures on drugs that do not make it past the laboratory-development stage, that enter clinical trials but fail in those trials or are withdrawn by the drugmaker for business reasons, or that are not approved by the FDA. Those estimates also include the company’s capital costs—the value of other forgone investments—incurred during the R&D process. Such costs can make up a substantial share of the average total cost of developing a new drug. The development process often takes a decade or more, and during that time the company does not receive a financial return on its investment in developing that drug. The federal government affects R&D decisions in three ways. First, it increases demand for prescription drugs, which encourages new drug development, by fully or partially subsidizing the purchase of prescription drugs through a variety of federal programs (including Medicare and Medicaid) and by providing tax preferences for employment-based health insurance. Second, the federal government increases the supply of new drugs. It funds basic biomedical research that provides a scientific foundation for the development of new drugs by private industry. Additionally, tax credits—both those available to all types of companies and those available to drug companies for developing treatmentscof uncommon diseases—provide incentives to invest in R&D. Similarly, deductions for R&D investment can be used to reduce tax liabilities immediately rather than over the life of that investment. Finally, the patent system and certain statutory provisions that delay FDA approval of generic drugs provide pharmaceutical companies with a period of market exclusivity, when competition is legally restricted. During that time, they can maintain higher prices on a patented product than they otherwise could, which makes new drugs more profitable and thereby increases drug companies’ incentives to invest in R&D. Third, some federal policies affect the number of new drugs by influencing both demand and supply. For example, federal recommendations for specific vaccines increase the demand for those vaccines and provide an incentive for drug companies to develop new ones. Additionally, federal regulatory policies that influence returns on drug R&D can bring about increases or decreases in both the supply of and demand for new drugs. Trends in R&D Spending and New Drug Development Private spending on pharmaceutical R&D and the approval of new drugs have both increased markedly in recent years, resuming a decades-long trend that was interrupted in 2008 as generic versions of some top-selling drugs became available and as the 2007–2009 recession occurred. **In particular, spending on drug R&D increased by nearly 50 percent between 2015 and 2019.** Many of the drugs approved in recent years are high-priced specialty drugs for relatively small numbers of potential patients. By contrast, the top-selling drugs of the 1990s were lower-cost drugs with large patient populations. R&D Spending R&D spending in the pharmaceutical industry covers a variety of activities, including the following: Invention, or research and discovery of new drugs; Development, or clinical testing, preparation and submission of applications for FDA approval, and design of production processes for new drugs; Incremental innovation, including the development of new dosages and delivery mechanisms for existing drugs and the testing of those drugs for additional indications; Product differentiation, or the clinical testing of a new drug against an existing rival drug to show that the new drug is superior; and Safety monitoring, or clinical trials (conducted after a drug has reached the market) that the FDA may require to detect side effects that may not have been observed in shorter trials when the drug was in development. In real terms, private investment in drug R&D among member firms of the Pharmaceutical Research and Manufacturers of America (PhRMA), an industry trade association, was about $83 billion in 2019, up from about $5 billion in 1980 and $38 billion in 2000.1 Although those spending totals do not include spending by many smaller drug companies that do not belong to PhRMA, the trend is broadly representative of R&D spending by the industry as a whole.2 A survey of all U.S. pharmaceutical R&D spending (including that of smaller firms) by the National Science Foundation (NSF) reveals similar trends.3 Although total R&D spending by all drug companies has trended upward, small and large firms generally focus on different R&D activities. **Small companies not in PhRMA devote a greater share of their research to developing and testing new drugs,** many of which are ultimately sold to larger firms (see Box 1). By contrast, a greater portion of the R&D spending of larger drug companies (including those in PhRMA) is devoted to conducting clinical trials, developing incremental “line extension” improvements (such as new dosages or delivery systems, or new combinations of two or more existing drugs), and conducting postapproval testing for safety-monitoring or marketing purposes.

#### The aff crushes drug innovation.

Glassman 21 [Amanda; 5/6/21; Executive vice president and a senior fellow at the Center for Global Development, a nonpartisan, nonprofit think tank in Washington and London; “*Big Pharma Is Not the Tobacco Industry*,” Barron, <https://www.barrons.com/articles/big-pharma-is-not-the-tobacco-industry-51620315693>] Justin

But here is the crux of the problem: The pharmaceutical industry is not the tobacco industry. They are not merchants of death. The companies are amoral and exist to make money, but their business is not fundamentally immoral. Big Pharma (mostly) develops and sells products that people need to survive and thrive. Their products improve health and welfare. Fights over access to medicines are possible because medicines exist in the first place—medicines that were usually developed by Big Pharma. And yes, the pharmaceutical industry benefits from public subsidy and publicly financed foundational research. But the companies also put their own capital at risk to develop new products, some of which offer enormous public benefits. In fact, several of them did just that in the pandemic: invested their own money to develop patented manufacturing technologies in record time. Those technologies are literally saving the world right now. Public funding supported research and development, but companies also brought their own proprietary ingenuity and private investments to bear toward solving the world’s singular, collective challenge. Their reward should be astronomical given the insane scale of the health and economic benefits these highly efficacious vaccines produce every day. Market incentives sent a clear signal that further needed innovation—greater efficacy, single doses, more-rapid manufacturing, updated formulations, fast boosters, and others—would be richly rewarded. Market incentives could also have been used to lubricate supply lines and buy vaccines on behalf of the entire world; with enough money, incredible things can happen. But activist lobbying to waive patents—a move the Biden administration endorsed yesterday—sends exactly the opposite signal. It says that the most important, valuable innovations will be penalized, not rewarded. It tells innovators, don’t bother attacking the most important global problems; instead, throw your investment dollars at the next treatment for erectile disfunction, which will surely earn you a steady return with far less agita. It is worth going back to first principles. What problem are we trying to solve? We have highly efficacious vaccines that we would like to get out to the entire world as quickly as possible to minimize, preventable disease and deaths address atrocious inequities, and enable the reopening of society, trade, and commerce. Hundreds of millions of people have been plunged into poverty over the past year; in the developing world, the pandemic is just getting started. What is the quickest way to get this done? Vaccine manufacturing is not just a recipe; if you attack and undermine the companies that have the know-how, do you really expect they’ll be eager to help you set up manufacturing elsewhere? Is the plan to march into Pfizer and force its staff to redeploy to Costa Rica to build a new factory? Do the U.S. administration or activists care that this decision could take years to negotiate at the World Trade Organization, and will likely be litigated for years thereafter? Does it make sense to eliminate the incentive for private companies to invest in vaccine R&D or in the response to the next health emergency? And if the patent waiver is only temporary and building a factory takes months or years, will anyone bother to do so, even if they could? No, none of it makes sense. Worse still, we could solve the policy problem more easily by harnessing market incentives for the global good by ponying up cash to vaccinate the entire world. No confiscation necessary.

#### Pharma Innovation prevents Extinction – checks new diseases.

Engelhardt 8, H. Tristram. Innovation and the pharmaceutical industry: critical reflections on the virtues of profit. M & M Scrivener Press, 2008 (doctorate in philosophy (University of Texas at Austin), M.D. (Tulane University), professor of philosophy (Rice University), and professor emeritus at Baylor College of Medicine)

Many are suspicious of, or indeed jealous of, the good fortune of others. Even when profit is gained in the market without fraud and with the consent of all buying and selling goods and services, there is a sense on the part of some that something is wrong if considerable profit is secured. There is even a sense that good fortune in the market, especially if it is very good fortune, is unfair. One might think of such rhetorically disparaging terms as "wind-fall profits". There is also a suspicion of the pursuit of profit because it is often embraced not just because of the material benefits it sought, but because of the hierarchical satisfaction of being more affluent than others. The pursuit of profit in the pharmaceutical and medical-device industries is tor many in particular morally dubious because it is acquired from those who have the bad fortune to be diseased or disabled. Although the suspicion of profit is not well-founded, this suspicion is a major moral and public-policy challenge. Profit in the market for the pharmaceutical and medical-device industries is to be celebrated. This is the case, in that if one is of the view (1) that the presence of additional resources for research and development spurs innovation in the development of pharmaceuticals and med-ical devices (i.e., if one is of the view that the allure of **profit is one of the most effective ways not only to acquire resources but productively to direct human energies** in their use), (2) that given the limits of altruism and of the willingness of persons to be taxed, the possibility of profits is necessary to secure such resources, (3) that the allure of profits also tends to enhance the creative use of available resources in the pursuit of phar-maceutical and medical-device innovation, and (4) if one judges it to be the case that such innovation is both necessary to maintain the human species in an ever-changing and always dangerous environment in which new microbial and other threats may at any time emerge to threaten human well-being, if not survival (i.e., that such innovation is necessary to prevent increases in morbidity and mortality risks), as well as (5) in order generally to decrease morbidity and mortality risks in the future, it then follows (6) that one should be concerned regarding any policies that decrease the amount of resources and energies available to encourage such innovation. One should indeed be of the view that the possibilities for profit, all things being equal, should be highest in the pharmaceutical and medical-device industries. Yet, there is a suspicion regarding the pursuit of profit in medicine and especially in the pharmaceutical and medical-device industry.

### Covid CP

#### Counterplan: The World Trade Organization ought to

#### -Increase covax support

#### -prioritize trade facilitation

#### -commit to aid for LDC’s

#### -invest in pandemic preparedness

[**Violeta Gonzalez**](https://www.devex.com/news/authors/1581504)8-1-20**21**, "Opinion: 4 ways to promote vaccine equity through trade," Devex, https://www.devex.com/news/opinion-4-ways-to-promote-vaccine-equity-through-trade-100457

As of Monday, only [1.1 % of people in low-income countries](https://ourworldindata.org/covid-vaccinations) had received at least one COVID-19 vaccine dose. This is making it harder to battle a third wave of infections, as the highly transmissible [delta variant](https://news.un.org/en/story/2021/07/1095152) spreads across many nations. In the [World Health Organization](https://www.devex.com/organizations/world-health-organization-who-30562)’s Africa region — where a [high number](https://www.uneca.org/sites/default/files/com/2021/E2100045-English-CoM21-Progress-in-the-implementation-of-the-priority-areas-of-the-Programme-of-Action-for-the-Least-Developed-Countries-for-the-Decade-2011-2020_Istanbul-Programme-of-Action.pdf) of LDCs are located — COVID-19 fatalities [surged 44.2%](https://apps.who.int/iris/bitstream/handle/10665/342715/OEW28-0511072021.pdf) over one week in July. The coronavirus is [devastating](https://www.un.org/development/desa/dpad/2021/major-study-on-covid-19-impact-on-ldcs-released/) many LDCs’ already fragile economies and causing poverty and inequality to rise. Without equitable access to vaccines, [global economic recovery cannot be sustained](https://www.wto.org/english/news_e/news21_e/gc_05may21_e.htm) and progress toward the Sustainable Development Goals will be derailed. While trade alone cannot eradicate vaccine unequity or its negative consequences for the [economy](https://news.un.org/en/story/2021/05/1091732) and [vulnerable groups](https://observatoryihr.org/news/covid-19-vaccine-distribution-highlights-social-inequality/), it has a powerful contribution to make. Here are four actions that would make an impact: 1. Increase COVAX support **Vaccine equity can only be achieved if the global community eschews vaccine nationalism.** High-resource countries should [ramp up donations](https://www.devex.com/news/wto-chief-to-g-20-donate-2-3b-more-covid-19-vaccine-doses-100306) through the vaccine-sharing initiative COVAX and commit to securing a swift, workable resolution to ongoing debates around [technology transfers and intellectual property waivers](https://www.devex.com/news/wto-council-offers-hope-for-trips-vaccine-proposal-100125). While countries in the G-7 group of nations have [pledged to increase their support](https://www.who.int/news/item/13-06-2021-g7-announces-pledges-of-870-million-covid-19-vaccine-doses-of-which-at-least-half-to-be-delivered-by-the-end-of-2021) for COVAX, the initiative has faced hurdles in the form of [supply bottlenecks](https://www.devex.com/news/india-crisis-puts-covax-150-million-doses-behind-schedule-99860), [export restrictions](https://unctad.org/news/export-restrictions-do-not-help-fight-covid-19), and [logistical weaknesses](https://www.devex.com/news/the-cold-chain-storage-challenge-99869). Many currently available COVID-19 vaccines have short shelf lives and must be stored at low temperatures. LDCs can only benefit from donated doses if they have fast and efficient processing at their borders, modern transportation systems, and access to cold chain infrastructure. 2. Prioritize trade facilitation Accelerating implementation of the [World Trade Organization](https://www.devex.com/organizations/world-trade-organization-wto-44694)’s 2017 [Trade Facilitation Agreement](https://www.wto.org/english/tratop_e/tradfa_e/tradfa_e.htm) is critical for helping LDCs overcome these challenges. A total of [154 WTO members](https://www.tfafacility.org/ratifications) now support the agreement, which pledges investment in the simplification and modernization of the movement, release, and customs clearance of goods globally. It also aims to help low-income countries overcome these same barriers through technical assistance and capacity building. The [Global Alliance for Trade Facilitation](https://www.devex.com/organizations/global-alliance-for-trade-facilitation-102992) has made good progress in identifying barriers to vaccine equity and introducing solutions. In [Mozambique](https://www.tradefacilitation.org/article/two-new-mozambique-projects-aim-to-ease-access-to-vaccines-medical-products/), for example, the alliance is working to digitalize pre-shipment authorization for vaccine imports — a process that can take as long as two weeks, during which vaccine doses must be kept in storage. This digitalization should help Mozambique decrease wait times, improve shipment traceability, and reduce storage and inventory management costs. Yet more work remains to help governments overcome [challenges associated with implementing](https://www.wto-ilibrary.org/trade-facilitation-and-customs-valuation/world-trade-report-2015_f2985d96-en) the Trade Facilitation Agreement, such as changing domestic legislation and involving the private sector. Lower-income countries and LDCs have flagged a need around human resources and training, legal assistance, and the acquisition of information and communication technologies. 3. Commit to Aid for Trade For LDCs to participate fairly in global vaccine supply chains — as importers or exporters of inputs and finished products — they need financial and technical assistance to strengthen their [productive capacity](https://www.devex.com/news/cepi-ceo-concerted-effort-needed-to-build-lmic-vaccine-manufacturing-100013), streamline their cross-border standards and processes, and improve their logistics infrastructure and [technological know-how](https://www.wto.org/english/news_e/news21_e/dgno_21may21_e.htm). The Aid for Trade initiative exists to provide that support — but can only deliver if donor countries maintain or increase their official development assistance, or ODA. Preliminary figures from the [Organisation for Economic Co-operation and Development](https://www.devex.com/organizations/organisation-for-economic-co-operation-and-development-oecd-29872) show that [Development Assistance Committee](https://www.devex.com/organizations/development-assistance-committee-dac-100607) members [expanded their ODA by $10 billion](https://www.devex.com/news/what-to-make-of-the-2020-dac-stats-99641) between 2019 and 2020, mostly as part of their COVID-19 response. However, with several government donors having reprogrammed their aid budgets to focus on immediate health priorities, [fears are growing](https://www.weforum.org/agenda/2021/01/helping-small-businesses-build-resilience/) that their overall ODA may also be slashed — and, with this, their support for Aid for Trade. The generosity of some countries provides hope. Norway, for example, recently stepped up to help plug such gaps with [45 million Norwegian kroner](https://www.wto.org/english/news_e/news21_e/if_22jun21_e.htm) of additional funding for the WTO-backed [Enhanced Integrated Framework](https://www.devex.com/organizations/enhanced-integrated-framework-eif-78046), a global Aid for Trade program that aims to reduce poverty. 4. Invest in preparedness In 2019, only [$374 million](http://www.healthdata.org/sites/default/files/files/policy_report/FGH/2020/FGH_2019_Interior_Final_Online_2020.09.18.pdf) — or less than 1% — of the world’s total development assistance for health was spent on pandemic preparedness. Within months, the consequences of that underinvestment became clear. Integrating lower-income countries and LDCs into global and regional [pharmaceutical value chains](https://unctad.org/news/unctad-report-says-least-developed-countries-position-improve-access-medicines-through-local-0) is vital for ensuring the world is better prepared next time. Directing increased aid to help these countries become [producers and exporters](https://www.bloomberg.com/news/articles/2021-07-26/africa-must-build-vaccine-production-capacity-wto-chief-says) of medical equipment and vaccines has never been more needed. LDCs would not only receive more of the [vaccines and therapeutics they need now](https://trade4devnews.enhancedif.org/en/op-ed/access-denied-ensuring-vaccines-worlds-poorest-countries) but could actively contribute to the global response when the next pandemic inevitably hits.

### CP: HIF (Price/Access)

#### Counterplan – add a Health Impact Fund to incentivize Pharmaceuticals to voluntarily lower prices and increase access. This would add a complement to IPP rather than reducing it.

**Pogge 10** [Thomas Pogge, Thomas Winfried Menko Pogge is a German philosopher and is the Director of the Global Justice Program and Leitner Professor of Philosophy and International Affairs at Yale University. Cambridge University Press, “Incentives for Global Health: Patent Law and Access to Essential Medicines. The Health Impact Fund: Better Pharmaceutical Innovations at Much Lower Prices,” 2010, https://papers.ssrn.com/sol3/papers.cfm?abstract\_id=1431180]/ lm

The exclusion of the poor by the existing patent regime requires reform. Given the foregoing discussion, a straightforward and moderate reform would create a supplementary mechanism that, by addressing the needs of the poor, would remedy the injustice now imposed upon them. This reform proposal comprises six elements. First, just as the patent regime provides a general innovation incentive, so its complement encourages pharmaceutical innovation through an incentive that is specified in general terms: as a promise to reward any successful new medicine, in proportion to its success. This kind of mechanism has been described as a comprehensive AMC.14 Second, while the patent regime rewards medicines on the basis of the market demand each generates and then satisfies, thereby effectively excluding the poor, its complement gives equal standing to all by defining success simply in terms of human health. On this complementary track, the success of a medicine is assessed by the reduction in human morbidity and premature mortality it achieves – regardless of whether these harms are averted from rich or poor patients. Third, in order to help overcome the last-mile problem, the rewards available under the complementary mechanism should be tied not to what a medicine can do, but to what it actually achieves in the world. Fourth, when such a general mechanism provides large enough health impact rewards, it will attract sufficient innovation and sufficient efforts to ensure real access to new medicines worldwide. This avoids any need for compulsion. Innovators can be left free to choose between the two tracks, developing on the new track high-impact medicines needed also by many poor patients and on the conventional patent track low-impact medicines desired by the more affluent. Making the health-impact track optional is also crucial for the political success of the proposal. Fifth, in order to reinforce the incentive toward facilitating real access, health impact rewards should be conditional on the medicine being priced no higher than the lowest feasible cost of production and distribution.

Sixth, health impact rewards should be funded by governments as a public good. In order to minimise burdens and deadweight losses due to taxes, the cost should be spread as widely as possible. This suggests that the complementary funding mechanism should be global (rather than national) in scope. The reasons that make the reform compelling in any one country or region make it compelling everywhere. Moreover, global scope avoids the problems associated with large price differentials. Global scope also brings huge efficiency gains by diluting the cost of the scheme without diluting its benefits: no matter how many beneficiaries we may add, the cost of achieving an innovation remains the same even while its aggregate benefit increases with the number of beneficiaries.15 Finally, an international agreement would also reinforce the commitment of individual countries to the scheme. Pharmaceutical innovation is therefore best encouraged by promising to reward any safe and effective new medicine in proportion to its global health impact. Such a promise constitutes an AMC that is fully comprehensive: by including not merely all diseases but also all patients.

The proposal is then for the creation of a new international agency that offers to reward any new medicine based on its health impact during its first decade or so.16 This Health Impact Fund („HIF‟) would provide ample rewards for the development of new high-impact medicines without excluding the poor from its use.

#### That solves the aff by including the poor and increasing access but doesn’t trigger the disad because it’s voluntary, IPP remains unchanged, and increases innovation.

**Pogge 10** [Thomas Pogge, Thomas Winfried Menko Pogge is a German philosopher and is the Director of the Global Justice Program and Leitner Professor of Philosophy and International Affairs at Yale University. Cambridge University Press, “Incentives for Global Health: Patent Law and Access to Essential Medicines. The Health Impact Fund: Better Pharmaceutical Innovations at Much Lower Prices,” 2010, https://papers.ssrn.com/sol3/papers.cfm?abstract\_id=1431180]/ lm

Let us recapitulate how the HIF would provide a full systemic solution to the seven problems described earlier: High Prices would not exist for HIF-registered medicines. Innovators would typically not even want a higher price as this would reduce their health impact rewards by impeding access to their product by most of the world‟s population. The HIF counts health benefits to the poorest of patients equally with health benefits to the richest. Diseases Concentrated among the Poor, insofar as they substantially aggravate the GBD, would no longer be neglected. In fact, the more destructive ones among them would come to present some of the most lucrative R&D opportunities for biotechnology and pharmaceutical companies. This would happen without undermining the profit opportunities such companies now enjoy by developing remedies for the ailments of the affluent. Bias toward Maintenance Drugs would be absent from HIF-encouraged R&D. The HIF assesses each registered medicine‟s health impact in terms of how its use reduces mortality and morbidity worldwide – without regard to whether it achieves this reduction through cure, symptom relief, or prevention. This would guide firms to deliberate about potential research projects in a way that is also optimal for global public health: namely in terms of the expected global health impact of the new medicine relative to the cost of developing it. The profitability of research projects would be aligned with their cost-effectiveness in terms of global public health. Wastefulness would be dramatically lower for HIF-registered products. There would be no deadweight losses from large mark-ups. There would be little costly litigation as generic competitors would lack incentives to compete and innovators would have no incentive to suppress generic products (because they enhance the innovator‟s health impact reward). Innovators might therefore often not even bother to obtain, police, and defend patents in many national jurisdictions. To register a medicine with the HIF, innovators need show only once that they have an effective and innovative product. Counterfeiting of HIF-registered products would be unattractive. With the genuine item widely available near or even below the marginal cost of production, there is little to be gained from producing and selling fakes. Excessive Marketing would also be much reduced for HIF-registered medicines. Because each innovator is rewarded for the health impact of its addition to the medical arsenal, incentives to develop me-too drugs to compete with an existing HIF-registered medicine would be weak. And innovators would have incentives to urge a HIF-registered drug upon doctors and patients only insofar as such marketing results in measurable therapeutic benefits for which the innovator would then be rewarded. The Last-Mile Problem would be mitigated because each HIF-registered innovator would have strong incentives to ensure that patients are fully instructed and properly provisioned so that they make optimal use (dosage, compliance, etc) of its medicines, which will then, through wide and effective deployment, have their optimal publichealth impact. Rather than ignore poor countries as unprofitable markets, pharmaceutical companies would, moreover, have incentives to work with one another and with national health ministries, international agencies and NGOs toward improving the health systems of these countries in order to enhance the impact of their HIFregistered medicines there.