### 1AC – Framing – Soft left

#### The Standard is maximizing expected well-being –

#### 1] Binding – pain and pleasure are the only things with intrinsic value and disvalue – if I put my hand on a hot stove I will pull away – ethics must be binding bc if they arent then it’s impossible to generate obligations

#### 2] Actor specificity – Governments have the obligation to maximize the pleasure of their citizens – proven through laws that are designed to stop pain towards other subjects – Drunk driving laws, murder, robbery

#### 3] Existential threats distort moral reasoning and ignore ongoing and urgent violence.

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III The body and the emergency Though the body is often presumed to be the most basic unit where urgency might be detected, only some dictionaries link urgency and the body through a ‘medical’ reference to the compelling need to defecate or urinate.5 Focusing on the different meanings of urgency runs the risk of obscuring language categories, but pushing together the two definitions – urgency as the need to defecate and urinate, and urgency as overwhelming force – is useful here, because my aim is to illustrate that the ethical work of urgency has been hijacked by an hierarchical organization of scales of moral deliberation. Specifically, our research suggests that the urgent body is cast as subjective and impulsive, while larger scales, such as the region, state or society, emerge as the scale of a rational ethics. While these are not new arguments about states (Scott, 1998) and their institutions (Foucault, 1995), geographic insights into toileting and securitizations suggest that **technocratic practices both require and perpetuate an ethical distinction between the body and the large-scale future event**, **with the latter emerging as the only legitimate site of urgent claims and thus the dominant subject of moral reasoning**.In research related to contemporary global toileting, the defecating body’s status as a legitimate ethical concern is more likely to be acknowledged when **threatening the sanitation aims of cities and states**. This is perhaps most evident in large metropolitan areas where uneven access to toilets amplifies social inequalities and human suffering (McFarlane, 2013). Jewitt’s (2011) examination of waste management in India and other countries in the Global South reveals that taboos around feces often justify inequality in two ways; first, by creating conditions of precarity through taboos in discussing personal sanitation and toilet practices, and second, by justifying social exclusion on the basis of inferior sanitation practices. The lack of access to sanitation infrastructure can also provide reasons for excluding informally settled populations from ambitiously modernizing cities. In cities like Kampala, Uganda, planners, development workers, and community organizers frame those who cannot use modern toilet facilities as threatening (Terreni-Brown, 2014a). Terreni-Brown (2014b) describes a group of female migrants selling goods outside of a large, upscale mall in Kampala, and their strategies for balancing the lack of access to a toilet with the danger and humiliation of going in the area behind their street-side location. Their desperate pain, induced by waiting hours until they can finally return to a more private location, contrasts with complaints of city planners and NGO workers who point to moral lethargy in the informal settlements that puts the city at risk. The poor, illegal, marginalized body is not a reasonable scale of urgency, nor is it the product of a thoughtful weighing of circumstances; in the face of a morally rational prioritization of a future Kampala, these bodily urgencies literally have no place in the modern city. Though toileting might be thought of as a special case of bodily urgency, geographic research suggests that the body is increasingly set at odds with larger scale ethical concerns, especially large-scale future events of forecasted suffering. Emergency planning is a particularly good example in which the large-scale threats of future suffering can distort moral reasoning. Žižek (2006) lightly develops this point in the context of the war on terror, where in the presence of fictitious and real ticking clocks and warning systems, the urgent body must be bypassed because there are bigger scales to worry about:¶ What does this all-pervasive sense of urgency mean ethically? The pressure of events is so overbearing, the stakes are so high, that they necessitate a suspension of ordinary ethical concerns. After all, displaying moral qualms when the lives of millions are at stake plays into the hands of the enemy. (Žižek, 2006)¶ In the presence of large-scale future emergency, the urgency to secure the state, the citizenry, the economy, or the climate creates new scales and new temporal orders of response (see Anderson, 2010; Baldwin, 2012; Dalby, 2013; Morrissey, 2012), many of which treat the urgent body as impulsive and thus requiring management. McDonald’s (2013) analysis of three interconnected discourses of ‘climate security’ illustrates how bodily urgency in climate change is also recast as a menacing impulse that might require exclusion from moral reckoning. The logics of climate security, especially those related to national security, ‘can encourage perverse political responses that not only fail to respond effectively to climate change but may present victims of it as a threat’ (McDonald, 2013: 49). Bodies that are currently suffering cannot be urgent, because they are excluded from the potential collectivity that could be suffering everywhere in some future time. Similar bypassing of existing bodily urgency is echoed in writing about violent securitization, such as drone warfare (Shaw and Akhter, 2012), and also in intimate scales like the street and the school, especially in relation to race (Mitchell, 2009; Young et al., 2014).¶ As large-scale urgent concerns are institutionalized, the urgent body is increasingly obscured through technical planning and coordination (Anderson and Adey, 2012). The predominant characteristic of this institutionalization of large-scale emergency is a ‘built-in bias for action’ (Wuthnow, 2010: 212) that circumvents contingencies. The urgent body is at best an assumed eventuality, one that will likely require another state of waiting, such as triage (e.g. Greatbach et al., 2005). Amin (2013) cautions that in much of the West, governmental need to provide evidence of laissez-faire governing on the one hand, and assurance of strength in facing a threatening future on the other, produces ‘just-in-case preparedness’ (Amin, 2013: 151) of neoliberal risk management policies. In the US, ‘personal ingenuity’ is built into emergency response at the expense of the poor and vulnerable for whom ‘[t]he difference between abjection and bearable survival’ (Amin, 2013: 153) will not be determined by emergency planning, but in the material infrastructure of the city.¶ In short, the urgencies of the body provide justifications for social exclusion of the most marginalized based on impulse and perceived threat, while large-scale future emergencies effectively absorb the deliberative power of urgency into the institutions of preparedness and risk avoidance. Žižek references Arendt’s (2006) analysis of the banality of evil to explain the current state of ethical reasoning under the war on terror, noting that people who perform morally reprehensible actions under the conditions of urgency assume a ‘tragic-ethic grandeur’ (Žižek, 2006) by sacrificing their own morality for the good of the state. But his analysis fails to note that bodies are today so rarely legitimate sites for claiming urgency. In the context of the assumed priority of the large-scale future emergency, the urgent body becomes literally nonsense, a non sequitur within societies, states and worlds that will always be more urgent.¶ If the important ethical work of urgency has been to identify that which must not wait, then the capture of the power and persuasiveness of urgency by large-scale future emergencies has consequences for the kinds of normative arguments we can raise on behalf of urgent bodies. How, then, might waiting compare as a normative description and critique in our own urgent time? Waiting can be categorized according to its purpose or outcome (see Corbridge, 2004; Gray, 2011), but it also modifies the place of the individual in society and her importance. As Ramdas (2012: 834) writes, ‘waiting … produces hierarchies which segregate people and places into those which matter and those which do not’. The segregation of waiting might produce effects that counteract suffering, however, and Jeffery (2008: 957) explains that though the ‘politics of waiting’ can be repressive, it can also engender creative political engagement. In his research with educated unemployed Jat youth who spend days and years waiting for desired employment, Jeffery finds that ‘the temporal suffering and sense of ambivalence experienced by young men can generate cultural and political experiments that, in turn, have marked social and spatial effects’ (Jeffery, 2010: 186). Though this is not the same as claiming normative neutrality for waiting, it does suggest that waiting is more ethically ambivalent and open than urgency.¶ In other contexts, however, our descriptions of waiting indicate a strong condemnation of its effects upon the subjects of study. Waiting can demobilize radical reform, depoliticizing ‘the insurrectionary possibilities of the present by delaying the revolutionary imperative to a future moment that is forever drifting towards infinity’ (Springer, 2014: 407). Yonucu’s (2011) analysis of the self-destructive activities of disrespected working-class youth in Istanbul suggests that this sense of infinite waiting can lead not only to depoliticization, but also to a disbelief in the possibility of a future self of any value. Waiting, like urgency, can undermine the possibility of self-care two-fold, first by making people wait for essential needs, and again by reinforcing that waiting is ‘[s]omething to be ashamed of because it may be noted or taken as evidence of indolence or low status, seen as a symptom of rejection or a signal to exclude’ (Bauman, 2004: 109). This is why Auyero (2012) suggests that waiting creates an ideal state subject, providing ‘temporal processes in and through which political subordination is produced’ (Auyero, 2012: loc. 90; see also Secor, 2007). Furthermore, Auyero notes, it is not only political subordination, but the subjective effect of waiting that secures domination, as citizens and non-citizens find themselves ‘waiting hopefully and then frustratedly for others to make decisions, and in effect surrendering to the authority of others’ (Auyero, 2012: loc. 123).¶ Waiting can therefore function as a potentially important spatial technology of the elite and powerful, mobilized not only for the purpose of governing individuals, but also to retain claims over moral urgency. But there is growing resistance to the capture of claims of urgency by the elite, and it is important to note that even in cases where the material conditions of containment are currently impenetrable, arguments based on human value are at the forefront of reclaiming urgency for the body. In detention centers, clandestine prisons, state borders and refugee camps, geographers point to ongoing struggles against the ethical impossibility of bodily urgency and a rejection of states of waiting (see Conlon, 2011; Darling, 2009, 2011; Garmany, 2012; Mountz et al., 2013; Schuster, 2011). Ramakrishnan’s (2014) analysis of a Delhi resettlement colony and Shewly’s (2013) discussion of the enclave between India and Bangladesh describe people who refuse to give up their own status as legitimately urgent, even in the context of larger scale politics. Similarly, Tyler’s (2013) account of desperate female detainees stripping off their clothes to expose their humanness and suffering in the Yarl’s Wood Immigration Removal Centre in the UK suggests that demands for recognition are not just about politics, but also about the acknowledgement of humanness and the irrevocable possibility of being that which cannot wait. The continued existence of places like Yarl’s Wood and similar institutions in the USA nonetheless points to the challenge of exposing the urgent body as a moral priority when it is so easily hidden from view, and also reminds us that our research can help to explain the relationships between normative dimensions and the political and social conditions of struggle.¶ In closing, geographic depictions of waiting do seem to evocatively describe otherwise obscured suffering (e.g. Bennett, 2011), but it is striking how rarely these descriptions also use the language of urgency. Given the discussion above, what might be accomplished – and risked – by incorporating urgency more overtly and deliberately into our discussions of waiting, surplus and abandoned bodies? Urgency can clarify the implicit but understated ethical consequences and normativity associated with waiting, and encourage explicit discussion about harmful suffering. Waiting can be productive or unproductive for radical praxis, but urgency compels and requires response. Geographers could be instrumental in reclaiming the ethical work of urgency in ways that leave it open for critique, clarifying common spatial misunderstandings and representations. There is good reason to be thoughtful in this process, since moral outrage towards inhumanity can itself obscure differentiated experiences of being human, dividing up ‘those for whom we feel urgent unreasoned concern and those whose lives and deaths simply do not touch us, or do not appear as lives at all’ (Butler, 2009: 50). But when the urgent body is rendered as only waiting, both materially and discursively, it is just as easily cast as impulsive, disgusting, animalistic (see also McKittrick, 2006). Feminist theory insists that the urgent body, whose encounters of violence are ‘usually framed as private, apolitical and mundane’ (Pain, 2014: 8), are as deeply political, public, and exceptional as other forms of violence (Phillips, 2008; Pratt, 2005). Insisting that a suffering body, now, is that which cannot wait, has the ethical effect of drawing it into consideration alongside the political, public and exceptional scope of large-scale futures. It may help us insist on the body, both as a single unit and a plurality, as a legitimate scale of normative priority and social care.¶ In this report, I have explored old and new reflections on the ethical work of urgency and waiting. Geographic research suggests a contemporary popular bias towards the urgency of large-scale futures, institutionalized in ways that further obscure and discredit the urgencies of the body. This bias also justifies the production of new waiting places in our material landscape, places like the detention center and the waiting room. In some cases, waiting is normatively neutral, even providing opportunities for alternative politics. In others, the technologies of waiting serve to manage potentially problematic bodies, leading to suspended suffering and even to extermination (e.g. Wright, 2013). One of my aims has been to suggest that moral reasoning is important both because it exposes normative biases against subjugated people, and because it potentially provides routes toward struggle where claims to urgency seem to foreclose the possibilities of alleviation of suffering. Saving the world still should require a debate about whose world is being saved, when, and at what cost – and this requires a debate about what really cannot wait. My next report will extend some of these concerns by reviewing how feelings of urgency, as well as hope, fear, and other emotions, have played a role in geography and ethical reasoning.¶ I conclude, however, by pulling together past and present. In 1972, Gilbert White asked why geographers were not engaging ‘the truly urgent questions’ (1972: 101) such as racial repression, decaying cities, economic inequality, and global environmental destruction. His question highlights just how much the discipline has changed, but it is also unnerving in its echoes of our contemporary problems. Since White’s writing, our moral reasoning has been stretched to consider the future body and the more-than-human, alongside the presently urgent body – topics and concerns that I have not taken up in this review but which will provide their own new possibilities for urgent concerns. My own hope presently is drawn from an acknowledgement that the temporal characteristics of contemporary capitalism can be interrupted in creative ways (Sharma, 2014), with the possibility of squaring the urgent body with our large-scale future concerns. Temporal alternatives already exist in ongoing and emerging revolutions and the disruption of claims of cycles and circular political processes (e.g. Lombard, 2013; Reyes, 2012). Though calls for urgency will certainly be used to obscure evasion of responsibility (e.g. Gilmore, 2008: 56, fn 6), they may also serve as fertile ground for radical critique, a truly fierce urgency for now.

### 1AC – Advantage – Access(soft left)

Ww – 2mins v slow

#### Companies can have monopolies over medications, set the prices outlandishly high, and then renew the patent multiple times – the plan solves through the impeding the ability for pharma companies to hike up prices

Amin 18 [Tahir Amin, co-founder and co-executive director of I-MAK.org, a non-profit organization comprised of senior attorneys, scientists and health experts who have worked to lower drug prices for 15 year, 6-27-2018 “The problem with high drug prices isn’t ‘foreign freeloading’ it’s the patent system” CNBC, Accessed 7-29-2021, <https://www.cnbc.com/2018/06/25/high-drug-prices-caused-by-us-patent-system.html> ww

Americans continue to suffer the highest prescription drug costs of anone in the world. One in four are unable to fill prescriptions due to high prices, according to a recent poll. And even though drug prices tripled over the last decade, analysts predict they will double again in the next ten years.¶ We have a runaway problem on our hands, and while new proposals from Congress and the president seek to improve the drug pricing system, we will fail to reach lasting solutions unless we address a root factor in this national crisis: patents.¶ Contrary to the Trump administration’s recent claims, the source of our prescription drug problems is not “foreign freeloading” governments creating unfair pricing schemes—it’s the unfair pricing systems created right here in the U.S. Today’s drug patent monopolies are deeper, longer and stronger than at any point in the last century—and it’s costing Americans and people around the world.¶ Before a prescription drug even enters the market—before pricing negotiations occur between payers, government agencies, insurers, and so on—the U.S. patent office awards exclusivity to drug makers for intellectual property claims that have a huge impact on the market.¶ And unfortunately, while patenting is an important mechanism for incentivizing and rewarding invention, pharmaceutical companies have figured out how to game the system—prolonging monopolies, claiming newness where there often is none, and taking patients on a ride they can barely afford.¶ In a recent study of every drug on the market between 2005 and 2015, a University of California School of Law professor found a “startling departure from the classic conceptualization of intellectual property protection for pharmaceuticals.”¶ 'Evergreening'¶ Instead of going to new medicines, the study finds that 74 percent of new patents during the decade went to drugs that already existed. It found that 80 percent of the nearly 100 best-selling drugs extended their exclusivity protections at least once, and 50 percent extended their patents more than once—with the effect of prolonging the time before generics could reach the market as drug prices continued to rise.¶ The strategy is called “evergreening”: drug makers add on new patents to prolong a drug’s exclusivity, even when the additions aren’t fundamentally new, non-obvious, and useful as the law requires.¶ One of the most expensive cancer drugs on the market, Revlimid®, is a case in point: priced at over $125,000 per year of treatment, Celgene has sought 105 patents on Revlimid®, many of which have been granted, extending its monopoly until the end of 2036. That gives the Revlimid® patent portfolio a lifespan of 40 years, which is being used to block or deter generic competitors from entering the market.¶ But a recent I-MAK analysis finds that several of Celgene’s patents are mere add-ons—not fundamentally new to deserve a patent. And because of the thicket of patents around Revlimid®, payers are projected to spend $45 billion in excess costs on that drug alone as compared to what they could be paying if generic competitors were to enter when the first patent expires in 2019. Meanwhile, Celgene is also among the pharmaceuticals that have been recently scolded by the FDA for refusing to share samples with generic makers so they can test their own products against the brands in order to attain FDA approval.¶ In the absence of genuine competition in the U.S. prescription drug market, monopolies are yielding reckless pricing schemes and prohibitively expensive drugs for Americans (and people around the world) who need them. In 2015, for example, U.S. Senators Wyden and Grassley found after an 18-month bipartisan investigation that the notorious $84,000 price tag for the hepatitis C drug made by Gilead was based on “a pricing and marketing strategy designed to maximize revenue with little concern for access or affordability.”¶ Gilead’s subsequent hepatitis C drug Harvoni® was introduced to the market at a still higher cost of $94,500. Who benefits when drugs are priced so high? Not the 85 percent of Americans with hepatitis C who are still not able to afford treatment.¶ Few affordable solutions¶ “Since the early 2000s, very few new drugs or indications have provided a tangible advance for patients,” the French medical journal Prescrire wrote in 2014. This is the problem with drug pricing today. Plenty of top-dollar drugs armored in patents, but too few solutions for patients that are genuinely affordable and helpful.¶ Until our patent system is reformed, the pharmaceutical industry will continue to abuse it—denying real competition, blocking incentives for actual new drug discoveries and using clever marketing strategies around “new” products that do not improve health outcomes.¶ For a free and competitive market that will actually help America’s patients, what we really need is to restore fairness to the patent system in the U.S. It may be convenient to blame foreign countries or insurance companies or any number of culprits for our high drug prices, but until we look at the heart of the problem and stop deflecting, patients in the U.S. and around the world will continue to lack treatments they can access and afford.

#### Pharma companies misuse their profits from these high drug prices – Over 100% of their profits go to the shareholders – not innovation

Lazonick & Tulum 19 [William Lazonick and Öner Tulum, 2-26-2019, “How High Drug Prices inflate C.E.O.s’ Pay” The New York Times, Accessed 7-30-2021, <https://www.nytimes.com/2019/02/26/opinion/drug-pricing-senate-hearing.html> ww

Drug company executives faced tough questions from Congress on Tuesday as they attempted to explain why, thanks to high drug prices, per capita spending on pharmaceuticals in the United States is double the average of other advanced countries. For decades, American drug makers have justified these high prices by asserting that the higher profits they generate fund research that accelerates the development of new medicines. Our data shows, however, that these companies spend every penny of their profits on distributions to shareholders in the forms of cash dividends and stock buybacks.¶ Because the greater part of management compensation is linked to stock price, the prime beneficiaries of this abuse of corporate profits are the executives who claim that high drug prices redound to the common good. At the same time, drug giants such as Merck and Pfizer seem to have become focused more on buying companies with successful new drugs rather than developing their own.¶ Congress has been raising alarms over drug prices for years. In 1985, Representative Henry Waxman, a California Democrat who was chairman of the House health subcommittee, accused the pharmaceutical industry of “gouging the American public,” driven by “greed on a massive scale.” But the escalation of drug prices has only gotten worse, as documented in various Senate investigations.¶ Despite their claims, the big American drug companies have not been using profits from high prices to ramp up investment in drug development. Our research shows that for 2008 through 2017, 17 pharmaceutical companies in the S. & P. 500 distributed just over 100 percent of their combined profits to shareholders, $300 billion as buybacks and $290 billion as dividends. These distributions were 12 percent greater than what these companies spent on research and development.¶ With most of their compensation coming from exercising stock options and stock awards, senior executives benefit immensely. We gathered data on the 500 highest-paid executives in the United States from 2008 through 2017. The number who came from the drug industry ranged from 21 (in 2008 and 2011) to 42 (in 2014). The total compensation of those 42 executives averaged about $73 million, compared with an average of an already over-the-top $32 million for all 500 in 2014.¶ A total of 88 percent of the 2014 compensation was based on stock. In 2017, 28 drug executives in the top 500 averaged more than $41 million in total compensation, with 83 percent stock-based. By jacking up product prices and distributing the increased profits to shareholders, executives lift stock prices and their take-home pay.

#### Pharma companies use the market exclusivity from patents to hike up prices – drastically reducing access

Chaudhry 20 [Faisal Chaudhry, Professor of Law, University of Dayton, 1-28-2020, “A secret reason Rx drugs cost so much: A global web of patent laws protects Big Pharma” The Conversation, Accessed 8-2-2021, <https://theconversation.com/a-secret-reason-rx-drugs-cost-so-much-a-global-web-of-patent-laws-protects-big-pharma-122028> ww

The high price of insulin, which has reached as much as US$450 per month, has raised outrage across the country. Sen. Bernie Sanders (I-Vt.) has called it a national embarrassment, wondering why U.S. residents should have to drive to Canada to buy cheaper insulin.¶ As a legal scholar who focuses on the contradictory role of property rights on economic well-being, including through the role of intellectual property rights, my research makes it clear that drug pricing is far more complicated than any candidate on the debate stage has time to explain.¶ To fully understand these complexities requires looking at a web of international patent law and trade agreements.¶ Why no generic insulin?¶ Scientists working in Canada’s public sector discovered insulin nearly a century ago. The first techniques for synthesizing the compound, which should have more readily allowed for the production of generic versions, emerged some four decades ago. Yet today insulin remains unavailable in any significant generic version.¶ One of the three companies that control 90% of the world insulin market, Eli Lilly, recently did bow to public pressure by announcing a forthcoming “authorized generic” version called Lispro. But that could still run some people $140 per prescription.¶ U.S. consumers are not alone in facing high prices of insulin and other life-saving drugs. For the last two decades, intense controversy has raged around multinational pharmaceutical giants being able to monopolize access to vital medicines the world over. A key means of doing so is through the legal power of patents, and the monopoly-like profits – or what some experts call unearned economic rents – they guarantee.¶ Think of rent as a windfall gained for making little effort of one’s own. Being “unearned,” rents are thus usually distinguished from ordinary business profits. In this way, they are comparable to the fees a medieval lord would charge for access to cropland on a vast estate.¶ To fully explain the problem of economic rents and access to medicines, however, we need to look still further: to the controversies that have swirled around pharmaceutical patents in countries far less wealthy than the U.S.¶ A worldwide problem, but hidden from sight¶ For more than 20 years, in various parts of Africa, Asia and Latin America, countries have been battling a global system of rent-taking, or “rentierism” for short, that disproportionately benefits Big Pharma.¶ This state of affairs could not exist without the government officials whom Big Pharma has lobbied successfully in wealthy countries. Patents and other intellectual property rights allow the multinationals to capture rent by evading competition for years on end.¶ This global battle around pharmaceutical patents began in earnest with the founding of the World Trade Organization(WTO) in 1994. This included an annex agreement on intellectual property rights known as the Trade-Related Aspects of Intellectual Property Rights.¶ Many countries already allowed for patents before 1994, but only on “processes” of manufacture or synthesis. After 1994, WTO member countries were required to extend patents to the vital end products of such processes as well.¶ For inhabitants of developing countries, whose greatest public health problems at the time derived from diseases like malaria, tuberculosis and HIV-AIDS, this crystallized various questions of great import. Should the agreements enable Big Pharma’s monopoly-like patent rights to trump the ability of the sick and dying to obtain generic versions of life savings medicines? And if so, to what extent?¶ By 2001, all WTO member states officially had conceded the rights of developing countries to take measures to increase access to lifesaving medicines. But Big Pharma and its allies have never relented in pressing for more, not less, stringent intellectual property protections around the world.¶ Shaky justifications¶ Since 1994, Big Pharma has imposed ever more severe requirements around patent rights. They have insisted that patent rights are necessary to “incentivize” the availability of drugs for conditions like tuberculosis and malaria that, having no markets in the developed world, require guaranteed premiums from whatever countries they are sold in.¶ Yet for just as long, critics have alleged that Big Pharma typically uses inflated, misleading or otherwise opaque cost data to tout the billions of dollars it claims to spend on drug development. Likewise, critics have continuously called attention to the way that most drug development is built on publicly funded research.¶ And, finally, critics have never stopped highlighting the fact that Big Pharma long ago largely abandoned research and development for drugs for infectious ailments in developing nations, and increasingly switched to spending on blockbuster noninfectious disease drugs.¶ Yet as diseases such as cancer and heart disease begin to take an even greater toll in the developing world, patents will extract an ever greater toll on patient populations across the world.¶ In a developing world where public health problems increasingly look similar to the developed world’s, in fact, multinational pharmaceutical corporations could become better – not worse – placed to expand their profits by tapping new markets for drugs like insulin and beta blockers.¶ A convergence between the sick across the globe¶ One unexpected lesson from this is that ordinary people around the world will increasingly find themselves in the same boat when it comes to accessing the medicines they need.¶ Therefore, if countries in the developing world are forced to give up the fight against patent rentierism, it should be a concern both to their own residents and to residents of wealthy countries too.¶ Just this past September, for example, Indian Prime Minister Narendra Modi signaled that his country – which has a robust generic drugs industry that supplies low-cost medicines to people around the world – was ready to concede to the demands of Big Pharma by moving toward abdicating his country’s vital role as “the pharmacy of the world.” India has now signed an interim trade agreement with the Trump administration that will require it to more strictly enforce the patent rights of pharmaceutical multinationals, with the latest news reports indicating it may even now be finalized.¶ Over the course of the current battle for the Democratic nomination, many will have heard about the plight of residents of Michigan who are left asking how insulin costs 10 times in the U.S. what it costs 10 minutes away across our northern border.¶ Given the larger conversation about patent rents and access to medicines that we should be having, however, it behooves those of us who live in places like the U.S. to look not only to Canada but to what is happening around the world, where the sick and dying face increasingly similar ailments – and fights – as our own.

#### **Unequal access to Medicines exacerbates health inequalities, uneven death rates, lower earning, and higher rates of advanced stage illness prove**

Riley 12 (Wayne Riley; 2012; *“Health Disparities: Gaps in Access, Quality and Affordability of Medical Care”*; accessed 7/30/21; <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3540621/>; Wayne J Riley, MD, MPH, MBA is a distinguished physician executive currently serving as the President of the State University of New York (SUNY) Downstate Health Sciences University, Brooklyn, NY, USA where he holds tenured professorships in internal medicine, and health policy and management. He is an elected member of the US National Academy of Medicine, a Commissioner of the US Medicare Payment Advisory Commission, Chair of the Board of the New York Academy of Medicine, President of the Society of Medical Administrators – an organisation of leading North American physician executives, and a President Emeritus of the American College of Physicians.) HB

THE SIGNIFICANCE OF RACIAL AND ETHNIC DISPARITIES IN HEALTHCARE Racial and ethnic disparities in healthcare are important for a number of reasons. They pose significant moral and ethical dilemmas for the US healthcare system. As a nation, we have an abundance of healthcare facilities, cutting edge technologies, and pharmacotherapeutics and other assets that are the envy of the world, but which are not accessible for a myriad of reasons to all segments of the population. Also, healthcare as a resource is tied to various notions of social justice, opportunity, and quality of life for our patients, our communities, and the nation at large. A closely allied concern is the nation's economic well-being, which is both directly and indirectly tied to the health status of our population in general, and of specific population groups in particular. As a result, inadequate, inaccessible, and/or poor medical care further exacerbates increasing healthcare costs that have broad implications for the overall quality of care experienced by all Americans. Evidence garnered over the past 3 to 4 decades is compelling. Health and disease states are unevenly visited upon various population groups. A few examples are illustrative: infant mortality for black babies remains nearly 2.5 times higher than for white babies; the life expectancy for black men and women remains at nearly 1 decade fewer years of life compared with their white counterparts; diabetes rates are more than 30% higher among Native Americans and Latinos than among whites; rates of death attributable to heart disease, stroke, and prostate and breast cancers remain much higher in black populations, and minorities remain grossly under-represented in the health profession's workforce relative to their proportions in the population. HEALTH DISPARITIES DEFINED Health disparities are differences and/or gaps in the quality of health and healthcare across racial, ethnic, and socio-economic groups. It can also be understood as population-specific differences in the presence of disease, health outcomes, or access to healthcare. Another useful definition has been provided by the Institute of Medicine that suggests that health disparities are racial or ethnic differences in the quality of healthcare that are not due to access-related factors or clinical needs, preferences, and appropriateness of intervention. Despite the usefulness of these definitions, it is important to understand that health disparities are not just based on race, ethnic, and cultural differences within the population. Lifestyle choices, age, sexual orientation, lack of access, and personal, socio-economic, and environmental characteristics are also to be included. THE LANDMARK MALONE-HECKLER REPORT The emergence of greater awareness and focus on health disparities has its genesis in the 1985 landmark Report of the Secretary's Task Force on Black & Minority Health issued by then US Health and Human Services Secretary, Margaret M. Heckler (1). The poor health status, poor outcomes, and constricted access to medical care for more than 300 years, anecdotally well known by many African Americans, and in some cases by a small cohort of academicians and public health officials, gained greater awareness with the “Heckler Report.” The report objectively detailed the wide disparity in the excess burden of death and illness experienced by blacks and other minority Americans as compared with the nation's population as a whole. It also put forth that such disparities had been in existence for as long as federal health statistics were routinely collected. The report further emphasized the fact that six medical conditions between blacks and whites accounted for 86% of excess black mortality and the fact that close to 45% of deaths up to the age of 70 years (58,000 of 138,000) in the black population would have been avoidable if better evaluation, detection, and treatment had been available. The six conditions were: cancer (3.8%), heart disease and stroke (14.4%), diabetes (1.0%), infant mortality (26.9%), cirrhosis (4.9%), and homicide and accidents (35.1%). UNEQUAL TREATMENT: CONFRONTING RACIAL AND ETHNIC DISPARITIES IN HEALTHCARE Although generally well received, the impressive work and initial analysis detailed in the Heckler-Malone Report was not followed up until 2003 when the Institute of Medicine published its groundbreaking report “Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare” (2). This IOM analysis began with a simple approach to rigorously review the 600 or so articles published in the medical literature over the prior 3 decades that addressed racial and ethnic disparities in healthcare. As part of this analysis, there was a specific focus on the 100 highest-quality studies covering cancer, cerebrovascular disease, renal transplantation, HIV/AIDS, asthma, diabetes, analgesia, and cardiovascular care. The IOM analysis revealed even more objective evidence of major differences and raised the specter of the role of bias and discrimination with regard to populations with equal access to healthcare. Underscoring the resultant discrepant quality of care experienced by populations as manifested in the appropriateness of clinical care and patient preferences, and the often confusing and challenging nature of the healthcare system and its legal and regulatory environment, are the roles of bias, discrimination, and uncertainty. The IOM report contributed further to a more robust dialogue on health disparities by offering an integrated model of health disparities that places in context the complex and multifactorial etiology for disparate treatment decisions and outcomes (Figure 1). DISPARITIES IN CARDIOVASCULAR CARE Subsequent to the release of “Unequal Treatment,” there was understandable skepticism by many in the House of Medicine that such disparities existed at all—and that, in part, they could be caused by disparate treatment decisions based on ethnic, racial, and/or cultural differences. The American College of Cardiology and the Henry J. Kaiser Family Foundation jointly undertook an analysis of the cardiology services. After an extensive review (3) of 81 of 158 studies on the topic, they that affirmed that there was credible evidence that African Americans were less likely than whites to receive diagnostic and revascularization procedures and thrombolytic therapy even when patient characteristics were similar. Among the key studies included was the work of Whittle et al (4). In a retrospective study of cardiovascular procedures among black and white veterans, Whittle et al found that there was a clear discrepancy in cardiac catheterization rates, angioplasty, and coronary artery colon bypass grafting absent financial barriers: Blacks were less likely to undergo invasive cardiac procedures in the Veterans healthcare system. Another study by Schulman et al (5) also found racial and sex differences in recommendations for cardiac catherization, and Chen et al (6) showed similar differences in the utilization of catherization after acute myocardial infarction. DISPARITIES IN COST AND AFFORDABILITY A plethora of data further emphasizes a major contributor to the problem of health disparities: the cost and access to many Americans for obtaining the medical care they require. Clear disparities exist in rates of health insurance coverage among black and Latino population groups. The consequences of being uninsured are significant and include use of fewer preventive services, poorer health outcomes, higher mortality and disability rates, lower annual earnings because of sickness and disease, and the advanced stage of illness (i.e., many are “sicker” when diagnosed). Thus, the uninsured tend to be disproportionately poor, young, and from racial and/or ethnic minority groups. An analysis by the Joint Center for Political and Economic Studies and Johns Hopkins University explored the economic burden of health inequalities in the United States and revealed that there is a significant financial burden (7). The elimination of health inequalies for minorities would have reduced total costs by approximately $1.5 trillion over a 3-year period. THE CHALLENGES AHEAD In the 27 years since the release of the Heckler Report, significant strides have been made in addressing health disparities. The report served as a catalyst for the coordination of federal and state responses to address disparities and the establishment of the Office of Minority Health within the US Department of Health and Human Services. However, despite such progress, it is clear that much work remains to be done to fully address health inequities. As documented by Benz et al (8), overall awareness of ethnic and health disparities remains somewhat disappointing, particularly in racial and ethnic groups, about certain disease conditions such as HIV/AIDS. In addition, although medical education has made perceptible progress in what is commonly referred to as cultural competency training for students, trainees, and physicians in general, recent evidence emphasized by Haider et al (9) reveal worrisome implicit preferences for whites and upper-class patients in implicit association testing instruments. Furthermore, in the emerging era of health reform, cost-conscious care and pay-for-performance reimbursement schemes for hospitals and physicians, recent evidence by Jha et al (10) emphasizes the challenge in even more stark terms: Lower performing hospitals, as manifested by quality performance data and metrics, tend to treat higher percentages of minority patients and have higher overall costs. Failure to address these disparities will only serve to worsen pre-existing disparities in access, quality, and costs of medical care for the most our most vulnerable populations. Indeed, much work remains.

#### The plan is solves evergreening

Feldman 18 [Robin Feldman, December 2018, “May your drug price be evergreen” Journal of Law and the Biosciences, Volume 5, Issue 3, Pages 590–647, <https://doi.org/10.1093/jlb/lsy022> ww

V. SOLUTIONS¶ As described in the opening of this article, the intellectual property system in general and the patent system in particular are designed to provide an opportunity for innovators to garner a return. Competition may be held in abeyance for a limited time, but those who receive the benefit must pay for the privilege by disclosing sufficient information that competitors will be able to step in. This design reflects the deeply rooted notion that providing a period of exclusivity for inventors is intended to rebound to the benefit of society as a whole, not simply to the benefit of the inventors. The patent protection should end, returning the market to a competitive state.¶ This foundational structure of the patent system—one that delicately balances innovation and competition—is crumbling, whittled away across time as one good idea after another creates a special carve-out. Each carve-out, standing on its own, presents an appealing cause. Together, however, the result is a complete undermining of the system for pharmaceutical innovation as the repeated addition of protections, one after another, pushes competition further into the future, threatening innovation in the process. The behavior is not limited to a few bad apples. Our research reveals that it is endemic to the pharmaceutical industry.¶ In short, this is not an image of innovation and competitive entry. It is an image of a system that provides for repeated creation of competition-free zones, pushing a competitive market further and further out into the future. The problem is not only pervasive and persistent, but it is also growing across time.¶ The impact created by these repeated competition zones is not some abstract problem that our grandchildren may face. Rather, the nation's pharmaceutical system is in crisis today, with prices soaring to heights that distort both individual and government budgets.151 These dire circumstances bring calls for price controls, for government marching in to direct drug production, and for other strong measures.152 The US Government's history of directly managing pharmaceutical innovation, however, has been disappointing. In fact, prior to the Bayh-Dole Act of 1980, the federal government took responsibility for handing out licenses for innovation developed through government-funded research. Bayh-Dole shifted that responsibility from the federal government to universities, precisely because the government failed so miserably in this role. There is little reason to expect a different result this time.153¶ Competition is a powerful and effective tool, however, and paving the way for competition whenever it is possible remains the optimal approach. When the government itself bestows benefits that are stifling competition, society has both an obligation and an opportunity to act. One cannot, however, enter into such action lightly; it must be designed with thought and care. Pharmaceutical research and development are expensive, and companies must have sufficient incentive to travel down that risky road. Nevertheless, by incentivizing game-playing rather than innovation, society has clearly missed the mark.¶ V.A. One-and-done¶ This study offers a disappointing view of the state of pharmaceutical innovation, but this result is not inevitable. With sufficient political will—always a challenging task in the US landscape—our valued patent system can operate in the manner intended. The following section sketches out an approach that could roll back the repeated creation of competition-free zones documented in our research.¶ Specifically, one could implement of the principle of ‘one-and-done’ in which a drug would receive one period of exclusivity, and only one. The choice of which ‘one’ could be left entirely in the hands of the pharmaceutical company, with the election made at the moment of drug approval. Perhaps development and approval on the drug has gone swiftly and smoothly, so the remaining life of one of the drug's patent is of greatest value. Perhaps those processes languished through many setbacks, such that designation as an orphan drug or some other benefit would bring greater reward. The choice would be up to the company itself, based on its own calculation of the maximum benefit. The result, however, would be that a pharmaceutical company must choose whether its period of exclusivity should be a patent, or an orphan drug designation, or a period of data exclusivity for safety and efficacy data, or something else—just not all of the above and more.¶ Crafting the one-and-done implementation at the FDA level underscores the fact that these problems and solutions are designed for pharmaceuticals, not other types of technologies. Although there are similarities within the patent system for all inventions, given the drug approval processes—including the Hatch-Waxman system for approval of generic drugs and the Biosimilars pathway for approval of follow-on biologics—pharmaceuticals are different.¶ Much of one-and-done could be implemented through legislative changes to the FDA drug approval system, which would apply to patents granted going forward. Statutory amendments could specify that once a company elects a particular patent or exclusivity, competitors wishing to obtain approval of a generic version of the drug through the Hatch-Waxman system need only certify to that one exclusivity.¶ The election could be crafted so that it mandates relinquishment of any other patent or exclusivity claims as to the generic drug being approved. This approach would be somewhat analogous to an election that currently exists under the current Hatch-Waxman Act. When a generic applicant makes a Paragraph IV certification claiming that the brand-name company's patents are invalid or do not apply to the drug, the brand-name company has a period of time to challenge that certification in court. If the brand-name company fails to challenge the assertion, it relinquishes various rights, particularly, the right to an automatic 30-month stay of the generic's approval. Without the 30-month stay, the brand would have to prove likelihood of success on the merits and other preliminary injunction factors to keep the generic off the market during the period of the litigation.154 Similarly, in the proposed system, the company's choice to designate a particular form of exclusivity upon approval could serve to relinquish its right to challenge the generic under any other exclusivity.¶ The compromise embodied in the original Hatch-Waxman system could provide a model for crafting the one-and-done system. Specifically, the Hatch-Waxman legislation included both the expedited system for generic approval and an expansion of the patent term to reflect delays in the federal approval system. Similarly, in implementing a one-and-done system, Congress could choose to expand the periods of the current exclusivities available, in recognition that pharmaceutical companies will no longer be able to tack so many periods of protection on to each other. One could argue that the current effects of the patent and exclusivities were never what Congress intended. Nevertheless, it may be politically expedient to follow the path blazed by Hatch-Waxman. In a similar vein, Congress could choose to standardize the periods of protection offered by various exclusivities, which currently range from 6 months to 7 years. As described in the section below on simplification, the complexity of these various systems provides opportunities for game-playing. Standardization may reduce those opportunities.¶ Some commentators may be tempted to claim that any relinquishment of patent or exclusivity rights constitutes a taking of private property. In particular, one scholar, Adam Mossoff, has asserted that patent rights are constitutionally protected property, and as such, would be subject to the Fifth Amendment Takings Clause.155 Even Mossoff, however, acknowledges that ‘modern courts and scholars … seem to agree in a rare case of unanimity that the historic record reflects no instance of a federal court holding that the Takings Clause applies to patents’.156¶ In a 2018 case upholding the inter partes review system at the Patent and Trademark Office, the Supreme Court specifically avoided ruling on the question of whether patents are property for the purpose of the Takings Clause.157 In paragraph that begins by noting, ‘[w]e emphasize the narrowness of our holding’ and presents a litany of what the decision does not address, the court cryptically concludes by noting that ‘our decision should not be misconstrued as suggesting that patents are not property for purposes of the Due Process Clause or the Takings Clause’. The Justices then cite two cases related to sovereign immunity and whether the state can be sued for using a patented item without paying for it.158 In contrast, the two dissenting Justices use language that would move the status of patents much closer into the realm of traditional property rights. This suggests that whether, and the extent to which, patents are treated as property for Constitutional purposes is likely to arise in future Supreme Court cases.¶ The notion of patents as full property rights—akin to the type of core property rights protected by the Constitution—would require ignoring significant aspects of patent history and theory. Patent rights are theoretically, doctrinally, and practically distinct from real property, making the notion of an absolute right to exclude particularly inapplicable159. More important, unlike real property, patent rights are granted by the government for limited times and for limited purposes, namely promoting the progress of the useful arts160 for the benefit of society. The utilitarian roots of their theory and design bear little resemblance to natural rights theories of the types of property protected by the Constitution.¶ One particularly cogent modern description of the issue appears in a dissent to the 2015 Supreme Court decision in the Teva case, in which the dissenters reviewed the history of patent rights in contrast to core property rights.¶ The Anglo-American legal tradition has long distinguished between ‘core’ private rights—including the traditional property rights represented by deeds—and other types of rights. These other rights [include] ‘privileges’or’franchises,’ ‘which public authorities have created purely for reasons of public policy and which ha[ve] no counterpart in the Lockean state of nature. Notwithstanding a movement to recognize a core property right in inventions, the English common law placed patents squarely in the final category as franchises.161¶ As the text of the dissent also explained, our own ‘Framers adopted a similar scheme’.162¶ In short, patents are not core property rights, and attempting to characterize them as such threatens the reverence that the nation has traditionally held for core property rights. Although concerns may play out in the context of due process, the notion that the Takings Clause would prevent Congress from shortening the length of time or the interaction among various patent rights163 would be misguided, at best.¶

#### Spec is in the doc, please ask for further spec in cx, I will meet reasonable interps – we should avoid a theory or topicality debate.

#### 1] Reduce means to diminish in size

Michigan District Court 11 “SAGINAW OFFICE SERVICE, INC., Plaintiff, v. BANK OF AMERICA, N.A., Defendant. Civil Action No. 09-CV-13889 UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF MICHIGAN, SOUTHERN DIVISION,” Lexis

In determining whether the words "reduce" and "adjust" are ambiguous, the Court is directed to consider the ordinary meanings of the words, Rory, 703 N.W.2d at 28, and to harmonize [\*11] the disputed terms with other parts of the contract, Royal, 706 N.W.2d at 432 ("construction should be avoided that would render any part of the contract surplusage or nugatory"). "When determining the common, ordinary meaning of a word or phrase, consulting a dictionary is appropriate." Stanton v. City of Battle Creek, 466 Mich. 611, 647 N.W.2d 508 (Mich. 2002). The Court finds that the plain meanings of these terms do not unambiguously support the Bank's position. The dictionary definition of "adjust" is to "adapt" or "to bring to a more satisfactory state." Webster's Third New Int'l Dictionary 27 (2002) ("Webster's"). This is a fairly broad definition, which may be subject to, alternatively, narrower or more expansive scope. To say that the complete elimination of a schedule brings it to a more satisfactory state is undoubtedly an expansive viewof adjustment. It is the Court's duty to determine the intent of the contracting parties from the language of the contract itself, Rory, 703 N.W.2d at 30 ("the intent of the contracting parties is best discerned by the language actually used in the contract"), and in this case, it cannot unambiguously be said that the sense in which the parties used these [\*12] terms embraces the Bank's more expansive definition. Likewise, "reduce" means "to diminish in size, amount, extent, or number," Webster's, at 1905, but the term does not, in the context of the TSA, unambiguously embody an expansive scope that views complete deletion as a subset of diminution.

#### Intellectual property protections of medicines refers to Patents, copy rights, and trademarks over substances used in treating disease.

#### 2] Intellectual property Protections refers to patents, copy rights, and trademarks

WIPO ND[World Intelectual Property Organization, ND, “What is Intellectual Property?” Accessed 6-26-2021, <https://www.wipo.int/about-ip/en/> ww

Intellectual property (IP) refers to creations of the mind, such as inventions; literary and artistic works; designs; and symbols, names and images used in commerce.¶ IP is protected in law by, for example, patents, copyright and trademarks, which enable people to earn recognition or financial benefit from what they invent or create. By striking the right balance between the interests of innovators and the wider public interest, the IP system aims to foster an environment in which creativity and innovation can flourish.

#### 3] Medicine refers to a substance used in the treatment of disease

Merriam Webster ND [“Medicine.” Merriam-Webster.com Dictionary, Merriam-Webster, Accessed 27 Jun. 2021 [https://www.merriam-webster.com/dictionary/medicine.](https://www.merriam-webster.com/dictionary/medicine.%20)  Ww

Definition of medicine¶ 1a : a substance or preparation used in treating disease cough medicine¶ b : something that affects well-being he's bad medicine— Zane Grey¶ 2a : the science and art dealing with the maintenance of health and the prevention, alleviation, or cure of disease She's interested in a career in medicine.¶ b : the branch of medicine concerned with the nonsurgical treatment of disease¶ 3 : a substance (such as a drug or potion) used to treat something other than disease